



WORLD HEALTH ORGANIZATION

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# **EXECUTIVE BOARD**

**117TH SESSION**

**GENEVA, 23-27 JANUARY 2006**

**SUMMARY RECORDS**

GENEVA  
2006

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

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

## **PREFACE**

The 117th session of the Executive Board was held at WHO headquarters, Geneva, from 23 to 27 January 2006. 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 EB117/2006/REC/1.

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<sup>1</sup> As adopted by the Board at its first meeting (23 January 2006).

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| EB117/1 Rev.1      | Agenda <sup>1</sup>   |
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| EB117/2            | Report by the Director-General to the Executive Board at its 117th session  |
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| EB117/4            | Eradication of poliomyelitis  |
| EB117/4 Add.1      | Report on administrative and financial implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>3</sup> |
| EB117/5            | Strengthening pandemic-influenza preparedness and response  |
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| EB117/15                                    | eHealth: proposed tools and services   |
| EB117/16                                    | Eleventh General Programme of Work, 2006-2015  |
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| EB117/21 Add.1 and<br>EB117/21 Add.1 Corr.1 | Human resources: annual report   |
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<sup>1</sup> See document EB117/2006/REC/1, Annex 4.

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| EB117/23                             | Confirmation of amendments to the Staff Rules <sup>1</sup>  |
| EB117/23 Add.1 and<br>EB117/23 Add.2 | Report on administrative and financial implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>2</sup>           |
| EB117/24                             | Relations with nongovernmental organizations. Report of the Standing Committee on Nongovernmental Organizations <sup>3</sup>  |
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<sup>1</sup> See document EB117/2006/REC/1, Annex 1.

<sup>2</sup> See document EB117/2006/REC/1, Annex 4.

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| EB117/35       | Prevention of avoidable blindness and visual impairment   |
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**Information documents**

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| EB117/INF.DOC./1 | Statement by the representative of the WHO staff associations   |
| EB117/INF.DOC./2 | Health-related Millennium Development Goals. Development of a strategy for strengthening health systems |
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<sup>1</sup> See document EB117/2006/REC/1, Annex 4.

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**UNITED STATES OF AMERICA**

Dr W.R. STEIGER, Special Assistant to the Secretary for International Affairs, Office of the Secretary, Department of Health and Human Services, Washington, DC  
Ms M.L. VALDEZ, Deputy Director for Policy, Office of Global Health Affairs, Office of the Secretary, Department of Health and Human Services, Washington, DC  
Mr M. ABDOO, International Health Officer, Office of Global Health Affairs, Office of the Secretary, Department of Health and Human Services, Washington, DC  
Ms A. BLACKWOOD, Director for Health Programs, Office of Technical and Specialized Agencies, Bureau of International Organization Affairs, Department of State, Washington, DC  
Ms D. GIBB, Senior Technical Adviser, Bureau for Global Health, United States Agency for International Development, Washington, DC  
Mr D.E. HOHMAN, Health Attaché, Permanent Mission, Geneva  
Ms K. KRUGLIKOVA, International Resource Management Officer, Permanent Mission, Geneva  
Mr J. SANTAMAURO, Intellectual Property Attaché, Office of the United States Trade Representative, Permanent Mission, Geneva

**UZBEKISTAN**

Mr B. OBIDOV, Chargé d'Affaires, a.i., Permanent Mission, Geneva

**VENEZUELA (BOLIVARIAN REPUBLIC OF)**

Sra. R. POITEVIEN CABRAL, Embajadora, Encargada de Negocios a.i., Representante Permanente Adjunta, Ginebra  
Sr. E. BITETTO GAVILANES, Primer Secretario, Misión Permanente, Ginebra

**ZAMBIA**

Mr A. ZULU, First Secretary, Permanent Mission, Geneva



**ZIMBABWE**

Mrs P. NYAGURA, Counsellor, Permanent Mission, Geneva

**OBSERVERS FOR A NON-MEMBER STATE****HOLY SEE**

Mgr S.M. TOMASI, Nonce Apostolique, Observateur permanent, Genève

Mgr J.-M. MPENDAWATU, Conseil pontifical pour la Pastorale des Services de la Santé,

Dr G. RIZZARDINI, Expert

**OBSERVERS****INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES**

Mr R. MISTER, Coordinator, Inter-Agency Cooperation

Mr B. GARDINER, Manager, HIV/AIDS Unit, Health and Care Department

Ms J. MULLER, International Representation Officer

**REPRESENTATIVES OF THE UNITED NATIONS  
AND RELATED ORGANIZATIONS****United Nations**

Dr D. NABARRO, Senior United Nations  
System Coordinator for Avian and Human  
Influenza

Ms L. OLDRING, Human Rights Officer,  
Office of the United Nations High  
Commissioner for Human Rights, Geneva

Mr E. FONTAINE, Inspector, Joint Inspection  
Unit of the United Nations System, Geneva

**United Nations Children's Fund**

Dr S. KUMAR, Regional adviser for CEE/CIS,  
UNICEF Office, Geneva

**United Nations Environment Programme**

Ms A. SUNDEN-BYLEHN, Senior Scientific  
Officer, UNEP Chemicals, Geneva

**United Nations Human Settlements  
Programme (UN-HABITAT)**

Mr A. ABBAS, Acting Director,  
UN-HABITAT Geneva Office

**United Nations Population Fund**

Ms S. HAMID, External Relations Officer

Mr V. FAUVEAU, Senior Maternal Health  
Adviser, UNFPA Office in Geneva

Mr E. PALSTRA, Officer-in-Charge, UNFPA  
Office in Geneva

Ms K. NILSEN, External Relations Officer,  
UNFPA Office in Geneva

**United Nations Relief and Works Agency  
for Palestine Refugees in the Near East**

Dr H. MADI, Acting Director of Health

Mr M. BURCHARD, Chief, UNRWA Liaison  
Office, Geneva

**Office of the United Nations High Commissioner for Refugees**

Ms C. LINNÉR, Head, Inter-Organization Desk, Secretariat and Inter-Organization Service

Mr M. LOFTUS, Adviser, Inter-Organization Desk, Secretariat

**UNAIDS**

Dr P. PIOT, Executive Director

Mr M. SIDIBE, Director, Country and Regional Support

Ms P. MANE, Director, Policy, Evidence and Partnerships

Ms S. MEHTA, Deputy Director, Country and Regional Support

Mr E. MURPHY, Associate Director, Governance, Donor and United Nations System Relations

Mr E. HAARMAN, Chief, Finance and Administration

Ms J. GIRARD, Chief, Human Resources Management

Mr J. FLEET, Senior Adviser, Care and Public Policy

Mr G. TEMBO, Team Leader, United Nations Action at Regional and Country Level

Ms S. SMITH, Adviser, Civil Society Partnership

Mr B. N'DAW, Adviser, Care and Public Policy

Mr J. TYSZKO, External Relations Officer, Governance, Donor and United Nations System Relations

**International Narcotics Control Board**

Professor H. GHODSE, President

Mr K. KOUAME, Secretary of the Board

**SPECIALIZED AGENCIES AND RELATED ORGANIZATIONS****Food and Agriculture Organization of the United Nations**

Mr T. MASUKU, Director, FAO Liaison Office with the United Nations in Geneva

Mr P. PAREDES PORTELLA, Liaison Officer, FAO Liaison Office with the United Nations in Geneva

Mr J. SLINGENBERGH, Senior Officer, Animal Health Service, Animal Production and Health Division, Agriculture, Biodiversity, Nutrition and Consumer Protection Department

**World Bank**

Mr J. INGRAM, Special Representative to the United Nations and the World Trade Organization, World Bank Office in Geneva

Mr P. REICHENMILLER, Policy Officer, World Bank Office in Geneva

**World Meteorological Organization**

Mr C. WANG, Senior External Relations Officer

**World Intellectual Property Organization**

M. C. MAZAL CASELLA, Conseiller principal, Section des relations interinstitutions

Mme K.L. RATA, Conseillère principale, Relations extérieures et coopération avec certains pays d'Europe et d'Asie

M. A. TAUBMAN, Directeur par intérim et Chef, Division des savoirs traditionnels, PCT et brevets, Centre d'arbitrage et de médiation et questions mondiales de propriété intellectuelle

**United Nations Industrial Development Organization**

Mr V. HINOJOSA-BARRAGAN, Senior Liaison Officer, UNIDO Office at Geneva

**International Atomic Energy Agency**

Ms M.L. DAVIDSSON, Head, Nutrition Section, Division of Human Health

**World Trade Organization**

Mme J. WATAL, Conseillère, Division de la  
propriété intellectuelle  
Mme WU Xiaoping, Juriste, Division de la  
propriété intellectuelle

M. W. MEIER-EWERT, Juriste, Division de la  
propriété intellectuelle  
Mme L.A. JACKSON, Economiste, Division  
de l'agriculture et des produits de base

### **REPRESENTATIVES OF OTHER INTERGOVERNMENTAL ORGANIZATIONS**

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M. S. ALFARARGI, Ambassadeur,  
Observateur permanent, Genève  
Dr O. EL HAJJE, Délégation permanente,  
Genève

Mr T. BÉCHET, Minister Counsellor, Head of  
United Nations Section, Permanent  
Delegation, Geneva  
Dr M. RAJALA, Minister Counsellor,  
Permanent Delegation, Geneva  
Mr N. FAHY, Deputy Head of Unit,  
Directorate General for Health and  
Consumer Protection  
Mr B. SLOCOCK, First Secretary, Permanent  
Delegation, Geneva

**Office International des Epizooties**

Dr W. DROPPERS, Chargé de Mission

**African Union**

Mr S. PALAYATHAN, Chargé d'Affaires a.i.,  
Permanent Delegation, Geneva  
Dr T. BISIKA, Head, Division of Health,  
Nutrition and Population

**International Organization for Migration**

Dr D. GRONDIN, Director, Migration Health  
Services

**Commonwealth Secretariat**

Dr D. DE SILVA, Adviser and Head of Health  
Section, Social Transformation  
Programmes Division

**Organization of the Islamic Conference**

Mr A.V. MOJTABA, Deputy Permanent  
Observer, Geneva  
Mr M.A. JERRARI, Minister Counsellor,  
Permanent Observer Mission, Geneva

**European Commission**

Mr C. TROJAN, Ambassador, Permanent  
Representative, Geneva

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

**African Medical and Research Foundation**

Dr H. JEENE

Dr M. KURIAN  
Ms A. LINDSAY  
Ms A. MOROT  
Ms A. STÜCKELBERGER  
Ms G. UPHAM

**CMC - Churches' Action for Health**

Ms A. BEUTLER  
Dr G. JOURDAN

**Christoffel-Blindenmission**

Mr C. GARMS

**Commonwealth Association for Mental Handicap and Developmental Disabilities**

Dr G. SUPRAMANIAM

**Consumers International**

Mr J. ARKINSTALL

Ms E. 'T HOEN

Ms C. DANIELS

Ms A. ALLAIN

Ms N. EL RASSI

Dr L. LHOTSKA

Ms A. LINNECAR

Mr J. LOVE

Dr T. BALASUBRAMANIAM

Ms N. DENTICO

Dr T. HUBBARD

Ms S. SHASHIKANT

**Corporate Accountability International**

Ms L. WYKLE-ROSENBERG

**Council for International Organizations of Medical Sciences**

Dr J.E. IDÄNPÄÄN-HEIKKILÄ

Dr J. VENULET

Mr S. FLUSS

**Council on Health Research for Development**

Professor C. IJSSELMUIDEN

Ms S. DE HAAN

Mr M. DEVLIN

**European Centre for Ecotoxicology and Toxicology of Chemicals**

Dr M. GRIBBLE

**FDI World Dental Federation**

Dr J.T. BARNARD

Dr H. BENZIAN

Dr M. AERDEN

Professor M. HOBDELL

**Global Forum for Health Research**

Professor S.A. MATLIN

Dr A. DE FRANCISCO

Ms M.A. BURKE

Dr A. GHAFAR

Ms S. JUPP

Mr J.-J. MONOT

Ms S. OLIFSON

Ms L. SUNDARAM

**Inter-African Committee on Traditional Practices affecting the Health of Women and Children**

Mrs B. RAS-WORK

Mrs J. KOCH

**International Agency for the Prevention of Blindness**

Prince ABDULAZIZ BIN AHMAD BIN  
ABDULAZIZ AL SAUD

Dr F. AL DOSARI

Dr M. ALAMUDDIN

Dr A. AL RAJHI

Dr H. RAFAT

Dr G.N. RAO

Mr R. PORTER

Mr A. HOSHAN

**International Alliance of Women**

Ms H. SACKSTEIN

Mrs M. PAL

**International Association for Maternal and Neonatal Health**

Dr R. KULIER

**International Association for the Study of Obesity**

Professor P. JAMES

Ms K. BAILLIE

Mr N. RIGBY

**International Catholic Committee of Nurses and Medico-social Assistants**

Mrs D. ROSIER

**International College of Surgeons**

Professor P. HAHNLOSER  
 Professor N.S. HAKIM  
 Dr R. DIETER  
 Mr M. DOWNHAM

**International Confederation of Midwives**

Ms K. HERSCHDERFER  
 Ms R. BRAUEN  
 Ms J. BONNET

**International Council of Nurses**

Dr J.A. OULTON  
 Dr T. GHEBREHIWET  
 Mr D.C. BENTON

**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**

Ms J. KAMMEYER

**International Federation of Pharmaceutical Manufacturers and Associations**

Dr H.E. BALE, Jr  
 Dr E. NOEHRENBURG  
 Ms O. MORIN  
 Dr R. KRAUSE  
 Mr T. SANO  
 Ms C. RAMIREZ  
 Ms S. CROWLEY  
 Dr R. HYER  
 Mr J. PENDER  
 Mr R. BURDEN  
 Mr M. OJANEN

Mr A. AUMONIER  
 Mr P. HEDGER  
 Mr G. SAMUELS  
 Mr C. BURCKY  
 Mr B. AZAIS

**International Federation of Surgical Colleges**

Professor S.W.A. GUNN  
 Professor P. MCLEAN

**International Hospital Federation**

Professor P.-G. SVENSSON  
 Dr R. MASIRONI

**International Lactation Consultant Association**

Ms M. LEHNERS-ARENDT

**International Organization for Standardization**

Mr T.J. HANCOX

**International Pediatric Association**

Dr J. SCHALLER

**International Pharmaceutical Federation**

Mr T. HOEK  
 Mr XUAN HAO CHAN  
 Ms T. WULIJ

**International Pharmaceutical Students' Federation**

Ms K. HAKKARAINEN  
 Ms G. GÁL  
 Ms Y. GOCHO  
 Ms Y. SALAH KORAIEM  
 Mr J. MÖNKÄRE  
 Mr M. NADER

**International Planned Parenthood Federation**

Dr K. ASIF

**International Special Dietary Foods Industries**

Dr A. BRONNER  
Dr E. FARMAKALIDIS  
Mr H. SCHOLICK  
Mr M. MIRANDA  
Mr THIEN LUONG VAN MY  
Ms C. DROTZ  
Ms J. KEITH  
Mr D. HAWKINS  
Ms A. JUNG  
Mr M. DE SKOWRONSKI  
Ms S. WALKER  
Ms S. ALLONCLE  
Ms H. MOUCHLY-WEISS  
Mr P.C. BURCKY

**International Union of Architects**

Mr L. WESSELS

**OXFAM**

Mrs P. SAUNDERS  
Mr T. HUBBARD  
Sir JOHN SULSTON

**Rotary International**

Mr G. COUTAU  
Mr R. HÖRNDLER

**Soroptimist International**

Ms I.S. NORDBACK

**The International Association of Lions Clubs (Lions Club International)**

Mr C. KUSIAK  
Mr G.E. CANTAFIO

**The Network: TUFH**

Dr G. MAJOOR  
Dr P. KEKKI

**The Royal Commonwealth Society for the Blind (Sight Savers International)**

Mr R. PORTER

**The Save the Children Fund**

Ms R. KEITH  
Mr E. EMRU  
Ms C. D'ALESSANDRO  
Mr G. NAIR

**World Association of Girl Guides and Girl Scouts**

Ms J. VERKOOIJEN  
Ms S. LAKE  
Ms A. KAHANPÄÄ

**World Association of Societies of Pathology and Laboratory Medicine**

Dr U. MERTEN  
Dr R. BACCHUS

**World Federation for Medical Education**

Dr H. KARLE  
Professor L. CHRISTENSEN

**World Federation for Mental Health**

Mrs M. LACHENAL  
Dr S. FLACHE

**World Federation of Chiropractic**

Mr D. CHAPMAN-SMITH

**World Federation of Hydrotherapy and Climatotherapy**

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

**World Federation of Public Health Associations**

Professor T. ABELIN  
Mrs J. BELL DAVENPORT

**World Heart Federation**

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

**World Medical Association**

Dr K. LETLAPE  
Dr Y. BLACHAR  
Dr O. KLOIBER

**World Organization of the Scout Movement**

Mr R. GARCIA SANTOS  
Ms C. TAVARAYUTH

**World Self-Medication Industry**

Dr D. WEBBER  
Mrs S. STAMATIADIS

**World Vision International**

Mr T. GETMAN

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

### 1. Programme, Budget and Administration Committee

Ms J. Halton (Australia), Dr N.A. Haffadh (Bahrain), Dr J. Singay (Bhutan), Mr I. Shugart (Canada), Professor D. Houssin (France), Dr A.M. Ali Mohammed Salih (Iraq), Dr J. Junor (Jamaica), Dr M. Phooko (Lesotho), Dr D. Hansen-Koenig (Luxembourg, member ex officio), Mr M.N. Khan (Pakistan, member ex officio), Professor J. Pereira Miguel (Portugal), Dr J.D. Ntawukuliryayo (Rwanda), Dr Suwit Wibulpolprasert (Thailand), Dr V. Tangi (Tonga).

**Third meeting, 18-20 January 2006:** Ms J. Halton (Australia, Chairman), Dr S.A. Khalfan (Bahrain, alternate to Dr N.A. Haffadh), Dr J. Singay (Bhutan), Mr D. MacPhee (Canada, alternate to Mr I. Shugart), Mr G. Delvallée (France, alternate to Professor D. Houssin), Dr S.N. Mahmood (Iraq, alternate to Dr A.M. Ali Mohammed Salih), Dr B. Wint (Jamaica, alternate to Dr J. Junor), Mr T. Ramatsoari (Lesotho, alternate to Dr M. Phooko), Dr D. Hansen-Koenig (Luxembourg, member ex officio), Professor J. Pereira Miguel (Portugal), Dr Viroj Tangcharoensathien (Thailand, alternate to Dr Suwit Wibulpolprasert), Dr V. Tangi (Tonga).

### 2. Standing Committee on Nongovernmental Organizations

Mr O.K. Shiraliyev (Azerbaijan), Dr J. Andrade Gaibor (Ecuador), Dr H.N. Acharya (Nepal), Dr T. Botros Shokai (Sudan), Mrs Le Thi Thu Ha (Viet Nam).

**Meeting of 24 January 2006:** Mr O.K. Shiraliyev (Azerbaijan), Dr J. Andrade Gaibor (Ecuador), Dr H.N. Acharya (Nepal), Dr I.E.M. Abdulla (Sudan, alternate to Dr T. Botros Shokai), Mrs Le Thi Thu Ha (Viet Nam).

### 3. 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 25 January 2006:** Mr M.N. Khan (Pakistan, Chairman), Professor K. Kiikuni (representative of the founder), Dr V. Tangi (Tonga).

### 4. 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 26 January 2006:** Mr M.N. Khan (Pakistan, Chairman), Dr S.A. Khalfan (Bahrain, alternate to Dr N.A. Haffadh), Mr N.K. Al Budoor and Mr A.H. Al Humood (representatives of the founder).

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



**5. 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 26 January 2006:** Mr M.N. Khan (Pakistan, Chairman), Dr A. Al-Saif (representative of the founder), Dr S.A. Khalfan (Bahrain, alternate to Dr N.A. Haffadh).

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## SUMMARY RECORDS

### FIRST MEETING

**Monday, 23 January 2006, at 09:40**

**Chairman:** Mr M.N. KHAN (Pakistan)

**1. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA:** Item 1 of the Provisional agenda (Documents EB117/1 and EB117/1(annotated))

The CHAIRMAN declared open the 117th session of the Executive Board and welcomed all participants.

He recalled the decisions reached at a consultation between the Secretariat and the Officers of the Board, set out in document EB117/1(annotated). He also proposed that item 6.3 of the provisional agenda should be deleted as there was no proposed amendment to the Financial Regulations and Financial Rules.

Dr BUSS (Brazil) pointed out that provisional agenda items 4.3, International trade and health: draft resolution, and 4.10, Intellectual property rights, innovation and public health, were closely related, and proposed that item 4.10 should be considered immediately after item 4.3.

Mr GUNNARSSON (Iceland), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, expressed disappointment with the Secretariat's proposal<sup>1</sup> to defer consideration of the draft global strategy on prevention and control of sexually transmitted infections (provisional agenda item 4.6) to the 118th session of the Board. The deferral would entail a further delay of 12 months, because approval by the Health Assembly could not be given until 2007. As he understood that the deferral was mainly due to delays in translation of the draft strategy, he suggested that, once all the documents were available, the Board should review the draft strategy by electronic means following the current session, so that it could be considered at the Health Assembly in May 2006.

He further proposed that item 9.5 of the provisional agenda, Health promotion: follow-up to the 6th Global Conference on Health Promotion should be considered as a technical and health matter, preferably after item 4.11, Health-related Millennium Development Goals. In addition to the Conference, WHO initiatives on health promotion in 2005 had included the publication of a report on Preventing chronic diseases.<sup>2</sup> Given that noncommunicable diseases accounted for some 60% of the global disease burden and also given the direction of the Eleventh General Programme of Work, it was therefore appropriate for the Board to discuss those aspects of public health and to transmit its conclusions, together with any draft resolution formulated, to the forthcoming Health Assembly.

Dr NYIKAL (Kenya) said that Kenya wished to submit a draft resolution under item 4.10, Intellectual property rights, innovation and public health. He supported the proposal made by the previous speaker in relation to item 9.5, as a more in-depth consideration of health promotion was needed.

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<sup>1</sup> See document EB117/8 Rev.1.

<sup>2</sup> *Preventing chronic diseases: a vital investment: WHO global report*. Geneva, World Health Organization, 2005.

Dr ANTEZANA ARANÍBAR (Bolivia) supported the proposal by the member for Brazil. Other subjects under item 4 were interrelated, for example those concerning disease control, and might also be considered jointly.

Professor PEREIRA MIGUEL (Portugal) supported the proposals made by the member for Iceland.

Dr SUWIT WIBULPOLPRASERT (Thailand) proposed that, in view of the concerns raised at the Board's last session in relation to the draft resolution on international trade and health (item 4.3),<sup>1</sup> informal consultations should be held after the meeting to consider outstanding issues and the proposal by the member for Brazil. He welcomed the submission of a draft resolution under item 4.10, as proposed by the member for Kenya. He supported the proposal made by the member for Iceland in relation to item 9.5 and would welcome a draft resolution on follow-up to the 6th Global Conference on Health Promotion.

Dr RAHANTANIRINA (alternate to Dr Jean Louis, Madagascar) said that the African group of countries would be submitting a draft resolution for consideration under item 4.8, Sickle-cell anaemia.

Mr AITKEN (Director, Office of the Director-General) said that there were no procedural difficulties with the submission of resolutions and the proposal made by the member for Iceland on health promotion. It would be possible logistically to combine consideration of item 4.10 with that of item 4.3, but it might be preferable to consider during informal consultations how best to schedule the discussion. He confirmed that the problems encountered in relation to the draft global strategy on sexually transmitted infections were logistic rather than substantive and that the procedure proposed by the member for Iceland for revising the draft by electronic consultations would be possible and would enable consideration of the draft strategy at the Health Assembly in May 2006.

**Subject to the outcome of informal consultations in relation to agenda items 4.3 and 4.10, the agenda, as amended, was adopted.<sup>2</sup>**

Referring to the preliminary timetable, the CHAIRMAN proposed that item 9.4, Report of the Advisory Committee on Health Research should be discussed immediately following consideration of item 4.12, WHO's role and responsibilities in health research, to take advantage of the presence of the Chairman of the Advisory Committee.

**It was so agreed.**

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the Member States of the European Union, said that the European Community and its Member States worked closely with WHO on a wide range of subjects within the European Region and at a global level. As agreed in the exchange of letters of 2000 between WHO and the Community on the consolidation and intensification of cooperation, and without prejudice to any future conclusion of a general agreement between WHO and the European Community, the European Commission attended the sessions of the Board as an observer. However, under Rule 4 of the Board's Rules of Procedure, such representatives were not automatically invited to participate in the work of subcommittees or other subdivisions of the Board, such as drafting groups and working groups. That had given rise to unfortunate situations in the past in which the Commission's representative had been asked to leave certain drafting groups, meaning that the Commission had been unable to contribute to the discussions concerned. To avoid a

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<sup>1</sup> Document EB116/2005/REC/1, summary records of the second and third meetings.

<sup>2</sup> See page ix.

recurrence of such difficulties, he proposed that the European Commission should be invited to participate without vote in the deliberations of the subcommittees or other subdivisions of the Board that addressed matters falling within Community's competence, namely matters relating to technical agenda items 4.1 to 4.13, in particular items 4.3 and 4.10. The request related only to the 117th session of the Board.

Dr ANTEZANA ARANÍBAR (Bolivia) supported the request, which reflected the clear interest by the European Community in intensified cooperation with WHO and countries less fortunate than the Member States of the European Union. Its participation would enable the Community to contribute more effectively to discussions on matters of global concern rather than interfere in the Board's work.

Ms HALTON (Australia) said that Australia had always been prepared to consider requests for enhanced participation by the European Commission, on a case-by-case basis and in line with the Rules of Procedure and the distribution of competencies between the European Community and the Member States of the European Union. She was prepared to consider the current request on the following conditions: provision of a clear statement of competencies by the Presidency of the European Union with the support of all its Member States; agreement that the European Commission and the European Union Member States (including the Presidency) would not seek to intervene in discussions on the same subject matter; and the expectation that the status of the European Commission at meetings of the Board's subcommittees and other subdivisions should not subsequently be relied upon in any way to strengthen the Commission's claims for additional participation rights in other international forums.

Mr HOHMAN (United States of America)<sup>1</sup> endorsed that position. On the understanding that the specific areas of exclusive competency for the European Commission at the current Board session were agenda items 4.3 and 4.10, he supported its participation in the deliberations of the subcommittees and other subdivisions of the Board at its 117th session.

Professor PEREIRA MIGUEL (Portugal) said that the conditions proposed by the previous two speakers were acceptable.

Dr SUWIT WIBULPOLPRASERT (Thailand) requested clarification of the implications of granting of the European request for the future participation of other intergovernmental organizations, such as ASEAN, in meetings of the subsidiary bodies of the Board.

Mr BURCI (Legal Counsel) said that the request had been made under Rule 4 of the Board's Rules of Procedure, which stated that intergovernmental organizations required an invitation to participate in the meetings of the Board's subcommittees and other subdivisions. The request related to the 117th session of the Board only, subject to the conditions just stated, for participation in the meetings of working groups and drafting groups that might be established in relation to technical agenda items. The Rules did not preclude such participation and the Board had the authority to regulate as it saw fit the participation of observers in its deliberations, including those of its subsidiary bodies. The European Community was unusual among international organizations in that the Member States of the European Union had transferred to the Community and its common institutions competence in certain areas of work, such as those covered by agenda items 4.3 and 4.10. It was therefore the Community that exercised competence on behalf of the Member States in such areas, whereas in other areas competence was shared. To his knowledge, in no other organization had such a transfer of competence occurred. Similar requests from other intergovernmental organizations would be considered in the light of those circumstances.

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

The CHAIRMAN proposed that the Legal Counsel should consider the matter further, for future reference, and that in the meantime the Board should grant the request, subject to the comments made by members of the Board, which related to its 117th session only.

**It was so agreed.**

The CHAIRMAN noted that meetings of the Standing Committee on Nongovernmental Organizations, the Sasakawa Health Prize Selection Panel, the United Arab Emirate Health Foundation Selection Panel and the State of Kuwait Health Promotion Foundation Selection Panel were scheduled to take place during the Board's current session. Because the nominations received for the Ihsan Dogramaci Family Health Foundation Prize had not fulfilled the requirements of the Foundation's statutes, the Foundation's Selection Panel would not meet. The Board had appointed him, as a representative of Pakistan, to be a member of the State of Kuwait Health Promotion Foundation Selection Panel.<sup>1</sup> As Chairman of the Board, however, he was a member ex officio of the Panel. Another member from the Eastern Mediterranean Region should therefore be appointed in his place. Following consultations with the Regional Office it was proposed that Dr S.A. Khalfan, alternate to Dr N.A. Haffadh (Bahrain), should be appointed.

**Decision:** The Executive Board, in decision EB114(4), appointed Mr M.N. Khan (Pakistan) as a member of the State of Kuwait Health Promotion Foundation Selection Panel for the duration of his term of office on the Executive Board. In his capacity as Chairman of the Board, Mr Khan is member ex officio of that Panel. The Board therefore decided to appoint Dr S.A. Khalfan, alternate to Dr N.A. Haffadh (Bahrain), to replace Mr Khan as a member of the State of Kuwait Health Promotion Foundation Selection Panel for the duration of Dr Haffadh's term of office on the Executive Board. It was understood that if Dr Khalfan were unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Panel.<sup>2</sup>

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

## **2. REPORT BY THE DIRECTOR-GENERAL:** Item 2 of the Agenda (Document EB117/2)

The DIRECTOR-GENERAL, illustrating his comments with overhead projections, said that the beginning of the millennium had been marked by a strong awareness of the close relationship between poverty, health and development, and WHO had continued to deal with that important area of concern. However, a new area of interest had emerged, namely, health and security.

The recent, unexpected appearance of human cases of avian influenza in Turkey demonstrated the dangers posed by the disease in birds and the importance of surveillance and effective early warning systems; it also increased the threat of pandemic influenza, which could occur with little or no warning of infection in poultry. The experience had also shown how quickly governments and the international community could act in a crisis. In Turkey, the results of analyses of patient samples had been available within 24 hours of collection, 100 000 treatment courses of oseltamivir had been delivered one day after the first cases had been confirmed and WHO experts were already assessing the situation in Turkey and Ukraine; WHO teams would shortly be working with the governments of a further seven neighbouring at-risk countries. The threat was real, and the devastating human and economic impact of a pandemic could only be reduced if thorough preparations were made on a global basis. The recommended strategic actions in response to the threat contained the key elements that all countries needed to implement and the draft containment plan would soon be finalized. At the

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<sup>1</sup> Decision EB114(4).

<sup>2</sup> Decision EB117(1).

International Pledging Conference on Avian and Human Influenza (Beijing, 17-18 January 2006), WHO had requested US\$ 100 million of the US\$ 1900 million pledged to be earmarked for its activities. The Organization was grateful to Roche for its generous donations of five million treatment courses of oseltamivir for regional and international stockpiles. A staff member had been seconded as the Senior United Nations System Coordinator for Avian and Human Influenza. Member States would undoubtedly demonstrate their commitment to shared responsibility by complying immediately with selected provisions of the International Health Regulations (2005), since it was vital that protocols were standardized.

Poliomyelitis eradication epitomized international commitment. Only four countries currently had transmission of indigenous wild-type poliovirus, and poliomyelitis epidemics in 15 of 21 reinfected countries had been eliminated. That success was due not only to enhanced campaigns, particularly in Africa, where synchronized immunization campaigns had been conducted across 25 countries, but also to the availability in all countries of two new monovalent vaccines against types 1 and 3 polioviruses. To complete eradication, however, the funding shortfall for activities in 2006 of US\$ 150 million needed to be filled.

With regard to HIV/AIDS, the target of the “3 by 5” initiative had not been reached, but the campaign had demonstrated the importance of combining prevention with treatment and had led to a commitment by the G8 group of countries and the 2005 Millennium Summit to provide universal access to care and treatment. New, simplified treatment and care regimens were proving to be successful, the range of pre-qualified drugs had increased and the prices of many antiretroviral agents had continued to fall. The inclusion of HIV treatment as part of essential care, which was already available to women and children in many parts of the world, would contribute to the scaling up of access to HIV services.

The global burden of malaria continued to increase despite new long-lasting insecticide-treated bednets and effective artemisinin-based combination therapies. The newly created global malaria programme, to which a new Director had been appointed, would enable WHO to redouble its efforts to control the disease.

The Second Global Plan to Stop TB (2006-2012), to be launched at the end of January 2006, was based on a new strategy to reduce the global burden of tuberculosis. The Plan outlined the resources needed to achieve the Millennium Development Goals relating to tuberculosis control. The Global Drug Facility, which provided high-quality essential medicines efficiently to large numbers of people, had enabled DOTS coverage to almost double from 2001 to 2005.

Some 167 countries and the European Community had so far become signatories to the WHO Framework Convention on Tobacco Control and 115 countries and the European Community had become Contracting Parties. The first Conference of the Parties would be held from 6 to 17 February 2006. WHO was committed to supporting countries in the implementation process, given the significant public health implications of tobacco control for the reduction of chronic diseases.

Three of WHO's publications issued in 2005 covered topics that had received insufficient attention in the past. *Preventing chronic diseases: a vital investment*<sup>1</sup> detailed the toll taken by heart disease, stroke, cancer, chronic respiratory diseases and diabetes, which were the major causes of death among adults in most countries. Four out of five deaths due to chronic disease were in low- and middle-income countries. The *WHO multi-country study on women's health and domestic violence against women*<sup>2</sup> reported on the enormous toll that intimate-partner violence took on the health and well-being of women around the world. *The world health report 2005*<sup>3</sup> focused on the fact that many women and children still had no access to potentially life-saving care, and called for the wider use of key interventions and a “continuum of care” approach for mother and child. The recently launched

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<sup>1</sup> *Preventing chronic diseases: a vital investment: WHO global report*. Geneva, World Health Organization, 2005.

<sup>2</sup> *WHO multi-country study on women's health and domestic violence against women. Initial results on prevalence, health outcomes and women's responses*. Geneva, World Health Organization, 2005.

<sup>3</sup> *The world health report 2005: Make every mother and child count*. Geneva, World Health Organization, 2005.

Partnership for Maternal, Newborn and Child Health would support countries in their efforts to deliver such care. The actions recommended in the reports formed the basis of WHO's work in the areas in question. The WHO Commission on Intellectual Property Rights, Innovation and Public Health would submit its report in 2006. *The world health report 2006*<sup>1</sup> would deal with the crisis in human resources for health.

The Organization had continued to support the revitalization of health services within communities after the earthquakes and tsunamis in south Asia and to work closely with the governments of the countries affected by the recent earthquake in Asia.

Much of WHO's work continued to be carried out in collaboration with partners. With the creation of the International Finance Facility for Immunization, the Global Alliance for Vaccines and Immunization (in which WHO and UNICEF were partners) would have nearly US\$ 4000 million to disburse over the next 10 years, and would thus contribute significantly to attainment of the goals of the Global Immunization Vision and Strategy, 2006-2015. The World Alliance for Patient Safety had launched a global initiative to address patient safety issues.

WHO's efforts towards achieving the Millennium Development Goals should be in harmony with the efforts of Member States. The Eleventh General Programme of Work, 2006-2015 would provide the framework for many joint achievements.

On the financial side, voluntary funding had increased by US\$ 550 million since the 2002-2003 biennium and had currently reached US\$ 1920 million. As at the end of November 2005, some 63% of funds for the 2004-2005 biennium had been spent in regions and countries. The new global management system, which would be introduced in 2006 and 2007, would enable financial and human resources to be managed more efficiently.

The Global Private Network provided reliable and secure access to information and to affordable telecommunication facilities for many WHO offices. Currently 85 locations were connected and a further 55 would be added by mid-2006. Country offices in the African Region had joined the network in 2005. The Strategic Health Operations Centre continued to facilitate collaboration with key partners during public health crises.

He introduced the senior members of staff who had joined the Organization since the 116th session of the Executive Board, and thanked those members of staff engaged in programmes that were less well known than those concerning pandemic influenza or poliomyelitis eradication, such as dracunculiasis eradication, leprosy control and radiation safety, but whose work was equally valuable and appreciated.

Mr GUNNARSSON (Iceland) commended the achievements and the Director-General's overview, particularly the emphasis on the close relationship between poverty and health, on health and security and on the social determinants of health, through the establishment of the Commission on Social Determinants of Health. Among the reported setbacks had been the failure to meet the goals of the "3 by 5" initiative; work on the initiative should be pursued, however, as the goals served as a catalyst for further action. The daunting challenges raised by the recent series of natural disasters had elicited a prompt and able response by WHO.

Dr SHANGULA (Namibia), speaking on behalf of the African group of countries, expressed sympathy to the victims of the earthquake in south Asia and other humanitarian crises, and urged continued support for the survivors. With regard to current global health issues, most countries in the African Region lacked the capacity to respond to pandemic influenza and draw up national contingency plans. The review of achievements towards implementing the United Nations Declaration of Commitment on HIV/AIDS (2001) and the "3 by 5" initiative should provide an opportunity to learn lessons for making progress towards the goal of universal access to treatment by 2010 set at the 2005 World Summit by the United Nations General Assembly.

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<sup>1</sup> *The world health report 2006: working for health*. Geneva, World Health Organization, 2006.

Essential though the focus on communicable diseases was, noncommunicable diseases posed a growing threat; deaths in Africa from such diseases were projected to increase by 27% by 2010. Cooperation with other Member States, for example on tobacco-control mechanisms, was among the strategies followed by the African countries. Twenty-three African Member States had already ratified or otherwise accepted the WHO Framework Convention on Tobacco Control.

The commitment of African Heads of State and Governments to improving the health status of their people was demonstrated by such measures as the Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases (2001), the Health Strategy of the New Partnership for Africa's Development and the prioritization of diseases such as sickle-cell anaemia.

The group welcomed the report on strategic resource allocations,<sup>1</sup> especially the explicit principle of support for countries in greatest need, in particular least developed countries. It acknowledged the current priority given to the African Region in the budget allocations and looked forward to further strengthening of that principle. The difficulties faced by countries' health systems in the Region were further compounded by the human resource crisis and the group was keen for implementation of recent Health Assembly resolutions on international migration of health personnel.

Dr SHINOZAKI (Japan) said that among the main health issues confronted in recent years had been several major natural disasters, to whose victims WHO had committed support in cooperation with other United Nations organizations. Only through WHO could such a prompt response have been provided. WHO's leadership and response in preparing for potential pandemic influenza was equally to be commended. Japan had recently hosted the Japan-WHO Joint Meeting on Early Response to Potential Influenza Pandemic (Tokyo, 12-13 January 2006).

He welcomed the theme of *The world health report 2005*. In order to maintain the success of maternal and child health programmes, essential medicines, health facilities, health information systems and other components must be integrated into sustainable public health systems, with particular emphasis on human resources development, which should indeed be the cornerstone of the public health network. Development partners should provide support for that approach.

Globalization processes increased the potential impact across national borders of new and re-emerging infectious diseases and the shortening of life expectancy through the spread of HIV. WHO should tackle the broader, not strictly health-related, impact of the spread of diseases and health crises. He reiterated his country's support for WHO's work.

Dr BUSS (Brazil) stressed the importance, particularly for the least developed countries, of the establishment of the Commission on Social Determinants of Health. Brazil was itself establishing a commission on the social determinants of health. Pandemic influenza preparedness was another issue on which WHO's leadership had proved crucial. The Hemispheric Conference on the Surveillance and Prevention of Avian Influenza (Brasília, 30 November – 2 December 2005), held under the auspices of PAHO, had likewise mobilized the countries in the region.

Regarding HIV/AIDS, he agreed that it was important to learn lessons from the "3 by 5" initiative and move towards the goal of universal access to treatment and effective preventive education. Brazil had considerable experience in the prevention and treatment of HIV/AIDS, but faced serious difficulties in relation to intellectual property rights and difficult access to new drugs. It therefore welcomed the initiative in establishing the WHO Commission on Intellectual Property Rights, Innovation and Public Health and considering the issue of international trade.

Professor PEREIRA MIGUEL (Portugal) said that he was speaking on behalf of the Presidency of the European Union and its 25 Member States because Austria, the current holder of the Presidency, was not at that time entitled to designate a member of the Executive Board. The acceding countries Bulgaria and Romania, the candidate countries Croatia, The former Yugoslav Republic of Macedonia

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<sup>1</sup> Document EB117/17.



and Turkey, and the country of the Stabilisation and Association Process and potential candidate Serbia and Montenegro aligned themselves with his statement.

The Director-General's report had to be evaluated in the spirit of United Nations General Assembly resolution 60/35, on enhancing capacity building in global public health, adopted two months earlier, which recognized the expertise and positive performance of WHO in a broad range of activities, and offered some proposals to assist its Member States in formulating health-related policies.

The issues mentioned by the Director-General were of concern to both the European Union and the international community. On the question of pandemic-influenza preparedness and response, he welcomed the appointment of a WHO staff member as Senior United Nations System Coordinator for Avian and Human Influenza. The European Union acknowledged the importance of the International Health Regulations (2005) in supporting national efforts to address the threat.

The year 2005 had rightly been described as the "year of development". In adopting United Nations General Assembly resolution 60/1, on the 2005 World Summit Outcome, the international community had reaffirmed its common determination to achieve the relevant Millennium Development Goals. The resolution recognized, however, that "HIV/AIDS, malaria, tuberculosis and other infectious diseases pose severe risks for the entire world and serious challenges to the achievement of development goals". Health was essential to achieving the Goals, and the physical, economic and social environment, the quality and accessibility of education and information, and the availability of qualified health care and health care providers were important factors in that regard. The European Union noted the commitment expressed in the resolution to "developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it". It was also vital to ensure that the target of universal access to sexual and reproductive health, a target that had been set out in the Programme of Action adopted at the International Conference on Population and Development (Cairo, 1994) and reaffirmed at the 2005 World Summit, was integrated in efforts to achieve Goals 4 and 5. The European Union, as the biggest provider of official development assistance, was making a significant contribution to efforts to achieve the Goals and targets.

The European Union shared the concerns about the limited progress made in reducing child mortality and the alarmingly increased rate of HIV infection among children and young people. Comprehensive measures were urgently needed, including full recognition of the sexual and reproductive needs of young people and their right of access to information to enable them to protect themselves. The European Union's first priority in that area was to reinforce and implement relevant Health Assembly resolutions. In the wider context of joint efforts to combat HIV/AIDS, the European Union had noted with interest the information about the preparation of a policy and planning framework for neonatal health, and the development of a strategy to optimize fetal growth and make pregnancy and childbirth safer.<sup>1</sup> The European Union looked forward to receiving further information on the subject, including concrete results.

He congratulated WHO on its noncommunicable disease strategy and reaffirmed the importance of the work already done under the Global strategy on diet, physical activity and health, and the need for concerted action to reduce the harmful use of alcohol. The Bangkok Charter for Health Promotion in a Globalised World, adopted at the 6th Global Conference on Health Promotion (Bangkok, 7-11 August 2005), pointed to the need to focus on the health determinants. Synergies with the new European Union Programme of Community action in the field of public health (2007-2013) should be identified and put to use.

The European Union welcomed the progress made on patient safety. The World Alliance for Patient Safety provided a global framework for activities, the importance of which was underscored by the participation of the Director-General at the European Union's Patient Safety Summit (London, 28-30 November 2005). Increased international collaboration, support for the agreed research agenda

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<sup>1</sup> Document EB117/13.

and the promotion of existing patient safety interventions were needed to achieve the goals endorsed by that meeting.

It was essential to meet the differing prevention, treatment and care needs of women and men in an equitable manner. Women's health was among the main topics of the current Presidency of the European Union. It was regrettable that the consultation process on gender, women and health had not yet been finalized. The European Union looked forward to the issue being taken up in January 2007.

In order to achieve the health-related Millennium Development Goals he emphasized the importance of appropriate training, deployment and support for health workers. He looked forward to World Health Day and the findings of *The world health report 2006* on the question.

It was also regrettable that the draft global strategy for the prevention and control of sexually transmitted infections had not yet been submitted to the Board. The delay in approving it would have a negative impact on the important work of WHO on sexual and reproductive health. The European Union took note of document EB117/8 Rev.1 as an additional progress report, and urged the Director-General to finalize the draft strategy before the Fifty-ninth World Health Assembly. He welcomed the assurances in that regard already given by the Director-General.

The year 2005 had seen several major natural disasters. The international community was needed to support the reconstruction, and the European Union was giving prompt and substantial assistance to the relief efforts. The Fifty-eighth World Health Assembly had called upon the Director-General to improve further WHO's contribution to internationally conducted humanitarian assistance in major natural disasters. The European Union looked forward to the Director-General's progress report on that subject to the Health Assembly, taking note of document EB117/29, section D, and of document EB117/30 on WHO's response to the earthquake in south Asia. He thanked the Director-General for his contribution towards a better coordinated United Nations response, and for the work to help the survivors.

European Union Member States had contributed to a European Region consultation on the proposed Eleventh General Programme of Work, which should be seen as part of a package, including the resource allocation principles and the medium-term strategic plan. It had been agreed that the aim of that Programme of Work ought to be clarified, since some of the areas proposed for action seemed to be too broad, and the document itself seemed to advocate a global health strategy rather than a programme of work. The European Union Member States looked forward to being involved in further consultations on the Programme of Work as soon as possible.

The European Union welcomed the work done on resolution WHA58.25 on the United Nations reform process, and on the role of WHO in harmonizing operational development activities at country level. Following the 2005 World Summit, it was vital to support the Secretary-General's efforts to achieve long-overdue reform of the international development system. Urgent action was needed to improve the quantity, quality and impact of aid. The Secretary-General had made clear his intention of seizing the opportunities offered by the follow-up to the Millennium Review Summit outcomes and the preparations for the triennial comprehensive policy review in 2007, and Member States and United Nations bodies must do the same. He looked forward to hearing more about the current WHO efficiency and effectiveness reforms, especially the work with the United Nations Development Group and specific programming processes at country level, the Common Country Assessment and the United Nations Development Assistance Framework. Austria would take forward the question of United Nations reform during its Presidency of the European Union.

The first meeting of the Conference of the Parties to the WHO Framework Convention on Tobacco Control would take place shortly. As key players in the negotiation process, the European Commission and its Member States were strongly committed to controlling the harmful effects of tobacco consumption, and looked forward to the Conference of the Parties adopting a clear timetable for elaborating protocols to the Convention.

He congratulated the Director-General and his staff on their work and assured him of the continued support of the European Union.

Speaking as the member for Portugal, he emphasized the range and quality of the work done in the European Region on strengthening pandemic-influenza preparedness and response, and thanked the Regional Director and the Secretariat for their efforts.

Dr ACHARYA (Nepal) welcomed the Director-General's comprehensive report and praised the "3 by 5" initiative which had played a catalytic role in the treatment of HIV/AIDS worldwide. The South-East Asia Region had 25% of the world's population and 40% of the disease burden, and he urged that the Region should receive its due share of resources.

Dr WINT (Jamaica) thanked the Director-General for his report, which recognized important areas of achievement, particularly in disease control, poliomyelitis eradication, response to natural disasters and the possible influenza pandemic. The Member States in the Caribbean were particularly vulnerable to the social and economic impact of catastrophes on the health sector. He looked forward to the promised intensified WHO collaboration and cooperation, particularly with respect to chronic disease prevention, the control of violence in the home and the community, and the increasing human resources crisis, which threatened to undermine the sustainability of health systems.

Dr ANTEZANA ARANÍBAR (Bolivia) commended the Director-General's report. Appropriate, effective and efficient management was essential and reform of management was of the utmost importance at all levels of the Organization. A significant percentage of the budget was being allocated to regions and countries. A better understanding of the use of those resources and, where appropriate, of coordination of management between headquarters, regions and countries would be welcome.

Poverty meant lack of opportunity and of access to technology, and weaker health services. Action was needed to improve the social determinants of health. Health should be seen from a global perspective, rather than merely in terms of specific policies and programmes.

Dr TANGI (Tonga) thanked the Director-General for his clear, vivid and focused presentation. He emphasized the special strengths of WHO, namely, the dedication of its staff at all levels, the unnamed faces behind the achievements, the embrace of advanced technology and the constant availability of up-to-date technology.

Dr MANDIL (alternate to Dr Botros Shokai, Sudan) welcomed the Director-General's excellent report. He emphasized the importance of WHO support that improved a country's capacity and infrastructure to deal with the challenges it faced. More of WHO's support should be channelled towards creating tools and services that countries could integrate into their national public health systems.

Mr SHUGART (Canada) thanked the Director-General and his staff for their enthusiastic efforts over the previous year. He wished to raise the subject of the Eleventh General Programme of Work at that juncture given the strategic importance of the issues raised.

An effective response to pandemic influenza and to high-burden, communicable, poverty-linked diseases, as well as to chronic noncommunicable diseases, depended on a well-functioning and well-resourced WHO. Canada strongly supported WHO's ongoing efforts to create a more effective, efficient and transparent organization, and considered WHO to have become a leader in the results-based approach among the specialized agencies in the United Nations system. Canada commended the work done on the Eleventh General Programme of Work, and the efforts made to consult widely on the document. It provided good contextual information but needed more focus on WHO's specific role, its strengths and comparative advantages and especially its priorities. Given limited financial resources, WHO could not be all things to all people all of the time.

A governance issue of serious concern to Canada was the high dependency of WHO's programme work on voluntary funding which represented more than 50% of the funding requirements for WHO's global health activities. If WHO was to be fully effective, essential functions such as disease surveillance and response activities must not be overly reliant on unpredictable voluntary contributions.

Canada, even though it was also a contributor of voluntary funding, was among those countries that would request that certain action be taken by the Secretariat. In order to resolve any apparent

contradiction, WHO had to give a clear signal about its core functions and priorities; the General Programme of Work was the vehicle through which that could be done.

The DIRECTOR-GENERAL said that the unnamed staff members to whom the member for Tonga had paid tribute merited the credit that often went to him as Director-General. WHO had some 150 country offices throughout the world, with six regional offices as well as its headquarters. Its staff came from very diverse backgrounds and origins yet rose as one body to meet challenges, such as the outbreak of avian influenza in Turkey. All six regional offices had provided staff and other resources. That was what made it a credible organization, and credibility and its reputation were its most important assets, to be protected and enhanced.

Concerning the draft strategy on the prevention and control of sexually transmitted infections,<sup>1</sup> he said that the delay in its issuance was attributable solely to the need to ensure total accuracy in such an important document. In future, every effort would be made to ensure that reports were issued in a timely fashion, including through electronic means.

The arrival of Dr D. Nabarro in New York to serve as Senior United Nations System Coordinator for Avian and Human Influenza meant that the United Nations secretariat had someone on hand to validate technical data, keep the Secretary-General informed about the situation and coordinate the work of FAO, WHO and other bodies. Clearly, that was a great advantage for WHO and a good example of how the United Nations system worked.

He had benefited greatly from the work of previous Directors-General, Dr Brundtland on the reform process, Dr Nakajima on poliomyelitis and other emerging diseases, and Dr Mahler on primary health care. Valuable contributions had likewise been made by past members of the staff. Thus, when the work of the Organization was commended, such commendations should be addressed to all staff members, past and present.

The CHAIRMAN thanked Board members for their moving words of sympathy with the earthquake victims in his country.

Professor AYDIN (Turkey)<sup>2</sup> expressed gratitude to the Director-General and the Regional Director of the Regional Office for Europe and his staff for the close cooperation from which his country had benefited. Turkey appreciated the timely and excellent support given by the Regional Office for Europe and the team sent to Turkey in response to its request. Globally sustainable cooperation and international awareness were the keys to combating avian influenza. Turkey was doing its best to share its data and information with WHO and other relevant international organizations in a transparent manner. He expressed gratitude for the support of all the parties that had contributed to the progress made so far in combating the outbreak.

### **3. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 3 of the Agenda (Document EB117/3)**

Ms HALTON (Australia), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, summarized the findings of the report. She affirmed that much had been achieved at the Committee's third meeting, held the previous week. The Committee's report should be of genuine benefit to the Board in its consideration of a number of items on its agenda. It highlighted areas where specific action was recommended to the Board. She pointed out the report's

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<sup>1</sup> Document EB117/8 Rev.1.

<sup>2</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

recommendations regarding the periodicity of meetings and the necessity for an extraordinary meeting in February 2006.

The CHAIRMAN said that comments on individual matters should be made during discussion of the appropriate agenda item.

(For continuation of the discussion and adoption of a decision, see summary record of the tenth meeting, section 2.)

**The meeting rose at 13:00.**

## **SECOND MEETING**

**Monday, 23 January 2006, at 14:30**

**Chairman:** Mr M.N. KHAN (Pakistan)

**TECHNICAL AND HEALTH MATTERS:** Item 4 of the Agenda

**Earthquake in south Asia: WHO's response:** Item 4.1 of the Agenda (Document EB117/30)

**A video was shown illustrating the response by the people and Government of Pakistan, and by the international community, to the earthquake in south Asia**

Dr ALWAN (Representative of the Director-General for Health Action in Crises), introducing the report, said that the response of both India and Pakistan to the earthquake had been prompt and effective. Since the role of WHO was to support national authorities, the capacity and human resources of the Regional Office for the Eastern Mediterranean had been fully mobilized, with support from headquarters and the regional offices for the Americas and Europe. The Regional Office for South-East Asia had similarly been prompt in supporting the national response in India. WHO had also worked closely with the United Nations Resident Coordinator system, UNICEF, UNFPA and other members of the United Nations Inter-Agency Standing Committee Health Cluster. The value of the health cluster approach had been amply demonstrated.

There remained an emergency focus to operations, owing partly to the cold weather and partly to the magnitude of the disaster. Provision of adequate shelter remained a challenge in many affected areas. The surveillance and early warning system in which WHO had invested was currently working effectively. Respiratory infections were a major cause for concern, but there had been no outbreak of disease. The mortality rate remained under the threshold for emergency situations.

The priorities for the winter plan, developed by the Health Cluster and the Government of Pakistan, included strengthening primary health care and hospital services and maintaining public health functions. Populations in major camps had good access to such services, but the challenge was to extend the same level of services to people in isolated camps in remote areas. Immunization campaigns continued. More than one million children had been vaccinated against measles, and tuberculosis programmes were operational. A large number of personnel had been trained to deal with the mental health problems commonly experienced by survivors of disasters of such magnitude.

Work was still in the emergency phase. More shelter for primary health units was required and prefabricated structures were being built, although the delivery of some had been delayed. Donors had been generous, but more financial resources were needed to cover all components of the winter plan and to support the recovery work. WHO had participated in the needs assessment for reconstruction and was currently supporting the recovery phase.

WHO's response in Pakistan had provided valuable experience. A preliminary review had been conducted and further reviews would focus on any deficiencies. The lessons learnt after the earthquakes and the tsunamis in south Asia would strengthen the Organization's response in crises. Emergency preparedness was also crucial, and more emphasis would therefore be placed in future on assisting countries to develop comprehensive preparedness and mitigation strategies.

Dr GEZAIY (Regional Director for the Eastern Mediterranean) expressed his gratitude to the other regional offices that had immediately sent experts to the sites affected, thus providing invaluable assistance, and for the support from headquarters. The United Nations Health Cluster mechanism, although functioning for the first time, had proved its worth: all participants had known their roles.

Although cases of poliomyelitis had occurred, there had been no major outbreak and no epidemics in the earthquake region. Full use had been made of experts for poliomyelitis surveillance and other aspects of disease control. Close attention had also been paid to the problem of mental health. The Organization's response had been good, and important lessons had been learnt on how to deal with similar disasters in the future.

The CHAIRMAN, speaking as the member for Pakistan, recalled the scale of the tragedy: 73 000 people had died and 140 000 were wounded. The support shown and the rapid response by WHO, however, had been heartening. He paid tribute to the efforts of the Pakistani people and to the coordination between his Government, WHO, other United Nations agencies, and national and international nongovernmental organizations. The immunization programme launched on 16 October 2005 had averted further deaths, but the next two-and-a-half months would be critical for survivors because so many factors were against them, namely the extreme winter conditions, the injuries they had suffered and the fact that they had lost their homes and families. The situation was nevertheless currently under control and there had been no deaths or outbreaks of disease in the refugee camps.

The reconstruction phase represented a further challenge; primary health care units were urgently needed, and human resources would have to be replenished since some 35% of doctors and nurses in Kashmir had died. Mental trauma presented a further problem. Trauma teams had been set up, including international experts with experience gained in the south Asia tsunami.

Dr MANDIL (alternate to Dr Botros Shokai, Sudan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that recent disasters had resulted in major human, environmental and economic losses, demonstrating the need for better disaster-preparedness and more effective and timely emergency response. Effective delivery of humanitarian assistance during the acute phase of crises, and provision of sustained support for long-term rehabilitation and reconstruction, called for solidarity and commitment on the part of the international community. The south Asia tsunami and the earthquake in Pakistan had shown the need for effective systems for early detection, and major investment was required to strengthen capacities, assess needs, map vulnerabilities and organize responses.

Currently, many countries did not have either disaster preparedness programmes or staff trained to manage them, and their lack of emergency systems and resources made it difficult for them both to respond adequately to catastrophes and to prepare for future emergencies.

The lessons learnt from past disasters had yet to be applied at national and local levels, particularly in regard to policy, planning and resource allocation, and countries should take steps to remedy that situation. WHO's support was required in building national preparedness and response capacities, including effective information and logistics systems, and in coordinating international efforts to assist countries.

Mr GUNNARSSON (Iceland) praised the Chairman for presiding over the work of the Board as well as supervising disaster relief operations in his own country. WHO, the United Nations and the rest of the international community needed to coordinate their actions in order to respond to emergencies promptly. The International Pledging Conference on Avian and Human Influenza (Beijing, 17-18 January 2006) had shown that the international community could be generous in providing funding where necessary. He called on the Director-General to investigate the possibility of establishing a disaster relief fund at headquarters for immediate funding of emergency operations.

The CHAIRMAN, speaking as the member for Pakistan, said that he and his Prime Minister had recently discussed the establishment of such a fund with the Secretary-General of the United Nations.

Dr ALI MOHAMMED SALIH (Iraq) agreed that a disaster relief fund should be established within WHO's existing budget. Such a step was already authorized by Article 58 of the Constitution:

“A special fund to be used at the discretion of the Board shall be established to meet emergencies and unforeseen contingencies.”

Dr SINGAY (Bhutan) recalled that WHO, the rest of the international community and nongovernmental organizations had provided prompt support following the disaster. Although there was need to strengthen emergency preparedness and response, it was also important to strengthen health systems in the long term, so that they could provide a sustainable response to emergencies.

Professor FIŠER (Czech Republic) said that every country in earthquake-prone areas needed an emergency preparedness and response plan, such as that described in paragraph 28 of the report. Plans should be evidence-based and regularly re-evaluated.

Dr SOPIDA CHAVANICHKUL (adviser to Dr Suwit Wibulpolprasert, Thailand) said that her Government had contributed in both cash and kind to the relief effort after the disaster. The world must be equipped to cope with natural disasters. The fundamental requirements were safe drinking-water, effective sanitation, vaccination and the prevention of communicable diseases. Community participation was essential if people were to help themselves in the first 24 hours following a disaster, before help could arrive from outside. In the recent earthquake, the entire infrastructure of the area had been destroyed and the people thus had been entirely dependent on external assistance.

She commended WHO's prompt and well-organized approach, and expressed her appreciation for the generous support of donor countries, United Nations agencies, the World Bank, the Asian Development Bank and the Islamic Development Bank. She called on the Director-General to continue his collaboration with partner agencies in disaster preparedness and response and to strengthen national capacity in the area of emergency medical services.

Dr SADRIZADEH (Islamic Republic of Iran)<sup>1</sup> said that two devastating earthquakes had struck his country in 1990 and 2003. Lessons had been learnt. In-country preparedness was crucial: emergency preparedness at local and national levels must be improved, and an emergency coordination centre must be set up in the capital of the affected country. A global emergency fund should be established, as other speakers had already suggested. Disease surveillance was a high priority in emergency situations. Psychosocial support for survivors of a disaster would inevitably be required: following the earthquake in Bam in December 2003, mental health had been accorded a high priority for the first time in any natural disaster affecting the region. Improving the living conditions and health status of survivors of a disaster was another important priority.

Dr ALWAN (Representative of the Director-General for Health Action in Crises) said that WHO was reallocating existing funding to emergency preparedness and response, and had set up a group dedicated to preparedness and disaster mitigation. In three weeks' time, a global consultation of experts would take place to strengthen WHO's capacity to provide support to Member States in developing comprehensive and multisectoral plans for preparedness and mitigation. Emergency medical services and large-scale management of casualties were also a priority. There were currently gaps in the available knowledge about emergency preparedness activities at country level: WHO was working on a global database of human resources, institutions and logistics, which could be used to deploy staff and other resources rapidly following a disaster.

Some members had suggested the establishment of an emergency relief fund. WHO was currently working to expand access to emergency funding, but a global fund would require increased contributions from the international community. In October 2005, the Eastern Mediterranean Region had established a regional solidarity fund, to which most Member States in the Region had agreed to contribute.

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



(For continuation of the discussion, see summary record of the tenth meeting, section 3.)

**Strengthening pandemic-influenza preparedness and response:** Item 4.2 of the Agenda (Document EB117/5)

- **Application of the International Health Regulations (2005): follow up** (Documents EB117/31 and EB117/31 Add.1)

Dr CHAN (Assistant Director-General), in a statement accompanied by an illustrated presentation, said that documents EB117/5 and EB117/31 provided an update on developments in avian influenza and pandemic-influenza preparedness, the relevant actions taken by WHO between May and November 2005, information on the pandemic risk assessment, and important meetings held since November 2005.

WHO's level of pandemic alert remained unchanged at phase 3, although the outbreak of avian influenza was continuing to spread, with poultry in several countries having been affected in November and December 2005, particularly in China and Turkey. There continued to be sporadic human cases in six countries, five of them in Asia, and in 2006 reports of human cases had been received from China, Indonesia and Turkey. There had so far been no evidence of human-to-human transmission. The Government of Turkey had provided useful data, which were helping to improve understanding of the virus and the situation on the ground. Further studies were being conducted in conjunction with that Government to gauge the size of the problem, and to improve knowledge of the risk factors affecting different target groups and of the different control measures required.

At the Joint FAO/WHO/OIE/World Bank Conference on Avian Influenza and Human Pandemic Influenza (Geneva, 7-9 November 2005), a consensus had emerged on the technical measures to be taken by countries in the formulation of their integrated national plan. Eight of the 12 action points defined were relevant to WHO, which had started work immediately. For example, a meeting on pandemic communications involving major partners such as FAO, UNICEF and OIE had been held in December 2005, at which the issues of strategy and WHO support to Member States had been addressed. A meeting of the Global Outbreak Alert and Response Network had also been held, strengthening regional and global solidarity in outbreak response. At a meeting held in Geneva on 12 December 2005 to discuss early containment strategy, agreement had been reached on the principles and doctrine that would govern standard operating procedures in the event of an emerging influenza pandemic. That meeting was followed by the technical Japan-WHO Joint Meeting on Early Response to Potential Influenza Pandemic (Tokyo, 12-13 January 2006). A task force had been set up to strengthen internal capacity to ensure WHO's prompt response in providing support to countries for diagnosis, risk assessment and management of clinical cases.

As a result of a generous donation by Roche, WHO had acquired five million courses of oseltamivir: three million for the international stockpile to respond to urgent situations in the early stages of a pandemic and two million for support in resource-poor locations in the event of an outbreak of human disease due to H5N1 virus. Another important issue was pandemic vaccine development, to which two meetings had already been devoted, with a further three planned; the central issues were research and development, how to increase production capacity, and how to improve access to affordable vaccines.

Based on the discussions held in Geneva and on the initial work done, a pandemic influenza strategic action plan had been drawn up, with five priority strategic actions for the Organization over the next two years. Following the International Pledging Conference on Avian and Human Influenza (Beijing, 17-18 January 2006), she was glad to report that US\$ 1900 million had been pledged, US\$ 1000 million in the form of a grant and US\$ 900 million in the form of a loan.

Several key issues had emerged from an informal meeting held in Beijing of donors, partners and Member States. The country involved must itself "take centre stage" and focus on the development of an integrated national plan, discussion with potential donors for resource mobilization, good mechanisms for prompt implementation, monitoring and accountability to donors.

With regard to coordination within the United Nations system, she had been in regular contact with the Senior United Nations System Coordinator for Avian and Human Influenza. Coordination was complex; because of the different financing mechanisms involved, different coordination mechanisms would be required to ensure that activities at national, regional and global levels were consistent and that results were synergistic.

Dr ALI MOHAMMED SALIH (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the avian influenza pandemic threat greatly concerned all countries, which shared responsibility for its prevention or mitigation, because of the need for sensitive surveillance systems and rapid reporting and response in order to comply with the International Health Regulations (2005). However, many unfortunately did not have the communications resources to meet these requirements; equipment, software and training were lacking. Global cooperation was increasingly essential for strengthening surveillance systems for potentially epidemic diseases. Nevertheless, countries of the Region supported the proposal for immediate voluntary compliance with the relevant provisions of the Regulations. It was to be hoped that resources would be mobilized accordingly, particularly for developing countries, and that WHO would provide technical support when requested.

He commended WHO's efforts to reduce the risk of, and increase preparedness for, pandemic influenza. Member States of the Region had drawn up their preparedness plans as best they could, but many did not consider themselves ready because they lacked adequate capacity for diagnosing, and confirming diagnoses of, avian influenza. Obtaining appropriate antiviral agents for stockpiling, at affordable cost, and uncertainty regarding the distribution of appropriate vaccines were also problems. Disparities in resources and access could be reduced by transferring technology for production of antiviral agents and vaccines to the Eastern Mediterranean and other regions, and by helping less privileged countries to strengthen the non-pharmaceutical aspects of their national preparedness plans.

Speaking as the member for Iraq, he said that, in order to improve the level of preparedness in developing countries, health staff needed to be trained in field activities, especially in those countries exposed to the risk of disease. Training was also required in surveillance and notification. Iraq had committed itself to complying with preparedness requirements, but because of the security situation the movements of WHO staff were restricted, thus depriving his country of their expertise. He called for all possible efforts to be made to ensure greater flexibility of movement for WHO staff, especially given that Iraq could provide the necessary protection in those areas of the country where security had been established.

The CHAIRMAN welcomed the suggestion that antiviral agents might be stockpiled by the Regional Office for the Eastern Mediterranean. With regard to current restrictions on the movement of WHO personnel in Iraq and the possible effect on the emergence and spread of avian influenza, the situation was already under consideration by the Director-General.

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the European Union and its 25 Member States, the acceding countries, Bulgaria and Romania, the candidate countries, Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates, Bosnia and Herzegovina and Serbia and Montenegro, highlighted the importance of strengthening pandemic-influenza preparedness and response. The Asian strain of the avian influenza virus had become a trans-regional threat to both poultry and other birds, in addition to humans. Its occasional transmission by migratory birds showed that it could cross regions, reach developing countries and have serious economic and health consequences; no part of the world could ignore the potential threat. To minimize the risk, it was crucial to take steps to combat avian influenza where it appeared and in areas to which it might spread. WHO's rapid response, in cooperation with the Turkish Ministry of Health, the European Community and the European Centre for Disease Prevention and Control, to the recent appearance of human cases of avian influenza in Turkey had shown the willingness of the main institutions for disease control in the European Region

to cooperate. It would also facilitate early clarification regarding whether human-to-human transmission had occurred; such information was crucial for evaluating the potential for a pandemic spread of the disease. Recent developments in countries on the borders between Europe and Asia were nevertheless giving cause for concern and emphasized the need to address the root causes of avian influenza and to assist affected countries.

The European Union welcomed the Beijing Declaration, issued at the previous week's International Pledging Conference, which reflected countries' political will to join forces to control avian influenza and to prepare for a possible human influenza pandemic. It set out key principles, including the need to mobilize international support. The European Union welcomed, in particular, the unequivocal commitment to transparency and information sharing and the call for all partners to report swiftly on animal and human cases of avian influenza through appropriate international channels in compliance with OIE's standards for veterinary services and the International Health Regulations (2005). Rapid information sharing, including biological specimens derived from suspected and confirmed cases in humans and animals, would enable adequate and comprehensive preparedness and response actions to be developed.

Although it welcomed the initiatives and coordination strategies adopted at various international forums in recent months, the European Union regarded FAO, WHO and OIE as the main international organizations for dealing with all aspects of avian and human pandemic influenza. It fully subscribed to the global strategic framework for avian influenza control and pandemic influenza preparedness as developed and promoted by FAO, WHO and OIE, and which conformed to the principle of good practice developed, disseminated and applied in compliance with relevant international standards based on the conclusions of the recent joint conference on Avian Influenza and Human Pandemic Influenza (Geneva, 7-9 November 2005). The European Union was ready to share its collective experience of avian influenza and human pandemic influenza prevention and preparedness. Recognizing that transparency and information sharing were essential elements of any containment strategy, it was also willing to allow concerned countries and institutions to participate in its avian and human pandemic influenza forums in the hope that its own approach might add value to their respective strategies and contribute to effective implementation of the measures laid down in the FAO, WHO and OIE strategic framework. He urged the European Union's partners to do likewise. The European Union agreed that support for country-owned national response strategies, based on a multisectoral approach that gave priority to strengthening the animal and public health sectors, including surveillance and alert systems, together with alleviation of the socioeconomic effects on the poorest people, must be at the centre of a coordinated international response under the global control strategy for avian influenza proposed by FAO, WHO and OIE. The threat was global, but the coordinated response could be initiated and led at national level, in consultation with civil society, including farming organizations and private sector representatives. The provision, within long-term strategic partnerships, of adequate financial and technical support to developing countries, particularly least developed countries, both affected or at risk, would be vital in controlling health, finance, trade and security threats linked to avian influenza globally.

The Beijing International Pledging Conference had been timely, and the fact that the international community had pledged a total of US\$ 1900 million, which exceeded the estimated overall financing shortfall for the next few years, should be a source of considerable satisfaction. The European Union had also demonstrated its commitment by announcing its intention to contribute some US\$ 260 million. It had already initiated several activities to strengthen national pandemic influenza preparedness. One of the most effective had been the Union-wide exercise entitled "common ground", which had been carried out in November 2005 and devised to test Union-wide structures and the interoperability of national plans in the event of an influenza pandemic. The results would be published in a comprehensive report to permit adaptation and improvement of national and Union-wide pandemic preparedness. In that context, the International Health Regulations (2005) were a key instrument. In view of the seriousness of the situation and the risk for health worldwide, WHO should consider the possibility of anticipating the application of the parts of the Regulations that were crucial for early detection, reporting and containment of an evolving pandemic, pending their entry into force

in 2007. Having played a major role in the instrument's elaboration and adoption, the European Union would support corresponding proposals for voluntary compliance with the Regulations.

The report contained in document EB117/5 rightly underlined the urgent need to help countries to acquire adequate surveillance systems and laboratory capacity to increase the chance of successful preventive intervention at the start of a pandemic. In particular, WHO should continue and enhance its assistance to countries in establishing their core capacities required under the Regulations, and mobilize and dedicate technical resources, using capacities available in regional offices and collaborating centres to expand and accelerate training efforts in epidemic surveillance, alertness and response, laboratory capacity, biosafety and quality control.

The European Union supported the proposal that the Director-General should submit an annual report to the Health Assembly on the progress made in supporting Member States to implement and comply with the Regulations.

Mrs LE THI THU HA (Viet Nam) welcomed the report contained in document EB117/5 and congratulated WHO on its leadership role in alerting the world to a possible influenza pandemic. Her Government had acted decisively to prevent further outbreaks of avian influenza in poultry, to prevent human infection with H5N1 virus, and to prepare for a possible influenza pandemic. The combined measures included political commitment at high level, transparency and multisectoral cooperation and operation; surveillance and reporting of avian influenza in poultry, mass vaccination, disinfection and control of poultry movement; improved surveillance and detection of human cases and massive information, education and communication campaigns. With, in addition, international support, Viet Nam had been able to contain avian influenza in poultry. No human case had been reported in more than two months. Nevertheless, the Government remained vigilant and was fully prepared for any re-emergence of the disease.

WHO should continue to provide support to Member States to improve their surveillance capabilities. For countries like Viet Nam where the H5N1 virus appeared to be entrenched, support for early detection and rapid response and containment were priorities.

Expanding global influenza vaccine production capacity was vital but had progress been satisfactory? If not, the Board should consider the actions needed to accelerate development and enhance global capacity.

Stockpiling antiviral agents was expensive and time-consuming. With reports of resistance to amantadines and neuraminidase inhibitors (such as oseltamivir), there was an urgent need for clear policy guidance to ensure cost-effective national policies and to prevent development of resistance. Such guidance needed to be timely and Member States should be assisted in developing rational procurement and prescription policies. Mass prophylaxis with oseltamivir near the start of a pandemic in order to reduce the risk of emergence of a fully transmissible virus was a highly ambitious but potentially heroic intervention that would require detailed pre-planning. Success would depend entirely on local capacity to detect the emergence of a new virus and to respond rapidly. As full and rapid cooperation would be needed from the Member State first affected, the Board might wish to recommend that the Health Assembly should seek the agreement of all Member States on cooperating with the Secretariat to implement the proposed intervention, including importation of the medicine, deployment, and monitoring of effectiveness.

An important issue not raised in the report was the integration and sustainability of technical and financial support nationally, regionally and globally. The increasing response to avian and pandemic influenza from national and international organizations and the donor community complicated the situation. Much work was being done on enhanced surveillance, laboratory capacity and vaccine development, but the sustainability of the programmes had not been given enough attention. There was also a risk of establishing new structures ill-adapted to existing systems. Advocacy for integration and sustainability always being regarded as primary issues in connection with all initiatives concerning avian and pandemic influenza should be considered.

WHO's report on "Responding to the avian influenza pandemic threat: recommended strategic actions" stated as an objective the need to conduct research to guide response measures.<sup>1</sup> Research was crucial because good scientific knowledge was needed in order to formulate effective public health policies. Over the past two years, scientists from WHO and elsewhere had discussed research subjects with Vietnamese scientists, but progress had been slow. WHO could play a role in facilitating that research. Although information technology and geographical information systems were valuable aids to effective surveillance and communication, it was important to recognize the variations in the quality and nature of existing information technology in Member States. The first priority should be to strengthen national capacity in a way that was both compatible with existing national systems and sustainable.

Dr HANSEN-KOENIG (Luxembourg) thanked WHO for its leadership, actions, and effective support to Member States. She likewise commended the clear, objective reports prepared by the Secretariat on the item under consideration. Clear messages and guidelines based on scientific knowledge were more important than ever, in the face of the pandemic threatening all Member States. The difficulty of striking a balance between clear, unambiguous messages that encouraged Member States to step up preparedness, with calls on their population to cooperate, and messages causing global panic had already been apparent. WHO's advice and leadership was also required in that area. In particular, she expressed her appreciation of the efforts concerning vaccines, and requested the latest information about the universal non-specific pandemic vaccine referred to by the Director-General in his closing speech at the November 2005 meeting on pandemic avian influenza. She supported the proposal for immediate voluntary compliance with the relevant provisions of the International Health Regulations (2005), and expressed the hope that the Secretariat would help all Member States to achieve that.

Dr ACHARYA (Nepal) said that, although as yet unaffected by the avian influenza outbreak in Asia, Nepal was considered to be at risk. The absence of border controls between India and Nepal was a serious problem offering a potential route for the disease into Nepal should India suffer an avian influenza outbreak. Although there was less traffic across its border with Tibet, that route posed a similar risk as outbreaks of the disease had been recorded in Tibet in 2004 and 2005. The Government had recognized the need to improve national preparedness for emerging diseases, such as avian influenza, and had established a multisectoral national task force, which had drafted a national avian and pandemic influenza preparedness and response plan that was awaiting Government approval. The plan aimed to facilitate the implementation of actions by the health and agricultural sectors to prevent and contain avian influenza in poultry and humans, and to reduce the risk and mitigate the impact in the event of an influenza pandemic. At national level, surveillance systems for both animal and human health needed strengthening. In the health sector, a system of district rapid-response teams to investigate outbreaks had been established and teams had been trained to deal with illnesses resembling influenza. Laboratory capacity to deal with influenza surveillance and a possible pandemic response required significant strengthening in terms of equipment and training. The current global priority given to pandemic-influenza preparedness and response capacity could provide an opportunity to improve Nepal's own outbreak preparedness.

Given the cross-border implications of avian influenza and influenza pandemics, countries in the region needed to increase collaboration in controlling the movement of animals and to strengthen health-sector disease-surveillance and reporting mechanisms in order to detect infected people and limit the spread of avian influenza. Necessary action included the integration of interventions in the Government's programmes; additional financing; improved inter-country collaboration; creating public-private partnerships; and technical assistance for capacity-building in the relevant programmes.

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<sup>1</sup> Document WHO/CDS/CSR/GIP/2005.8.

Mr GUNNARSSON (Iceland), recalling the support for immediate voluntary compliance with the relevant provisions of the International Health Regulations (2005) expressed at both the joint meeting on avian influenza and human pandemic influenza (Geneva, 7-9 November 2005) and the pledging meeting (Beijing, 17-18 January 2006), endorsed the draft resolution contained in document EB117/31. Given the present concern with a disease transmitted by birds, it was important to focus on transparency and on compensation for poor farmers, without forgetting the need to develop antiviral agents and vaccines in the event that the disease could later be transmitted among humans. Commending the summary of the issues presented by the Director-General at the meeting on avian influenza and human pandemic influenza set out in the annex to document EB117/31, he sought the latest information on vaccine development, in particular that of “smart” vaccines.

Dr NYIKAL (Kenya), speaking on behalf of the Member States of the African Region, said that many countries in Africa were at high risk of infection from avian influenza as they lay in the path of migratory birds from Europe. A large proportion of poultry in Africa was domestic free-range, mingling easily with wild birds and humans. Since poultry were often kept indoors at night with people, there was a high likelihood of disease in humans even without human-to-human transmission.

At the Regional Meeting on Pandemic Influenza (Brazzaville, 12 and 13 January 2006), areas in which preparedness in African countries required strengthening and support had been identified as: surveillance and early-warning systems; improvement of laboratory capacity and linkage between laboratories working on human and veterinary aspects; international networking of laboratories; preparation of national contingency plans; community and national capacity-building; public education and information; stockpiling of appropriate antiviral agents and vaccines; ensuring biosafety; a legal framework; and resources for culling and compensation for farmers. Africa expected to receive funds from bilateral and multilateral donors, which could pose coordination problems at the national level.

He welcomed early voluntary implementation of the International Health Regulations (2005) and supported the draft resolution, with the addition of a subparagraph 5(5)(d) that would read “to establish a monitoring framework to ensure voluntary compliance with the International Health Regulations by Member States;”.

Drawing attention to the country preparedness plan completed by Kenya, he highlighted the difficulty his country would experience in implementing it owing to its limited resources.

Dr SUWIT WIBULPOLPRASERT (Thailand) expressed appreciation for the work of WHO and commended the appointment of the Assistant Director-General, Communicable Diseases, who had considerable experience in combating avian influenza in her own country, as Representative of the Director-General for Pandemic Influenza.

For antiviral security, there had been neither the production capacity nor the money to provide developing countries with antiviral agents: for instance, at a cost of US\$ 3, a single tablet of oseltamivir phosphate represented 80% of the minimum daily wage in Thailand. After his Government had followed Brazil in beginning production of a generic version to be sold at half the price, the original manufacturers had proposed to sell tablets for US\$ 1.4 each. Similarly, developing countries, where any pandemic was likely to occur first, would clearly have difficulty in obtaining pandemic vaccines given that they lacked resources for research and development and that current global production capacity (under 500 million doses a year) would cover less than 10% of the world's population.

Several hundred thousand people in Thailand relied on poultry farming for a living and the industry had already been reduced by one third as a result of the current avian influenza epidemic. Outlining the double standards faced by farmers who, if they decided to vaccinate their birds before export, could see them refused by importing countries allowing vaccination of its own poultry, he advocated genuine collaboration, harmonization of policies and transparency in dealing with international poultry-trade issues. Given the time spent by experts in discussing the issue, he feared that the longer it took for any pandemic to develop, the greater its repercussions would be.

He supported the draft resolution, but wished to see a clear definition of suspected human cases provided in paragraph 4(3) in the form of a footnote or by replacing the phrase with “probable” or “highly suspected” human cases. A new subparagraph should be inserted after paragraph 4(3) to highlight the importance of working together on human and animal health as follows: “to strengthen collaboration on human and zoonotic influenzas with organizations responsible for human and animal health, in order to strengthen surveillance and immediate measures for outbreaks in animals, and human cases of avian influenza;”. The influenza pandemic task force referred to in paragraph 4(6) should include experts from affected countries. He sought an explanation of the specific “measures in Parts II and III of the Regulations falling under the responsibility of WHO” in paragraph 5(2). As the earliest possible international assistance would be crucial, he proposed that the words “especially when control measures against international spread are unlikely to succeed” in paragraph 5(5)(b) should be deleted with insertion of the words “especially among affected countries” before “lacking sufficient operational capacity”.

Professor FIŠER (Czech Republic) had noted with pleasure the prompt and adequate response of the Regional Office for Europe to the incidence of human cases of avian influenza caused by the H5N1 virus in Turkey through its creation of a group including experts from WHO, the European Commission, and the European Centre for Disease Prevention and Control. Efficient sharing and coordination of information between WHO and the European Centre was of key importance, for the European Region in particular, in tackling the risks of pandemic influenza. Negotiations had been launched in his country with manufacturers to make the “pandemic vaccine” available as early as possible in the event of an outbreak of pandemic influenza, but some producers had indicated that the amount of the vaccine supplied would be determined primarily by how much seasonal influenza vaccine had been ordered in previous years. The Czech Republic regarded that approach as discriminatory and would welcome discussion of the issue.

Dr HUDA (alternate to Dr Al-Keeb, Libyan Arab Jamahiriya) said that the Member States of the Eastern Mediterranean Region, despite their best efforts, were far from ready to cope with an influenza pandemic. Many lacked the capacity to diagnose avian influenza, so that a global alert and response was needed. She consequently supported immediate voluntary compliance with the International Health Regulations (2005), which would require mobilization of resources. She recommended that the Secretariat should enhance its technical capacity in veterinary public health so as to increase its ability to respond to the requirements of Member States, and stressed the need for transfer of technology relating to production of antiviral agents and influenza vaccines to some countries in her Region in order to diminish the disparity between developed and developing countries in access to such medicines.

Dr SINGAY (Bhutan) said that, being traversed by and a destination for migratory birds, Bhutan was a country at high-risk. Although no case of avian influenza had been detected, it was ensuring strong collaboration between the various bodies concerned and the Ministry of Agriculture. The country had a weak public health structure; it lacked capacity for producing antiviral agents and vaccines, and there was a need to focus on non-pharmaceutical interventions. It also lacked appropriate collaboration with other relevant sectors and the resources to combat a pandemic. It was therefore necessary to build public health capacity. He welcomed the proposed voluntary implementation of the International Health Regulations (2005) but had doubts about how effective that would be without adequate public health infrastructure and capacity.

Mr SHUGART (Canada) said that, for human resources, whether at country level or in the Secretariat, contingency and training plans should be instituted while there was time. On the subject of communication between countries and with WHO, as well as with the public, had lessons been learnt from the outbreak of avian influenza in Turkey? Global media interest had increased and therefore the communications aspect was particularly important. As money would begin to flow after the recent

successful International Pledging Conference in Beijing, care must be exercised to resist the temptation for various participants to act individually. Canada stressed that there must be a single, global plan, developed at WHO headquarters, for dealing with avian and pandemic influenza. All the agencies concerned must be made responsible for consolidating the plan and everyone must adhere to it, tailoring it to their capacity and circumstances; otherwise, trouble lay ahead.

Canada supported the draft resolution on voluntary implementation of the International Health Regulations (2005), to which he proposed two amendments: insertion of the words “and on compliance with the International Health Regulations (2005)” in paragraph 5(5); and the addition in paragraph 5(7) of “and to report annually thereafter on the progress achieved in assisting Member States on compliance with and implementation of the International Health Regulations (2005)”. The first amendment would make it clear that the global community was already implementing the Regulations and the second would maintain attention on the Regulations, especially in the early years, by requiring ongoing reporting. That would be a useful discipline, for both the Secretariat and Member States.

Dr SEPÚLVEDA (alternate to Mr Bailón, Mexico) said that his country had played an active part in international meetings on preparedness and response to an influenza pandemic. At an international ministerial meeting in Ottawa in September 2005, the Mexican Minister of Health had outlined his country’s position: first, to guarantee equitable access to antiviral agents and vaccines for all countries, especially those with scant resources; secondly, to support the establishment of a world stock of antiviral agents, administered by WHO, to provide support to the countries in greatest need in the event of a pandemic – he understood that such a reserve was being constituted, as originally proposed by Thailand, with the donation of oseltamivir. It had also been suggested that countries contribute part of their national reserves to the WHO global reserve. Thirdly, Mexico also favoured establishing agreements on the transfer of technology and the training of human resources, allowing production of vaccines in developing countries that had the capacity. Those proposals had received the support of the G7 group of countries. Mexico had drawn up a national plan to combat an influenza pandemic, based on the suggestions distributed by the Secretariat to Member States in August 2005. The Mexican Congress had authorized US\$ 50 million to support epidemiological surveillance and a further US\$ 10 million for information dissemination activities. Mexico supported the definitions and measures advocated by the Secretariat in order to mitigate the repercussions of an influenza epidemic.

Ms HALTON (Australia) commended WHO’s competent leadership and the priority it had given the issue. Also, the secondment of a staff member to be the Senior United Nations System Coordinator for Avian and Human Influenza was an example of the multisectoral cooperation that was crucial at the international as well as country and interregional levels. Such leadership sent an important message to the international community about the serious consideration WHO was giving to the matter.

She welcomed the openness shown by several countries; their willingness to act rapidly in that way had enabled the international community to respond quickly. The spirit of openness and cooperation had to continue if a pandemic were to be prevented. She also supported the need for balance in communication; information needed to be conveyed in a way that was practical and responsive, without causing panic.

Given its position in the Asia-Pacific region, her country had long been an active advocate of an international response and welcomed the recent initiative of the Canadian Government and the outcome of the International Pledging Conference on Avian and Human Influenza (Beijing, 17-18 January 2006), both welcome signals of the galvanization, mobilization and attention that the issue needed.

Her Government, which had welcomed the adoption of the International Health Regulations (2005), therefore supported in principle the draft resolution with its call upon Member States to comply immediately, on a voluntary basis, with the relevant provisions of those Regulations before their entry into force. It had already begun an analysis of the country’s capacity to comply with the



obligations of the Regulations in June 2007 and even before that date. She urged other Member States to commence such investigations already. The capacity of some countries in the Asia-Pacific region to implement surveillance, ensure preparedness and respond to emerging infectious diseases was limited. That had implications not only for medium- and long-term assistance from WHO and the international community to support such countries in meeting the core capacity requirements under the Regulations but in the short-term too for enabling immediate compliance. Australia remained committed to working in partnership regionally and globally to build capacity to prevent and control outbreaks of such diseases.

**The meeting rose at 18:00.**

### THIRD MEETING

Tuesday, 24 January 2006, at 09:15

Chairman: Mr M.N. KHAN (Pakistan)

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

**Strengthening pandemic-influenza preparedness and response:** Item 4.2 of the Agenda (Document EB117/5) (continued)

- **Application of the International Health Regulations (2005): follow up:** (Documents EB117/31 and EB117/31 Add.1) (continued)

Dr ANTEZANA ARAN BAR (Bolivia) drew attention to an inconsistency in document EB117/5 which needed to be clarified. Paragraph 1 stated in that the causative agent, the H5N1 strain of *Influenzavirus A*, had crossed the species barrier and had infected humans, proving fatal in more than half the cases, whereas in paragraph 4 it was stated that no human case had been associated with any of the most recent animal outbreaks. If the causative agent had not crossed the species barrier, what then was the etiology of the human cases? Such conflicting information caused alarm and hysteria. It was vital that the information provided by WHO should be clear and correct, particularly as the media passed on that information to the general public. Furthermore, it was essential that the assumptions on which the strategy for responding to the threat of an avian influenza pandemic depended should be constantly updated to reflect any new evidence that became available.

Dr BRUNET (alternate to Professor Houssin, France) welcomed WHO's efforts to mobilize the necessary resources to assist Turkey and noted the participation of the European Centre for Disease Prevention and Control and the European Commission in those efforts. In addition to immediate crisis response, countries must also look to the longer term by establishing sustainable capacities for response at all levels. Like the other European Union Member States, France supported the draft resolution calling for immediate voluntary compliance by Member States with the relevant provisions of the International Health Regulations (2005).

Sustainable capacities required increased human resources which entailed training activities not mentioned in the draft resolution. With the agreement of other Member States of the European Union he proposed the insertion of a new subparagraph (7) in paragraph 5 of the draft resolution, to read: "to mobilize and dedicate technical resources from WHO where possible, using capacities available in regional offices and collaborating centres to expand and accelerate training efforts in the areas of epidemic surveillance, alert and response, and laboratory capacity, biosafety and quality control, in order to help Member States in the implementation of the International Health Regulations;". The European Union also supported all the amendments proposed by the members for Canada, Kenya and Thailand. However, in the new subparagraph 4(4) proposed by Thailand, the word "national" should be inserted before "organizations", as the amendment concerned action to be taken by Member States.

Dr SHINOZAKI (Japan) commended WHO's efforts to tackle the threat of avian and human pandemic influenza. The potentially catastrophic economic and social impact made domestic and international coordination strategies essential for response. The public must also be kept well informed of the facts. Japan was strengthening its response to emerging scenarios and would continue to support pandemic-influenza preparedness technically and financially, in cooperation with the international community.

Japan endorsed early and voluntary compliance with the relevant provisions of the International Health Regulations (2005). Communication with local residents or health workers, who were likely to be the first to detect a case, was of vital importance. Member States should inform WHO of the measures they had taken to deal with avian influenza in voluntary compliance with the Health Regulations.

As provided for in the draft resolution, Japan recognized the need to reinforce its surveillance and early warning systems. He urged the Director-General to explore the possibilities for enhanced surveillance systems for avian influenza through the use of geographical information systems, especially in rural areas in order to control infectious diseases and reduce the impact of natural disasters, as Japan had discovered by developing a disaster reduction information system following the major earthquake in the Kobe-Hyogo region of the country in 1995.

Dr SÁ NOGUEIRA (Guinea-Bissau) expressed concern at the threat of an avian influenza pandemic. In Guinea-Bissau and some other African countries, natural parks were host to various species of migratory birds. In addition, the raising of free-range domestic poultry resulted in contact with wild birds, and increased the likelihood of transmission of the virus to humans. He welcomed the efforts of the Regional Office for Africa to counter the threat. Voluntary compliance with the relevant provisions of the International Health Regulations (2005) before their entry into force offered an essential strategic advantage, and would strengthen the all-important epidemiological surveillance phase. His country hoped to receive the necessary financial and technical support to assist it in implementing those provisions, and he therefore supported the draft resolution with the amendments proposed.

Dr ANDRADE GAIBOR (Ecuador) said that Ecuador, too, was exposed to the threat of avian influenza from migratory birds and was preparing to cope with an influenza pandemic, in terms of both preparedness and response, in line with WHO and PAHO recommendations. The Government had strengthened some of those recommendations, improving epidemiological surveillance, emergency response and contingency plans, detection, diagnosis and treatment, protocols, vaccination strategies, essential services, communication, research and assessment plans, risk management and reporting. Reliable information to local authorities in order to avoid false alarms and institutional capacity-building in both the health and the farming sectors were particularly important. Preparedness measures must extend to hospitals, which must be equipped with the appropriate diagnostic, emergency response and treatment facilities. Civil defence structures must likewise be properly informed and associated with contingency planning. Information strategies must be elaborated so as to inform and educate the general public. Should a pandemic occur, priorities must be set and the availability and affordability of medicines ensured.

Mr BARBOSA DA SILVA Jr (alternate to Dr Buss, Brazil) said that pandemic influenza required WHO to reinforce its role of coordination and technical guidance. WHO's progress in strengthening global capacity to deal with the threat was to be commended. He recommended strengthening the surveillance system, including laboratory capacities worldwide, and implementing the International Health Regulations (2005). He supported the proposal for voluntary compliance with relevant provisions of the Regulations, close collaboration between health ministries and animal health authorities and increased vaccine production capacity.

In Brazil, seasonal influenza vaccine was administered free of charge to all persons over 60, with more than 80% coverage in that group. Production was set to increase to 40 million doses per year. All possibilities for securing affordable antiviral medicines must be explored and access by developing country producers to new technologies facilitated. He praised WHO for providing support to countries in preparedness planning, and for mobilizing resources to compensate poor farmers and for implementing appropriate actions. He requested further information about the global stockpile of vaccines.

Dr TANGI (Tonga) noted that the level of pandemic alert was currently contained at phase 3. Tonga and other Pacific small island developing States were grateful to Australia and New Zealand for making their pandemic action plans available to them. He feared that, should a pandemic occur, assistance in the form of medicines and vaccines would not be readily forthcoming for the less developed countries. A more proactive advanced preparedness approach was needed. Experience from the 1918 influenza pandemic had shown that strict maritime quarantine policies, notably border controls, on the part of the Australian Government had prevented the virus from being imported into certain Pacific islands.

He proposed an amendment to subparagraph 4(3) of the draft resolution, adding at the end of the text: “and to share information and relevant biological materials related to highly pathogenic avian influenza and other novel influenza strains in a timely and consistent manner;”.

Dr WINT (Jamaica) commended WHO’s leadership in pandemic-influenza preparedness and response. His subregion was vulnerable on account of international travel, trade and bird migration. A new culture of surveillance was needed in the agricultural sector. The health sector was ill-equipped for influenza prevention and control, with little diagnostic capacity and no vaccine or antiviral agent available. Guidance from WHO was needed in respect of access to antivirals, and he endorsed the suggestion to establish regional stockpiles. He supported the draft resolution but only increased resources would enable timely implementation in his region. He agreed with the member for Australia that health systems needed to be reviewed and contingency plans drawn up.

Dr ILIESCU (Romania) thanked headquarters and the Regional Office for Europe for the prompt, effective and expert assistance provided following the recent cases of avian influenza in Romania. No human case had occurred. Numerous preparedness measures had been taken: including introduction of active country-wide surveillance, extensive vaccination, antiviral therapy, and legislation enacted. Domestic and international communication had emphasized a rational approach on that emotive subject. Romania had a vaccination capacity which, with some technical adjustment and financial support, would be self-sustaining. He stressed the importance of preventive measures and of cooperation at all levels.

Dr KHALFAN (Bahrain) expressed gratitude for the information provided by WHO. Bahrain had established an institutional infrastructure and taken preventive measures including the drawing up of national contingency plans required to deal with potential outbreaks of avian and human influenza. Information had been provided notably through the Regional Office for the Eastern Mediterranean. Antiviral medicines had been bought and agreements concluded with pharmaceutical laboratories, particularly for the provision of diagnostic materials. He stressed the importance of coordination between WHO and OIE in order to ensure the widespread availability of vaccines against avian influenza and urged all countries to share information.

Mr XING Jun (China)<sup>1</sup> commended the report and WHO’s significant work to improve surveillance, stockpile vaccines and raise public awareness of the risk. The recent International Pledging Conference on Avian and Human Pandemic Influenza (Beijing, 17-18 January 2006) had been attended by delegates of over 100 countries and more than 20 international organizations. In the Beijing Declaration, they had committed themselves to a consolidated prevention and control strategy, undertaken to establish international strategic partnerships, and agreed to strengthen veterinary and public health infrastructures, and to ensure transparency in the sharing of information. A total of US\$ 1900 million had been pledged for the prevention and control of avian influenza. The Conference would be influential for global prevention and control. WHO should exploit its technical superiority in the matter. The Secretariat should strengthen its collaboration with Member States and provide effective technical support to improve their capacity for surveillance and response.

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

China's considerable experience in prevention and control had enabled the planning of contingency response and timely diagnosis and treatment, based on clinical diagnosis and intervention. It had established, and was improving, a surveillance and reporting system for pathogens of unclear origin, which could be very effective for detection of highly pathogenic avian influenza viruses. China stood ready to share its experience in traditional remedies against viral diseases. Disease knew no borders, and China was eager to join the international community to arrest the spread of avian influenza.

Dr STEIGER (United States of America)<sup>1</sup> thanked the Director-General for his work on the issue and his public stance in drawing attention to the threat. The Director-General, and the Organization, did not always get the credit they deserved, as evidenced by the reporting of his remark to the Board that the emphasis on the threat of avian influenza was not misplaced under the headline "WHO Denies Exaggerating Bird Flu Threat". His attendance at the Beijing pledging conference was also appreciated. The lack of attendance by his counterpart at FAO was regrettable: it was important that the senior officials of the international organizations concerned should be seen to work together. The commitment to place a rapid response protocol on the WHO web site by the end of the week was appreciated.

He agreed on many points with previous speakers, including the member for Viet Nam on the need for countries to make a formal commitment to adhere to a joint strategy and do everything in their power to accelerate the entry of the necessary goods and personnel when a pandemic was expected. Many speakers had mentioned the need for investment to help countries to prepare for meeting the requirements of the International Health Regulations (2005). The funds already pledged by the international community at the Beijing conference, which would largely be used for building laboratory and surveillance infrastructures, should be regarded as part of that investment. The developing countries could in turn, by identifying their needs, help donors to coordinate their efforts. It should also be borne in mind that some things were better done at regional than national level. He agreed with the member for Tonga that border controls could be effective, as his own country's experience in American Samoa had proved. However, experts in the United States claimed that even if 99% of persons exposed to cases of disease from an affected area were refused entry or screened, the arrival of a pandemic would be delayed only by three weeks or a month.

The efforts to harmonize vaccine standards were praiseworthy. Middle-income countries should be encouraged to install vaccine-manufacturing capacity, but care should also be taken to respect intellectual property rights and regulatory requirements. Companies would not be eager to invest in influenza vaccines if existing incentives were destroyed.

International, regional and national stockpiling of antiviral medicines should not be seen as equivalent to international or national preparedness to counter the threat of avian influenza. According to a recent article in *Nature*, oseltamivir was of only limited effectiveness.

Public information about the threat should be coordinated and avoid causing panic. The emphasis should be on presenting a clear, consistent and uniform message.

The relevant provisions of the International Health Regulations (2005) should be implemented voluntarily as soon as possible through national focal points, and he looked forward to the international meeting on the subject to be held in the European Region in April 2006. He supported the draft resolution in document EB117/31, but proposed the deletion of the word "any" from subparagraph 4(6). National governments would not be willing to be bound in advance by recommendations issued by a future Director-General. He also wanted a clarification by the Legal Counsel of the use of the term "compliance" in relation to the Regulations. As they would not enter into force until June 2007, compliance in the meantime must surely be voluntary.

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

Ms EZHLOVA (Russian Federation)<sup>1</sup> said that the Russian Federation was preparing a national early warning plan and supported Board members' proposals for combating the threat of avian and human pandemic influenza, including voluntary compliance and early application of the International Health Regulations. It would be allocating more than US\$ 40 million, mostly for supporting and strengthening its laboratory network, to prevention and control on its own territory and in the Commonwealth of Independent States. To achieve the aim of early detection and diagnosis, the worldwide network of WHO collaborating centres and reference laboratories should be expanded, and the Russian Federation was prepared to propose the establishment of such a centre on influenza for the countries of eastern Europe and central Asia, at the State Research Centre of Virology and Biotechnology "Vector" in the Novosibirsk region.

Infectious diseases, including avian and human pandemic influenza, would be on the agenda of the forthcoming G8 summit, to be chaired by the Russian Federation. A national early warning plan being prepared would include a range of measures to be carried out by federal agencies. Thanks to a timely combination of veterinary health measures, an outbreak of avian influenza in poultry had been contained in the Russian Federation in 2005, and transmission to people in contact with sick or dead birds prevented. The Russian Federation was ready to share with others its knowledge and experience of preventing and controlling avian influenza.

Dr NABARRO (Senior United Nations System Coordinator for Avian and Human Influenza) said that leaders of countries facing the threat of an influenza pandemic were showing a firm commitment to respond. Much emphasis was being placed on the need for technical leadership from FAO and WHO. WHO should be congratulated on the strategy it had developed and the level of cooperation between the regional offices and headquarters in building a consensus around it. A single global plan of action, with accompanying protocols and guidance, was vital. His own role was to prompt the United Nations system as a whole to find ways of supporting the technical leadership of FAO and WHO.

He agreed that the health sector must not be left to deal with the threat on its own, and that means must be found to involve the entire machinery of government, together with the private sector, nongovernmental organizations and the media, in taking the necessary measures. A strong partnership was needed among all the relevant actors. WHO's work in setting up a special communications group to involve the media was to be commended. Commitment and involvement were essential in order to protect vulnerable countries from a threat that would damage their economies and affect the livelihoods of all, especially the poor.

When external assistance was offered, it was important to ensure that it would be accessible. Substantial funds had been pledged at the Beijing conference, but certain governments had complained of difficulties in gaining access to assistance because of the duplication of some resources and shortages of others. He agreed with the representative of the United States of America that the receiving countries should help the donors to coordinate their efforts, bearing in mind that there were different channels for providing technical assistance. The United Nations was committed to coordinating its assistance to countries, and to maximizing synergies while minimizing duplication in countering the threat.

The DIRECTOR-GENERAL said that he was grateful to Dr Nabarro for accepting the duties of Senior United Nations System Coordinator. Coordinating sometimes unwilling partners was a difficult and thankless task and, in the present instance, it entailed dealing with the agencies that had the most staff in the field and whose responsibilities related to food, in particular FAO, UNICEF and WFP.

Mr RAJALA (European Commission) said that the Commission aligned itself with the statement already made on behalf of the European Union. The European Commission had

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

strengthened its capacity for surveillance to deal with pandemic influenza and in December 2005 had issued two documents on the subject. The existence of the European Centre for Disease Prevention and Control had also improved the Union's prevention and control capabilities. The Commission had cosponsored the Beijing conference, was providing staff and expertise to assist Turkey in the present crisis, and was ready and eager to offer training and human resources to help build capacity, preparedness and response in WHO's Member States.

Dr BALE (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that, in anticipation of a possible influenza pandemic, the Federation had, in February 2002, set up the Influenza Vaccine Supply International Task Force to develop and test prototype and smart vaccines with a view to rapid approval and high-volume production of pandemic vaccines. At least 28 prototype vaccines were being developed by the 13 different Task Force members around the world. As there was no certainty that the H5N1 strain would form the basis for a possible pandemic, the prototypes focused on six main viral strains using a range of vaccine types. The production techniques for many prototype vaccines were based on use of eggs, but others used cell culture, which could provide for a more rapid production. Many different dosing regimens and three types of adjuvant were being tested. In certain cases, mock-up files had already been submitted to regulatory authorities in order to speed up the regulatory process for the approval of candidate vaccines.

Pharmaceutical companies were also scaling up production of new-generation antiviral medicines in order to buy time while the pandemic strain was identified and tailored vaccines were prepared. Industry and the international community must work together as full partners in key planning and decision-making processes, in order to meet pandemic-influenza challenges whenever and wherever they occurred.

Dr OMI (Regional Director for the Western Pacific) said that participants in the Japan-WHO Joint Meeting on Early Response to Potential Influenza Pandemic (Tokyo, 12-13 January 2006) had agreed that, under certain circumstances, transmission could be contained provided that any outbreak was detected and assessed rapidly and that appropriate interventions, including restriction of movement, social distancing and the distribution of antiviral medicines, were performed in a timely manner. As the nature of the pandemic strain was still uncertain, no accurate estimate of the transmissibility of the virus could be made. However, reaction time was limited; rapid containment measures had to be implemented at the latest two or three weeks after detection of the potential pandemic event. That target had so far been met for only half of the reported human H5N1 cases, and there was clearly a need to strengthen the capacity for early detection and reporting of avian influenza, particularly at grass-roots level. The response capacity developed for avian influenza would be effective for dealing with any other new diseases that might emerge in the future. Efforts currently being made to tackle avian influenza would therefore help countries to improve their capacities to implement the International Health Regulations (2005).

Mr BURCI (Legal Counsel), responding to the point raised by the representative of the United States of America, said that "compliance" meant behaving in conformity with something, on the basis of either an obligation or a voluntary decision. He therefore saw no inherent contradiction between use of the term "compliance" and the fact that the International Health Regulations (2005) had not yet entered into force. The text of the draft resolution had tried to avoid any ambiguity by inclusion of the word "voluntary" before the word "compliance". He therefore suggested that the word "voluntary" should be added before "compliance" in the amendment to subparagraph 5(5) proposed by the member for Canada.

Mr SHUGART (Canada), in response to an observation by Mr BURCI (Legal Counsel), said that as a member of the Board he would be pleased to second the amendment to the draft resolution proposed by the representative of the United States of America.

Dr CHAN (Assistant Director-General) welcomed the useful comments and constructive suggestions. The Secretariat owed its strong performance in pandemic influenza preparedness and response to the support of Member States and partners, strong leadership and management, and the dedication of the staff behind the scenes.

She reaffirmed the importance of strengthening surveillance, laboratory diagnosis and early warning systems. In countries where such capacity was weak, WHO, with the support of its partners, could provide technical assistance and training. The activities of the WHO Lyon Office of the Department of Epidemic and Pandemic Alert and Response had been re-prioritized with a view to enhancing national capacity with a strong linkage to the implementation of the International Health Regulations (2005).

Containment was one of WHO's top priorities, and a draft operational protocol would be posted on the web site by the end of the week. Comments would be welcome for discussion at a global meeting scheduled for March 2006. In the event of a pandemic, a standard operation procedure would not suffice; details of items to be prepared, such as stockpiles of antiviral agents and personal protective equipment, needed to be established, and the means for their deployment considered. Countries also needed to be consulted about legal and implementation concerns. Already, nearly every country had some kind of pandemic preparedness plan that reflected national levels of readiness and capacity development. WHO would work closely with countries to refine further and rehearse their plans. It would examine means to strengthen the capacity for diagnosis and management of cases and human resources planning. Maintenance of essential services, information management systems and communications strategy would be discussed with countries.

The media was an important partner and should never be regarded as the enemy. It provided a means of gauging a population's anxiety and level of knowledge, and WHO would continue to work closely with that industry. Communication was vital; informing the community would encourage social mobilization and promote behavioural change in order to reduce the risks of exposure. A pandemic communication meeting had been organized; subgroups were already working with the relevant agencies and Member States to formulate recommendations for countries. The efforts of both the Chinese and Thai Governments in mobilizing the community to undertake surveillance were commendable. A suitable surveillance system should be set up in all countries.

Research into and development of pandemic vaccines and antiviral agents would be coordinated. Recommendations and guidelines would be revised in the light of the latest information and the clinical experience of countries which had dealt with human cases of avian influenza. WHO was working closely with the manufacturers of antiviral agents with the aim of increased capacity. Sub-licences had been granted to China and India, and the manufacturers were prepared to work with developing countries that had the potential and capacity to manufacture oseltamivir. Close cooperation would be continued with the pharmaceutical sector with a view to fast-tracking development work on a pandemic vaccine in addition to a seasonal influenza vaccine.

The high level of support for voluntary compliance with the International Health Regulations (2005) before their entry into force was encouraging. WHO would provide support to countries for capacity building: the core competencies required by the Regulations were similar to those needed for surveillance and prevention of avian influenza. Resources invested in avian influenza would serve the interests of global health security in the long term.

Universal and smart vaccines were still in the research stages and it was too early to say when they would be available for use on a mass scale. She affirmed the importance of cross-country and regional cooperation, and was grateful to leaders in countries such as Canada and the United States of America for promoting an international partnership, that would next meet in April 2006.

Guidance on the stockpiling of antiviral medicines would be provided in due course. Country coordination was not easy, but United Nations agencies would provide support through their Resident Coordinators; regional and global monitoring and coordinating mechanisms would have to be discussed with donors.

Regarding technology transfer for the production of vaccines and antiviral agents, WHO had already provided technical assistance to Viet Nam, and she had noted the request for acceleration of



such efforts. Under the International Health Regulations (2005), Articles 5 and 8 to 13 in Part II imposed obligations on WHO to work with countries and Articles 15 and 49 in Part III were also relevant.

She told the member for the Libyan Arab Jamahiriya that WHO was already working closely with FAO and OIE, and would continue to support countries in developing integrated national plans covering both the animal and human sectors. Such plans were particularly important as donors had indicated that they would become the basis for funding support.

She thanked the member for Bhutan for his remark on the importance of non-pharmaceutical interventions, which, according to a WHO guideline, should be included in national preparedness plans. The latest evidence from meetings would be reviewed and promulgated to Member States.

Compensation for farmers and others was an important strategy, but a good balance had to be struck between overcompensation and undercompensation. The compensation experiences in countries affected by avian influenza should therefore be assessed, and she understood that the World Bank, perhaps with other financial institutions, was prepared to look into that.

In response to the question from the member for Bolivia, she said that poultry outbreaks did not always lead to human infection, especially when prompt measures were taken to control the outbreak. With regard to the early containment strategy referred to in paragraph 17, for perhaps the first time in human history, there was early warning of a pandemic and a narrow window of opportunity to prevent its devastating human and economic consequences. The importance of early containment work could not therefore be over-emphasized.

She thanked the member for Japan for the information provided and for his country's commitment to supporting countries in technical and financial terms. Geographical information systems were an important tool, and were being used in WHO's eventmanagement system, aimed at rapid provision of multidimensional information for mapping risk factors and response actions.

The role of migratory birds in spreading the disease had been acknowledged by FAO, WHO and OIE, but more research was needed to define that role. The member for Brazil had referred to WHO's coordinating role, which was certainly part of its core mandate. No global stockpile of a pandemic vaccine existed or could be generated, in view of the uncertainty as to which virus might spark a pandemic. Nevertheless, vital research and development to shorten the time frame for producing a pandemic vaccine was being undertaken by manufacturers.

She welcomed the proposal by the member for Tonga and agreed that the longer phase 3 could last, the better. The window of opportunity remained open, and, as long as all concerned worked together, there would be more time for pandemic preparedness. It was impossible to predict when a pandemic would occur, but since the virus was endemic in many parts of south-east Asia, sporadic human cases were likely to be seen, and each offered an opportunity for the virus to mutate. Vigilance was therefore imperative: countries had to prepare for the worst and hope for the best.

She thanked Romania for its prompt collaboration with WHO and its partners; the situation had been well controlled. Bahrain's initiative and information-sharing had been instructive and helpful. China was to be thanked for hosting the Beijing meeting which had brought together donors, partners and Member States.

She strongly supported the view of the representative of the United States of America that a stockpile of antiviral medicines was not a silver bullet and should not be used as a surrogate for pandemic preparedness. Vaccines were the first line of defence, but antiviral agents had an important role to play in the interim, before the arrival of the pandemic vaccine.

It was too soon to say whether WHO would issue travel advice and impose border controls, which were problematic. Based on the current understanding of the influenza virus, such measures were unlikely to be very effective. Nevertheless, the transmission dynamics and attack rate of the new pandemic virus would need to be monitored before evidence-based recommendations could be made to Member States. She thanked the United States of America for its commitment to supporting Member States in building core competencies for implementation of the International Health Regulations (2005) and pandemic preparedness.

In connection with the aspiration of the Russian Federation and other countries to host a WHO reference laboratory, she undertook to review the issues surrounding designation as a WHO collaborating centre. The standard imposed on collaborating centres was extremely high. The rights, obligations and commitment required in terms of human and material resources would be communicated to Member States.

The DIRECTOR-GENERAL said that it was evident that WHO must work hard on preparedness and then act and react to coming events.

The CHAIRMAN said that the Secretariat would consolidate the proposed amendments to the draft resolution in a revised version that would be considered at a later time. In the meantime, in the absence of any objection, he took it that the Board wished to take note of the report on strengthening pandemic-influenza preparedness and response.

**The Board noted the report.**

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

- **Strengthening health and surveillance systems: use of information technology and geographical information systems** (Document EB117/32)

The CHAIRMAN said that he took it that the Board, having commented on the report in the course of its discussion on strengthening pandemic-influenza preparedness and response, wished to take note of the report.

**The report was noted.**

**2. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA:** Item 1 of the Agenda (Document EB117/1 Rev.1) (continued from the first meeting, section 1)

Dr SUWIT WIBULPOLPRASERT (Thailand), reporting on the informal consultations concerning the consideration of agenda items 4.3, International trade and health: draft resolution; 4.10, Intellectual property rights, innovation and public health; and 4.12, WHO's role and responsibilities in health research, proposed that the three items should be taken in sequence, and in numerical order. As a revised draft resolution on international trade and health had only just been circulated for informal consultation, the discussion could not take place before the morning of Thursday, 26 January 2006 if the 48-hour rule was to be respected.<sup>1</sup> The Board could, however, decide to waive that rule and bring the discussions forward to the afternoon of Wednesday, 25 January 2006.

The CHAIRMAN said that, if there were no objection, he would take it that the Board agreed to discuss the three agenda items in sequence as proposed, beginning on the afternoon of Wednesday, 25 January 2006 or the morning of Thursday, 26 January 2006, depending on progress with other items.

**It was so agreed.**

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<sup>1</sup> Rule 11 of the Rules of Procedure of the Executive Board.

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

#### **Eradication of poliomyelitis:** Item 4.4 of the Agenda (Documents EB117/4 and EB117/4 Add.1)

Mr GUNNARSSON (Iceland), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, welcomed the considerable progress achieved in moving towards global eradication of poliomyelitis. However, recent events, including the fact that in 2005, for the first time, the number of poliomyelitis cases in countries newly affected through imported poliovirus had been higher than in countries endemic for the disease, indicated that national vaccination plans must be strengthened in order to prevent re-emergence of the disease. Funds were needed to buy vaccines, conduct immunization campaigns, implement emergency outbreak responses, sustain sensitive disease surveillance and provide technical support to Member States. He therefore supported the draft resolution.

Dr RAHANTANIRINA (alternate to Dr Jean Louis, Madagascar) said that the countries of the African Region, including Madagascar, welcomed the recognition in the report of the efforts being made by countries in Africa and Asia. In Africa, strengthening of the Expanded Programme on Immunization through the approach of reaching every district, enhancement of epidemiological surveillance, and supplementary immunization campaigns had enabled Member States to make significant advances toward the eradication of poliomyelitis. All countries had established national committees for certification of poliomyelitis eradication and had access to reference laboratories. The main obstacles to eradication remained the low level of coverage of routine immunization in remote areas, the persistent lack of funds to sustain gains already made and inadequate human resources, especially in rural areas. Intensification of surveillance of acute flaccid paralysis, which provided improved guidance for immunization activities in pockets of transmission, and additional mobilization of resources would be needed to reinforce activities in the period to 2008 in order to interrupt transmission of the wild-type poliovirus in Africa and obtain certification of eradication.

She supported the draft resolution but proposed that in paragraph 1(3) the words “a minimum of two to five million children” should be replaced by “at least 90% of children” so that the provision was applicable to all countries, regardless of the size of their child population.

Dr ACHARYA (Nepal) said that Nepal had remained free from wild-type poliovirus from 2000 until September 2005, since when the virus had reappeared and two cases of poliomyelitis had been detected in a district on the border with India. The immediate response had included epidemiological surveillance in that and the surrounding areas in accordance with the national protocol. Continued support from WHO and development partners would be needed to sustain and consolidate eradication activities, and conduct supplementary immunization campaigns. He supported the draft resolution but asked for clarification of paragraph 1(5) in respect of the geographical extent of the poliomyelitis immunization campaigns required following the detection of poliovirus.

Dr SUWIT WIBULPOLPRASERT (Thailand), referring to both the report and conclusions and recommendations arising from the October 2005 meeting of the Advisory Group on Poliomyelitis Eradication,<sup>1</sup> said that it was disturbing to note the continuing risk from transmission of wild-type poliovirus in Nigeria, that 12 countries had reported imported wild-type poliovirus, that for the first time the number of poliomyelitis cases in countries newly affected through imported poliovirus had been higher than in countries endemic for the disease, and that more than 60% of poliomyelitis cases reported in 2005 were in outbreaks in countries previously free from the disease following importations of wild-type poliovirus from endemic countries. The ongoing outbreaks in Angola, the countries of the Horn of Africa, Indonesia and Yemen were of particular concern. He urged endemic

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<sup>1</sup> *Weekly epidemiological record*, 2005, **80**(47):410-416.

countries to exercise greater responsibility in containing the disease. All countries must implement concerted actions in order to interrupt transmission of wild-type poliovirus.

He supported the draft resolution before the Board, even though it proposed actions to be taken only in previously poliomyelitis-free Member States in response to the detection of circulating poliovirus. The resolution would have little impact unless measures were also taken in endemic countries, as recommended by the Advisory Committee on Poliomyelitis Eradication. He therefore proposed the insertion, before paragraph 1, of a new paragraph that would read “URGES poliomyelitis-endemic Member States to foster their commitments and responses in interrupting transmission of wild poliovirus and the application of monovalent oral poliomyelitis vaccine;” the existing paragraphs to be renumbered accordingly. Paragraph 1(3) should be amended to make it applicable to countries with a child cohort smaller than two to five million, by inserting the words “or as indicated by the total size of” after “two to five million children”. Paragraph 2(2) should be amended by inserting “and ensure adequate supplies of monovalent oral poliomyelitis vaccines” after “outbreak”. A new paragraph 2(4) should be added that would read “to report to the Executive Board at its 119th session on progress made in the implementation of this resolution;”.

Dr SINGAY (Bhutan), endorsing the remarks of previous speakers, supported the draft resolution, which emphasized the need for prompt and comprehensive action in response to the detection of circulating poliovirus, including a substantial increase in immunization coverage, more aggressive mobilization of funds by partners, led by WHO, and increased international collaboration as early as possible at all stages of the response. Bhutan had been free from poliomyelitis since 1986 and had succeeded in sustaining immunization coverage of more than 90% thanks to generous support from Japan to its Expanded Programme on Immunization.

Dr GASHUT (alternate to Dr Al-Keeb, Libyan Arab Jamahiriya), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, thanks to support from WHO and other partners, only three countries in the Region remained endemic for poliomyelitis. Political commitment, full engagement of national authorities and sustained intensification of efforts in the three endemic countries had resulted in a significant reduction in the disease, with only 113 cases reported in 2003 compared with some 35 000 in 1988. Following suspension of poliomyelitis immunization activities in 2003 in one country, a new epidemic had developed and poliovirus had spread to many countries previously free from the disease, resulting in re-establishment of infection. Despite that setback, which had necessitated significant investment over and above that needed for the endemic countries, progress in the three countries was encouraging; one had been free from the disease for more than a year and interruption of transmission was expected soon in the other two.

She supported the draft resolution but proposed the insertion of a new preambular paragraph to read “Noting the significant support extended by partners, appreciating their ongoing cooperation, and calling for their continuing support to national programmes in the final phase of the global eradication effort;”.

Experience had shown that any country that fell behind in its poliomyelitis eradication efforts was a danger to all. It was vital to preserve the gains made so far and realize the dream of a poliomyelitis-free world.

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

## **FOURTH MEETING**

**Tuesday, 24 January 2006, at 14:00**

**Chairman:** Mr M.N. KHAN (Pakistan)

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

**Eradication of poliomyelitis:** Item 4.4 of the Agenda (Documents EB117/4 and EB117/4 Add.1) (continued)

Mr SHUGART (Canada) said that the poliomyelitis eradication strategy's links with routine immunization and micronutrient supplementation should be mentioned in reports to the governing bodies as evidence of its integrated nature. WHO's staff working on the poliomyelitis programme had valuable experience, in surveillance for example, which could be transferred to influenza and other communicable diseases as poliomyelitis activities were wound down. That might help to alleviate the problem of human resources discussed the previous day in relation to influenza.

Dr BRUNET (alternate to Professor Houssin, France) said that the eradication of poliomyelitis was a key commitment of the international community. The Secretariat's activities were highly effective, being based on a high level of technical expertise, a swift response and a flexible and intelligent approach. France had increased its financial support for the eradication of poliomyelitis since 2004, and offered technical assistance where WHO considered necessary. He supported the draft resolution.

Dr SHINOZAKI (Japan) commended the Director-General's leadership in the effort to limit the international spread of wild-type poliovirus transmission since 2003. He supported the draft resolution, but observed that it referred only to action to be taken when wild-type poliovirus was detected in a previously poliomyelitis-free country; preventive action, such as maintaining a sufficiently high coverage of routine immunization, was also important. Was the recommendation that an oral poliomyelitis vaccine should be used also intended to apply to those poliomyelitis-free Member States which used inactivated vaccine? If not, WHO should develop further guidelines for the Member States concerned. It should also draw up a timetable for the eradication of poliomyelitis.

Dr PHOOKO (Lesotho), speaking in English, followed by Dr SÁ NOGUEIRA (Guinea-Bissau), speaking in French, on behalf of the Member States of the African Region, said that, as at the end of September 2005, 524 laboratory confirmations of wild-type polioviruses had been reported in eight countries of the Region, a decrease of 26% compared with the same period in 2004. Wild-type poliovirus transmission had re-emerged in five countries in 2004, owing to a failure to eradicate imported wild-type polioviruses. However, 29 of the 46 Member States of the African Region had been poliomyelitis-free for more than three years, despite improvements in their acute flaccid paralysis surveillance leading to the detection of more cases. By the end of June 2005, 35 countries in the Region had met the standards to qualify for certification. Almost all countries had established national expert committees and national certification committees, and most had established national task forces for the biocontainment of wild-type poliovirus.

The main challenge to eradication was the resurgence of wild-type poliovirus transmission in the Region since 2003, fed by intensified transmission in Niger and Nigeria, the scaling-down of supplementary immunization in recently poliomyelitis-free countries, low coverage of routine immunization and persistent shortfalls in funding. Health systems, including human resources, should be strengthened for the sake of greater vigilance and increased routine immunization coverage. The eradication of poliomyelitis called for a high degree of commitment.

Professor PEREIRA MIGUEL (Portugal) said that, as a partner in the Global Polio Eradication Initiative, his country strongly supported action to interrupt the final chains of wild-type poliovirus transmission worldwide. Member States must agree on a date when they would all stop using oral poliomyelitis vaccine, while maintaining their political and financial commitment to eradicating poliomyelitis. His country's health authorities had prepared a post-eradication action plan, designed to maintain high immunization coverage, sustain clinical, epidemiological and laboratory surveillance of acute flaccid paralysis and guarantee laboratory biocontainment of wild-type poliovirus. Portugal was committed to cooperation both directly with the Secretariat and through the European Union, to ensure that children in all countries were protected from poliomyelitis. He supported the draft resolution.

Dr ALI MOHAMMED SALIH (Iraq) thanked WHO for its support, which had enabled his country to build up its immunization capacity and remain poliomyelitis-free since 2000, despite its critical situation. Two urgent vaccination campaigns had been conducted in June and September 2005, achieving a coverage rate of more than 96%. As the national immunization programme covered only 85% of demand, he called on WHO to support at least two immunization campaigns annually. The country was building up its infrastructure, relying on primary health care and improving security. Environmental surveillance of the last remaining areas of endemic wild-type poliovirus was an essential part of the eradication process.

Dr SHANGULA (Namibia) supported the draft resolution, with the following amendments: paragraph 1(2) should be amended to read: "... three large-scale rounds of immunization using a type-specific monovalent oral poliomyelitis vaccine including, where applicable, house-to-house immunization. The first round ...". Paragraphs 1(3) and 1(4) should be combined and amended to read "targeting all children aged less than five years in the affected and adjacent geographical areas and using independent monitoring ...".

Dr ABDULLA (alternate to Dr Botros Shokai, Sudan) said that he too was concerned that insufficient attention was being given to poliomyelitis-endemic countries and those in which the disease had recurred. Three years' freedom from poliomyelitis was not enough to guarantee that a country would remain free of the disease permanently, as the experience of his country showed. He called for greater support of endemic countries and those where poliomyelitis had recurred, in the form of better surveillance systems, effective national immunization days, strengthening of routine immunization services, and improving immunization rates among hard-to-reach children. He supported the amendments to the draft resolution proposed by the member for Thailand.

Dr ANTEZANA ARANÍBAR (Bolivia), observing that the Americas had been declared free of poliomyelitis, expressed concern about the statement in the report that 57% of cases of poliomyelitis reported in 2005 had occurred in supposedly poliomyelitis-free countries. States must avoid complacency, remain vigilant and maintain their capacity, in terms of both laboratory facilities and human resources, to keep track of circulating wild-type polioviruses. He supported the draft resolution, but wanted sufficient emphasis on the need for vigilance in countries declared free of poliomyelitis.

The CHAIRMAN, speaking as the member for Pakistan, said that wild-type virus was still circulating in his country. However, there had been only 24 cases of infection in 2005, and it was hoped that mopping-up activities could begin in September 2006. Transmission had been interrupted in 100 of the country's 126 districts, and was expected to be stopped in the rest during 2006. Only one type of poliovirus was circulating at present. An efficient and sensitive surveillance system for acute flaccid paralysis was in operation, and a monovalent vaccine, three times more effective than other vaccines, had been used for the most recent round of immunizations. Coverage of 99.7% had been achieved. His Government was working with Afghanistan to ensure coverage of people who unofficially crossed the border between the two countries. Pakistan was fully committed, at the highest levels, to poliomyelitis eradication. It was conducted completely transparently and all data were shared

with WHO. He thanked the Secretariat and in particular the Regional Office for the Eastern Mediterranean, the Government of Japan and Rotary International for support.

Dr STEIGER (United States of America)<sup>1</sup> thanked Egypt, Niger, Pakistan, Afghanistan and Nigeria for their efforts to eradicate poliomyelitis in 2005. Much progress had been made, which was also to the credit of the Secretariat. The United States had long supported the campaign to eradicate poliomyelitis. WHO's contribution and such partnerships as those with the African Union and the Organization of the Islamic Conference were essential in mobilizing national commitment and political leadership. He observed that poliomyelitis due to wild-type poliovirus, after eradication, was listed as a disease requiring immediate notification under the International Health Regulations (2005), and urged all nations to adhere to that reporting requirement through voluntary compliance with the Regulations and to cooperate fully with the international campaign by reporting cases early and consistently. He supported the draft resolution and the proposed amendments. He called for contributions to make good the funding shortfall for 2006 and beyond.

Mr HÖRNDLER (Rotary International), speaking at the invitation of the CHAIRMAN, commended the dedication shown to the global eradication of poliomyelitis, to which he pledged his organization's continued commitment. Despite the many challenges in 2005, phenomenal progress had been made. Africa's efforts to eradicate poliomyelitis were back on track, after successful multinational, synchronized immunization campaigns. India, once accounting for more than 70% of the global poliomyelitis burden, had almost achieved eradication with only 65 cases reported in 2005. Egypt, one of the world's six poliomyelitis-endemic countries, had been poliomyelitis-free for over a year. By the time of global certification, Rotary International would have contributed more than US\$ 600 million, in addition to the countless hours its volunteers had spent immunizing over 3000 million children in 122 countries. The poliomyelitis initiative had been hailed as an example for other global health endeavours and, having come so close, must be brought to a successful conclusion.

The CHAIRMAN praised Rotary International for its highly commendable contribution to poliomyelitis eradication.

Dr HEYMANN (Representative of the Director-General for Polio Eradication) thanked Member States, on behalf of the other core partners in the Global Polio Eradication Initiative, UNICEF, Rotary International, and the United States Centers for Disease Control and Prevention, for their comments and poliomyelitis eradication efforts. He welcomed the proposed amendments to the draft resolution. Of the 21 poliomyelitis-free countries where reinfections had been detected since 2003, all but seven had been able to stop transmission of poliovirus, thanks to strong political support from such groups as the Organization of the Islamic Conference, the Commonwealth, the African Union and the G8. The availability of monovalent vaccines for types 1 and 3 polioviruses would enable responses to be tailored to countries' needs. In addition to its role in detecting disease and ensuring that children received vaccines, the poliomyelitis eradication infrastructure had contributed to other initiatives such as campaigns for the provision of vitamin A and for the supply of bednets to women and young children to prevent malaria, as well as strengthening country proposals to the Global Alliance for Vaccines and Immunization. The poliomyelitis surveillance network had also contributed to the response to major outbreaks and disasters, for example its assessment of the infectious disease situation after the earthquake in Pakistan, its work in Angola during the outbreak of Marburg haemorrhagic fever and its work during the outbreak of severe acute respiratory syndrome. Discussions were under way to determine the network's potential role in the area of communicable diseases, including avian influenza. The guidelines for response to outbreaks involved the use of monovalent oral poliomyelitis vaccine, but recommendations for inactivated poliomyelitis vaccine

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

would also be included. He thanked partners for their efforts in reducing the 2006 shortfall of US\$ 200 million to US\$ 150 million, and for the work they had done in general to eradicate poliomyelitis.

Mr AITKEN (Director, Office of the Director-General) read out the proposed amendments that members had supported. Two new preambular paragraphs had been proposed: “Noting that the majority of new cases have come from areas which had already stopped transmission of indigenous polioviruses;” and “Noting the significant support extended by partners, appreciating their continuous cooperation, and calling for their ongoing support to national programmes in this final phase of the global eradication effort;”. A new paragraph 1 would read: “URGES polio-endemic Member States to foster their commitment to interrupting transmission of wild polioviruses with the application of appropriate monovalent oral poliomyelitis vaccines;”. The original paragraph 1(2) had been slightly reworded to read: “implementing a minimum of three large-scale rounds of immunization using a type-specific monovalent oral poliomyelitis vaccine, including, where applicable, house-to-house vaccination, ...”. After informal consultations with members, the following merged version of paragraphs 1(3) and 1(4) was proposed: “targeting all children aged less than five years in the affected and adjacent geographical areas, using independent monitoring to determine whether at least 95% immunization coverage has been reached;”. Paragraph 1(5) would read: “ensuring that at least two full rounds of poliomyelitis immunization are conducted in the targeted area after the most recent detection of polioviruses”. Paragraph 2(2) would read: “to assist in mobilizing funds and ensuring adequate supplies of monovalent oral poliomyelitis vaccine to implement emergency response to an outbreak;” and a new final subparagraph should be added: “to report to the Executive Board at its 119th session on progress made in the implementation of this resolution”.

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

**HIV/AIDS:** Item 4.5 of the Agenda

- **Universal access to prevention, care and treatment** (Document EB117/6)
- **Nutrition and HIV/AIDS: draft resolution** (Documents EB117/7 and EB117/7 Add.1)

The CHAIRMAN drew attention to a draft resolution on implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, proposed by Austria, Belgium, Canada, the Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Madagascar, Malta, Mexico, Monaco, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, South Africa, Spain, Sweden, Switzerland and the United Kingdom of Great Britain and Northern Ireland, which read:

The Executive Board,

Having considered the report on HIV/AIDS: universal access to prevention, care and treatment,<sup>2</sup>

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

The Fifty-ninth World Health Assembly,

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<sup>1</sup> Resolution EB117.R1.

<sup>2</sup> Document EB117/6.



Taking note of the report on HIV/AIDS and universal access to prevention, care and treatment;

Recognizing the role of WHO as a cosponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS);

Recalling the decisions of the Seventeenth Programme Coordinating Board of UNAIDS (27-29 June 2005, Geneva);

Commending the final report of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors;<sup>1</sup>

Noting, in that regard, that improved coordination and harmonization of efforts and a clear division of responsibilities between UNAIDS and its cosponsors will be required, together with coordination with national and global partners;

Noting the emphasis placed on support for action at country level and on developing the national response,

1. ENDORSES the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors;

2. REQUESTS the Director-General:

(1) to implement the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, to prepare appropriate plans of action, in collaboration with UNAIDS and the other cosponsors, and to maintain the momentum created by the Global Task Team, within the deadlines set;

(2) to report to the Health Assembly on progress made in implementation of the recommendations of the Global Task Team and to use that report to inform the Programme Coordinating Board of UNAIDS;

(3) to provide effective technical support to national governments and, in conformity with the agreed division of work, to focus on those areas in which WHO has an advantage compared to other bodies.

Ms TOR DE TARLÉ (France), introducing the draft resolution, summarized the main recommendations of the Global Task Team. It was important that WHO join other international bodies in officially endorsing those recommendations. The draft resolution should have no administrative or financial implications; on the contrary, implementation of the recommendations would, through the resulting synergy achieved between the different international players, lead to optimal use of resources.

Mr GUNNARSSON (Iceland) endorsed the report on universal access and strongly agreed that treatment and care should go hand-in-hand with prevention. To that end, primary health-care systems must be strengthened. His country, together with the Nordic countries, welcomed the proposal in the report to establish a rapid and participatory process at country level for setting country-specific targets on prevention, treatment, care and support services to be reached by 2010. He supported the draft resolution.

Dr WINT (Jamaica) commended the report. Thanks to the “3 by 5” initiative 60% coverage with antiretroviral treatment had been achieved in his country in just more than one year since its introduction. Jamaica was still working towards full implementation of the Three Ones principle, and recognized the importance of involving multiple stakeholders and networks of people living with

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<sup>1</sup> Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors: Final Report 14 June 2005, Geneva, UNAIDS, 2005.

HIV/AIDS. Jamaica's experience was testimony to the reported "lessons learnt", in particular the decentralization of the programme and its greater integration within other local level programmes. Control of sexually transmitted infections was closely related to HIV/AIDS control, and he noted the importance of training in voluntary counselling and testing at community level. Access for vulnerable groups in particular needed to be improved, and the stigmatization and discrimination concerning HIV/AIDS constituted an additional major challenge for his country, hindering achievement of universal access to prevention, care and treatment. Nutrition was a crucial element in treatment. He welcomed the draft resolution.

Dr ALI MOHAMMED SALIH (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, in the area of universal access, those countries had shown increasing political commitment in their response to HIV/AIDS. Some had been offering free antiretroviral treatment to all in need for several years. Others were having difficulty fulfilling their commitments, owing to weak health systems and infrastructure. The high cost of antiretroviral treatment and laboratory tests was halting the expansion of services, and stigmatization was a major obstacle to the uptake of prevention and treatment services. In September 2005 the Regional Committee for the Eastern Mediterranean had endorsed the regional strategy to strengthen the health-sector response to HIV/AIDS. He therefore welcomed the global commitment to universal access. There was a growing need, however, for technical assistance to support capacity building, advise countries about antiretroviral treatment costs and provide tools and guidelines for ensuring greater prevention, treatment and care.

Mr AZIZ (alternate to Dr Ali Mohammed Salih, Iraq) said that measures to prevent transmission of HIV must be taken within the context of the International Health Regulations (2005) and treaties. The media had to be used to raise popular awareness about the disease. Strategies needed to be regularly reviewed over the 10 years ahead in order to assess and control transmission, and be set within the framework of the Millennium Development Goals.

Dr SHANGULA (Namibia), speaking on behalf of the Member States of the African Region, said that the HIV/AIDS pandemic remained one of the greatest public health challenges in the Region, with an estimated three million new infections and 2.5 million AIDS-related deaths in sub-Saharan Africa in 2004. It also had serious implications for national security and socioeconomic development. In many countries, access to prevention and care services remained elusive. Countries had responded positively to the global call to increase access to comprehensive care for people living with HIV/AIDS within the context of the "3 by 5" initiative, but the weaknesses of health systems meant that access to both prevention and treatment services remained insufficient to stem or reverse the epidemic. Nevertheless, considerable progress had been made in the provision of antiretroviral therapy. By June 2005, 500 000 people in sub-Saharan Africa were receiving antiretroviral treatment. Botswana, Namibia and Uganda had already met their "3 by 5" targets. Such results had been achieved through increasing advocacy and partnerships, the commitment of national governments and their ownership of control programmes, the provision of technical support and support for mobilization of funds from donor agencies.

Botswana, Burkina Faso, Côte d'Ivoire, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Madagascar, Malawi, Mauritania, Namibia, Nigeria, Seychelles, Swaziland, Uganda, Zambia and Zimbabwe had initiated comprehensive HIV testing and counselling services, but otherwise progress towards improving access to such services had been limited. Although access to services for prevention of mother-to-child transmission of HIV had improved, they still only reached 10% of those in need. Incipient declines in prevalence rates in pregnant women in Burkina Faso, Burundi, Kenya, Namibia, Uganda and Zimbabwe were encouraging. Among the challenges facing the African Region, Member States needed to ensure delivery of locally-defined essential prevention and care interventions, strengthen HIV prevention sufficiently to have an impact on the epidemic; to ensure universal access to comprehensive care; and to generate and better use strategic information. He urged WHO to continue its valuable contribution to partnerships, which were crucial to success.

Ms HALTON (Australia) affirmed Australia's commitment to the United Nations 2005 World Summit goal to come as close as possible to universal access to treatment by 2010. Her Government accepted that a package of interventions for HIV/AIDS must involve prevention, treatment and care but noted the absence of an internationally agreed target for universal access to prevention or care services. Defining universal access to prevention was also difficult. In working towards the goal of universal access to treatment, Member States should ensure that they did so without jeopardizing prevention and care programmes. Countries should aim to achieve a balance in their investment in prevention, care and treatment that was appropriate to national needs. In areas with rapidly emerging epidemics, such as the Western Pacific Region, it was crucial to maintain a strong preventive response while building capacity to meet increasing needs for treatment and care. National governments must provide the resources, funding and capacity to implement and maintain universal access to treatment in the medium to long term.

The "3 by 5" initiative had been an important catalyst, but problems remained relating to capacity, funding and human resources, on which the Organization should continue to focus. Implementing the recommendations of the Global Task Team had been promising, and WHO and other UNAIDS cosponsors should ensure the swift operationalization of the UNAIDS division of labour for technical support. Australia wished to be added to the list of sponsors of the draft resolution.

Mrs LE THI THU HA (Viet Nam) welcomed the process proposed by WHO and UNAIDS to enhance commitment to universal access by 2010, and the lessons that had been learnt from the "3 by 5" initiative. In March 2004, her Government had approved a national strategy for HIV/AIDS prevention and control up to 2010, with objectives and targets in line with universal access: 100% of urban dwellers and 80% of those living in mountainous and rural areas should understand about HIV transmission and how to prevent it; high-risk groups should have access to comprehensive harm-reduction measures, such as safe injections and condoms; 90% of infected adults, 100% of HIV-infected pregnant women and 100% of HIV-infected or HIV-affected children should receive appropriate treatment, care and counselling, and 70% of AIDS patients should be treated with specific medicines. The national strategy included harm reduction, care and support, surveillance, monitoring and evaluation. Insufficient funding created bottlenecks and her country would appreciate assistance to implement its national strategy, building on the "3 by 5" initiative. Additional practical guidance was needed in all those areas.

The continuing high cost of antiretroviral medicines posed a further problem. She requested information on the plans to expand the WHO Prequalification Project and further steps to promote prevention based on the progress made by the "3 by 5" initiative.

Coordination and harmonization of different initiatives in countries were crucial to expanding HIV services. WHO had supported countries in elaborating technically sound national guidelines and protocols. For injecting drug users, however, she asked whether general practical guidance was being issued. She supported the draft resolution.

Dr MUSTAFA (alternate to Dr Botros Shokai, Sudan) said that Sudan was the most affected country in the Eastern Mediterranean Region. Increased control of HIV/AIDS was needed. Although attitudes towards HIV/AIDS interventions were becoming more open, the response was still not equal to the challenge. The goal of universal access would entail strengthening the entire health system, from ensuring continuous supplies of antiretroviral medicines to training personnel and creating monitoring and evaluation systems. Sudan could achieve the present target to provide 4000 patients with antiretroviral medicines. So far 400 people were receiving treatment and medicines were available for a further 1500. The number of treatment sites had increased from 3 to 14 between 2004 and 2005.

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the Member States of the European Union, the acceding countries, Bulgaria and Romania, the candidate countries, Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates, Albania, Bosnia and Herzegovina, and Serbia and

Montenegro, said that the fight against HIV/AIDS was one of the biggest global health challenges. In 2005 the group of countries had made a commitment to developing and implementing a package for HIV/AIDS prevention, treatment and care to achieve near universal access by 2010. In only 12 months under the “3 by 5” initiative, the number of people in Africa receiving treatment had trebled. However, the target set had not been reached. Recent figures from UNAIDS showed that the number of cases of infection and death continued to increase; the Millennium Development Goal of halting and reversing the HIV/AIDS epidemic by 2015 was therefore still a long way off.

In Europe, high rates of HIV infection in some vulnerable groups were a continued threat for the spread of the disease in the general population and reignition of the epidemic among those groups. In December 2005, the European Commission had adopted a new Communication on combating HIV/AIDS within the European Union and in neighbouring countries for the period 2006 to 2009. The European Union strongly supported the work of the Global Steering Committee on Scaling Up towards Universal Access, which initiative should be a country-led process and cover the full range of necessary activities from prevention to treatment and care. It also placed great emphasis on the relevance of the final report of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, and on WHO being the implementor of the report’s recommendations. Countries establishing a single United Nations team had been given priority. If United Nations agencies, including WHO, would focus on their core mandate and move from competition to coordination and collaboration, the global community would be better served. The United Nations High-level Plenary Meeting (New York, September 2005) had welcomed the recommendations contained in the Global Task Team report and several UNAIDS cosponsors had already endorsed its recommendations, as had the Global Fund to Fight AIDS, Tuberculosis and Malaria. The recommendations signalled a commitment to operational change. WHO also needed to give greater responsibility to its regional and country offices. The European Union encouraged the Board to endorse the recommendations. He invited other European Union Member States to sponsor the draft resolution.

During the Third Meeting of the Global Fund’s Voluntary Replenishment Mechanism (London, 5-6 September 2005) the Union had emphasized its commitment to the Fund’s role as a major mechanism for ongoing investment in the fight against HIV/AIDS, tuberculosis and malaria. Several European Union Member States, as well as the European Commission, had made significant pledges to the Global Fund for the 2006-2007 biennium.

The European Union had noted recent progress in connection with HIV/AIDS regarding nutrition and orphans and stressed the importance of such activities, which were vital in enabling both WHO’s health targets and the health-related Millennium Development Goals to be met in the most affected regions. For World AIDS Day 2005, the European Union had adopted a Statement on HIV Prevention recognizing the need for a massive expansion of activities and emphasizing universal access to sexual and reproductive health information and harm-reduction commodities; provision of accessible and integrated health promotion and harm reduction services for drug users; reliable access to essential sexual and reproductive health; universal access to education and provision of life-skills and sex education; integration of prevention measures, including voluntary counselling and testing, into other health services; action to confront and address gender-based violence and to provide protection and support for victims of violence; support for investment in developing new biomedical prevention technologies, including microbicides and vaccines; and the promotion and adoption of good workplace practice.

The European Union recognized WHO’s key role in the response to HIV/AIDS. The United Nations General Assembly special session on HIV/AIDS, to be held in September 2006, would review the status of implementation of its Declaration of Commitment.

Speaking in his capacity as the member for Portugal, he said that his country, where the incidence of HIV infection remained unacceptably high, accorded high priority to HIV/AIDS and had devised a national plan. The national policy focused on testing as an essential first step in prevention, treatment and care. However, there was consistent evidence of low prevalence among pregnant women; it also appeared that perinatal transmission was close to being controlled. Cases of infection among injecting drug users had decreased, but heterosexual transmission was rising. Managing

HIV/AIDS was part of a wider fight against sexually transmitted diseases, hepatitis C and tuberculosis. A new integrated policy approach could provide access to the necessary care.

Portugal was committed to promoting research and action on HIV/AIDS and nutrition, in particular, through a network of trained nutritionists in both hospital and outpatient services. Since nutrition was considered essential in education about the treatment of HIV/AIDS, a manual on antiretroviral adherence for people living with AIDS was being prepared in collaboration with several nongovernmental organizations.

Dr SOPIDA CHAVANICHKUL (adviser to Dr Suwit Wibulpolprasert, Thailand) said that Thailand wished its name to be added to the list of sponsors of the draft resolution.

The current increase in HIV incidence and the inadequacy of prevention services to meet the need represented a major threat to global AIDS responses. Universal access to treatment and care should not be at the expense of prevention efforts. According to UNAIDS data, fewer than one in five people at risk of contracting HIV had access to basic prevention services; only one in 10 people thought to be living with HIV had been tested for the virus. In South-East Asia, only 0.1% of people between 15 and 49 years had received counselling or been tested. In sub-Saharan Africa, only 5% of pregnant women living with HIV had access to services to prevent vertical transmission. Attention needed to be paid to overcoming operational barriers to effective management and delivery of prevention programmes. It would be beneficial to integrate prevention, care and treatment. A wider uptake of HIV testing could mean less stigmatization and denial. Intensified prevention was needed to make treatment affordable and sustainable. The cost of first-line medicines was still high in poor countries, and second-line antiretroviral medicines were unaffordable even in middle-income countries. Costs posed a major challenge for the years ahead.

Ms TOR DE TARLÉ (alternate to Professor Houssin, France) recalled that, with regard to universal access, several Board members had already emphasized the problems arising from funding and the high cost of medicines. The President of France was committed to the principle that everyone in need should have access to antiretroviral treatment and, therefore, the Declarations that had come from the Summit of the G8 group of countries (Gleeneagles, Scotland, 6-8 July 2005) and the United Nations High-level Plenary Meeting (New York, September 2005), both of which had emphasized the objective of ensuring universal access to treatment by 2010, had been extremely welcome. She drew attention to the link between prevention and care and the importance of mobilizing civil society and of integrating any new actions in existing primary care and reproductive health programmes. Six million people with HIV in the developing world urgently needed antiretroviral treatment, yet current production levels and market forces made it impossible to meet the demand.

In order to combat AIDS, it was imperative to ensure drug security. France considered that official development aid would not be enough to generate sufficient and sustained resources needed by developing countries. It therefore proposed setting up an international solidarity fund by placing a tax on air tickets. A proportion of the revenue generated would be used to purchase drugs and encouraging increased production of antiviral and antimalarial drugs. It also proposed the creation of an international drug purchase facility that would mobilize resources over the medium- to long-term to facilitate the purchase of drugs and other medical products such as diagnostic kits necessary for the treatment of AIDS, tuberculosis and malaria. The facility would promote a restructuring of the market in medicines, particularly antiretroviral agents, enabling costs to be lowered through better-organized competition and a relatively long-term mutual commitment between manufacturers and purchasers. Quality would be ensured through prequalification by WHO and by approved agencies. The emphasis would be on making use of existing mechanisms rather than on creating new international systems.

Mr SHUGART (Canada) said that his country was deeply disturbed by the tenacity of the scourge of HIV/AIDS, the increase in new infections, the destabilizing potential of the disease and the human suffering it caused. It fully supported WHO's approach, in particular the principle of universal access to prevention, care and treatment. Canada also supported the emphasis given by UNAIDS to the need to ensure a human rights-based approach, which should also be adopted by WHO. Scaling up

universal access should be assessed in the context of strengthening health-care systems generally, notably in regard to human resources, and interventions should be closely linked to primary health care and to reproductive health services.

He proposed that paragraph 1 of the draft resolution introduced by France should be strengthened by the addition of the words “and furthermore endorses all the related decisions of the Programme Coordinating Board”. In paragraph 2(3) the word “agreed” should be deleted and the words “agreed among the UNAIDS cosponsors” added after “division of work”.

Dr SHINOZAKI (Japan) commended the Director-General’s leadership in launching the “3 by 5” initiative. It was important to identify the obstacles that had prevented the expansion of treatment services. He welcomed the approach to universal access outlined in the report and looked forward to an implementation plan. Monitoring and evaluation would be crucial.

Dr GASHUT (alternate to Dr Al-Keeb, Libyan Arab Jamahiriya), speaking on behalf of the Member States of the Eastern Mediterranean Region, proposed that the words “and the United Nations Framework on Priority Action in HIV and Infant Feeding” should be added at the end of paragraph 1(3)(a) of the draft resolution contained in document EB117/7. That would ensure a consistent approach to policy-making in that area, in the light of the fact that resolution WHA57.14 made reference to the Framework.

Dr ANDRADE GAIBOR (Ecuador) said that enough had been said about prevention: the emphasis should turn to finding and following up infected persons. The disease did not affect only the poor or the sexually promiscuous, but was found in all sectors of society: in his country, for instance, renal dialysis had caused the virus to be transmitted on a massive scale to people without other risk behaviours. The focus should be on education for the public, patients and the community. Laboratory services, antiretroviral medicines and hospital care had to be accessible to all; they were still too expensive for many people. He supported the draft resolution contained in document EB117/7.

Dr RAHANTANIRINA (alternate to Dr Jean Louis, Madagascar) said that HIV/AIDS was one of the principal causes of death in Africa, especially sub-Saharan Africa. Universal access to treatment was crucial, and the “3 by 5” initiative had done much to accelerate achievement of the Millennium Development Goals. Harmonization and coordination of interventions would allow more effective use of resources.

She too supported the draft resolution introduced by France and endorsed the draft resolution contained in document EB117/7 as amended.

Dr BUSS (Brazil) expressed regret that it had not been possible to achieve the targets of the “3 by 5” initiative and asked for an inquiry into whether non-availability of medicines, management problems in the Secretariat, or human resource problems in countries had been responsible for the failure. Unless lessons could be learnt from that experience, there was a risk that future efforts too would be unsuccessful.

Brazil had spent US\$ 400 million in the previous year on antiretroviral medicines, 67% of that sum on three drugs alone, but had experienced enormous difficulties in negotiating prices with the big pharmaceutical companies. The problem of AIDS would not be solved unless the issue of intellectual property rights was resolved, enabling governments to take action to defend public health, and an integrated approach taken that promoted solidarity between countries. He urged the Board to take a strong ethical stand in regard to the availability of medicines. Brazil had been obliged to take funds from other programmes to finance its AIDS programme.

Brazil supported the international solidarity fund proposed by France.

Dr ACHARYA (Nepal) said that the epidemic of HIV/AIDS in his country was concentrated in certain high-risk groups: 50% of injecting drug users were infected, as were 17% of female sex workers. In all, some 62 000 people were estimated to be infected, with up to 9000 needing

antiretroviral treatment, of whom only 450 were receiving it. Cross-border migration caused by insurgencies further compounded the risk of infection; in such situations, the solidarity between countries referred to by the previous speaker would be invaluable in controlling the spread of the disease. The HIV infection rate was rising rapidly, although it was difficult to gain reliable data, in part because of social stigmatization. Provision of antiretroviral medicines and community care was insufficient, and technical and financial assistance was still urgently required.

Dr TANGI (Tonga) thanked those governments that had been providing assistance in combating AIDS in the Pacific area. The Global Task Team had improved coordination between donor agencies and institutions.

Dr RUÍZ MATUS (alternate to Mr Bailón, Mexico) said that his country supported the commitment to tackle the epidemic by placing emphasis on prevention as well as treatment. In 2004, Mexico had reached the target, originally set for 2006, of providing antiretroviral medicines to those in need who were not covered by social security. It had also progressed in creating new models for those living with HIV/AIDS: from 2004, day-patient centres for prevention and treatment of AIDS and other sexually transmitted infections had been set up in various parts of the country. Mexico was also working to fight discrimination against people with AIDS, in conjunction with civil society bodies, and had become the Latin American representative in the Global Fund to Fight AIDS, Tuberculosis and Malaria. The draft resolution proposed by France and other countries would help to avoid poor resource use. Coordination was essential.

Dr SINGAY (Bhutan) also supported that draft resolution and welcomed the progress achieved towards universal access by 2010, which would help Member States to achieve the relevant Millennium Development Goals by 2015. The “3 by 5” initiative had made it possible for Bhutan, which was in the early stages of an HIV/AIDS epidemic, to render access to antiretroviral medicines universal. Coverage had risen and as a result people were living longer: that was a significant achievement of the initiative that ought to be recorded and appreciated.

Health systems particularly in primary health care must be strengthened in order to achieve universal access, and people living with HIV/AIDS should be represented in HIV/AIDS programmes. In view of the high cost of first-line and second-line drugs, prevention must be prioritized. For Bhutan, combating HIV/AIDS was going to be a major challenge.

Dr ANTEZANA ARANÍBAR (Bolivia), referring to the administrative and financial implications of the proposed draft resolution contained in the report,<sup>1</sup> asked for similar estimates for the implementation of countries’ HIV/AIDS programmes. He shared the concerns expressed by the members for Brazil and Canada.

The CHAIRMAN, speaking as the member for Pakistan, said that his Government was fully committed to the national strategic framework for HIV/AIDS control. Despite the apparent low prevalence of HIV in Pakistan, coordinated action was needed to prevent an epidemic. Eleven antiretroviral medicines had recently been included in Pakistan’s essential medicines list and free access to such drugs was available with the help of the Global Fund.

Young people had to be educated to realize that antiretroviral medicines did not provide a solution to HIV/AIDS and that promiscuous behaviour should be avoided. Pakistan fully supported the process proposed by WHO and UNAIDS for providing universal access to HIV/AIDS prevention, care and treatment by the year 2010. It was crucial to engage world leaders, the pharmaceutical industry and the general population on the issue of antiretroviral medicines. Further studies were needed on the links between HIV/AIDS and other diseases. Many countries had the capacity to produce antiretroviral

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<sup>1</sup> Document EB117/7 Add.1.

agents, and a moral decision was needed on the issue of intellectual property rights in order to allow them to do so.

Dr STEIGER (United States of America),<sup>1</sup> endorsed the views of the previous speaker on prevention. On the question of treatment and universal access, his country, as a member of the G8 group of countries and under the President's Emergency Plan for AIDS Relief, was committed to near universal access to antiretroviral treatment by 2010. In the past two years, it had helped to provide such treatment for more than 400 000 people. Some challenges remained, such as the price of pharmaceuticals, and his country was working closely on that issue with generic drug manufacturers from many countries. The United States had an approval process to ensure that products from producers in developing countries were safe and effective and thus eligible for procurement under its programme. National governments should look to producers who had already received approval before using their resources to build up national companies; many safe and effective products were already available. Countries also had to help by reducing tariffs charged on imported medicines, and he appealed to WHO and governments to assist in breaking down regulatory barriers.

The three medicines mentioned by the member for Brazil were basically second-line therapies. Treatment was failing in many countries, and resistance to present drugs was growing. The question of who would be willing to make the third-line drugs if incentives were removed for the private sector to continue to invest in HIV therapy should be borne in mind.

He supported the draft resolution introduced by France, but pointed out that his country endorsed not a global action plan but the concept adopted by the United Nations General Assembly, namely the recommendation for consolidated action consistent with a country-driven process. The United States did not equate "country-driven" with "government-dominated"; it expected everyone to work with the private sector, nongovernmental organizations and civil society, and notably with faith-based and community organizations, as partners in the process. It supported and encouraged WHO's work in that regard.

Mrs FURMAN (Israel)<sup>1</sup> asked for Israel to be included among the sponsors of the draft resolution.

Ms MANE (UNAIDS) assured the Board that the process towards universal access was country-led and multi-partnered, aiming mainly at identifying major obstacles to access and practical solutions to overcome them. Prevention, treatment, care and support were equally important, but she particularly appreciated the attention paid by WHO to prevention. UNAIDS was working on an action plan to support accelerated prevention.

National authorities were holding consultations with stakeholders on how to work towards universal access in order to formulate regional strategies. The Global Steering Committee had met first in January 2006. It was likely to recommend that countries should establish their own targets for 2010 and that UNAIDS should assist by offering existing indicators that could be used in national target-setting and reporting. The targets would be finalized by 2006, and would include some interim progress targets for 2008.

Ms KEITH (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, supported the focus on universal access and the need to overcome barriers such as weak health systems, lack of human resources for health and payment for health services at the point of access. The subject related to other items on the agenda, and in relation to item 4.12, WHO's roles and responsibilities in health research, the Secretariat should, with UNAIDS and other stakeholder partners, commission research into the cost of providing an essential health-care package, including HIV care and treatment, that would be free at the point of access. Such research would update the

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



2001 figure, since it would need to take into account new treatments. Reference should be made to resolution WHA58.31, which dealt with such issues.

Her organization had carried out research, over a period of five years, on conditions in seven countries in east and central Africa, and specifically on the negative impact of chronic illness on household expenditure, and access to health care for poor families. Technical and financial resources should be allocated, both nationally and internationally, to determine what mechanisms could ensure that health and HIV services could be provided free at the point of access for all.

She welcomed the establishment of the Global Task Team.

Concerning the impact of HIV on children, she urged WHO and donors to support research into paediatric formulations of antiretroviral medicines. Programmes on the social determinants of health and HIV, such as gender, power relations, education and poverty, should also be supported. Further work should be done on health promotion, especially with regard to stigmatization and discrimination. She supported the statement by the European Union and the draft resolution introduced by France.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN, commended WHO's bold "3 by 5" initiative, which had acted as a catalyst in improving access to prevention, treatment and care. The millions of nurses that he represented would continue to collaborate with WHO in combating HIV/AIDS, striving to achieve the Millennium Development Goals, and supporting WHO's priority programmes.

The Council had undertaken much work on human resources in nursing, and for the past two years had shared all its information with WHO for inclusion in the planned progress report to the Fifty-ninth World Health Assembly on nursing and midwifery. It had therefore been distressing to learn that the matter had not been included on the agenda of that Health Assembly. During the discussion of strengthening of nursing and midwifery at the Fifty-sixth World Health Assembly, some 40 Members had spoken and a progress report had been requested for 2006.<sup>1</sup> Such a report had been promised by the then Executive Director, Evidence and Information for Policy, and he hoped that the promise would be honoured.

Dr ASAMOA-BAAH (Assistant Director-General), welcoming the tributes paid to the "3 by 5" initiative, said that in a few short years the conventional wisdom on AIDS treatment had mutated from hopelessness to hope, largely owing to the technical and financial support provided by international donors, especially Canada. As several speakers had pointed out, however, treatment remained expensive and elusive for many people, and the HIV/AIDS situation worldwide was deteriorating despite increased awareness. He had taken note of the concerns raised, such as the need for WHO to devote more attention to treatment and prevention and for practical guidelines on harm reduction for injecting drug users to be issued. WHO was evaluating the "3 by 5" initiative; the final report, by an independent team, would be issued in March 2006 and could provide valuable lessons for the future. He commended the work of the Global Task Team, in which WHO participated.

Mr SHUGART (Canada) proposed deletion of the final phrase of paragraph 2(8) of the draft resolution, contained in document EB117/7, which read "submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria".

Dr SHANGULA (Namibia), speaking on behalf of Member States of the African Region, said that good nutrition was vital for people infected with HIV; poor nutrition undermined immune systems and increased susceptibility to other infections. In sub-Saharan Africa, the rate of HIV infection and malnutrition had reached alarming levels. Following the consultative meeting on nutrition and HIV/AIDS in Africa held in April 2005, a regional training course in nutritional care and support for people living with HIV/AIDS had been organized for 11 countries. Plans had been developed to

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<sup>1</sup> Document WHA56/2003/REC/3, summary record of the seventh meeting of Committee A, section 3.

implement the framework for priority action on HIV and infant feeding<sup>1</sup> by 20 countries in the African Region. He welcomed the proposed meeting on the inclusion of nutrition as a component for funding by the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria.

The African Region needed to reverse the current unacceptably high rates of malnutrition, HIV infection and food insecurity if it was to achieve the Millennium Development Goals. It also needed to ensure that adequate nutrition was available to optimize the effects of antiretroviral medicines, at the same time tackling the proliferation of untested diets promoted by those who sought to profit from people infected with HIV. The health and well-being of children infected or affected by HIV/AIDS, especially young girls, must be protected.

Good nutrition did not prevent HIV transmission; it was not an antiviral agent; it enhanced the capacity of the body to cope with infections. He therefore proposed that, in paragraph 1(1)(c) of the draft resolution contained in document EB117/7, the word “prevention” should be deleted. Secondly, a new paragraph 1(3)(e) should be added, to read “ensuring that institutions training health workers review curricula to be in line with current recommendations”.

Dr SOPIDA CHAVANICHKUL (adviser to Dr Suwit Wibulpolprasert, Thailand), supported by Mr GUNNARSSON (Iceland), endorsed the draft resolution as amended by the member for the Libyan Arab Jamahiriya.

Dr OROOJ (alternate to Mr M.N. Khan, Pakistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, urged the Board to consider the diversity of income, development, population size, health systems development and educational standards among the countries in his Region. They had in common relatively low access to health systems, even where epidemics were widespread. Despite commendable support from WHO, the Region lacked models and tools that took into account the experience of such countries, and they should therefore be included in global technical consultations so that appropriate tools and guidelines could be developed for them. WHO should work with governments to devise mechanisms to facilitate implementation and supervision strategies.

Mr ABDULLA (alternate to Dr Botros Shokai, Sudan) supported that suggestion.

Ms TOR DE TARLÉ (France), emphasizing an integrated approach, proposed the addition of the following preambular paragraph to the draft resolution in document EB117/7: “Underlining the importance of ensuring cooperation on this question with other United Nations agencies, including the World Food Programme, the Food and Agriculture Organization of the United Nations and the United Nations Children’s Fund”.

Dr LE GALÈS-CAMUS (Assistant Director-General) pointed out that WHO had always emphasized the importance of properly-structured cooperation with FAO, UNICEF and WFP. Such cooperation would continue in the interests of countries that lacked resources.

Mr AITKEN (Director, Office of the Director-General) read the amendments proposed to the draft resolution contained in document EB117/7. A new final preambular paragraph should read: “Underlining the importance of ensuring cooperation on this question with other United Nations agencies, including WFP, FAO and UNICEF,”. The word “prevention” should be removed from paragraph 1(1)(c), which should conclude: “... to incorporate nutrition into HIV treatment and care programmes;”. At the end of subparagraph 1(3)(a), the words “and the United Nations framework of priority action in HIV and infant feeding” should be added. A new subparagraph 1(3)(e) should be added, to read: “ensuring that institutions training health workers review curricula to be in line with

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<sup>1</sup>*HIV and Infant Feeding: Framework for Priority Action*, Geneva, World Health Organization, 2003.

current recommendations;”. Finally, paragraph 2(8) should end with the word “proposals”, the words “submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria” being deleted.

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

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

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

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<sup>1</sup> Resolution EB117.R2.

## **FIFTH MEETING**

**Wednesday, 25 January 2006, at 09:15**

**Chairman:** Mr M.N. KHAN (Pakistan)

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

#### **Prevention and control of sexually transmitted infections: draft global strategy:** Item 4.6 of the Agenda (Document EB117/8 Rev.1)

Mr AITKEN (Director, Office of the Director-General) recalled the explanations given in the first meeting to the effect that logistic reasons had delayed the production of the draft strategy. There had appeared to be consensus, however, that the draft would be issued in electronic form around mid-February and, after a final round of electronic consultations among Member States, produced in final form in time for the Fifty-ninth World Health Assembly.

In response to questions from Dr SUWIT WIBULPOLPRASERT (Thailand), he explained that the delay had been caused by the unforeseen consecutive scheduling of two major meetings – the current session of the Board and the Conference of the Parties to the WHO Framework Convention on Tobacco Control. Every effort would be made to avoid a recurrence of such circumstances in the future.

Mr MAHMOOD (alternate to Dr Ali Mohammed Salih, Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that any interventions in the area of the prevention and control of sexually transmitted infections must be culture-sensitive, and urged that Member States from his Region should be represented in all technical consultations on that issue. WHO should also develop tools that were applicable and adaptable to the specific cultural contexts of all countries. WHO support at all stages of adopting the strategy, including advocacy, adaptation, planning, capacity building, implementation and monitoring and evaluation remained crucial, since the area of sexually transmitted infections was underserved in many countries, particularly in the public sector. Countries also required assistance in the form of tools to create and foster partnerships between the public and the private sectors in that regard.

Dr HANSEN-KOENIG (Luxembourg) expressed regret that it would not be possible to discuss the draft global strategy at the current session, as it would certainly have provided useful input to the discussion on HIV/AIDS and the health-related Millennium Development Goals. The proposed procedure should enable the draft strategy to be discussed at the forthcoming Health Assembly.

She regretted, too, the removal from the agenda of a related item on women's health and gender issues, on which a draft strategy should also be elaborated for early discussion by the Board. Women after all accounted for 50% of the world's population and were most vulnerable, and should not be neglected by WHO.

Dr BRUNET (alternate to Professor Houssin, France), endorsing the comment by the previous speaker, said that issues relating to sexually transmitted infections and women's health were too closely related to the Millennium Development Goals and WHO's role in attaining them to be shelved for logistic reasons. Dealing with such issues in an appropriate manner was a matter of priority.

Mrs PHUMAPHI (Assistant Director-General), noting the concerns expressed about the delay in presenting the draft strategies on sexually transmitted infections and gender, agreed that action

against HIV/AIDS and sexually transmitted infections would be strengthened through both strategies. She thanked Member States for their support and for making experts available for the development of the draft strategy on sexually transmitted infections. Special care had been taken in the consultation process to ensure that the approach in the draft strategy was culture-sensitive and adaptable and hence usable by all countries. The draft strategy would be available electronically for final consultations and subsequent revision and submission to the forthcoming Health Assembly.

She assured the members for France and Luxembourg that women's health was taken very seriously. A gender strategy was being developed; the reason why consultations were being prolonged was to ensure that all cultural settings and sensitivities were duly taken into account.

Dr ANTEZANA ARANÍBAR (Bolivia) accepted the explanations, observing that the important point was that the draft strategy that would be submitted to the Health Assembly should reflect the relevant resolutions and the concerns of Member States, including those expressed at the current meeting by the members for France and Luxembourg.

The CHAIRMAN said that he took it that the Board wished to note the report and agreed that the item should be placed on the agenda of the Fifty-ninth World Health Assembly. The Secretariat would organize an electronic consultation with Member States on the draft strategy, which would be issued in electronic form shortly and, in the light of comments received and those made at the current session, would present a revised draft to the forthcoming Health Assembly.

**It was so agreed.**

**Smallpox eradication: destruction of variola virus stocks:** Item 4.7 of the Agenda (Document EB117/33)

Dr SHINOZAKI (Japan) said that, while the threat of bioterrorism remained a pressing issue, the ultimate goal was the total eradication of the variola virus worldwide through the destruction of stocks held in laboratories. He understood that the WHO Advisory Committee on Variola Virus Research and the Secretariat were properly monitoring the fruitful progress of research activity. Reports should be updated regularly and care taken to ensure their impartiality.

Dr OROOJ (alternate to Mr M.N. Khan, Pakistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the impressive research results contributed significantly to an understanding of smallpox virus. The broad research agenda covered increasingly complex scientific issues. Research activities were not time-limited and many were of limited public health significance. Their continuation obviously delayed destruction of the remaining stocks of smallpox virus. The research agenda should be confined to essential issues and the Board should set a time limit for completion of the studies so that remaining stocks of smallpox virus could be destroyed.

Dr SHANGULA (Namibia), speaking on behalf of the Member States of the African Region, acknowledged the work of the WHO Advisory Committee on Variola Virus Research and other reported research results. He recalled the concerns expressed at the Fifty-eighth World Health Assembly about the proposed expression of variola virus genes in other orthopoxviruses<sup>1</sup>. He drew attention to the decision taken and concerns raised by health ministers at the fifty-fifth session of the Regional Committee for Africa, including their request that the issue should be a substantive agenda item rather than an item for information at the current Board session. The Regional Committee, noting the temporary retention of the variola virus for research purposes in the Russian Federation and the United States of America, was concerned about security and proposed that the variola virus stocks

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<sup>1</sup> Document WHA58/2005/REC/3, summary record of the seventh meeting, section 4.

should be retained in a secure place within WHO and be entrusted to Member States. The ministers remained opposed to the proposed expression of variola virus genes in other orthopoxviruses on account of the risks of laboratory accidents, deliberate release or bioterrorism and the risks posed by more dangerous forms of the virus that might emerge. The group welcomed the decision of the Advisory Committee to withdraw that recommendation in its entirety. The ministers were likewise concerned about the composition of the Advisory Committee and suggested that it should be reviewed to ensure balanced representation, with the inclusion of experts from developing countries. It also proposed a balanced and broader representation of advisers and observers to the Committee. The fundamental issue was the eventual destruction of the remaining stocks of the variola virus rather than the expansion of research. The condition for temporary retention of the variola virus stocks was that approved research would remain outcome-oriented and time-limited and that its findings would be periodically reviewed. It would appear from the report that most of the essential research requiring the use of live variola virus had been concluded. It was therefore time to consider whether the benefits of destruction of the remaining stocks did not far outweigh those of continued research, and to reach global consensus on the timing of the destruction of existing stocks, setting a new date for their destruction.

The Member States of the African Region therefore proposed that the Director-General should be requested to broaden the representation of the WHO Advisory Committee on Variola Virus Research in keeping with Regulation 3 of the Regulations for Expert Advisory Panels and Committees and relevant Health Assembly resolutions, and to resolve the issue of the representation of advisers and observers to the Committee. They undertook to identify qualifying experts and to inform the Director-General accordingly. They further proposed that an open-ended intergovernmental working group should be established to work on a draft resolution addressing the foregoing issues and any others that might be raised by other Member States. The working group should start its work with immediate effect and present a draft resolution to the Fifty-ninth World Health Assembly.

Mr GUNNARSSON (Iceland) said that, as the member for Japan had pointed out, further study of the variola virus might be required if the need arose for a new vaccine. In the past, laboratories in the Nordic countries would have been able to produce such a vaccine. For that purpose, it would be useful to know whether the research findings would remain in the public domain or would be patented by commercial companies.

Dr BRUNET (alternate to Professor Houssin, France) supported the view expressed by the member for Iceland. Could the Secretariat confirm the present composition of the Advisory Committee, which ought to be taken into account if it was expanded in future? It would be premature to decide to terminate research. He endorsed the objective of eventual total eradication of smallpox, but that would only be achieved when the remaining stocks of variola virus had disappeared completely, even from the laboratories in which it was currently retained. However, the time was not yet ripe to destroy the stocks. In the framework of ongoing research, further testing was needed of diagnostic methods that distinguished between infection with variola virus and other orthopoxviruses. If smallpox were to reappear, the initial diagnosis would have such far-reaching implications that a differential diagnosis would have to be absolutely reliable. Work to improve the primate model of human smallpox should also be continued, to make way for the development of antiviral treatments. The second- and third-generation vaccines also needed to be improved, in order to have available a lower-risk vaccine for immunocompromised people. In many countries there was a significant proportion of such patients, owing to the prevalence of HIV, and they were at significant risk from the existing vaccines.

Dr SUWIT WIBULPOLPRASERT (Thailand) observed that the Health Assembly had agreed retention of the existing stocks of live virus up to, but not later than, 2002. Four years later, no serious attempt was being made to set a date for final destruction. Rather than continually seeking to buy time on the issue, the Board should move forward by supporting the proposal of the member for Namibia

for more balanced representation on the Advisory Committee, and for the establishment of an open-ended working group to set a time-limit for the destruction of the virus.

Mr SHUGART (Canada) said that the retention of the virus in the repositories should be determined by means of a scientific peer review assessment, in the light of the public health benefits, with the ultimate goal of destroying the remaining stocks. The present uncertainty about the value of continuing research mirrored the uncertainty inherent in the science itself. Canada continued to seek clear guidance from WHO and the experts available to it, given the nature of risks, as the report made clear. He agreed with the member for Japan that the report was valuable and that its approach should be followed in future reports. That would help the Board to exercise due vigilance with regard to the public health benefits of further research using the live virus.

Dr NYIKAL (Kenya) concurred that a clear time-limit should be set for destroying the virus, whether in line with a recommendation from the proposed working group or in the light of the research findings themselves. The process of appointing members of the Advisory Committee, which should have a broader membership, should be explained. He agreed with the members for France and Iceland that the Board should seek clear guidance on how the research findings would be owned and used.

Ms HALTON (Australia) said that the issue was difficult because research was, by definition, an imprecise science. In such a new area caution was highly desirable, and it would be premature to set a timetable for destroying the virus as long as fundamental questions remained unanswered. The secure maintenance of the stocks was naturally high among the concerns of members of the Board and mentioned in the report. The two laboratories had a very important responsibility in that regard; they also had to ensure enough transparency in their work to reassure the Board as a whole. The research should therefore be allowed to continue to its natural end-point on the topics mentioned in the report, especially on sequence analysis and the development of diagnostic assays and second- and third-generation vaccines. Work on other areas mentioned in the report, such as the use of animal models and development of potential antiviral drugs, might also be warranted. The report also showed an awareness of the potential dangers of mixing genetic material from highly pathogenic organisms, particularly in respect of other orthopoxviruses. She agreed with the remarks of previous speakers about the need for improved transparency in the appointment of members of the Advisory Committee.

The CHAIRMAN recalled that resolution WHA55.15 had authorized the further retention of the existing stocks of live virus on the understanding that all approved research would remain “outcome-oriented and time-limited” and be periodically reviewed. However, the consequences of the virus being released could be catastrophic. The Board’s decision must be properly balanced.

Dr TANGI (Tonga) pointed out that the Health Assembly delegates who had adopted resolution WHA52.10 had already been replaced by a new generation, who in turn were being advised by scientists in laboratories. There was no obvious end to the process. It was in the nature of scientific work on any topic that those engaged in it preferred to continue, and, in so doing, raised fresh questions to which they then sought answers. A new generation of scientists would invariably produce new research proposals. The Board’s members, as the policy-makers, should set for the present generation of scientists a definite time-limit, perhaps eight years, in which to pursue their research.

Mrs MTSHALI (South Africa)<sup>1</sup> recalled that it was almost 26 years since the global eradication of smallpox had been agreed upon in resolution WHA33.3. Subsequent Health Assembly resolutions on the subject of the variola virus stocks had agreed to their temporary retention for approved

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

research, with a view to their eventual destruction. The excellent results in terms of the efficacy of second- and third-generation vaccines, especially the evidence that suggested fewer adverse effects in children and immunocompromised people, were encouraging, and she was pleased to note that the Advisory Committee did not see any need, on scientific or regulatory grounds, to use live variola virus in order to assess smallpox vaccines; she was also pleased to note the conclusion that no further research requiring access to live virus was considered essential for the purpose of sequence analysis of variola virus DNA. The Committee had found no scientific justification for performing further research on the hybrid viruses in the United States collection, nor was it believed that any additional research using live variola virus was required for the purpose of diagnostic assays. Owing to the requirements for regulatory approval of antiviral agents in the United States of America, further work might require the use of live variola virus. Such work should therefore be expedited to eliminate the use of live virus. She supported the Committee's recommendation for an urgent review of all current research proposals, in order to indicate the essential research that still required the use of live variola virus, and thus the timing for the destruction of the stocks. In the light of resolution WHA55.15 and the reported research accomplishments, she encouraged the Board to support the proposal to establish an open-ended intergovernmental working group to draft a resolution on those issues. She requested the Director-General to put additional measures in place to strengthen the biosafety of the storage and research facilities.

Dr STEIGER (United States of America)<sup>1</sup> said that, as policy-making organs, the Health Assembly and the Executive Board had made a correct decision in establishing an Advisory Committee to define a research agenda and review the research periodically, while retaining stocks of the live virus in the two authorized repositories. It was not the right time to change that decision. He welcomed the report's conclusions on antiviral drugs, second- and third-generation vaccines, genomic sequencing of the virus strains and the development of new diagnostic tools, and agreed with the members for Australia and France that it would be premature either to decide on destroying the stocks or to set an arbitrary date or timetable for completing the programmes of scientific research, which should be allowed to continue to their natural conclusion. There was a need for greater transparency, a matter in which his country and others had been at fault. However, they had nothing to hide, and the scientists involved would be available in the coming months for briefings, which would be arranged in consultation with the Member States of the African Region. With regard to biosafety, in late 2005 both the United States of America and the Russian Federation had called for additional inspections, and were working in full cooperation with WHO to ensure that the repositories remained absolutely safe. His country was also eager to address the issue of representation on the Advisory Committee, and had already worked with the Secretariat to find additional experts from Africa and other parts of the world. His country had also been assisting other countries to develop their capacity for manufacturing their own vaccines, and was prepared to continue that work.

Mr CHESTNOV (Russian Federation),<sup>1</sup> observing that smallpox remained a potential threat to the entire world community, said that his country would continue its cooperation on the subject with all interested partners. The research centres in his country and in the United States of America were conducting research into smallpox under the aegis of WHO: each year, the Advisory Committee reviewed the research undertaken and made adjustments where necessary. In order to achieve all the objectives set, work should continue on developing a more effective and safer smallpox vaccine, and on improving diagnostic methods. Effective antiviral drugs should also be produced, animal models developed, and the virus genome and pathogenesis studied further. The Russian Federation understood the concerns expressed, including those of the African Member States, about the need for greater transparency. It would welcome better representation of countries on the Advisory Committee, and the provision of more information about the research undertaken, as a confidence-building measure.

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



WHO should provide a comprehensive report on the results of its inspections of the repositories, in order to reassure the international community that all the steps necessary for the safe retention of the virus were being taken. The Russian Federation looked forward to receiving the support of the international community, including the African countries, to continue working with the live virus in the interests of mankind as a whole.

Dr CHAN (Assistant Director-General), acknowledging the long history of the debate on the destruction of the virus, said that, while destruction had always been recognized as the end point, the decision to embark upon that action must be taken with great care.

In reply to the question by the member for France regarding the composition of the Advisory Committee, she explained that the Secretariat was doing its utmost to ensure geographical and gender representation and balance. The subject was highly technical, but the criteria for the selection of experts were transparent: experts needed to have relevant laboratory and public health expertise in the field of orthopox infections, including field and laboratory experience of smallpox before eradication, and relevant expertise in the field of orthopoxvirus research was also important; expertise in the fields of biosafety and biosecurity, and field experience relevant to communicable diseases prevention, emergence, intervention and control, were also required. The Advisory Committee and its subcommittees were WHO committees, and, in their deliberations, took into account the relevance of the live virus from the public health perspective in order to ascertain the public health benefits of the recommended research. The Advisory Committee consisted of 19 members, of whom three were from the African Region, three from the Region of the Americas, one from the Eastern Mediterranean Region, seven from the European Region, two from the South-East Asia Region, and three from the Western Pacific Region. WHO also sought to maintain a geographical balance among the 35 advisers; currently one expert was from the African Region, 14 were from the Region of the Americas, 17 from the European Region, one from the South-East Asia Region and two from the Western Pacific Region, but none from the Eastern Mediterranean Region. There was also one observer from the Region of the Americas. Geographical representation had improved in recent years. WHO would continue to do its utmost to work with the regions to find experts with the relevant expertise and improve representation further. She thanked South Africa for its assistance in that regard.

With regard to the issue of biosafety, WHO had recently conducted an additional inspection of the facilities and was satisfied that the biosafety and biosecurity measures at the two repositories were consistent with international best practices.

The Secretariat would be guided by the Board regarding the suggestion by the member for Namibia concerning the establishment of an open-ended intergovernmental working group. As indicated in paragraph 17 of the report, much progress had been made in recent years, but there was still much work to be done. The Committee had perceived an urgent need to review all proposals for further research, and the deadline for submission of research proposals had been set for the end of January 2006. The review process had already started, and proposals would be examined to ensure that they remained in line with the relevant Health Assembly resolutions.

Dr ANTEZANA ARANÍBAR (Bolivia), supported by Dr ALI MOHAMMED SALIH (Iraq), expressed concern that the criteria for the selection of experts were likely to exclude scientists from the poor and least developed countries. Consideration might therefore be given to appointing experts from such countries to the Advisory Committee and its subcommittees to enable them to improve their knowledge and expertise.

Dr CHAN (Assistant Director-General), in response to a request for further clarification from Mrs MTSHALI (South Africa),<sup>1</sup> said that WHO did not have a P4 laboratory to allow it to be the custodian of live virus stocks. She would need to consult colleagues before replying to the question on the patent issue.

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

Dr NYIKAL (Kenya) pointed out that research on the variola virus differed from other research, in that it was of interest to every country. When the issue of patents was considered, it should not be forgotten that the whole world had a stake in the research.

Dr SHANGULA (Namibia) asked whether the authority over the viruses was held by the States in which those viruses were located or whether WHO had any authority over the stocks.

Mr BURCI (Legal Counsel), replied that the situation was not clear-cut. Following the eradication of smallpox it had been decided that countries holding the live virus would give their stocks to a limited number of laboratories that had secure locations. The documentation available to WHO setting out the terms under which countries had given their stocks either to the laboratory in the United States of America or that in the Russian Federation was not complete. In cases where countries had given stocks “in trust” for WHO, the Organization would, arguably, have some measure of control and authority over those viruses; in other cases, terms had not been specified, and it was not clear whether those countries wished to retain legal title. At the present juncture, therefore, he was unable to give a definitive answer but would endeavour to provide a more substantive response at a later meeting if the Board so wished.

Dr CHAN (Assistant Director-General) said that, in her previous intervention, she had been responding to the suggestion that the two repositories should be housed in a WHO laboratory. WHO itself did not have a P4 laboratory; however, the two laboratories holding the repositories met the very high requirements for biosafety and biosecurity.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that the question put by the member for Namibia raised another question concerning submission of viruses by Member States of WHO, including severe acute respiratory syndrome and avian influenza virus. At least three conditions should obtain in such situations: first, WHO would ensure that the viruses were kept securely out of the reach of bioterrorists; secondly, the viruses would be used for appropriate research to benefit humankind; and thirdly, if the viruses were used to produce vaccines, the countries that had submitted them and developing countries that lacked the capacity to produce them would be given access.

There seemed to be no problem with the first condition, even though it appeared that WHO had no practical control, but only a moral influence, over the laboratories that were storing the viruses. As to the second and third conditions, clarification was needed as to whether viruses submitted to WHO would be used for research to benefit all countries. Would countries that needed the vaccines produced receive them? The Secretariat should provide clear information on mechanisms to ensure that the second and third conditions would be met.

Mr LEÓN GONZÁLEZ (Cuba)<sup>1</sup> said that he was surprised by the Assistant Director-General’s comment regarding WHO’s lack of control over stocks of virus that were retained in two locations. It raised a further question as to the extent of such control and what WHO was able to do to ensure that the products of research were really used to benefit all. Since the Legal Counsel was going to provide further information on that subject, perhaps he could also explain what means could be used to enhance the Organization’s control over the viruses, including possible action by the Health Assembly.

Dr STEIGER (United States of America)<sup>1</sup> recalled that, at the initiative of the Health Assembly and the Board, WHO had created a smallpox vaccine reserve, which as a result of work done on the virus had created a stock of vaccine specifically for the use of developing countries in an emergency.

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

His Government, the Government of Canada and many others had made additional contributions, whether physically or through a virtual commitment, of vaccine stocks out of their national stockpiles in order to augment the physical reserve held in Geneva.

Dr CHAN (Assistant Director-General), responding to the question by the member for Thailand, said that influenza virus isolates had been submitted to four WHO collaborating centres which had high standards of biosafety and biosecurity. Every year, those laboratories helped to develop the prototype vaccine for influenza, which was distributed to manufacturers free of charge through WHO. As to developing countries, discussions were currently under way on providing Viet Nam with prototype vaccine from WHO collaborating centres on the understanding that they could produce the vaccine safely at recognized facilities. As to research, where viruses were required for developing diagnostics, WHO would try to make them available. It must be emphasized, however, that the quantity of viruses submitted to WHO was small, and the demand was high.

Further to the comments by the representative of the United States, she said that about five million doses were currently stockpiled in Geneva. Progress had already been made towards meeting the virtual commitment to a smallpox vaccine reserve of 200 million doses: France had already pledged five million doses, Germany two million, the United Kingdom of Great Britain and Northern Ireland four million and the United States of America 20 million. The stocks would be available for use by developing countries.

The DIRECTOR-GENERAL said that much, unfortunately, was left unsaid about vaccines and virus stocks. The virus strains in repositories in the Russian Federation and the United States of America were the only ones in known locations. The fact that some countries had stockpiled the vaccine and that WHO had millions of doses of it did not reflect fears about the natural re-emergence of smallpox but rather was an indication of the current times — one could not gamble.

Dr NYIKAL (Kenya) said that the news that vaccine was being stockpiled was a matter for concern. While it was reassuring to hear that some of the vaccine was intended for developing countries, the question arose to what extent those countries would be involved in the process.

The DIRECTOR-GENERAL said that both the WHO and the international vaccine stockpiles were intended to be deployed rapidly to developing countries in the event of need.

Mrs MTSHALI (South Africa)<sup>1</sup> said that there was some concern that stocks of the virus might exist outside the Russian Federation and the United States of America and that some live virus might be retained in other countries for purposes other than research. That concern should be clearly dealt with.

The CHAIRMAN said that it would be helpful if a list of the experts who were members of the WHO Advisory Committee on Variola Virus Research could be circulated to Board members. Even poor countries had enough expertise to participate in the Committee's work.

Mr AITKEN (Director, Office of the Director-General) suggested that the best course of action might be for the Secretariat to prepare a draft resolution. In advance of the Health Assembly, a working group open to all members and with interpretation in all six official languages would be convened in Geneva to examine the draft and make any necessary adjustments. The Director-General would submit the resulting text to the Health Assembly for its consideration.

**It was so agreed.**

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

**The Board noted the report.****Sickle-cell anaemia:** Item 4.8 of the Agenda (Document EB117/34)

The CHAIRMAN drew attention to the draft resolution entitled Sickle-cell anaemia proposed by Angola, Belgium, Burkina Faso, Congo, Côte d'Ivoire, France, Guinea-Bissau, Kenya, Lesotho, Madagascar, Namibia, Rwanda, Senegal, South Africa and Sudan which read:

The Executive Board,  
Having examined the report on sickle-cell anaemia;<sup>1</sup>

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

The Fifty-ninth World Health Assembly,  
Recalling resolution WHA57.13 on genomics and world health, and the discussion of the Executive Board at its 116th session on control of genetic diseases which recognized the role of genetic services in improving health globally and in reducing the global health divide;<sup>2</sup>

Recalling decision Assembly/AU/Dec.81 (V) of the Assembly of the African Union at its Fifth Ordinary Session;

Noting the conclusions of the 4th International African American Symposium on sickle-cell anaemia (Accra, 26-28 July 2000), and the results of the first and second international congresses of the International Organization to Combat Sickle-Cell Anaemia (respectively, Paris, 25-26 January 2002 and Cotonou, 20-23 January 2003);

Concerned at the impact of genetic diseases, and of sickle-cell anaemia in particular, on global mortality and morbidity, especially in developing countries, and by the suffering of patients and families affected by the disease;

Recognizing that the prevalence of sickle-cell anaemia varies between communities, and that insufficiency of relevant epidemiological data may present a challenge to effective and equitable management;

Deeply concerned at the absence of official recognition of sickle-cell anaemia as a priority in public health;

Recognizing the current inequality of access to safe and appropriate genetic services throughout the world;

Recognizing that effective programmes for sickle-cell anaemia must be sensitive to cultural practices, and appropriate for the given social context;

Recognizing that the management of sickle-cell anaemia raises specific ethical, legal and social issues that require appropriate consideration,

1. URGES Member States:

- (1) to develop, implement and reinforce in a systematic, equitable and effective manner national, integrated programmes for the management of sickle-cell anaemia, including dissemination of information, awareness-raising, and screening, such programmes being tailored to specific socioeconomic and cultural contexts and aimed at reducing the incidence, morbidity and mortality associated with this genetic disease;

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<sup>1</sup> Document EB117/34.

<sup>2</sup> See document EB116/2005/REC/1, summary record of the first meeting, section 4.

- (2) to develop their capacity to evaluate the situation regarding sickle-cell anaemia and the impact of national programmes;
  - (3) to intensify the training of specialist health professionals in high-prevalence areas;
  - (4) to develop and strengthen medical genetics services, within existing primary health care systems, in partnership with parent/patient organizations;
  - (5) to promote community education, including health counselling, and associated ethical, legal and social issues;
  - (6) to establish effective international cooperation in combating sickle-cell anaemia;
  - (7) in collaboration with international organizations, to support basic and applied research on sickle-cell anaemia;
2. REQUESTS the Director-General:
- (1) to increase awareness of the international community of the global burden of sickle-cell anaemia, including by launching a world sickle-cell anaemia day, and to promote equitable access to health services for prevention and management of the disease;
  - (2) to provide technical support and advice to national programmes of Member States through the framing of policies and strategies for prevention and management of sickle-cell anaemia;
  - (3) to support intercountry collaboration in order to expand the training and expertise of personnel and to support the further transfer of advanced technologies and expertise to developing countries;
  - (4) to continue WHO's normative functions in drafting guidelines on prevention and management of sickle-cell anaemia and fostering the establishment of regional groups of experts.

Dr WINT (Jamaica) said that it should be made clear whether the subject was sickle-cell anaemia, sickle-cell disease or sickle-cell disorders, since sickle-cell anaemia was only one piece of the picture. In his country, the prevalence of sickle-cell disease was about 10%, and it led to severe morbidity, reduced quality of life and premature mortality. There was a need for more comprehensive programmes for prevention and control, encompassing early diagnosis, registration and follow-up of the individuals affected and the training of providers at both primary and secondary health-care levels to improve recognition and the care given. The recommendation on increased research activity was noteworthy, as was the progress reported in treatment, including bone marrow transplantation, which was seen as a potential cure, although in countries such as his own it remained only a dream.

He supported the draft resolution, but proposed the following amendments. In paragraph 1(1), the word "comprehensive" should be inserted before "national"; the words "prevention and" should be inserted before "management"; and "surveillance," should be inserted before "dissemination of information". In paragraph 1(3), the word "specialist" should be replaced by "all". Paragraph 1(6) was addressed more to the Director-General than to Member States; accordingly, it might be better to strengthen paragraph 2(3) by inserting the words "promote and" before "support intercountry collaboration". A new paragraph 2(5) should be added, to read: "to promote, support and coordinate the needed research on sickle-cell disorders in order to improve the duration and the quality of life of those affected by those disorders".

Dr RAHANTANIRINA (alternate to Dr Jean Louis, Madagascar), speaking on behalf of the Member States of the African Region, said that sickle-cell anaemia, one of the most common genetic diseases in the world, spared no country, and, owing to population movements and intermarriage, its prevalence was increasing. Moreover, the highest birth rate of homozygotes was found in the most impoverished countries, 230 000 to 240 000 children being born annually in Africa with sickle-cell

anaemia. In sub-Saharan Africa, the rate of healthy carriers (heterozygotes) was between 10% and 30% of the population in some countries. Paradoxically, optimal treatment was available only in countries where the disease was least common, once again demonstrating the North-South health disparity.

The expansion of referral centres had revealed that, with healthy living habits and ready access to care, many adult sufferers could be fully integrated into society and lead a normal family and professional life. In many developing countries, mortality rates for children and pregnant women remained high, and proper treatment was hampered by economic problems, and lack of information and training for health care providers, political decision-makers and the general population.

The First Ladies of the Central African Republic, Chad, Congo, Mali and Senegal had endeavoured through appeals and conferences to raise awareness about the disease. Those countries had launched an appeal at the Fifty-eighth World Health Assembly for the international community to intensify the fight against sickle-cell anaemia. The Member States of the African Region had accordingly requested the Director-General to include the current item on the Board's 117th session, with a view to consideration of the draft resolution by the Fifty-ninth World Health Assembly.

Referring to paragraph 2(1) of the draft resolution, she said that the launching of a world sickle-cell anaemia day might entail heavy expenditure. Accordingly, the Member States of the African Region suggested that the reference thereto should be replaced by a reference to the early inclusion of "Strengthening the fight against sickle-cell anaemia" as a topic for World Health Day. In paragraph 2(4), the words "with a view to elaborating regional plans" should be inserted after "sickle-cell anaemia".

Professor PEREIRA MIGUEL (Portugal) observed that the model national control programme developed in high-resource countries was clearly not appropriate for most low-resource settings, but that sickle-cell disorders should be covered by health service planning in all countries where they were common. Interventions undertaken in countries in the Mediterranean area with a high prevalence of haemoglobinopathies had demonstrated that prevention of acute forms was possible through the detection of individuals carrying the relevant genetic mutations and prenatal diagnosis.

Prevalence in Portugal was around 1% and a national control programme, established in 1984, covered genetic counselling to couples at risk, prenatal diagnosis, prevention, training of health professionals, dissemination of up-to-date information, research, and cooperation with patient-support organizations. Given its considerable experience, Portugal was willing to cooperate in the preparation of a global prevention and control strategy and to provide training for laboratory, clinical and primary health-care professionals from developing countries. Portugal therefore wished to be included as a sponsor of the draft resolution.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that haemoglobinopathies were widespread, with sickle-cell anaemia in African and Mediterranean countries and thalassaemias in Asian countries. Thailand had intended to suggest that an agenda item on thalassaemia should be included on the agenda for the next sessions of the Board and Health Assembly. The technologies to prevent and treat such genetically inherited diseases were generally similar, however. He therefore proposed that all types of haemoglobinopathies should be considered under a single agenda item, entitled "Haemoglobinopathies: sickle-cell anaemia and thalassaemia", in order to reflect the global nature of the public health problems concerned and to avoid duplication of effort. He endorsed the proposal to select haemoglobinopathies as the theme for a future World Health Day and supported the draft resolution.

Dr KHALFAN (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that greater attention should be paid to blood disorders. In order to prevent sickle-cell anaemia, it was important to encourage the implementation, where facilities were available, of mandatory premarital genetic screening in high-risk communities; pre-pregnancy genetic screening in cases where premarital screening had not been undertaken; and pre-implantation genetic diagnosis

in cases of in vitro fertilization. Bahrain and Saudi Arabia had achieved good results with such measures.

WHO had a pivotal role to play in promoting services development, research and training for countries in greatest need. Activities should include the development of global and regional guidelines on the prevention and treatment of blood disorders, the promotion of collaboration among relevant institutions, with the establishment of networks and centres of excellence, and the provision of technical support to Member States. WHO should also promote the development of a quality control programme for biochemical, cytogenetic, haematological and molecular tests.

Speaking as the member for Bahrain, which had a high prevalence of sickle-cell anaemia, he said that his country wished to be included as a sponsor of the draft resolution.

Dr BRUNET (alternate to Professor Houssin, France), speaking on behalf of the Member States of the European Union, expressed support for the draft resolution. Speaking as the member for France, he stressed that the amendments proposed by the member for Madagascar would reduce the financial implications of the resolution for WHO.

Dr SINGAY (Bhutan) endorsed the view that prevention and control of sickle-cell anaemia, which was prevalent in some Member States in the South-East Asia Region, should form part of general health services and programmes to combat all types of genetic blood disorders. WHO's efforts to update and disseminate information should encompass all such disorders. He supported the draft resolution.

Dr SHINOZAKI (Japan) welcomed the recognition by WHO of the significance of sickle-cell anaemia as a public health issue for many countries, especially in Africa. The Secretariat, other international organizations and donor countries should tackle a disease that had received little attention to date, partly because of its geographical distribution. He supported the draft resolution and endorsed the remarks made by the member for Thailand.

Dr ACHARYA (Nepal) said that sickle-cell anaemia had not been detected in Nepal. He supported the draft resolution and emphasized the need for preventive measures, including health education, genetic counselling, marriage counselling and prenatal diagnosis as well as collaborative research and capacity-building. He endorsed the views expressed by the members for Thailand and Bhutan regarding the need to combine efforts on all types of genetic blood disorders.

Ms VALDEZ (United States of America)<sup>1</sup> asked how the Secretariat intended to respond to the significant financial implications of implementing the draft resolution in the current biennium and over the lifespan of the resolution, given that there was no allocation to the area in the current programme budget.

Dr LE GALÈS-CAMUS (Assistant Director-General) agreed that there were clearly similarities among the measures needed to tackle the various haemoglobinopathies and that efficiencies would be gained by combining efforts, rather than concentrating on each form, as in the draft resolution before the Board. However, given the regional characteristics of the distribution of the diseases, and the diversity of the populations affected, strategies must be tailored to regional and national situations. The inclusion of all haemoglobinopathies would clearly have an impact on the financial implications of the draft resolution, in particular for the current biennium and in terms of support to the regional offices concerned, as well as on the speed and intensity with which activities could be introduced. She expressed appreciation for the offer of support from Portugal.

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

Mr AITKEN (Director, Office of the Director-General) re-read the proposed amendments. Paragraph 1(1) would read: “to develop, implement and reinforce in a systematic, equitable and effective manner comprehensive national, integrated programmes for the prevention and management of sickle-cell anaemia, including surveillance, dissemination of information, ...”. In paragraph 1(3), the word “specialist” would be replaced by “all”.

He took it that the member for Jamaica would accept the rephrasing of paragraph 1(6) to read: “to promote effective international cooperation in combating sickle-cell anaemia;”.

The second phrase in paragraph 2(1) would read: “... including as part of a World Health Day, ...”. The beginning of paragraph 2(3) would read: “to promote and support intercountry collaboration ...”. Paragraph 2(4) would read: “to continue WHO’s normative functions in drafting guidelines on prevention and management of sickle-cell anaemia with a view to elaborating regional plans and fostering the establishment of regional groups of experts” and a new paragraph 2(5) would read: “to promote, support and coordinate the needed research on sickle-cell disorders in order to improve the duration and quality of life of those affected by those disorders”.

Dr SUWIT WIBULPOLPRASERT (Thailand) asked whether there was to be any decision regarding his proposal for the inclusion of all haemoglobinopathies under one agenda item. If that was not possible, he would propose that a new item on thalassaemia should be included on the agenda for the Board’s next session.

Dr LE GALÈS-CAMUS (Assistant Director-General) said that, if the scope of the draft resolution were to be expanded, it would be necessary to define precisely the range of diseases covered.

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

**Prevention of avoidable blindness and visual impairment:** Item 4.9 of the Agenda (Documents EB117/35 and EB117/35 Add.1)

The CHAIRMAN drew attention to the draft resolution set forth in paragraph 12 of the report.

Mr AITKEN (Director, Office of the Director-General) observed that the text of the draft resolution did not include the request contained in the resolution adopted by the Regional Committee for the Eastern Mediterranean at its fifty-second session in September 2005, namely, that the Director-General should make the item a priority area of work. That was a matter for the Health Assembly to decide when it considered the budget. He suggested that, to convey the essence of that request, the words “to give priority to this issue and” should be inserted after “REQUESTS the Director-General”, in paragraph 2 of the draft resolution.

Dr WINT (Jamaica) said that trauma was a significant cause of avoidable blindness in his subregion, particularly among young people, and should be mentioned in the draft resolution. In the fifth preambular paragraph, the word “families,” should be inserted before “communities”. With regard to paragraph 2, he supported the amendment suggested by the Secretariat, but questioned the need for the words “on request or as appropriate”. He proposed adding a new subparagraph to paragraph 2, to read: “(2) to monitor progress in the Global Initiative for the Elimination of Avoidable Blindness in collaboration with international partners and to report to the Health Assembly every three years”.

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<sup>1</sup> Resolution EB117.R3.



Mr GUNNARSSON (Iceland), expressing support for the draft resolution, said that blindness was an important issue, particularly since nine out of 10 blind persons lived in low-income countries. All members of the Nordic group of countries endorsed the amendment suggested by the Secretariat and hoped that the Health Assembly would soon make preventable blindness and visual impairment a priority area of work. It was his understanding that private funds were available for technical assistance in that area.

Professor PEREIRA MIGUEL (Portugal) expressed support for the draft resolution, if amended to take into account the proposal of the Regional Committee for the Eastern Mediterranean. However, the actions requested of Member States should be limited to those set out in subparagraphs (1) and (2) of paragraph 1. Moreover, paragraph 1(2) should be amended to read “to provide support for these plans in the context of a comprehensive national health strategy in each country”. Portugal had extensive experience in programme and health strategy development in the area of preventable blindness and offered to share that experience with WHO.

Dr SOPIDA CHAVANICHKUL (adviser to Dr Suwit Wibulpolprasert, Thailand) supported the draft resolution as amended by Jamaica. She proposed that, in paragraph 2, the words “, as well as support for collaboration among Member States,” should be inserted after “Member States”.

Mrs LE THI THU HA (Viet Nam) said that, as a signatory to Vision 2020: The Right to Sight, her country supported the draft resolution as amended by Jamaica and Thailand and with the addition suggested by the Secretariat.

Dr ANTEZANA ARANÍBAR (Bolivia) commended the clarity and concision of the report and welcomed the inclusion in the draft resolution of a reference to the Vision 2020 initiative, which had created such high expectations at its launch. The goals and objectives of Vision 2020 were easily attainable, given the wide availability and the low cost of treatment of avoidable blindness and visual impairment. Member States needed to commit themselves to international cooperation and providing support for prevention programmes, as Portugal had done. His own country had received valuable support from Spain. He therefore fully supported the draft resolution with the addition suggested by the Secretariat and endorsed the remark by the member for Jamaica regarding the need to mention trauma as a cause of avoidable blindness.

Dr SINGAY (Bhutan) said that his country commended the three pillars of the Vision 2020 initiative, namely, reducing the burden of blindness; developing human resources and infrastructure; and advocacy, programme development and management. Bhutan fully supported the draft resolution as amended by the members for Jamaica and Thailand.

Dr KHALFAN (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that it had been estimated that more than 22 million people in his Region were visually impaired and six million were blind, cataract being the main cause of those conditions. Cost-effective solutions were available, but the countries most affected needed technical and financial support from the international community and WHO. Moreover, Member States needed to establish national prevention programmes and national Vision 2020 plans and prioritize the strengthening of primary and secondary eye-care services. A renewed global initiative was needed which would mobilize governments, communities and individuals and involve the private sector. The Member States of the Region therefore supported the draft resolution, and proposed that paragraph 2 should be amended so as to include a further request, to read: “REQUESTS the Director-General to take the necessary action to submit the prevention of blindness to the Fifty-ninth World Health Assembly”.

Ms GILDERS (alternate to Mr Shugart, Canada) welcomed the report and concurred with the proposed actions to respond to identified priorities for the prevention of avoidable blindness and visual

impairment. Through the Canadian International Development Agency, her country supported a number of blindness prevention and treatment programmes in developing countries. Canada endorsed the draft resolution and amendments and urged the Director-General to provide Member States with the necessary technical support for the prevention of avoidable blindness and visual impairment. Canada also appreciated the costing estimates.

Mr AZIZ (alternate to Dr Ali Mohammed Salih, Iraq) said that only 32% of the targeted countries had drafted a national Vision 2020 plan by August 2005. Recent figures suggested a decrease in global blindness, probably due to the initiative and its focus on the treatment of ocular infections. The impact of the initiative would be even greater if the remaining two thirds of targeted countries became involved. However, the chronic, noncommunicable diseases affecting eyesight such as cataract, glaucoma and diabetic retinopathy also needed to be tackled. Each country needed to identify the priorities that would enable it to reduce blindness and visual impairment and to mobilize human and financial resources to implement Vision 2020. Countries must show the necessary political will to ensure the success of the initiative.

Dr SHINOZAKI (Japan) commended WHO's leading role in avoidable blindness prevention. Blindness reduced the quality of life and had a significant economic impact on individuals and societies. His country supported the work of Vision 2020, such as increased commitment and the strengthening of human resources and technologies, and would support targeted countries by providing technical assistance in setting up national Vision 2020 plans. He endorsed the draft resolution with the amendments proposed.

Dr PHOOKO (Lesotho), expressing support for the draft resolution as amended, stressed that blindness and visual impairment were widespread on the African continent and that interventions had become costly because of limited facilities and infrastructure.

Dr ABDULLA (alternate to Dr Botros Shokai, Sudan) endorsed the request by the member for Bahrain that WHO should make the prevention of avoidable blindness and visual impairment a priority area of work. A joint study by WHO and the World Bank had suggested that interventions against blinding diseases, in terms of disability-adjusted life years gained, were as cost-effective as immunization, and had shown that the global productivity loss due to blindness was almost US\$ 28 000 million. The leading causes of avoidable blindness and visual impairment could be tackled by simple and cheap interventions that could enable blind people to resume economically active lives, thus reducing the substantial economic impact of blindness. Of the 37 million blind people worldwide, 17 million could be cured by a 15-minute operation with a 98% success rate, costing US\$ 50. It could be seen from document EB117/35 Add.1 that the total estimated costs of implementing the resolution were modest.

Dr TANGI (Tonga) welcomed the report and endorsed the request that WHO should make the prevention of avoidable blindness and visual impairment a priority area of work. Tonga was a signatory of the Vision 2020 initiative. He expressed his country's gratitude to Australia, Israel, New Zealand, the United States of America and the European Union for the voluntary work being carried out in Tonga by their specialists, and for the resources they supplied. To witness the gratitude of a person whose sight had been restored through cataract operations was truly a rewarding experience.

**The meeting rose at 12:50.**

## **SIXTH MEETING**

**Wednesday, 25 January 2006, at 14:10**

**Chairman:** Mr M.N. KHAN (Pakistan)

**later:** Dr H.N. ACHARYA (Nepal)

**later:** Mr M.N. KHAN (Pakistan)

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

**Prevention of avoidable blindness and visual impairment:** Item 4.9 of the Agenda (Documents EB117/35 and EB117/35 Add.1) (continued)

Mr BAILÓN (Mexico) commended the report and endorsed the draft resolution, as amended by the members for Jamaica and Thailand; it was in line with Mexico's domestic policy. Full integration of persons with disabilities into society required maximum input from the private and public sectors and the creation of programmes for the prevention and cure of blindness and visual impairment, which account for 14.6% of disabilities in Mexico. His country had recently established a national council for the prevention and treatment of visual impairment, and a national reference centre for cataract surgery. What would be the financial implications of making the prevention of avoidable blindness and visual impairment a priority area of WHO's work?

Dr NYIKAL (Kenya) welcomed the report and expressed support for the draft resolution. In his country, cataracts, trachoma, glaucoma and preventable diseases such as diabetes mellitus were prevalent. Kenya had benefited from the mobilization of resources resulting from the Vision 2020 initiative. Blindness had a major socioeconomic impact, particularly when it affected heads of household. He therefore endorsed the call for the prevention of blindness to be given priority in WHO's activities.

Dr RAHANTANIRINA (alternate to Dr Jean Louis, Madagascar) commended the clear, comprehensive report. Adoption of the draft resolution would enable major progress in socioeconomic development to be made and enhance commitment to the Vision 2020 initiative, leading to considerable savings in resources in the long term. She therefore endorsed, and wished to cosponsor, the draft resolution.

Ms HALTON (Australia) also expressed her support for the draft resolution as amended. In November 2005, in response to resolution WHA56.26, Australian health ministers had approved a national framework for action to promote eye health and prevent avoidable blindness and vision loss, which affected not only developing countries but also Australia, particularly its indigenous populations. She was grateful for the acknowledgement of Australia's support in initiatives to eliminate avoidable blindness, which remained a priority for her Government. Technical assistance would continue to be provided to developing countries in the Asia-Pacific and other regions, as would funding for eye health research, which had considerable long-term benefits. She joined the member for Canada in welcoming the information provided on the resource implications of resolutions.

Mr LEÓN GONZALEZ (Cuba)<sup>1</sup> commended the report and welcomed the inclusion of the item on the agenda of the Board and the forthcoming Health Assembly. He supported the request by the member for Mexico for information on the financial implications of designating the prevention of avoidable blindness as a WHO priority area of work. He asked for clarification of the additional commitment needed to eliminate visual impairment (paragraph 6). He was concerned at the statement (paragraph 10) that implementation of national plans and projected resources were falling, and asked the Secretariat to help to identify impediments to reaching Vision 2020 objectives. He stressed international cooperation to help all countries to plan for Vision 2020. The importance of such cooperation had been demonstrated in the Region of the Americas with *Operación Milagro* (Operation Miracle), which promoted exchange of ophthalmic technology, experts and human resources, in order to facilitate eye operations. Bolivia, member countries of the Caribbean Community, Cuba, Ecuador, Panama, Uruguay and the Bolivarian Republic of Venezuela were currently participating in that expanding regional programme and WHO could facilitate greater integration in the Region.

Mr SAMOU (alternate to Dr Al-Keeb, Libyan Arab Jamahiriya) said that prevention of avoidable blindness and visual impairment should be considered within the framework of the Millennium Development Goals, especially Goal 3 (Target 4, gender disparity), Goal 4 (Target 5, mortality rate among children under five), Goal 7 (environmental sustainability) which was essential for avoiding diseases such as trachoma, and Goal 8 (global partnership for development), which successfully illustrated WHO's current cooperation with the International Agency for the Prevention of Blindness, which should continue. He requested the Director-General to ask the Fifty-ninth World Health Assembly to designate prevention of avoidable blindness as a WHO priority area of work and included it in the Medium-Term Strategic Plan.

Dr ANDRADE GAIBOR (Ecuador) endorsed the comments of the representative of Cuba on the importance of regional cooperation for the exchange of medical experience and expertise. Ecuador had been helped by Cuba, for example, in the 1991 outbreak of cholera and in the more recent outbreak of dengue fever. Over the past year the Cuban Government had treated more than 5000 Ecuadorian patients in Cuba for different types of eye problems, and there were plans to adapt Ecuador's hospital infrastructure in order to reduce patients' transport costs.

The CHAIRMAN, speaking as the member for Pakistan, said that the surgical treatment of cataract could result in worldwide economic gains estimated to be as high as US\$ 223 000 million, and change the economic status of families, nations and even continents, thus reducing poverty. Pakistan had invested 2850 million Pakistan rupees in a national plan for cataract treatment. He strongly supported the draft resolution, and recommended that WHO should provide the necessary technical support for its implementation.

Dr BRANDRUP-LUKANOW (Germany)<sup>1</sup> also commended the report and endorsed the draft resolution. In Germany, programmes for the prevention of avoidable blindness and visual impairment focused on early detection through the screening of children, particularly preschool-age children, developments in technology, and work with "self-help" groups of people living with visual impairment. Those aspects could have been included in the report.

Germany had supported efforts to combat onchocerciasis through cooperation with WHO and the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. More recently it had worked closely with the WHO initiative on capacity strengthening for neglected diseases, including other causes of blindness such as trachoma. Germany would be pleased to continue exchange of expertise with national research institutions in that area and to support further the health-care management and systems in partner countries.

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

Dr BELLO DE KEMPER (Dominican Republic)<sup>1</sup> said that the prevention of avoidable blindness was of great concern to her country, which had had experience of a blind president. In the framework of Vision 2020, retinopathy due to premature birth had been identified as one of the avoidable causes of blindness that must be eradicated. That topic could have been mentioned in the report (in relation to childhood blindness). In recent years her country had seen a rise in the number of babies born blind as a result of insufficient intrauterine development and, according to a report by the national association for blind persons, 36% of those people referred to the association were blind owing to premature birth. It was necessary to raise the awareness of perinatal and neonatal specialists of the visual health of premature babies, particularly concerning treatment in the first weeks of life. She supported the amendments to the draft resolution proposed by the member for Jamaica and endorsed the statement made by the representative of Cuba.

Prince ABDULAZIZ BIN AHMAD BIN ABDULAZIZ AL SAUD (International Agency for the Prevention of Blindness), speaking at the invitation of the CHAIRMAN, said that his agency was the umbrella body representing more than 60 international organizations seeking to eliminate blindness. He expressed his appreciation of the efforts of Member States of the Eastern Mediterranean Region, particularly in the context of the Vision 2020 initiative, and hoped that the Board would adopt the draft resolution.

Vision 2020 had alleviated suffering throughout the world, and reduced the number of the blind and visually impaired, resulting in huge economic benefits. He thanked WHO for its assistance, which he hoped would continue through to the landmark date of 2020. The Global Initiative for the Elimination of Avoidable Blindness should be made a priority area of WHO's work, and funds allocated accordingly.

Mr GARMS (Christoffel-Blindenmission), speaking at the invitation of the CHAIRMAN, recalled that his organization had collaborated with WHO in developing the underlying concepts and strategies of the Vision 2020 initiative. The need for eye-care resources was overwhelming. In resolution WHA56.26 a historic commitment had been made to the prevention of blindness. Implementation of that resolution depended on strengthening technical cooperation and providing support to Member States and collaborating nongovernmental organizations in the formulation of national plans, programme implementation, monitoring and evaluation. An explicit commitment to that end by WHO would benefit the millions of children, women and men who were needlessly blind or in imminent danger of losing their sight.

Mr PORTER (Sight Savers International), speaking at the invitation of the CHAIRMAN, recalled that his organization had been a founding member of Vision 2020, and had worked closely with the Secretariat for seven years. Recent WHO data confirmed that Vision 2020 had reduced the prevalence of avoidable blindness in some of the poorest countries leading to enormous economic benefits.

The Vision 2020 initiative had reached a critical moment. The near elimination of avoidable blindness by 2020 would be achievable, provided that WHO lent its full support to the campaign. Enhanced WHO input at regional and country levels, combined with the efforts of national governments and international nongovernmental organizations, would mean that many millions of people would be spared from unnecessary blindness. He called on the Board to consider and support the case for designating the prevention of blindness as a WHO priority area of work.

Mr BAILÓN (Mexico) endorsed the comments by the representative of the Dominican Republic. Premature retinopathy in developing countries, including Mexico, was a serious problem:

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

between 15% and 20% of premature babies who were underweight suffered from the disorder, and between 5% and 10% of babies with serious retinopathy would become blind.

Dr LE GALÈS-CAMUS (Assistant Director-General), responding to comments made, said that the prevention of avoidable blindness would have a significant impact on attaining the Millennium Development Goals. Seven years had elapsed since Vision 2020 had been launched, and the presence of representatives of the founding organizations indicated their commitment. Much of the success achieved so far could be attributed to such partnerships. The discovery of new causes of blindness and visual impairment, including chronic diseases and trauma raised new challenges. Retinopathy in children was also a serious problem, but Vision 2020 provided a framework that could be adapted to respond to specific problems and specific country needs.

The importance of the evaluation process envisaged in resolution WHA56.26 had been recognized, and the first meeting of the Evaluation Committee had recently taken place in Geneva. The Committee's findings would be included in the report to the Health Assembly. The financial implications of providing support to countries might seem significant, but, as the member for Sudan had noted, the interventions envisaged were extremely cost-effective. The amount required to restore the sight of children and the elderly was relatively modest and should justify the effort needed. The proposals and recommendations that had been put forward would be taken into account in the development of future activities.

Mr AITKEN (Director, Office of the Director-General) read out the proposed amendments. The fifth preambular paragraph would read "Acknowledging the links between poverty and blindness and that blindness places a heavy economic burden on families, communities and countries, ...". In paragraph 1(2) "integrated programmes for prevention of avoidable blindness and visual impairment" would be replaced by "these plans". Paragraph 2, as amended, would read "REQUESTS the Director-General to give priority to this issue, and to provide necessary technical support, not only to Member States, as well as support to collaboration among countries for the prevention of avoidable blindness and visual impairment". A new final subparagraph would read: "to monitor progress in the Global Initiative for the Elimination of Avoidable Blindness in collaboration with international partners and to report to the Executive Board every three years".

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

**Health-related Millennium Development Goals:** Item 4.11 of the Agenda (Documents EB117/12, EB117/13 and EB117/INF.DOC./2)

- **Update after the high-level plenary meeting of the United Nations General Assembly (September 2005)** (Document EB117/12)
- **WHO's contribution to implementation of the strategy for child and adolescent health and development, with particular emphasis on attainment of the Millennium Development Goals** (Document EB117/13)

Dr SHINOZAKI (Japan) observed that, as the difficulty of attaining the health-related Millennium Development Goals by the deadline of 2010 became increasingly evident, the need for a well coordinated approach had become vital. The Health Metrics Network, which had been established in 2004 to strengthen health systems but which had not been mentioned in the report, was an important resource, and information on its progress should be reported to the Board at its 119th session. He welcomed the efforts to draw up a strategy for strengthening health systems, in

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<sup>1</sup> Resolution EB117.R4.

response to a clear need and in the context of the Goals. It would also be a useful tool for long-term health development.

**Dr Acharya took the Chair.**

Dr ANTEZANA ARANÍBAR (Bolivia) said that attainment of the Goals would be complex because of the social factors involved, notably health and education. The United Nations General Assembly had established the Global Fund to Fight AIDS, Tuberculosis and Malaria and had proposed measures to deal with foreign debt, yet the political will in its Declarations had not been reflected in any practical action. The undertakings from the G8 Summit (Gleneagles, Scotland, 7-8 July 2005) had not been translated into concrete proposals for achieving the Goals. Few countries had so far complied with their commitment to contribute 0.7% of their gross domestic product to development aid.

The most effective way to reduce infant mortality would be through poverty alleviation and strengthened health services, notably human resources. Given the fundamental importance of mobilizing resources, WHO, when attending United Nations meetings, must clearly indicate progress towards attaining the health-related Goals. Member States must be able to provide precise figures for the financial resources thus far allocated to the attainment of the Goals.

Dr NTAWUKULIRYAYO (Rwanda) endorsed that view. The migration of health sector workers was particularly damaging to efforts to achieve the Goals. Health professionals travelled abroad and even within countries to find work that offered better prospects, leaving many people dying from malaria and tuberculosis. Rwanda, with its partners, had been trying to establish a fund that would enable it to retain and train health professionals in all branches of medicine and at all levels. Resources for that fund could be derived from international organizations or from national budgets of countries that had committed themselves to devoting 15% of their budgets to health by 2015. Guidelines were needed in order to build a national medical profession that would sustain a health system, with contributions to it through health insurance schemes such as the one currently being formulated in Rwanda.

Mr GUNNARSSON (Iceland) said that one of the central issues in achieving the health-related Millennium Development Goals was the right to sexual and reproductive health, as highlighted in resolution WHA57.12 "Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets" and the commitment re-emphasized at the 2005 World Summit to universal access to reproductive health by 2015. The Organization should re-examine the strong commitments undertaken in that area, including resolution WHA48.10 with its support for implementation of reproductive health strategies in keeping with the principles elaborated in the Programme of Action of the International Conference on Population and Development (Cairo 1994) and in particular to the problems of unwanted pregnancies and unsafe abortions: it was estimated that, in 2000, 19 million women had undergone unsafe abortions and that 68 000 women had died from post-abortion complications. The underlying public health issue should be tackled independently from the national legislations pertaining in different countries. He looked forward to evidence and guidelines produced by WHO in order to achieve the goal of access to reproductive health for all by 2015.

Dr VIROJ TANGCHAROENSATHIEN (adviser to Dr Suwit Wibulpolprasert, Thailand) noted with concern that, owing to poor resources and lack of health systems' capacity, several countries in Africa and south Asia were unlikely to achieve the goals relating to maternal and child mortality reduction by 2015. He welcomed the progress made in implementing the seven priorities for child and adolescent health set out in document EB117/3, but noted also the decrease in immunization coverage in the "fragile" States.

A strong health system that was well managed and well funded, with adequate staffing, was essential for attaining the Millennium Development Goals. The Secretariat could assist Member States

in strengthening their health systems on the basis of cost-effectiveness, strong leadership and adequate financing. He endorsed the notion of universal and equitable access, a central tenet of the Goals, and the introduction of social protection. The strategic directions should provide pragmatic advice on how to achieve health-system goals in developing countries, including the production of evidence and on how to prioritize programmes, guide resource allocation, target priority areas and serve as monitoring and evaluation tools. Much could be learnt from South-South cooperation.

Dr BRUNET (alternate to Professor Houssin, France) said that international recognition of the leading role played by health in the Millennium Development Goals placed a heavy responsibility on Member States and the Secretariat. The indicators and targets defined in the Goals would guide France in its cooperation with WHO.

Achievement of the Goals would require innovative ways to increase funding, and the need for further human resources to strengthen health systems. He welcomed the emphasis given in the 2005 World Summit Outcome to universal access to reproductive health. Further information was required on the issues surrounding illegal abortion, an important area affecting women's health. He was pleased to learn that the draft strategy on sexually transmitted infections would soon to be available.

It was the responsibility of the Board and other Member States to ensure that all those objectives were, explicitly and in detail, contained in the Eleventh General Programme of Work. France committed itself fully to that aim.

Dr GASHUT (alternate to Dr Al-Keeb, Libyan Arab Jamahiriya), speaking on behalf of the Member States of the Eastern Mediterranean Region, gave assurance that those countries were committed to achieving the Millennium Development Goals through encouraging political commitment, resource mobilization and strengthening technical assistance. Primary health-care services should be accessible to the poor, and country cooperation strategies and poverty reduction strategies should be oriented by the Millennium Development Goals. WHO should assist donor and recipient countries by facilitating sector-wide approaches to poverty reduction and direct budget support for the health sector.

Child health should remain a priority for Member States, and WHO's role as the global technical agency in that area should be enhanced. New initiatives such as a trust fund for child health should be promoted.

#### **Mr Khan resumed the Chair.**

Dr RAHANTANIRINA (alternate to Dr Jean Louis, Madagascar), speaking on behalf of Member States of the African Region, said that the Millennium Declaration had highlighted the responsibilities of world leaders to all their citizens, especially the most vulnerable. African countries had subscribed to the Millennium Development Goals and to the New Partnership for Africa's Development; many of them had adopted poverty reduction strategies that referred explicitly to the health-related Goals, and had undertaken to allocate 15% of their national budgets to health. Four or five countries had achieved the 15% health allocation, while around 10 had committed between 8% and 10%. African countries had pursued health improvement strategies thanks to support from WHO, the Global Alliance for Vaccines and Immunization, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Roll Back Malaria Initiative.

Health inequalities remained and trends were worsening, especially in sub-Saharan Africa. Only seven African countries were progressing towards Goal 4 (reducing child mortality), and Africa had the highest incidences of AIDS, malaria and tuberculosis in the world. Nevertheless, the problems were surmountable and many lives could be saved if health systems were strengthened, with increased investment in obstetric and neonatal equipment and facilities. Donors were therefore encouraged to allocate 0.7% of their gross domestic product to development aid, while African countries should allocate 15% of their budgets to health as set out in the Abuja Declaration on HIV/AIDS, Tuberculosis and other related Infectious Diseases. She paid tribute to the assistance provided by WHO and other



partners, and expressed optimism that the international community and the elaboration of a new strategy for strengthening health systems would help Africa to achieve the health-related Millennium Development Goals.

Dr RUÍZ MATUS (alternate to Mr Bailón, Mexico) welcomed the inclusion of access to reproductive health for all by 2015 in the Millennium Development Goals. Access was essential in order to achieve Goals 4 and 5, namely reducing child mortality and improving maternal health. Mexico had reduced child and maternal mortality, and had the fewest cases of malaria in its history while using the lowest number of insecticides. It had made strides in combating tuberculosis. It had achieved universal coverage with antiretroviral treatment for all AIDS patients and was combating stigmatization and discrimination against people with HIV/AIDS.

He welcomed the renewed focus on maternal health. Achievement of the health-related Goals was linked to poverty reduction as well as to universal access to high-quality health care. In Mexico, the Millennium Development Goals had been incorporated into Government policy.

Dr BUSS (Brazil) said that the huge inequalities between rich and poor was largely responsible for the explosive insecurity in the world. Overcoming poverty would result in a more secure world. The first issue was external assistance, the commitment by the rich countries to give 0.7% of their gross domestic product for combating poverty and enhancing development. Only a few countries had reached that target; the Board should request the other countries to fulfil that obligation. It was a moral issue since, without economic and social development, including education, health targets would not be reached.

Former colonies were the countries furthest from attaining the Goals. The former colonial powers should shoulder their responsibilities and provide help. The Board should assist in identifying the needs of each country for achieving the health-related Goals by 2010. Rather than neocolonization, it was the will of sovereign States, assisted by the United Nations, to improve their situation. He therefore asked for a report on the needs of each country in relation to the Goals. He urged the forthcoming Health Assembly to take action on the matter.

Coordinating external assistance within recipient countries was important. Brazil was doing its utmost to help lusophone African countries, from which it had received many slaves, whose descendants were advancing his country's development. Brazil would assist in technical assistance projects and give financial help. The Health Assembly should make a declaration on the whole moral issue, urging that countries fulfil their commitment to give 0.7% of their gross domestic product, for peace and security.

Mrs GILDERS (alternate to Mr Shugart, Canada), acknowledging WHO's efforts to achieve internationally agreed health-related goals concerning child, adolescent and maternal health, recognized that at the 2005 World Summit Member States had committed themselves to the goal of achieving universal access to reproductive health by 2015. She strongly supported the comprehensive WHO approach to maternal, newborn, child and adolescent health and welcomed the expansion of the Integrated Management of Childhood Illnesses strategy. Canada also commended the expanded access to antiretroviral treatment and adolescent-friendly sexual and reproductive health services, which should also include prevention. Her country encouraged WHO to recognize the particular vulnerability of youth and children to HIV/AIDS and commended the prevention and management of injuries suffered by women and children, including those caused by violence.

She urged that the work of the Secretariat should be enhanced in helping countries where abortion was legal to avoid unsafe abortions. It was important that WHO should deal with a public health issue that millions of women faced every year.

Dr HANSEN-KOENIG (Luxembourg) said that her country was committed to the Goals: in 2005, under its presidency, the European Union Member States had agreed to raise their development assistance to 0.56% of gross domestic product by 2010 and to 0.7% by 2015. Luxembourg currently

gave 0.85%, with a target of 1% in coming years. She supported two points raised by previous speakers: the importance of enhanced work on all aspects of reproductive health; and the essential role of health systems and human resources. The topics of effective and equitable health systems and appropriately trained personnel had informed all discussions since the beginning of the Board's session, reflecting the paramount role of WHO and the exceptional commitment it must make, with all Member States, to attain the Millennium Development Goals.

Professor PEREIRA MIGUEL (Portugal) said that availability of qualified health care and access were essential to achieving the Goals. Maternal and child mortality had been markedly reduced in Portugal, which was willing to share its experience. His country welcomed the adoption of the European strategy for child and adolescent health. Maternal and child health might also be a priority area in future cooperation with the Member States of the African Region and was a continuing priority in bilateral cooperation with lusophone countries.

Dr SINGAY (Bhutan) said that the Goals required multifaceted approaches, including cooperation across sectors and geographical areas, preventive health services, disaster preparedness and management mechanisms, and a special focus on vulnerable populations. Improvements in accessibility and quality of health systems were crucial, requiring planning, analysis and monitoring, good health management information and stable financing systems, and a properly trained and deployed workforce. An approach based on human security was important in addressing disparity. It could include the recording of inequalities, increasing the availability and quality of health services, promoting primary and essential care, and establishing risk-sharing arrangements.

Meeting the health-related Goals would require cross-sector investment in such areas as poverty reduction, educational achievement, gender equality, water supply and sanitation, and infrastructure. More domestic and external investment, and better use of resources and enhanced regional cooperation would be needed. Country ownership of Goal-based strategies required the involvement of many stakeholders including governments, nongovernmental organizations, civil society and the private sector. He prioritized maternal health since, in the developing countries, mortality of mothers and newborn infants remained high. That essential continuum of services deserved special consideration and must be strengthened through investment in relevant human resources, particularly in midwifery and nursing.

Dr NYIKAL (Kenya) said that the 2005 World Summit had noted that the Goals might not be met in Africa and would probably not be in his country. The real issue was development in a broader context, including trade relations, agriculture, debt burden, inflation and governance, as constantly reflected in underfunding, poor infrastructure and inadequate personnel in the health sector. The greatest hindrance to further enhancement of antiretroviral treatment in Kenya was currently lack of human resources and infrastructure. Many trained health officers went abroad to work having no qualms about subsequently lecturing their own countries on their lack of capacity. Efforts to reach the Goals must tackle those broad areas. He welcomed the development of strategies but stressed that the capacity must exist for their implementation.

Dr PHOOKO (Lesotho) said that important health indicators in Africa, such as maternal and child mortality, lagged behind those of other regions and were regressing in many countries. Poverty and hunger, and therefore illness, were increasing. Resolution WHA58.30 had called for a coherent and adequately resourced strategy to strengthen health systems. A clear focus on equity in access and outcomes needed substantial investment in both human and financial resources. Resolutions had also been adopted on reproductive health and universal coverage of maternal, newborn and child health interventions. All were high priorities since they concerned the needs of vulnerable populations. Such populations were at risk, however, not only from global health threats, such as avian influenza, HIV/AIDS or tuberculosis, but also from emigration of health personnel from developing countries. Urgent action was needed. Although African countries knew that they had to strengthen their primary

health care systems, they were suffering from a severe drain of health personnel. Even where indicators had improved through innovative use of alternative health personnel, implementation soon slowed for lack of supervisory expertise. Developing countries invested heavily in training health personnel; but such spending was negated by poverty, hunger and emigration, not to mention epidemic diseases. Fully functioning health systems would reduce morbidity and mortality and might enable African countries to attain internationally agreed health-related development goals, unlikely under current circumstances. The Secretariat should elaborate a strategy to strengthen health systems, emphasizing the need to retain health workers. Comprehensive debt relief for the least developed countries should also be urgently considered, with specific reference to health issues.

The CHAIRMAN, speaking as the member for Pakistan, said that, in adopting the Millennium Development Goals, States had undertaken a rights-based agenda that placed health at the centre of development. His Government had drawn up a national mother and child health policy and strategic framework for 2005-2006, setting out the requirements for achieving the relevant Goals in a national programme. A key element of the policy was reproductive health, but several programmes sought to empower women: to educate a woman was to educate a family and a nation; countries that excluded women from the mainstream of life did themselves a disservice.

One innovation was the introduction of 80 000 women health workers, working primarily for child and mother care in the villages. Such skilled help would reduce mortality rates markedly. The management of childhood illnesses had also been integrated and immunization and nutrition programmes had been established. Despite the recent earthquake, Pakistan remained fully committed to the Millennium Development Goals. States should work nationally, with each other and with WHO; humankind could do without disasters of its own making, in view of the carnage wrought by natural disasters. The people in his region had suffered terribly. In the health sector alone, US\$ 35 000 million-worth of infrastructure had been destroyed and thousands of the doctors and nurses who had staffed health facilities had been killed. He urged members to work together to bring sanity to the world for the sake of their children and their children's children.

Mr HILMERSON (Sweden)<sup>1</sup> endorsed the statements on the crucial role of sexual and reproductive health and rights in relation to attaining the Millennium Development Goals, and the role of WHO in that regard. He therefore regretted that the Secretariat was not giving the issue the attention that it deserved. The draft strategy on sexually transmitted diseases was hardly satisfactory. The discussions on the important issue of women, gender and health, scheduled for 2005, had been postponed, and participants in the interdisciplinary consultation on research priorities for preventing unsafe abortion and its consequences were wondering when the proceedings would be published. Meanwhile, the Eleventh General Programme of Work 2006-2015 described abortion simply as a "sensitive issue". WHO should show stronger leadership, accountability and transparency with regard to sexual and reproductive health and rights.

Dr STEIGER (United States of America)<sup>1</sup> stated his country's position concerning reproductive health. The United States understood that references to the United Nations International Conference on Population and Development (Cairo, 1994), the Beijing Declaration and Platform for Action, and the use of the phrase "reproductive health" in paragraphs 57(g) and 58(c) of the 2005 World Summit Outcome did not create a right and could not be interpreted as constituting support for or endorsement or promotion of abortion. In addition, the United States did not support the use of the term "sexual rights", of which there was no internationally agreed definition. Although every woman, wherever she lived, deserved the best medical care possible for her ailments, however acquired, it was not for the international organizations, including WHO, to promote abortion where it was not legal or to promote it as an intervention of birth or population control. He encouraged Member States and the Secretariat

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

to focus on fostering healthy and stable families, emphasizing the role of parents as primary caregivers, and ensuring the age-appropriateness of health and education interventions for children and adolescents.

Mr MARTIN (Switzerland)<sup>1</sup> said that WHO's activities on abortion went well beyond the mere challenge of the voluntary interruption of pregnancy, particularly in developing countries but also among young women living in poverty in developed countries. Although abortion should not be promoted as a form of family planning, and women's health was at risk from abortions performed in insanitary conditions, the prevention of unwanted pregnancies remained a priority. Whatever a country's legislation on abortion, it was an important public health issue and WHO should document its extent and impact, adopt strategies appropriate to the various national legislations and support governments seeking its assistance.

The documents relating to the Millennium Development Goals made little reference to United Nations reform, even though the Health Assembly had encouraged WHO's participation in that exercise.

Mr NAIR (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, expressed support for the report in document EB117/12, especially paragraph 5. In that context, agenda item 9.3 should be considered in conjunction with item 4.11. As to document EB117/13, his organization believed that the last sentence of paragraph 3 should read, in line with *The world health report 2005*:<sup>2</sup> "The challenge remains to identify delivery strategies which strengthen national health systems' ability to provide efficient, effective, accessible and equitable health services in order to rapidly increase coverage ...". A footnote specifically referring to resolution WHA58.31 should be included. With regard to paragraphs 7 and 16, increased support for technical guidance on neonatal health was welcome, but normative work in that area should also be well resourced. The emphasis on the impact of malnutrition on health was also welcome. On the question of health promotion, his organization's research indicated that information alone would not lead to changes in behaviour without changes in economic, social and political norms, including improved access to high-quality health and education services. Mechanisms to reach the most marginalized people needed to be prioritized and resourced. With regard to increased resources for immunization, mentioned in paragraph 13, such resources should go to strengthening national health systems. The report was right to emphasize, in paragraphs 15 and 16, the need to focus on the impact of HIV on children; donors should support research into paediatric formulations of medicines as a matter of urgency. Referring to the Secretariat's commitment to report on work on strategies on strengthening nursing and midwifery services to the Health Assembly,<sup>3</sup> it should be considered under agenda item 4.11.

Dr EVANS (Assistant Director-General) said that member's comments in general seemed to agree on the essential elements of national health systems. Infrastructure was, naturally, a critical element and one that could not be provided by the health sector alone. An effective information system was also vital for providing baseline data and indicating what progress was being made and how efficiently resources were being used. The Secretariat planned to submit a progress report on the Health Metrics Network to the next Health Assembly. By that time, a new edition of *World health statistics* should also be available, and it should be possible to break the data down to show the major social determinants, as the member for Thailand had suggested.

Human resources were another vital element of health-system infrastructure, and would provide the theme for *The world health report* and World Health Day in 2006. There was no simple answer to the problem of human resources: instead, solutions must be found for various aspects, such as training

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

<sup>2</sup> *The world health report 2005: make every mother and child count*. Geneva, World Health Organization, 2005.

<sup>3</sup> Document WHA56/2003/REC/3, summary record of the seventh meeting of Committee A, section 3.

the right number of health workers in appropriate skills, supporting workers in the workplace, occupational health and safety, retaining staff and planning for their retirement. It was essential to maintain an overview of the human-resources situation, particularly at a time of general population ageing.

Health financing was another priority. Although it was important to earmark more resources for international development assistance, it was also vital to develop and invest in national financing systems for health, as recommended in resolution WHA58.33, since the current level of international funding might not be available in 10 years' time. Leadership and governance of priority programmes must be taken into consideration. WHO's programmes relating to tuberculosis, HIV/AIDS and maternal and child health devoted considerable attention to the interface between their respective technical areas and national health systems. Working across different sectors and taking due account of the social determinants of health were likewise important. He looked forward to the results of the work of the Commission on Social Determinants of Health in that regard.

The 2005 World Summit had called on countries to implement comprehensive national development strategies. Such strategies went well beyond the health sector and WHO's role was, therefore, to coordinate its efforts with those of other development partners. For example, a seminar was taking place that afternoon on the efforts of two African countries to align WHO's work with their own broad development plans. WHO was working to improve its coordination of the contributions received from various donors.

The Secretariat was preparing a position paper on WHO's role in the current debate on reform of the United Nations, with particular reference to the future role of the specialized agencies, including WHO.

Members seemed to support the main points of the proposed draft strategy for strengthening health systems, which the Secretariat planned to submit during 2006. He had noted the Board's emphasis on both the strategy itself and how it would be implemented.

Mrs PHUMAPHI (Assistant Director-General) said that good reproductive health was critical to human development. Areas with poor access to reproductive health services and a high rate of unplanned pregnancies tended to have high maternal and child mortality rates and widespread ill-health and neglect of children. WHO took very seriously the task of coordinating its efforts with those of the other members of the global reproductive health community. Reproductive health was crucial to achievement of the Millennium Development Goals.

Safe abortion was one of the five core elements of the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health, adopted in resolution WHA57.12. In 2003, the Secretariat had published technical and policy guidance on safe abortion.<sup>1</sup> That publication referred to settings where abortion was legally permitted. More than 27 000 copies of the publication had been printed, and a further 18 000 copies had been downloaded from the WHO web site. Regional workshops had been conducted for interested Member States in the African, European and South-East Asia Regions. Technical support had been provided for individual countries, including Bangladesh, Ghana, Mongolia and Viet Nam. WHO published data on unsafe abortion and its consequences at five-yearly intervals, the most recent dating from 2004.

It was not part of WHO's mandate to promote abortion as a method of birth control, or to advocate its legalization. The interdisciplinary consultation on research priorities for preventing unsafe abortion and its consequences, referred to by the representative of Sweden, had involved researchers from all over the world. WHO had been asked to publish its proceedings, but some of the content of the report had been considered incompatible with WHO's mandate. Another institution that had taken part in the consultation might publish the proceedings instead.

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<sup>1</sup> *Safe abortion: technical and policy guidance for health systems*. Geneva, World Health Organization, 2003.

In 2003 the Health Assembly had welcomed the formulation of the strategic directions for improving the health and development of children and adolescents.<sup>1</sup> Subsequently, the Secretariat had encouraged regions to draw up their own strategies and helped countries to develop national implementation plans. The Integrated Management of Childhood Illness strategy was being evaluated and measures were being taken to close gaps in child and adolescent health services at country level.

The member for Brazil had asked for information about country needs. The Secretariat had detailed information about the needs of those Member States that had requested assistance and drawn up country plans.

Member States had committed themselves to implementing the recommendations of *The world health report 2004*<sup>2</sup> and the policy briefs published later. Many of the report's recommendations had also been adopted by WHO's partner agencies, including UNICEF and UNFPA, professional associations and nongovernmental organizations. Since the publication of *The world health report*, the Secretariat had helped to set up the Partnership for Maternal, Newborn and Child Health and had continued to build on the work begun by the Child Survival Partnership, in addition to promoting partnerships with the European Commission and other donor agencies. The Secretariat would continue to promote the principles of universal access, integration of services and the continuum of care.

The DIRECTOR-GENERAL apologized for any impression which members might have gained that WHO was giving too little attention to child and adolescent health. The Millennium Development Goals were a commendable target, but he was struck by the fact that many Member States had been unable to fulfil their commitments to the litmus test of the "3 by 5" strategy, even though life expectancy in many countries had dropped below 40 years, largely owing to the HIV/AIDS pandemic. If incapable of dealing with the HIV/AIDS problem together, the world could hardly hope to achieve the Millennium Development Goals in 10 years' time. By then, those succeeding the present decision-makers might simply change the targets.

It was important to aim for short-term achievements and build on small successes. It would not be possible to achieve the Millennium Development Goals by 2015, deceptively remote as it seemed, without a succession of small achievements in the meantime. It was not only a question of money; the target of 0.7% of gross domestic product for official development assistance was commendable, but countries had to have the resources and the political will for that. Good governance and a demonstrated ability to meet short-term goals, with some supplementary international support for national health systems, would achieve real change.

One third of the time laid down for achievement of the Millennium Development Goals had already elapsed. It was unrealistic to think that, if progress continued at the current rate, the Goals would be met by 2015. He had not yet seen any major change in national governance or commitment or in international contributions, with the exception of the reaffirmation of the Millennium Development Goals at the 2005 World Summit. The Secretariat must set short-term goals for the next one or two years and work with Member States to build on those successes.

he CHAIRMAN, affirming the need for collaboration for progress towards the Millennium Development Goals, called for support to Member States in improving their technical and support mechanisms. The 0.7% target had been endorsed by the World Summit, but increased national funding was also critical. Board members should encourage their governments to contribute funding themselves, in addition to the international assistance they received. Member States needed more information about the innovative financing schemes that had been mentioned. WHO needed the support of the United Nations and the political support from the Head of State of every country

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**The Board noted the reports.**

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<sup>1</sup> Resolution WHA56.21.

<sup>2</sup> *The world health report 2004: changing history*. Geneva, World Health Organization, 2004.

**International trade and health: draft resolution:** Item 4.3 of the Agenda (Documents EB117/10 and EB117/10 Add.1)

The CHAIRMAN invited the Board to consider the following draft resolution that had resulted from an informal consultation :

The Executive Board,  
Having considered the report on international trade and health,<sup>1</sup>

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

The Fifty-ninth World Health Assembly,  
Having considered the report on international trade and health;<sup>1</sup>  
Recalling resolutions WHA52.19, WHA53.14, WHA56.23, WHA56.27, WHA57.14 and WHA57.19;

Recognizing the demand for information about the possible implications of international trade and trade agreements for health and health policy at national, regional and global levels;

Mindful of the need for all relevant ministries, including those of health, trade, commerce, finance and foreign affairs, to work together constructively in order to ensure that the interests of trade and health are appropriately balanced and coordinated,

1. URGES Member States:

- (1) to promote dialogue at national level to consider the interplay between international trade and health;
- (2) to adopt, where necessary, policies, laws and regulations that address issues identified in that dialogue and take advantage of the potential opportunities, and meet the potential challenges, that trade and trade agreements may have for health;
- (3) to apply, or establish, where necessary, coordination mechanisms involving ministries of finance, health, and trade, and other relevant institutions, to address public health related aspects of international trade;
- (4) to create constructive and interactive relationships across the public and private sectors for the purpose of generating coherence in their trade and health policies;
- (5) to continue to develop capacity at national level to track and analyse the potential opportunities and challenges of trade and trade agreements for health-sector performance and health outcomes;

2. REQUESTS the Director-General:

- (1) to provide support to Member States, at their request and in collaboration with the competent international organizations, in their efforts to frame coherent policies to address the relationship between trade and health;
- (2) to respond to Member States' requests for support of their efforts to build the capacity to understand the implications of international trade and trade agreements for health and to address relevant issues through policies and legislation that take advantage of the potential opportunities, and meet the potential challenges, that trade and trade agreements may have for health;

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<sup>1</sup> Document EB117/10.

- (3) to continue collaborating with the competent international organizations in order to support policy coherence between trade and health sectors at regional and global levels, including generating and sharing evidence on the relationship between trade and health;
- (4) to report through the Executive Board to the Sixty-first World Health Assembly on progress made in implementing this resolution.

Mr AITKEN (Director, Office of the Director-General) said that, in paragraphs 1(2) and 2(2), the word “meet” should be changed back to the original word, “address”.

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

**The meeting rose at 17:50.**

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<sup>1</sup> Resolution EB117.R5.



## **SEVENTH MEETING**

**Thursday, 26 January 2006, at 09:10**

**Chairman:** Mr M.N. KHAN (Pakistan)

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

**Intellectual property rights, innovation and public health:** Item 4.10 of the Agenda (Document EB117/9)

The CHAIRMAN invited the Chairman of the WHO Commission on Intellectual Property Rights, Innovation and Public Health to brief the Board on its work to date.

Ms DREIFUSS (Chairman, Commission on Intellectual Property Rights, Innovation and Public Health), expressing sympathy for the suffering and loss of life among the people of Pakistan as a result of the recent earthquake, said that the long-term suffering of victims of disease had also been the theme of the work of the Commission. That work had been inspired by the hope of bridging the huge gap between the potential of modern science and its application to the needs of the neglected sick in the developing countries. Having worked for almost two years, the Commission had hoped to present its report to the Board at the current session, but regrettably members had had to extend their work. The report would be completed shortly and published in April 2006, in time for the Fifty-ninth World Health Assembly.

The reason for the delay was threefold: first, the Commission's method of work. Its terms of reference had been defined in the note by the Director-General to the Board at its 113th session.<sup>1</sup> The Commission had been asked to add value to existing work, through research and consultations, and to prioritize consulting and listening. The consultation phase, detailed on WHO's web site, had overrun but provided valuable material on the scientific, economic and political complexities underlying biomedical innovation and access to health care.

The Commission's own ambition had been a second delaying factor, because its rigorous analysis had entailed describing the complex system of biomedical innovation and explaining the failure to yield the results sought by developing countries. The impact of intellectual property rights on innovation differed at each stage of the cycle from basic research via research and development to access to medicines. The Commission was therefore offering an analytical matrix adapted to different types of disease that particularly affected the poor and the differing conditions prevailing in different categories of country. It had also attempted to show how the stakeholders had adapted to economic and political pressure, and to focus attention on their potential and responsibilities. In its report it would therefore distinguish between situations in which intellectual property rights could help to promote research and those in which they were likely to be ineffective. It would attempt to highlight the positive and negative effects of intellectual property regimes on biomedical innovation, access to medicines and the productive and innovative capacities of the developing countries, taking account of the influence of national implementation of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), the follow-up to the Doha Declaration on the TRIPS Agreement and Public Health, and the scope of bilateral and regional free-trade agreements on the capacity to attain public health objectives.

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<sup>1</sup> Document EB113/INF.DOC./1.

Other incentives and funding regimes were required in order to promote biomedical research into diseases that particularly affected poor people and foster developing countries' capacities in that area. The report would welcome the various public-private partnerships engaged in product development. More effort was needed to ensure both their sustainability and that the medicines, vaccines and diagnostic tools developed reached those in need of them. Member States bore a crucial responsibility for funding research, regulating the marketing of new medical products and organizing health-care systems, to name only three areas.

Thirdly, the Commission's 10 members represented a broad spectrum of experience, opinion and scientific disciplines. Finding common denominators had taken time. Members had striven to put aside ideological considerations and special interests so as to reach a consensus, and to prepare recommendations and proposals for action. The report would come at a time of mobilization and commitment, bringing together international awareness, additional (albeit still insufficient) resources, effective science and new types of partnership. The challenge facing the Commission was to show how to make that movement more sustainable and effective.

The CHAIRMAN invited the Board to consider, in particular, how the report of the Commission would best be presented to the governing bodies. He drew attention to the following draft resolution, proposed by the members of Brazil and Kenya:

The Executive Board,

Having considered current developments regarding access to medicines and the need to develop urgently new medicines and other health care technologies;

Noting the useful work being done by the WHO Commission on Intellectual Property Rights, Innovation and Public Health,

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

The Fifty-ninth World Health Assembly,

Recalling resolutions WHA52.19, WHA53.14, WHA54.10, WHA56.27, and WHA57.14;

Considering the paucity of safe, adapted and affordable new medicines developed for such communicable diseases as AIDS, malaria and tuberculosis, and the lack of medicines, vaccines and diagnostics for tropical diseases or other illnesses that primarily affect the world's poorest people;

Recognizing the importance of providing support for the development of treatments for diseases that have small client populations;

Concerned about the need for appropriate, effective and safe health tools for patients living in resource-poor settings;

Mindful that more than 70% of new drug approvals are for medicines that do not provide incremental benefits over existing ones;

Considering the urgency of developing new medicines to address emerging health threats such as multidrug-resistant tuberculosis, and other poverty-related and infectious diseases;

Aware that funding for research and development for new vaccines for AIDS and other illnesses is insufficient;

Recognizing the importance of global public undertakings such as the Human Genome Project, and the increasing relevance of open and accessible public research in advancing science and the transfer of technology;

Further aware of the promise of new, open models for the development of medical science, enhanced participation in, and access to, scientific advances, and increased knowledge;

Recognizing the importance of public/private partnerships devoted to the development of new essential drugs and research tools, but concerned about the need for governments to set a needs-based priority agenda for health, and to provide political support and sustainable sources of funding for such initiatives;

Recognizing the importance of public and private investment in the development of new medical technologies;

Considering that a number of developing countries have been strengthening their capacity in new health technologies, and that their role will be increasingly critical;

Recognizing that intellectual property rights are one of several important tools to promote innovation, creativity, and the transfer of technology;

Recognizing at the same time the importance of providing for a proper balance between intellectual property rights and the public domain, and the need to implement intellectual property rules in a manner that is consistent with the basic human right to health and the promotion of follow-on innovation;

Noting that UNDP's Human Development Report 2005 states that "the WTO's Trade Related Intellectual Property Rights (TRIPS) agreement, along with 'TRIPS plus' variants in regional and bilateral agreements, strikes the wrong balance between the interests of technology holders and the wider public interest";

Taking into account Article 7 of the TRIPS agreement that points out that "the protection and enforcement of intellectual property rights should contribute to the promotion of technological innovation and to the transfer and dissemination of technology, to the mutual advantage of producers and users of technological knowledge and in a manner conducive to social and economic welfare, and to a balance of rights and obligations";

Stressing that the Universal Declaration of Human Rights recognizes the right to protection of interests resulting from any scientific production balanced by the right to share in scientific advancements and its benefits;

Considering that it is imperative to reconcile the public interest in accessing new knowledge, with the public interest in stimulating invention;

Concerned about the impact of high prices of medicines on access to treatment, and the need to implement intellectual property laws in a manner that reconciles incentives for development of new medicines with the need to promote access to all, consistent with paragraphs 4, 5 and 7 of the Doha Declaration on TRIPS and Public Health;

Aware of the need for a new global framework to provide adequate and sustainable levels of financial support for patient-driven research, including in particular for priority medical research;

Bearing in mind a call from 162 scientists, public health experts, law professors, economists, government officials, members of parliament, nongovernmental organizations and others for an evaluation of proposals for a new global framework on medical research and development;

Considering the global appeal on research and development on neglected diseases launched on 8 June 2005 with the support of 18 Nobel Laureates, over 2500 scientists and health experts, academics, nongovernmental organizations, public research institutes, governments officials and members of parliament, calling for new policy rules to stimulate essential research and development in health, especially for the most neglected patients;

Aware of the need to promote new thinking in the mechanisms that support innovation;

Recognizing the importance of strengthening capacity of local public institutions and businesses in developing countries to contribute to, and participate in, research and development efforts,

1. URGES Member States:

- (1) to make global health and medicines a strategic sector, to take determined action to direct priorities in research and development according to the needs of patients, especially

those in resource-poor settings, and to harness collaborative research and development initiatives involving disease-endemic countries;

(2) to take an active part, within WHO and with other international actors, in the establishment of a framework for defining global health priorities, providing support for essential medical research and development predicated on the principle of equitable sharing of the costs of research and development, and determining incentives to invest in useful research and development in the areas of patients' need and public interest;

(3) to ensure that progress in basic science and biomedicine is translated into improved, safe and affordable health products – drugs, vaccines and diagnostics – to respond to all patients' needs, especially those living in poverty, and that essential medicines are rapidly delivered to people;

2. REQUESTS the Director-General:

(1) to establish a working group of interested Member States to consider proposals to establish a global framework for supporting needs-driven research, consistent with appropriate public interest issues and taking note of the work of the WHO Commission on Intellectual Property Rights, Innovation and Public Health;

(2) to ensure that bilateral, regional and global free-trade agreements and other trade agreements do not jeopardize the flexibilities of the TRIPS agreement and are in accordance with the Doha Declaration on TRIPS and Public Health;

(3) to submit a progress report of the working group of interested Member States to the Sixtieth World Health Assembly (May 2008) and a final report with concrete proposals to the Executive Board at its 121st session (January 2009), and to suggest alternative systems for protection of intellectual property, with a view to enhancing accessibility to new medicines;

(4) to ensure that the report of the WHO Commission on Intellectual Property Rights, Innovation and Public Health is included on the agendas of WHO's regional committees in 2006.

Dr NYIKAL (Kenya), speaking on behalf of the Member States of the African Region, noted the difficult and complex nature of the Commission's work, and welcomed the statement by its Chairman. Finding a sustainable means of meeting the health needs of poor people was of great significance to the African Region. The asymmetries of the present incentive mechanisms for research and development needed urgent redress. It was therefore disappointing that the Commission had been unable to submit its report to the current session of the Board.

Access to the products of research and innovation, including vaccines, diagnostic tools and treatments, was the key to improving the health of the people of Africa and the developing countries. Health and support for health were crucial to human development. UNDP's *Human development report 2005* highlighted the imbalance between the interests of the holders of technology and the wider public interest.<sup>1</sup> Unless a new framework secured access to the medicinal products of innovation, people in poor countries would continue to die. The report of the United Nations Millennium Project Task Force on HIV/AIDS, Malaria, TB, and Access to Essential Medicines had shown the inadequacy of research and development in the areas of medicines and vaccines for priority health problems in developing countries, such as the neglected diseases trypanosomiasis and leishmaniasis or second-line medicines for the treatment of malaria, tuberculosis and HIV/AIDS. There was no profit incentive for innovation and production in those areas, because the people affected could not pay for the drugs. That report had concluded that WHO had a significant role to play in supporting countries' efforts to achieve the Millennium Development Goals.

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<sup>1</sup> UNDP, *Human development report 2005: International cooperation at a crossroads – aid, trade and security in an unequal world*. New York, UNDP, 2005.

He proposed the establishment of a global framework on essential health research and development, based on the principle of equitable sharing of costs. The draft resolution responded to growing concern at the lack of a global system for supporting innovation in new medicines and other health technologies and the increasing numbers of people unable to gain access to essential medicines.

Dr BUSS (Brazil) recalled that Brazil had been among the countries proposing the establishment of the Commission, partly because of the sheer numbers of its poor and those in other regions unable to gain access to medicines, vaccines and diagnostic tools. He echoed the disappointment at the report's delay, and expressed the hope that it would be debated at the forthcoming Health Assembly. He urged the Board to adopt the draft resolution, which had been endorsed by some of the world's most eminent scientists, including Nobel Prize laureates, in a letter that was available to members.

Dr BOTROS SHOKAI (Sudan), speaking on behalf of the Member States of the Eastern Mediterranean Region, praised the draft resolution. All countries attached great importance to the need to make global health and access to medicines a strategic sector wherever intellectual property rights were applicable. However, the reference to defining global health priorities should be replaced by a definition of the scope of public health. A working definition of public health proposed by Member States of her Region read as follows:

“Public health is the science and art of promoting, protecting and/or restoring the physical, mental and social well-being of the people through prophylactic, diagnostic, therapeutic and rehabilitative measures, applied to human beings and their environments.”

Recent developments in science and technology offered potential benefits for all countries, especially developing countries. The draft resolution should therefore propose the establishment of global medicines funds, which could be used by WHO to purchase patents of new medicines for developing countries and use in public health programmes; to contract research and development for medicines in priority areas required by developing countries; and to establish and strengthen research and development centres in those countries.

She welcomed the Commission's emphasis on accessibility of pharmaceutical and biotechnology products to developing countries. However, in seeking to strike a balance between providing incentives for the development of new medicines and the goal of affordable access to existing medicines, the Commission must not sacrifice accessibility and affordability. The existing WTO patent system was not generating any marked increase in research and development activities for diseases prevalent in the developing countries; malaria was a good example. The Commission should therefore explore both “push” mechanisms, involving financial contributions for research and development, and “pull” mechanisms, aimed at ensuring an attractive level of demand if medicines or vaccines were successfully produced. Public/private partnership could be a viable means of achieving that goal.

She expressed concern that the full report would not be discussed at the current session. The Secretariat should circulate the completed draft document to members for their consideration and comment.

Dr BRUNET (alternate to Professor Houssin, France) thanked the Chairman of the Commission for her comprehensive introductory statement. He regretted that the Commission's report was not yet available but could appreciate the difficulties that had had to be overcome in order to ensure a fruitful debate. He requested clarification about the timetable for the report's publication; it must be made available to Member States well in advance of the forthcoming Health Assembly.

Dr TÜRMEŒEN (Representative of the Director-General) said that the report would first be posted on WHO's web site and then circulated to Member States and interested parties, probably in the third

week of April, together with the other documents of the Health Assembly. As the report had been compiled by an independent expert group, Member States were not called upon to provide input.

Dr ANTEZANA ARANÍBAR (Bolivia) pointed out that the Organization had been considering the complex and important issue for more than 10 years. The objective was to provide an alternative for access to both innovation and health inputs for the most deprived countries in order to enhance quality of life. How to achieve that objective had not been resolved. Research and access to knowledge would provide hope for the future. He recognized the need for a resolution on the subject, but the Board could not recommend the adoption of the draft resolution by the Fifty-ninth World Health Assembly because it did not yet know the findings of the Commission's report. A small group consisting of representatives from each region should be established in order to examine the Commission's report immediately after its publication and report to the Board on its findings.

Dr ANDRADE GAIBOR (Ecuador) endorsed the views expressed by the members for Kenya and Brazil. Poor people required access to medicines, and pharmaceutical companies needed to invest heavily in research in order to counter drug resistance. New-generation medicines for HIV/AIDS, malaria and tuberculosis, for example, were accessible only to the lucky few. He called on pharmaceutical companies to donate their medicines and reduce their research costs.

Dr SÁ NOGUEIRA (Guinea-Bissau) said that enhancing human resources and affordable access to medicines was a major challenge. It was paradoxical that, with all the talk about poverty reduction, huge numbers of people still had no access to medicines. He expressed strong support for the draft resolution.

Mr IWABUCHI (alternate to Dr Shinozaki, Japan), acknowledging the work of the Commission, said that its report should be published as soon as possible, including the differences of perspective referred to in paragraph 4 of the Secretariat's report.<sup>1</sup> He asked for a peer review in the interests of objectivity and neutrality.

Protection of intellectual property rights was important for pharmaceutical innovation; the patent system would work effectively as an incentive for the development of new medicines. He emphasized that research and development of pharmaceuticals for diseases prevalent in developing countries had been undertaken through the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases and other programmes.

Mr SHUGART (Canada) said that the issues raised in the draft resolution were of great importance. Canada was committed to accelerating the search for solutions to the twin problems of affordable access to medicines and the development of new medicines of benefit to the whole world and, in particular, the poorest populations with the heaviest disease burdens. It had legislated to facilitate greater access to medicines in the poorest parts of the world and had been supportive of the work of the Commission.

The Commission should aim for consensus, but there should be transparency with respect to any divergence of views, and no undue delay in publication of the report if consensus could not be achieved. The report should point the way forward and propose innovative and viable solutions.

The draft resolution sought to put in place immediately a process to establish a global framework for improving innovation and access to medicines in developing countries. While a procedure would be needed to generate consensus and secure progress on the issue, care should be taken not to duplicate or pre-empt completion of the Commission's work, but rather, to build upon its deliberations on practicable solutions. The proposal by the member for Bolivia to expedite

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<sup>1</sup> Document EB117/9.

proceedings was interesting. Once the Commission had completed its report, the Secretariat might wish to establish a group to formulate a draft resolution that could command consensus.

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the European Community and its Member States, recognized the importance of the highly complex issue set out in the draft resolution. The text, however, needed significant further work. The Member States of the European Union were concerned how best to respond to the important research and development questions identified, and regarded trade and related intellectual property rights as significant issues. Further reflection would be required once the Commission's report was available. A procedure such as the one proposed by the member for Bolivia, to build on the report with a view to achieving consensus, was desirable.

Dr HANSEN-KOENIG (Luxembourg) said that the complex and sensitive subject was of fundamental importance. She regretted that the Commission's report was not yet available, but a delay of a few weeks was understandable given the complexity of the issues. The work of the Commission should result in concrete solutions and a more action-oriented discussion. More sustainable access to medicines and innovation for all, particularly the poor, should be promoted.

She welcomed the draft resolution and hoped that a resolution could be approved by the Fifty-ninth World Health Assembly. Luxembourg supported previous speakers in their desire to discuss and take into account the findings of the Commission's report.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) acknowledged the hard work of the Commission. Welcoming the draft resolution, he noted that nine years remained in which to achieve the Millennium Development Goals. Public health interventions were no less important than social mobilization and closing the divide between the developed and the developing countries. The stakes were high; unless urgent action was taken, the Goals might not be achievable by the least developed countries, especially those in Africa and south Asia. Some members' fears that the current text of the draft resolution might not command consensus was understandable, but he urged the Board to recommend a draft resolution, taking account of the findings of the Commission's report, to the Fifty-ninth World Health Assembly for adoption. Failing that, the matter might drag on for several more years. Accordingly, he supported the proposal by the member for Bolivia for a small group to be convened and inform the Board of its findings.

Dr SINGAY (Bhutan) was encouraged that the Commission was focusing on the health needs and diseases of poor people, including access to innovative products. Intellectual property rights and public health had been discussed at the 23rd Meeting of Ministers of Health of Member States of the WHO South-East Asia Region (Colombo, 4-5 September 2005). The need to put patients before patents and to create a health space in trade negotiations had been stressed and agreed. Bhutan welcomed and supported in principle the draft resolution. As concerns and differences of view had been expressed, he supported the proposal to convene a small group to discuss those concerns and formulate a balanced draft resolution for submission to the forthcoming Health Assembly.

Dr TANGI (Tonga) endorsed the comments by the member for Canada on consensus. He looked forward to receiving the Commission's report and supported the proposal by the member for Bolivia. More time was needed for the Board to review and assimilate the report before the Fifty-ninth World Health Assembly. Deeper consideration should be given so that eventually the poor would have access to good quality medicine. That was indeed an exalted dream and difficult to fulfil.

Ms HALTON (Australia) acknowledged the complex and sensitive work of the Commission. Incentives to ensure continued access to new and innovative medicines were important, as was ensuring affordable access to medicines, and a proper balance between those two issues was essential.

It was necessary to progress. Such action, however, must be based on work already done and careful consideration of the report itself. It was particularly important to ensure transparency and that the divergence of views was clearly understood.

For the report to be available for the forthcoming Health Assembly, the timetable would have to be carefully managed. The Board needed the advice of the Secretariat on how its views should be transmitted to the Health Assembly for consideration.

Dr WINT (Jamaica) emphasized the urgency of taking action that would also contribute to progress towards achieving the Millennium Development Goals. The establishment of guidelines for research and development was critical, as was ensuring access to and affordability of products.

He endorsed the proposal by the member for Bolivia on the understanding that the Health Assembly should seek to resolve the issue in May 2006. The terms of reference for the group should include refinement of the draft resolution. As the Director-General would be unable to carry out the requests in the draft resolution without WTO, the Board should, in working out its strategy, find a way of involving that organization, both through national representatives and through the linkage between WHO and WTO.

Dr MIHAI (adviser to Dr Iliescu, Romania) emphasized the need for an accurate, dispassionate and transparent report. The matter must be resolved properly, and more time might therefore be needed.

Dr PHOOKO (Lesotho) recalled appeals for urgent action on several issues at the current session of the Board, including achievement of the Millennium Development Goals by developing countries, particularly in Africa, and reinforcement of their health systems, with a particular focus on human resources. Given the urgency for the developing countries of the issue under discussion, he supported the draft resolution, as it set out a framework for progress towards the availability of medicines in poor communities. He endorsed the proposal to establish a small group to examine the Commission's report and to brief the Board in a timely manner, and supported the proposal for the establishment of an informal group to work on the draft resolution.

Ms 't HOEN (Consumers International), speaking at the invitation of the CHAIRMAN, said that her statement was supported by *Médecins Sans Frontières* – Campaign for Access to Essential Medicines, Health Action International, Medico International, Third World Network and CPTech. Those bodies strongly supported the draft resolution, and particularly the timely and important proposal in paragraph 2(1) regarding the establishment of a global framework for supporting essential health research. Innovation was important for improving health care but had to meet real health needs and would be meaningless unless the results were accessible to all in need. The draft resolution offered a radically new way of looking at innovation by creating a forum for discussions among countries on the setting of priorities for and sharing the cost of research and development.

Except for discussions within the G8 group of countries, no existing agreement on trade, drug-pricing or intellectual property rules covered public-sector support for or market failures in research and development, such as for neglected diseases or the Human Genome Project. A balanced global framework for research and development was needed, with a mechanism that encouraged work in priority areas in order to ensure the development of essential medicines while allowing governments to protect consumers from high prices and access barriers. Recent examples had shown how political will could ensure international cooperation and the marshalling of tremendous resources. Unfortunately, the sense of urgency that had resulted in swift and efficient responses to the outbreak of severe acute respiratory syndrome and the potential avian influenza pandemic was entirely lacking with respect to research and development for diseases that predominantly affected poor people in developing countries.



WHO was well placed to host and encourage discussions on a new global framework that would ensure that essential health tools were developed and made available to all; adopting the draft resolution would be a major, first step in that process.

Sir John SULSTON (OXFAM), speaking at the invitation of the CHAIRMAN, fully supported the comments made by the previous speaker. He read an open letter to the Board, signed by more than 200 well known scientists, expressing their support for the draft resolution. They were concerned at the deficiencies in the translation of biomedical research results into treatments to improve health outcomes, particularly the lack of sustainable support for the research and development of medicines for neglected diseases, and deeply concerned by the inability of existing mechanisms to convert the huge progress in basic research science into a global improvement in public health. Legal restrictions such as intellectual property rights could interfere with data exchange and limit biomedical research progress, and the balance between medical need and resource allocation was not good. The draft resolution dealt with those issues in a balanced way and proposed long-term solutions for sustainable funding, prioritization and access, and deserved the Board's full support.

Dr BALE (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that everyone shared the goals mentioned by the previous speaker. The question was whether the intellectual property system generated what was needed across the world. He recalled that 28 avian influenza vaccine projects were being given priority by companies on the Influenza Vaccine Supply International Task Force, and the International Federation welcomed the close collaboration with WHO in that regard. Research was also continuing on medicines and vaccines to combat other diseases. For HIV/AIDS, 20 antiretroviral agents had been developed and there had been substantial investment in the development of 80 new medicines, including vaccines. For rotaviral disease, which killed around 500 000 children every year in developing countries, two new vaccines had been launched. Two new vaccines had been developed against human papillomavirus infection which caused cervical cancer (most of the disease burden of which was in the developing world), and vaccines were being developed against malaria, Ebola haemorrhagic fever and other tropical diseases. At least five public-private partnerships existed for the development of innovative antimalarial agents (including the Medicines For Malaria Venture), three for tuberculosis (through the Global Alliance for TB Drug Development) and four targeting African human trypanosomiasis, leishmaniasis and Chagas disease. The industry had developed almost 90% of the medicines on WHO's Essential Medicines List. It had also established major research and development laboratories in India, Singapore and Spain to develop new medicines for dengue fever, malaria, tuberculosis and other tropical diseases. The International Federation had presented its ideas for encouraging such partnerships to the WHO Commission. In addition, member companies were collaborating with WHO and other partners to limit or eradicate a variety of tropical diseases.

A comprehensive survey in 2005 of member companies' programmes in developing countries had shown that the industry had made available some 539 million health interventions since the adoption of the Millennium Development Goals in 2000, and access to antiretroviral agents was continuing to expand, with some 500 000 AIDS patients in developing countries currently receiving treatment.

The key element in all those activities was innovation protected by intellectual property rights. Such rights were essential. Patents and other elements of intellectual property encouraged the pharmaceutical companies, including a fast-growing number in countries such as China, India, Mexico and Singapore, to undertake research and to engage in partnerships with developing countries. Countries seeking to acquire technology also needed intellectual property protection, for example for patent licensing and clinical trials. That protection was just as important in relation to transfers of technology and knowledge from developing to industrialized countries as for the reverse. Intellectual property was the foundation of the global effort to develop new medicines and vaccines to combat viral pandemics, for the expansion of health care and for the spread of technological know-how around the world.

Dr NYIKAL (Kenya) pointed out that the Commission's report and the draft resolution were not mutually exclusive. Both should be submitted to the Fifty-ninth World Health Assembly. The two should proceed at the same time synergistically. The Board should be able to reach a decision on the draft resolution at the current session. There was still room for further input at the Health Assembly and into the Commission's report. Currently, no conclusions could be drawn about the content of that report and it might therefore not be appropriate to set up a sequential process. It was surely preferable to move forward in both areas with a working group on the report and a drafting group on the resolution and to bring the two together in due course, or the sense of urgency might be lost. The draft resolution called for the establishment of a global framework on essential health research and development by interested Member States. Nobody was excluded. Similarly the information from the Commission's report was not excluded. The significant work in preparing the draft resolution and by the Commission must not be lost.

Mr AITKEN (Director, Office of the Director-General) said that, after informal consultations, it had been suggested that, given the support expressed, efforts should be made to make progress on the draft resolution at the current session. To that end, further informal consultations should be held following the present meeting, to be chaired by the Vice-Chairman, Dr Shangula. It had also been suggested that the working group proposed by the member for Bolivia should essentially consist of 12 Board members, two from each WHO region, but be open to all interested Member States, and should be convened in Geneva following publication of the Commission's report. With the help of the Chairman of the Commission, the Secretariat would prepare a draft resolution on the report, which might also be considered by the working group, whose comments would then be forwarded to the Health Assembly. It would be difficult to make any further decisions regarding the draft resolution currently before the Board until after the proposed informal consultations. Should outstanding work on the resolution remain following the conclusion of the current session, the working group might possibly also be requested to take that forward.

Dr NYIKAL (Kenya) asked for further information on the possible interval between the meeting of the proposed working group and the Health Assembly. It might not be appropriate to anticipate the content of the Commission's report by suggesting that a separate resolution on the report should be prepared, while also suggesting that the current draft resolution would be reviewed in the light of the report.

Mr AITKEN (Director, Office of the Director-General) confirmed that the Commission's report was expected to be available by mid-April 2006. The Health Assembly would start on 22 May 2006. The working group would therefore need to meet towards the end of April 2006.

Mr ALCÁZAR (alternate to Dr Buss, Brazil), endorsing the remarks made by the member for Kenya, said that during the earlier discussions no objection to the draft resolution had been raised. Indeed, the member for Thailand had appealed for urgent action. The procedural problems would not have arisen had the Commission's report been available at the current session. There was no time for further delays and the Board should take a decision on the draft resolution before it.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) welcomed the proposal to consider the draft resolution further at informal consultations. However, careful consideration should be given to the proposal to establish a working group to consider the Commission's report and a draft resolution to be prepared by the Secretariat. If the draft resolution before the Board was adopted at the present session, then the second resolution would need to take that into account. Would a second resolution really be necessary? The Board should send a clear signal of its views to the Health Assembly with no possibility of contradiction, which two separate resolutions might introduce.

Mr SILBERSCHMIDT (Switzerland)<sup>1</sup> affirmed the consensus that the Fifty-ninth World Health Assembly ought to adopt a broad and strong resolution; the question was how to attain that goal. The draft resolution currently before the Board undoubtedly covered some of the same ground as the Commission's report would but it could not anticipate that report, in the light of which its text would need to be reviewed. He therefore endorsed the proposal to submit two draft resolutions to the Health Assembly.

Ms DREIFUSS (Chairman, Commission on Intellectual Property Rights, Innovation and Public Health) apologized for the delay in the publication of the Commission's report, and the ensuing procedural difficulties. She assured the Board that its sense of urgency was shared by the members of the Commission. The main difficulty was how to achieve a balance between the requirements of innovation, no longer only but still mostly in the industrialized countries, and the needs, in particular those relating to public health, of underprivileged populations in the developing countries. Several speakers had emphasized the need for a range of measures, not just relating to intellectual property rights. Organization of health systems to ensure delivery was as important as promotion of research and development. The report would therefore try to show the range of activities needed to promote innovation that was strategically directed towards the control of previously neglected diseases or to patients in populations that did not have access to the medicines, vaccines and diagnostic agents that were currently available. A second aim was to provide guidance to Member States, the Secretariat, and other international organizations, such as WIPO and WTO, in respect of the decisions they must take. Decisions might of course differ, depending on the governments and conditions concerned. The Commission could not dictate what those decisions should be but it could set out the elements that must be taken into account in order to take sound decisions and bring closer together those with responsibilities for trade and health. That was very much in line with the resolution on international trade and health adopted by the Board at its sixth meeting.<sup>2</sup>

Referring to the comments made by the members for Canada and Japan, she endorsed the view that it was pointless to waste time trying to achieve consensus when that outcome was unlikely. It was better to set out the disagreements clearly, and to that end the Commission had made great efforts to indicate the points in favour of or against the various positions, crystallizing the points of divergence. That did not mean that the members of the Commission would step back to their original divergent positions; the progress made in achieving convergence would not be lost, but the points where consensus had not been reached would be expressed transparently. The 10 members of the Commission had worked with good will for two years in trying to reach a common view. The areas in which that had not been possible would stand out clearly in the report.

In respect of timing, she suggested that, as soon as it had been finalized, the English version of the report should be made available on the Commission's web site. The other language versions would become available subsequently during April 2006.

The CHAIRMAN suggested that further consideration of the item should be deferred pending the outcome of informal consultations.

**It was so agreed.**

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

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

<sup>2</sup> Resolution EB117.R5.

**WHO's role and responsibilities in health research:** Item 4.12 of the Agenda (Documents EB117/14 and EB117/14 Add.1)

Dr NYIKAL (Kenya), speaking on behalf of the African group of countries, underlined the vital importance of health research in promoting health, preventing disease and clinical care. As Member States were in various stages of development, recommendations needed to be broad enough to cover the needs of all. Global research had underpinned the health revolution of the twentieth century, but developing countries had not benefited from those advances to the extent possible. Only 10% of financing for global health research was allocated to health problems that affected 90% of the world's population. In Africa, research into health systems had received least attention. Even in areas where much research had been done, there remained a gap between the knowledge generated and its application. It was crucial that WHO addressed those two issues.

He supported the draft resolution in document EB117/14 but proposed a new subparagraph 3(7), to read: "to assist Member States to develop capacity for health systems research".

Dr OROOJ (alternate to Mr Khan, Pakistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, urged WHO to earmark sustainable resources to enable developing countries to undertake essential health research and to ensure the appropriate use and dissemination of research findings. He also stressed the need for WHO to foster health research networks and interaction between developed and developing countries, and to engage with public sectors other than health and education to promote national health research agendas. Since many interventions failed in developing countries, WHO's research agenda should also evaluate the major disease-control and prevention programmes and initiatives in order to gain a better understanding of the implementation problems in developing countries. The research agenda should aim to contribute to attaining the Millennium Development Goals and should strengthen the capacity of health systems, as recommended by the Ministerial Summit on Health Research (Mexico City, 16-20 November 2004).

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) supported the draft resolution. As health research should also pursue the issues of poverty and inequality in health in order to amend policies, he proposed the insertion of a new preambular paragraph after the third that would read: "Recognizing that research into poverty and inequity in health is limited, and its important role in guiding policy to minimize the gap". He also suggested that, as some countries had already begun to allocate part of their health budgets to research, in paragraph 1(1) the words "to implement" should be replaced by "to accelerate the implementation of". In paragraph 2, he proposed the insertion after "medical research" of a comma and the words "especially research into poverty and inequity in health".

Mr GUNNARSSON (Iceland) welcomed the request in the draft resolution that the Director-General should review how and to what extent it based its major policy decisions and recommendations on research evidence. Since time constraints had not allowed WHO's partners to become properly involved in the drafting of the position paper referred to in the Secretariat's report, he asked for a review of that paper, in conjunction with WHO's country and regional offices and partners such as governments, bilateral donor agencies, foundations and nongovernmental organizations. The revised paper should be issued well in advance of the Fifty-ninth World Health Assembly in order to enable informed discussions to take place. Conducting the consultations electronically would save time and money.

**The meeting rose at 12:30.**

## **EIGHTH MEETING**

**Thursday, 26 January 2006, at 14:15**

**Chairman:** Mr M.N. KHAN (Pakistan)

**later:** Ms J. HALTON (Australia)

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

**WHO's role and responsibilities in health research:** Item 4.12 of the Agenda (Documents EB117/14 and EB117/14 Add.1) (continued)

Dr SINGAY (Bhutan), welcoming the report and supporting the draft resolution therein, observed that stronger links and improved coordination between ACHR, WHO headquarters and the regional offices would benefit the Organization's health research activities.

Dr BOTROS SHOKAI (Sudan) acknowledged WHO's role in health research, and supported the draft resolution. Health research would play a crucial role in reconstructing health systems and would be needed to monitor progress towards the Millennium Development Goals, achieve equity, reduce disparities and evaluate interventions. WHO must support countries in strengthening the culture of health research by providing examples of how its application had improved human health. Some partner institutes and programmes, such as the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, played a valuable role, yet tended to work centrally and needed to concentrate more on building countries' capacities.

Ms GILDERS (alternate to Mr Shugart, Canada) welcomed WHO's work on a system to report its health research activities and stressed the need for the Organization to continue to prioritize those activities and define the value it added in the area of research. Canada encouraged research into resolving health inequities. It had sponsored a workshop, the WHO-Canada Dialogue on Global Health Research (Ottawa, 3-4 November 2005), that had produced suggestions on ways to improve collaboration in health research between developed and developing countries. Other countries should host similar dialogues.

Ms HALTON (Australia) recalled that resolution WHA58.34, on the Ministerial Summit on Health Research, urged Member States to consider implementing the recommendation from 1990 that "developing countries should invest at least 2% of national health expenditures in research and research capacity strengthening, and at least 5% of project and program aid for the health sector from development aid agencies should be earmarked for research and research capacity strengthening". Since that resolution had been adopted after extensive discussions on the outcome of the Ministerial Summit, the wording of the draft resolution under consideration should be made consistent with that text, with paragraph 1(1) being replaced by paragraph 2(1) of resolution WHA58.34.

Dr NTAWUKULIRYAYO (Rwanda) supported the draft resolution, particularly as it highlighted the responsibility of Member States in health research and development. It should be easy to implement, provided that each party honoured its commitment. He welcomed its request for equal effort on the part of both the Director-General and Member States in strengthening health research.

Dr STEIGER (United States of America)<sup>1</sup> supported the proposal by the member for Australia. He further proposed inserting in paragraph 2 a comma after the words “spectrum of health”, deleting “and” before “medical”, and inserting “and behavioural” after “medical”. The text could also mention WHO’s two bodies that performed research: IARC and the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases.

Mr DEL PICÓ (Chile),<sup>1</sup> speaking on behalf of the Latin American and Caribbean Group, said that most countries in his region would be unable to meet the obligation of allocating 2% of their health budget to research. He therefore suggested inserting in paragraph 1(1), after the word “implement” and between commas, the phrase “in so far as possible”.

Mr DEVLIN (Council on Health Research for Development), speaking at the invitation of the CHAIRMAN, welcomed WHO’s endeavours to clarify its present activities and functions in health research and urged the Organization to give more attention to assessing its activities at the regional and country levels. In analysing its role, WHO should include external agencies, nongovernmental organizations and others in order to create assuredly beneficial partnerships for health research at the country level. He welcomed the proposal made by the member for Iceland to involve partners in reviewing the position paper and said that the Council would be willing to participate.

Dr LARIVIÈRE (IARC) said that IARC welcomed the efforts of ACHR to disseminate health research outcomes and to apply findings to policies and programmes. His organization had been established by the Health Assembly in 1965. Producing some 300 scientific publications annually, IARC made a unique contribution to global cancer prevention and control. It welcomed the draft policy on health research as an opportunity to share and optimize its extensive research experience for the benefit of WHO. To satisfy future needs in health research, a document was needed that would reflect the current research reality within WHO and meet future collective needs in health research. The open consultations proposed by the member for Iceland could lead to improvements in the position paper, which could be reconsidered at a later date.

Mr BAILÓN (Mexico) supported the amendment proposed by the representative of Chile. Allocating 2% of the health budget to research was an ideal, but he recognized that limited financial resources would make it difficult for many countries to achieve that figure. He asked WHO to devote more resources to systematic review of the scientific literature and to recommend that Member States should undertake that task so that all could acquire the best information available. Experts from low- and medium-income countries should be included in working groups so that their positions could be taken into account. Finally, a mechanism should be established whereby progress made in promoting health research could be evaluated.

Mr GUNNARSSON (Iceland) endorsed the proposal by the representative of the United States of America to add “behavioural” before “research” in paragraph 2.

Dr EVANS (Assistant Director-General), expressing openness to further consultations, said that, with only two months remaining in which to complete the position paper and as budgetary constraints would make it difficult to organize consultations, he urged Member States to provide feedback through electronic media. He thanked Member States for their comments, which would be taken into account.

Mr AITKEN (Director, Office of the Director-General) read out the amendments. A new paragraph had been proposed to follow the third preambular paragraph, to read: “Recognizing that

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

research into poverty and inequity in health is limited, and that this evidence is important to guide policy to minimize gaps;”. Bearing in mind the comment about the debate in May 2005, he suggested that the text of paragraph 1(1) submitted to the Fifty-ninth World Health Assembly should retain the wording of resolution WHA58.34, namely: “to consider implementing the recommendation made by the Commission on Health Research for Development in 1990 that ‘developing countries should invest at least 2% of national health expenditures in research and research capacity strengthening, and at least 5% of project and program aid for the health sector from development aid agencies should be earmarked for research and research capacity strengthening’;<sup>1</sup>”. In paragraph 2, the text should read: “... the entire spectrum of health, medical and behavioural research, especially research into poverty, inequity and health; and to maintain ...” A new subparagraph 3(7) had been proposed, to read: “to assist Member States to develop capacities for health systems research”.

Ms GILDERS (alternate to Mr Shugart, Canada), supporting the proposal by the representative of the United States of America to include a reference to existing research programmes, proposed adding mention of the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction as a sixth preambular paragraph.

Dr EVANS (Assistant Director-General) cautioned against singling out specific research programmes.

Mr AITKEN (Director, Office of the Director-General) suggested adding the words “noting, in particular, the work of IARC, the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases and the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction”.

The CHAIRMAN invited the Board to consider the draft resolution as amended.

**The resolution, as amended, was adopted.<sup>2</sup>**

## **2. MATTERS FOR INFORMATION: Item 9 of the Agenda**

**Report of the Advisory Committee on Health Research (ACHR):** Item 9.4 of the Agenda (Document EB117/37)

Professor WHITWORTH, speaking as Chair of ACHR, commended the long-standing personal support of the Chairman of the Board for health research in his country and internationally. The person designated Australian of the Year in 2006 was a health researcher. Introducing the Committee’s report on its forty-fifth session, she said that the Committee’s workplan for 2006-2007 included continued involvement in the partnership programme on health systems research, the clinical trials registry programme and the Evidence-informed Policy Networks initiative. The Subcommittee on Better Use of Research Evidence in WHO was examining WHO’s roles and responsibilities in the use of health research in order to inform decisions. Change demanded more rigorous processes for synthesis and interpretation of evidence than traditional approaches using expert opinion. WHO had the mandate to capitalize on those advances and show leadership. WHO should aim to exemplify best practice in the

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<sup>1</sup> Commission on Health Research for Development. *Health research: essential link to equity in development*. New York, Oxford University Press, 1990.

<sup>2</sup> Resolution EB117.R6.

use of research evidence, and WHO's leadership was encouraging. In-house capacity-building would be vital for implementation.

The Swedish International Development Agency's survey of WHO's research activities was welcomed by the Committee. An information system for more effective research management should be developed. The Committee strongly supported the position paper on WHO's role and responsibilities in health research<sup>1</sup> and the draft resolution. WHO should remain the foremost international health organization for advice based on best research evidence. Risk management could avoid exposure of perceived deficiencies in WHO's advice, recommendations or guidelines. Its own research practices should be consistent with best practice. That had been done for research ethics; similar high standards were achievable for research priority setting, peer review, dissemination and improved health outcomes.

She drew attention to the ministerial conference on research for health to be held in Africa in 2008. The Ministerial Summit on Health Research in 2004 had put research squarely on the agenda for policy-makers and the meeting in Africa in 2008 would build on that.

Dr SHINOZAKI (Japan) noted that the position paper on WHO's role and responsibilities in the area of health research referred to a supporting and collaborative mechanism for WHO research.<sup>1</sup> There was no single WHO policy or mechanism to coordinate the work of the existing 368 WHO collaborating centres and two specialized centres. Owing to limited financial and human resources, networking was not enough, and the work of those centres needed a coordination mechanism, which could best be developed by ACHR. He reaffirmed Japan's commitment to the mission of the WHO Centre for Health Development in Kobe, Hyogo, Japan, and welcomed the 10-year extension of its operations. The support received from the local consortium, the Kobe Group, was an outstanding example of how research could be sustained through public-private partnerships.

With regard to the Committee's report, the clinical trials registry was an important initiative for all countries, and WHO should support capacity-building to establish registers in developing countries. Promoting health systems research was also important. He stressed preparation and coordination for the 2008 meeting in Africa.

Dr BOTROS SHOKAI (Sudan), commending the ACHR report, asked, with reference to paragraph 5, why no links were proposed with other regional offices such as those for the Eastern Mediterranean and Africa. Regarding the survey of WHO's research activities (paragraph 7), she asked why repeated calls had had to be made for more effective management mechanisms for dissemination. She regretted that research contracts between external donors and developing country institutions put the latter at a disadvantage; that situation needed to be rectified.

Dr EVANS (Assistant Director-General) said in reply to the second question that, with the many research activities undertaken throughout the Organization, the task of eliciting specific responses defining and describing the work was not always simple, but that efforts to collate the information were being pursued. No research centre in the African and Eastern Mediterranean regions was specifically a WHO centre.

Dr ANTEZANA ARANÍBAR (Bolivia), referring to paragraph 6 of the report, stressed consideration of the eventual use of research results. Clearly, the aim should be to ensure that research outcomes were used to improve health systems in all countries and not, as was sometimes the case, to see them in print for the benefit of their authors. He, too, urged cooperation in preparation for the 2008 African conference.

**The Board noted the report.**

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<sup>1</sup> Document ACHR45/05.16.



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

**Strengthening pandemic-influenza preparedness and response: follow up:** Item 4.2 of the Agenda (Document EB117/5) (continued)

- **Application of the International Health Regulations (2005): follow up** (Documents EB117/31 and EB117/31 Add.1) (continued from the third meeting, section 1)

The CHAIRMAN invited the Board to consider the revised draft resolution on application of the International Health Regulations (2005), which read:

The Executive Board,  
Having considered the report on application of the International Health Regulations (2005);<sup>1</sup>

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

The Fifty-ninth World Health Assembly,  
Having considered the report on application of the International Health Regulations (2005);

Recalling resolutions WHA58.3 on revision of the International Health Regulations and WHA58.5 on strengthening pandemic-influenza preparedness and response;

Reaffirming the serious risk to human health, including the possible emergence of a pandemic virus, arising from ongoing outbreaks in poultry of highly pathogenic avian influenza, caused by the H5N1 strain of *Influenzavirus A*, in parts of Asia and elsewhere;

Noting with concern the persistence of outbreaks in poultry, the continuing occurrence of sporadic cases of severe human disease associated with these outbreaks, the endemicity of the virus in several countries, the spread of the virus through the migration of wild waterfowl to new areas, and its predicted further spread;

Aware that these and other developments have increased the probability that a pandemic may occur;

Highlighting the importance of WHO's global influenza preparedness plan<sup>2</sup> and the control measures recommended therein;

Mindful that rapid detection of human cases, supported by adequate national capacity, and rapid and transparent reporting of findings underpin WHO's ability to issue a reliable risk assessment and declare an appropriate phase of pandemic alert, and are further needed to ensure that the earliest epidemiological signals of increased transmissibility of the virus among humans are not missed;

Aware that several provisions in the International Health Regulations (2005) would be useful in ensuring a strengthened and coordinated response on the part of the international community both to the present situation and a possible pandemic;

Further aware that strengthened capacity to respond to human cases of avian influenza and the corresponding pandemic threat will strengthen the capacity to respond to many other emerging and epidemic-prone infectious diseases, and thus increase global public-health security against the threat of infectious diseases;

Noting that the International Health Regulations (2005) will not enter into force until 15 June 2007;

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<sup>1</sup> Document EB117/31.

<sup>2</sup> Document WHO/CDS/CSR/GIP/2005.5.

Recalling the main conclusions reached and recommended actions agreed on during a joint meeting convened by WHO, FAO, the *Office International des Epizooties* and the World Bank on avian influenza and human pandemic influenza (Geneva, 7-9 November 2005); and

Responding to the specific request, made during that meeting, to put forward proposals to the Fifty-ninth World Health Assembly through the Executive Board at its 117th session for immediate voluntary compliance with relevant provisions of the International Health Regulations (2005),

1. CALLS UPON Member States to comply immediately, on a voluntary basis, with provisions of the International Health Regulations (2005) considered relevant to the risk posed by avian influenza and pandemic influenza;
2. DECIDES that relevant provisions of the International Health Regulations (2005) shall include the following:
  - (1) Annex 2, in so far as it requires prompt notification to WHO of human influenza caused by a new virus subtype;
  - (2) Article 4 pertaining to the designation or establishment of a National IHR Focal Point within countries and the designation of WHO IHR Contact Points, and the definition of their functions and responsibilities;
  - (3) articles in Part II, pertaining to information-sharing, consultation, verification and public health response;
  - (4) articles 23 and 30-32 in Part V pertaining to general provisions for public health measures for travellers on arrival or departure and special provisions for travellers;
  - (5) articles 45 and 46 in Part VIII pertaining to the treatment of personal data and the transport and handling of biological substances, reagents and materials for diagnostic purposes;
3. NOTES that such voluntary compliance is without prejudice to the position of any Member State with regard to the International Health Regulations (2005) after their entry into force;
4. URGES Member States:
  - (1) to designate or establish immediately a National IHR Focal Point, as provided for in Article 4 of the Regulations, and inform WHO accordingly within 90 days, the said Focal Point having the authority to communicate official information and participate in collaborative risk assessment with WHO;
  - (2) to follow, in matters pertaining to human cases of avian influenza, mechanisms and procedures set out in the Regulations for a disease that may constitute a public health emergency of international concern;
  - (3) to provide transparent and urgent notification and subsequent continued communication to WHO of any ~~suspected~~ probable [Thailand] or confirmed human cases of avian influenza, including exported or imported cases, and to disseminate information and relevant biological materials related to highly pathogenic avian influenza and other novel influenza strains in a timely and consistent manner [Tonga];
  - (4) to strengthen collaboration on human and zoonotic influenzas with /national [France]/ organizations responsible for human and animal health, in order to strengthen surveillance and implement immediate measures to control outbreaks of avian influenza in humans and animals; [Thailand]
  - ~~(4)~~(5) to respect time frames stipulated in the Regulations for undertaking and completing urgent activities and communications, particularly for the reporting of

human cases of avian influenza, verification of events, and response to requests for further information from WHO;

~~(5)(6)~~ to collaborate, including through the mobilization of financial support, to build, strengthen, and maintain the capacity for influenza surveillance and response in countries affected by avian influenza;

~~(6)(7)~~ to follow ~~any~~ [USA/Canada] recommendations issued by the Director-General, with technical advice from the influenza pandemic task force, considered necessary for the international response to avian influenza or pandemic influenza;

~~(7)(8)~~ to inform the Director-General of the measures that they have taken in voluntary compliance with the International Health Regulations (2005);

5. REQUESTS the Director-General:

(1) to designate immediately WHO IHR Contact Points, as provided for in Article 4 of the Regulations;

(2) to implement, in so far as feasible and relevant for the purpose of this resolution, measures in Parts II and III of the Regulations falling under the responsibility of WHO;

(3) to further accelerate steps to establish a roster of experts and to invite proposals for its membership, pursuant to Article 47;

(4) to use the influenza pandemic task force as a temporary mechanism to advise the Organization on the response to avian influenza, the appropriate phase of pandemic alert and the corresponding recommended response measures, the declaration of an influenza pandemic, and the international response to a pandemic;

(5) to collaborate with Member States in implementation of the present resolution, and in voluntary compliance with the International Health Regulations (2005), [Canada] as appropriate, including through:

(a) provision or facilitation of technical cooperation and logistical support;

(b) mobilization of international assistance, including financial support, in consultation with Member States, especially among affected countries lacking sufficient operational capacity; especially when control measures against international spread are unlikely to succeed; [Thailand]

(c) production of guidelines to support Member States in development of capacities for a public-health response specific to the risk posed by avian influenza and pandemic influenza;

(d) establishment of a framework to monitor voluntary compliance of Member States with the International Health Regulations (2005); [Kenya]

(6) to collaborate with Member States to the extent possible in providing support to developing countries in building and strengthening the capacities required under the International Health Regulations (2005);

(7) to mobilize and dedicate WHO's technical resources where possible, using capacities available in regional offices and collaborating centres to expand and accelerate training efforts in the areas of epidemic surveillance, alert and response, and laboratory capacity, biosafety and quality control, in order to provide support to Member States in implementation of the International Health Regulations (2005); [France]

~~(7)(8)~~ to report to the Sixtieth World Health Assembly through the Executive Board at its 119th session on implementation of this resolution, and to report annually thereafter on progress achieved in providing support to Member States on voluntary compliance with, and implementation of, the International Health Regulations (2005) [Canada].

Mr AITKEN (Director, Office of the Director-General) informed the Board that the amendment proposed by the member for France regarding the expansion of training would have no additional financial implications.

Ms GILDERS (alternate to Mr Shugart, Canada) proposed that paragraph 4(3) should be divided into two subparagraphs, the first concerning notification and communication and the second the dissemination of biological materials. In paragraph 4(4), the word “with” before “national organizations” should be replaced by “between”. In paragraph 5(5)(b), “among” should be replaced by “for”; and in paragraph 5(8), “voluntary” should be deleted before “compliance”, since the Regulations would in due course enter into force.

Ms HALTON (Australia) agreed with the suggestion to delete “voluntary” from paragraph 5(8). She noted that there appeared to be some duplication in that connection with paragraph 5(5)(d).

Dr TANGI (Tonga) explained with reference to paragraph 4(3) that the reason for Tonga’s amendment was that notification of cases of influenza was not sufficient; information and relevant biological materials should be shared as well.

Dr CHAN (Assistant Director-General) accepted the logic of the proposal by the member for Canada to split paragraph 4(3) into two subparagraphs, which would then read: “(3) to provide transparent and urgent notification and subsequent continued communication to WHO of any probable or confirmed human cases of avian influenza, including exported or imported cases;” and a new subparagraph: “to share information and relevant biological material related to highly pathogenic avian influenza and other novel influenza strains in a timely and consistent manner with WHO collaborating centres”.

Dr BELLO DE KEMPER (Dominican Republic)<sup>1</sup> said that resolution WHA58.3 made it clear that compliance with the relevant provisions of the International Health Regulations (2005) should be voluntary. The wording of paragraph 5(8) should therefore remain unchanged, particularly since paragraph 3 stated that “such voluntary compliance is without prejudice to the position of any Member State with regard to the International Health Regulations (2005) after their entry into force”. Member States experiencing difficulties with the entry into force of the International Health Regulations would likely decide to apply the relevant provisions voluntarily, particularly in view of a possible outbreak of avian influenza and the threat posed by HIV/AIDS.

Dr CHAN (Assistant Director-General) said that the drafting of paragraph 5(7) in document EB117/31 took account of the views expressed by the Health Assembly when adopting resolution WHA58.3. Article 54 of the Regulations required the Director-General to report to the Health Assembly on their implementation “as decided by the Health Assembly”. In other words, the Health Assembly had the authority to request the Director-General to report at intervals as it deemed necessary. The Intergovernmental Working Group on Revision of the International Health Regulations had discussed the matter at length, and it would be necessary to decide whether the reporting request under discussion conflicted with that Group’s decision that the first report on implementation should concern the decision instrument<sup>2</sup> and would be submitted to the Sixty-first World Health Assembly. For the sake of clarity and to avoid any conflict with the Working Group’s decision, she suggested that paragraph 5(5)(d) should be retained and paragraph 5(5)(b) should become paragraph 5(8) with the corresponding text in document EB117/31.

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

<sup>2</sup> Resolution WHA58.3, Annex 2.

Ms GILDERS (alternate to Mr Shugart, Canada) said that the first report should be submitted to the Sixtieth World Health Assembly and that the reporting thereafter should be annual.

Dr STEIGER (United States of America)<sup>1</sup> said that neither the resolution nor the amendments suggested by the Secretariat contained clear wording on the desirability of annual reporting, which he regarded as essential.

Dr CHAN (Assistant Director-General), addressing the concerns of the previous two speakers, proposed the insertion of a full stop after “thereafter” and the deletion of the remainder of paragraph 5(8).

Dr ALI MOHAMMED SALIH (Iraq) said that paragraph 5(8) was too vague; the implications of voluntary compliance for Member States were unclear.

Dr NYIKAL (Kenya) said that his country had tabled its amendment because voluntary compliance with the Regulations, which were not due to enter into force until 2007, would be desirable, given the possibility of an avian influenza pandemic. The international community needed to know whether countries were complying.

Ms HALTON (Australia) said that the text of paragraph 5(8) required further work to meet the requirements of her own country and Canada.

Dr CHAN (Assistant Director-General) said that Article 54 of the Regulations provided an opportunity for requesting the Director-General to provide a report.

Ms GILDERS (alternate to Mr Shugart, Canada) said that paragraph 5(8) referred to reporting by the Director-General on efforts to provide support to Member States in implementing the Regulations, in which case the word “voluntary” was irrelevant.

Mr AITKEN (Director, Office of the Director-General), summarizing the discussion, said that under the International Health Regulations (2005) WHO had an obligation to report to the Health Assembly on their implementation. Those who had spoken in favour of retaining the text in paragraph 5(8) had noted that it contained more detail than a simple request for a report on implementation of the Regulations, namely that WHO should report not only on implementation of the Regulations, as it was required to do under the Regulations, but also on the support it was providing to Member States both in respect of voluntary compliance and in their implementation of the Regulations in general.

**The resolution, as amended, was adopted.<sup>2</sup>**

**Intellectual property rights, innovation and public health:** Item 4.10 of the Agenda (Document EB117/9) (continued from the seventh meeting)

Dr NYIKAL (Kenya), reporting on the informal consultations, said that the working group had studied the draft resolution proposed by Brazil and Kenya and, although satisfactory progress had been made, more time would be needed to complete the task.

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

<sup>2</sup> Resolution EB117.R7.

Following a procedural discussion involving Mr ALCÁZAR (alternate to Dr Buss, Brazil), Dr NYIKAL (Kenya), Dr NTAWUKULIRYAYO (Rwanda) and the Secretariat, it was agreed to continue the informal discussions the next day.

(For continuation of the discussion, see summary record of the tenth meeting, section 6.)

**HIV/AIDS:** Item 4.5 of the Agenda (continued)

- **Universal access to prevention, care and treatment** (Document EB 117/6) (continued from the fourth meeting)

The CHAIRMAN recalled the draft resolution on implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors and invited further comment.

Dr KAMAL (alternate to Mr Shugart, Canada) requested the Secretariat to prepare a paper on the technical aspects of universal access for submission to the forthcoming Health Assembly, given the interest shown during previous discussions.

Dr PHOOKO (Lesotho) supported the draft resolution, but suggested that paragraph 2(2) should read: “to report to the Sixtieth World Health Assembly and every two years thereafter on progress ...”.

Dr SOPIDA CHAVANICHKUL (adviser to Dr Suwit Wibulpolprasert, Thailand), welcoming the draft resolution, proposed including a new (seventh) preambular paragraph reading: “Recognizing the importance of leadership, national ownership of plans and priorities, fostering effective coordination, alignment and harmonization of programmes and support at country level as key determinants of effective national responses;”. She further requested the addition of a new paragraph 2 reading: “URGES Member States to accelerate the implementations of the 'Three Ones' policy according to country realities” and amended the proposal by the member for Lesotho for paragraph 2(2) so that it began: “to report to the 119th session of the Executive Board and to the Sixtieth World Health Assembly ...”. She also proposed adding the words “in particular health systems strengthening and human resources for health in response to scaled-up interventions.” at the end of paragraph 2(3).

Ms TOR DE TARLÉ (alternate to Professor Houssin, France) said that Cyprus, Estonia, Lithuania and Norway had also announced their sponsorship of the draft resolution.

Mr HOHMAN (United States of America)<sup>1</sup> recalled that certain amendments to the draft resolution had already been proposed by Australia, Canada and the United States of America.

Mr AITKEN (Director, Office of the Director-General) assured the previous speaker that the amendments to which he referred had been noted for inclusion in the draft resolution. He observed that Bolivia had asked to be added to the list of sponsors. He read out the proposed amendments. A new preambular paragraph should read “Recognizing the importance of leadership, national ownership of plans and priorities, the fostering effect of coordination, alignment and harmonization of programmes and support at country level are key determinants of effective national responses;”. Paragraph 1 should conclude with the additional words “and furthermore endorses all the related decisions of the Programme Coordinating Board” and should be followed by a new paragraph, which “URGES Member States to accelerate the implementation of the “Three Ones” policy according to country realities;”. The start of paragraph 2(2) should read: “to report to the 119th session of the Executive

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

Board and the Sixtieth World Health Assembly and every two years thereafter on progress made in implementation of ...". To reflect the various proposals for paragraph 2(3) the text should read: "to provide effective technical support to national governments and, in conformity with the division of labour agreed among UNAIDS cosponsors, to focus on those areas in which WHO has an advantage compared to other bodies, in particular health system strengthening and human resources for health in response to scaled-up interventions."

Responding to a concern raised by Dr ASAMOA-BAAH (Assistant Director-General), he suggested that the amendment by the member for Canada and others to paragraph 1 should be clarified to specify that it related to the decisions of the Seventeenth Programme Coordinating Board of UNAIDS.

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

**eHealth: proposed tools and services:** Item 4.13 of the Agenda (Document EB117/15)

Professor FIŠER (Czech Republic) said that electronic health was a field undergoing dynamic development that had the potential to help improve the quality, safety and availability of care. As the Tunis Agenda for the Information Society, evolved at the World Summit on the Information Society (second phase) (Tunis, 16-18 November 2005), had recommended that its international implementation mechanism should be facilitated by agencies of the United Nations system, WHO should lead in implementing the Geneva Plan of Action in the field of eHealth and partially in that of eEnvironment. He consequently suggested that a reference to that Summit should be included in the report and a link made between WHO's proposed activities and the Tunis Agenda.

The Czech Ministry of Informatics had made available a basic PC and Internet course that had been delivered three times in Kenya and would be part of the "road map" of the Regional Office for Africa for eHealth in early 2006.

Mr GUNNARSSON (Iceland) welcomed the report, as it had been unclear what specific tools or actions could be given priority within eHealth. Given that electronic medical records were an additional tool forming an essential part of eHealth programmes in many Member States, standardized terminology that could be used by all Member States could be made available; he requested that the matter be discussed by the Board at its 118th session.

Mr IWABUCHI (alternate to Dr Shinozaki, Japan) recognized that the use of information and communication technologies in the health sector, such as electronic health records, telemedicine systems, and the provision of health-related information to the general public, could enhance and promote public health.

WHO's promotion of global and regional eHealth activities, such as the Pacific Open Learning Health Net for the Pacific island States, was appreciated. WHO could continue to provide support to individual countries, bearing in mind differences in technologies.

Particular challenges in promoting eHealth were: the economic burden; standardization of medical information; system compatibility; information security; and collaboration between the public and private sectors. He looked forward to WHO's continued progress in that area.

Dr SOPIDA CHAVANICHKUL (adviser to Dr Suwit Wibulpolprasert, Thailand) drew attention to the imbalance in access to technologies between developed and developing countries, with one person in every 1000 having Internet access in the least developed countries compared with almost half of the population in high-income OECD countries.

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<sup>1</sup> Resolution EB117.R8.

The most effective eHealth systems required good infrastructure and computer-literate health personnel, especially in the remote areas where eHealth was most needed. Capacity-building should be a core activity in the proposed workplan. The plan should refer to setting up a committee that would consider legal, ethical and other issues in a detailed and practical manner. WHO should encourage eHealth initiatives that were suited to national health systems and cultural context. WHO should also guarantee the sustainable use of eHealth and provision of support to countries.

Professor PEREIRA MIGUEL (Portugal) welcomed the clear, concise and pragmatic report. Acknowledging WHO's efforts towards promoting eHealth policies in Member States, he endorsed the six proposed activity areas contained in the report. Portugal had been cooperating with WHO by translating documents into Portuguese for dissemination via an interregional network. Portuguese health institutions were preparing an Intranet site in order to develop eLearning tools for continuing education of health professionals. A health portal for the general public, that included access to advice on healthy lifestyles, had been launched at the end of 2005.

He supported the request by the member for Iceland for further discussion of electronic medical records and standardized terminology.

Ms GILDERS (alternate to Mr Shugart, Canada) commended the report's focused approach and acknowledged the potential of eHealth for improving the delivery of health services. Nevertheless, eHealth was not part of WHO's core mandate. WHO's services could be expanded later but, in the meantime, the Organization's resources should not be dissipated.

As Canada had significant experience of eHealth, it was willing to share best practices with other countries.

Dr SINGAY (Bhutan) welcomed the report and endorsed the proposed activities. With the assistance of WHO, Bhutan was in the early stages of implementing telemedicine, a tool that would be particularly useful in overcoming the geographic constraints of a scattered population and a shortage of available specialists. It was also examining the use of electronic health records, hospital information systems and telehealth. WHO's support was appreciated in developing eHealth systems, strategies and policies, best practices, norms and standards, eLearning and human resource development.

Dr BOTROS SHOKAI (Sudan), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed WHO's recognition that implementation of eHealth needed a systematic approach and human and financial resources. Many countries in the Region had enhanced health-care delivery services through eHealth projects, and the global eHealth survey was seen as valuable. The Health InterNetwork Access to Research Initiative was appreciated, but some countries lacked reliable Internet facilities; regular training was a prerequisite for making use of the Initiative. Proposed demonstration projects for specific countries, in collaboration with WHO, could be systematically evaluated and become a training platform for eHealth experts. The proposed budget should include support for country initiatives, intercountry and regional collaboration and sharing of experiences.

Dr MANDIL (alternate to Dr Botros Shokai, Sudan), also speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed WHO's role in eHealth. Unlike the member for Canada, he considered that eHealth fell within WHO's mandate, and it was to be hoped that the Director-General would intensify work on it. In its budget and programme orientations, WHO emphasized knowledge management and information technology for public health services, an approach he endorsed. eHealth could assist developing countries in providing improved, cost-effective health-care services, and management should therefore be strongly emphasized.

He welcomed all the proposals before the Board but favoured some prioritization, given the budget estimates. He asked whether those were net of staff costs; if not, the budget was very small. WHO was perhaps uniquely equipped to handle legal and ethical work. Digital security should be prioritized for health transactions over national and international networks, and in the work of the



proposed WHO eHealth legal and ethics committee. He endorsed the proposal made by the member for Iceland that a progress report be submitted to the Board at its 118th session. The tools and services proposed should be formally evaluated on the basis of their practical value to Member States.

Dr BRUNET (alternate to Professor Houssin, France) welcomed the information provided, particularly on the large amount of work being conducted by the regional offices. He commended the initiatives that would assist Member States to base their eHealth activities on reliable standards of quality, security and ethical access. He was particularly interested in information technology and in applications that could support training and human resources. France was undertaking an ambitious programme, involving 17 francophone countries and a network of French universities, based entirely on distance learning. Courses would be accessible to several categories of health professionals and would lead to diplomas approved by participating universities. In such action, involving close collaboration with WHO, lay the future.

Dr EVANS (Assistant Director-General) said that the response rate to the survey had been about 60%, and he urged other countries to reply in order to enhance the information obtained.

A link to the World Summit on the Information Society was crucial, especially for issues such as the digital divide, which transcended WHO's mandate. With respect to electronic health records and standardized terminology, WHO was ready to prepare some information for the Board at its 118th session but he pointed out that standardization was not specific to eHealth and was in greater demand because many of the instruments existed in electronic form. In regard to capacity strengthening at country level, WHO should not overextend its focus, and thus the scope of the strategy was institution-wide, with high input from all the regions.

The strategy was new, and full details could be provided. In response to the question raised by the member for Sudan, he confirmed that the budget was net of staff costs. On the issue of access to the Health InterNetwork Access to Research Initiative, its governing group would work to ensure greater access for those countries that had difficulties. Evaluation was critical, and he would encourage the eHealth group to indicate the timing and nature of a progress report. The initial eHealth survey had great value and could be used for comparison of progress in the next few years. On the issue of human resources and eHealth, distance learning provided a major opportunity by connecting remote communities and multiple institutions. He therefore welcomed the initiative described by the member for France and would be glad to work on other similar efforts.

**The Board noted the report.**

**Health promotion: follow-up to 6th Global Conference on Health Promotion:** Item 4.14 of the Agenda (Document EB117/11)

The CHAIRMAN drew attention to a draft resolution on health promotion in a globalized world, proposed by Austria, Bhutan, Bolivia, Brazil, Ecuador, Finland, France, Iceland, Ireland, Italy, Kenya, Luxembourg, Nepal, Norway, Pakistan, Portugal, Sweden and Thailand, which read:

The Executive Board,

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

The Fifty-ninth World Health Assembly,

Recalling resolutions WHA42.44 on health promotion, public information and education for health, WHA51.12 on health promotion, WHA57.16 on health promotion and healthy lifestyles, and the outcomes of the five international conferences on health promotion (Ottawa, 1986; Adelaide, Australia, 1988; Sundsvall, Sweden, 1991; Jakarta, 1997; Mexico City, 2000);

Having considered the report on follow-up to the 6th Global Conference on Health Promotion, which confirms the need to focus on health promotion actions to address the determinants of health;<sup>1</sup>

Drawing on the Declaration of Alma-Ata, the Ottawa Charter for Health Promotion, and the Bangkok Charter for Health Promotion in a Globalized World which sets out strategic directions for equitable health improvement in the first decades of the twenty-first century;

Considering the actions and commitments set out in the Bangkok Charter for Health Promotion in a Globalized World to make the promotion of health central to the global development agenda, a core responsibility for all governments, a key focus of communities and civil society, and a requirement for good corporate practice;

Noting that health promotion is essential for meeting the targets of the Millennium Development Goals, is intimately related to the work of WHO's Commission on Social Determinants of Health, and makes an important contribution to realizing the objectives of the Eleventh General Programme of Work;

Recognizing that the dramatic changes of the global burden of disease require greater attention, and call for adjustments in society at large and in resource allocation in order to tackle the immediate and underlying determinants of health;

Confirming the importance of addressing also the wider determinants of health, and of fulfilling commitments to, and undertaking action for, health for all, as set out in the Bangkok Charter for Health Promotion in a Globalized World,

1. URGES all Member States:
  - (1) to accelerate investments in health promotion as an essential component of equitable social and economic development;
  - (2) to establish mechanisms for involving government as a whole in order to address effectively the social determinants of health throughout the life course;
  - (3) to support and foster the active engagement of civil society, the private sector and nongovernmental organizations in health promotion;
  - (4) to monitor systematically health promotion policies, programmes, infrastructure and investments;
  - (5) to close the gap between current practices and evidence of effective health promotion by the full use of knowledge-based health promotion;
2. REQUESTS the Director-General:
  - (1) to strengthen the capacity for health promotion across the Organization in order to provide better support to Member States;
  - (2) to establish a forum for multisectoral stakeholders, interested organizations and other bodies in order to support the development and implementation of health promotion;
  - (3) to assure that global conferences on health promotion are held on a regular basis;
  - (4) to devise and implement a system to monitor global health promotion in order to measure progress and identify major shortcomings;
  - (5) to submit a report on progress in implementing this resolution to the Sixtieth World Health Assembly, through the Executive Board.

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<sup>1</sup> Document EB117/11.

Dr WINT (Jamaica) said that the Ottawa Charter for Health Promotion remained relevant, and noted the adoption of the Bangkok Charter for Health Promotion in a Globalized World which had built on its foundations. In particular, he noted the reference to good corporate practice and to health and safety in the workplace. The focus on workers' health provided an opportunity to engage the private sector. WHO's commitment to elaborate a general framework for health promotion strategy, mentioned in paragraph 13 of the report, was noteworthy and he encouraged the Secretariat to expand that activity. The elaboration of methods to measure the impact of health promotion was very important.

Mr GUNNARSSON (Iceland), recognizing the budget constraints, recalled that in October 2005 WHO had reported that no less than 60% of the global disease burden was due to noncommunicable diseases; that situation called for some reallocation of resources. As a sponsor he attached great importance to the proposed draft resolution. The wording needed strengthening. Belgium had requested that its name be added to the list of sponsors.

Ms HALTON (Australia) agreed that the draft resolution could be strengthened. Australia strongly supported health promotion, which was fundamental to the country's health system and had achieved significant results. She pointed out that paragraph 1(1) was inappropriate for countries that were already making significant investments in health promotion. She suggested replacing the beginning of the text by "to consider the need to increase investment in health promotion ...". In paragraph 2(2), as it was unclear what the constitution and working methods of the proposed forum would be, she suggested that the text should read "to optimize use of existing forums of Member States, multisectoral stakeholders, interested organizations and other bodies in order to support the development and implementation of health promotion and to report on the need for new forums or bodies to encourage health promotion".

Dr RUÍZ MATUS (alternate to Mr Bailón, Mexico) said that health promotion was a political and social process of worldwide importance. It was central to any health policy and a strategic factor in preparing against a possible influenza pandemic. The agreements reached at the 6th Global Conference on Health Promotion should be acted on, and he suggested renewing the commitments made at the 5th Global Conference in order to enhance national and international networks for health promotion. WHO should strengthen health promotion, through capacity building and transfer of technology. The Bangkok Charter should be incorporated into regional activities, and the Secretariat should take responsibility for that task.

Mexico had stressed investment in health promotion and disease prevention. He supported the draft resolution.

Dr BUSS (Brazil) recalled that 2006 was the twentieth anniversary of the 1st Global Conference on Health Promotion, held in Ottawa. Canada had continued to be one of the leading countries in health promotion. The adoption of the Ottawa Charter would be commemorated in Brazil during the 1st World Congress of the World Federation of Public Health Associations in 2006, and he cordially invited the Director-General and Board members to attend.

**Ms Halton took the Chair.**

Professor FIŠER (Czech Republic) proposed that in paragraph 1(3) the words "including associations of public health" should be added after "nongovernmental organizations". He wished the Czech Republic to be added to the list of sponsors.

Ms GILDERS (alternate to Mr Shugart, Canada) appreciated the efforts made by the sponsors of the draft resolution and the comments of the member for Iceland in regard to strengthening the wording. She thanked the member for Brazil for the reference to her country's commitment to health promotion. Canada wished to be added to the list of sponsors.

Paragraph 2(3) should be amended to read “to encourage that global conferences on health promotion be held regularly”, and paragraph 2(4) simplified to read “to evaluate progress and identify major shortcomings in public health promotion globally”. Her country would be hosting the next world conference of the International Union for Health Promotion and Education in Vancouver in 2007, an important occasion to follow up many of the activities discussed.

Dr NODA (alternate to Dr Shinozaki, Japan), confirming that noncommunicable diseases were a global health issue, said that since the 1st Global Conference on Health Promotion in 1986, there had been tremendous epidemiological research and public health efforts. Greater investment in disease prevention was reasonable because most noncommunicable diseases were preventable. In 2000, his Government had launched a 10-year health promotion programme. He supported the draft resolution.

Dr SINGAY (Bhutan) said that the report confirmed that health promotion was central to primary health care and public health. Health promotion must be fundamental to public policies in all countries, for equity and better health. It should be made a core function of government.

Dr ANTEZANA ARANÍBAR (Bolivia) appreciated the report, but regretted that it contained no reference to the Declaration of Alma-Ata. The core of the document was paragraphs 12, 13 and 14. Health promotion remained crucial, but health was related to a person's social conditions. The poorest populations had little choice in the matter. Commercial health promotion was neither profitable nor satisfactory. States should be responsible for health promotion.

Dr TANGI (Tonga) welcomed the reference in the draft resolution to the Millennium Development Goals, which were intimately bound up with health and health promotion. Tonga engaged in health promotion, given that its main health problems were due to noncommunicable diseases. A bill to establish a health foundation in Tonga was being prepared. His country wished to sponsor the draft resolution.

Professor PEREIRA MIGUEL (Portugal) said that health promotion was at the heart of primary health care and public health. With the support of the Regional Office for Europe, his Government was implementing its National Health Strategy 2004-2010, which had health promotion at its centre. It appreciated the building up of the health-promotion capacity of Member States and the proposed evaluation of the impact of health promotion. He favoured the health determinants approach, on which Portugal had hosted a major conference that had influenced the European Union Public Health Programme. The Regional Office for Europe had established the European Office for Investment for Health and Development to tackle the structural determinants of health.

Dr RAHANTANIRINA (alternate to Dr Jean Louis, Madagascar) said that, as health promotion was most effective in reducing the economic and social effects of disease, it should be supported by greater investment. Existing health promotion strategies should be strengthened. She acknowledged WHO's support for health promotion in her country and would welcome further assistance, particularly in the area of oral and dental health: almost 70% of the population suffered from bad teeth. The Government was setting up a salt fluoridation programme and relied on WHO for help. Madagascar wished to sponsor the draft resolution.

Dr SOPIDA CHAVANICHKUL (adviser to Dr Suwit Wibulpolprasert, Thailand) endorsed the amendment proposed by the member for Australia.

Dr BOTROS SHOKAI (Sudan), speaking on behalf of Member States of the Eastern Mediterranean Region, said that health promotion should be encouraged, especially activities that remove the stigmatization from conditions such as HIV/AIDS, mental illness and tuberculosis. Given that HIV/AIDS was most prevalent among young people, more should be invested in the promotion of sexual health, which should be included in school syllabuses. Greater investment was needed to

improve women's health in such areas as antenatal care. More should be invested in smoking cessation programmes, as active and passive smoking contributed to cancer.

Dr SADRIZADEH (Islamic Republic of Iran)<sup>1</sup> and Dr RUÍZ MATUS (alternate to Mr Bailón, Mexico) said that their respective countries wished to sponsor the draft resolution, and endorsed the amendment proposed by the member for the Czech Republic.

Dr MATHESON (New Zealand)<sup>1</sup> said that health promotion was potentially the most powerful and effective tool for improving health. The Bangkok Charter had reaffirmed the principles of health promotion in the light of increased globalization and the roles of civil society and the private sector. WHO should demonstrate the importance of disease prevention and health promotion in its own structures and functions.

Mr HOHMAN (United States of America)<sup>1</sup> affirmed that health promotion was important. The draft resolution would be strengthened if the two references to the Bangkok Charter, which was not an intergovernmentally negotiated document, were amended: the word "commitments" in the fourth and in the last preambular paragraphs should be replaced by the word "recommendations".

Ms GILDERS (alternate to Mr Shugart, Canada) supported that proposal.

Dr LE GALÈS-CAMUS (Assistant Director-General) said that the Ottawa Charter had been crucial in defining the Organization's activities, but in the subsequent 20 years new challenges had arisen, such as epidemics and noncommunicable diseases. WHO had taken action against smoking and alcohol abuse and in favour of good nutrition and physical exercise. A crucial element in health promotion was a set of reliable assessment indicators. WHO was therefore elaborating both specific and more general indicators so as to reach a better understanding of the progress that could be achieved.

**The resolution, as amended, was adopted.<sup>2</sup>**

#### **4. PROGRAMME AND BUDGET MATTERS: Item 5 of the Agenda**

**Eleventh General Programme of Work, 2006-2015:** Item 5.1 of the Agenda (Documents EB117/16, EB117/16 Add.1 and EB117/INF.DOC./3)

The CHAIRMAN recalled her comments on the report of the Programme, Budget and Administration Committee in the first meeting, and recalled that the Committee had considered the Eleventh General Programme of Work.

Dr NORDSTRÖM (Assistant Director-General), outlining the Eleventh General Programme of Work, said that it defined six core functions of WHO, which had changed only slightly since the previous General Programme of Work, with no change in the Organization's mandate. Its four strategic domains laid down specific priorities which would be reflected in the strategic objectives of the medium-term strategic plan. WHO's core functions needed to respond to changing circumstances and the increased volume of work. WHO needed to focus on results and ensure accountability; work with other agencies within the United Nations system and in public-private partnerships; concentrate

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

<sup>2</sup> Resolution EB117.R9.

on making a difference at country level; and, as a technical agency whose main task was to provide technical support, be a modern, competent and learning Organization.

Formulating the Programme had begun in 2004. At a seminar for members of the Board in Reykjavik, the Secretariat had presented various scenarios in order to elicit major challenges facing WHO. In January 2005, the Board had welcomed the scope of the General Programme and made numerous comments. Later in 2005, the regional committees had provided valuable input. Further comments from recent consultations<sup>1</sup> and the Programme, Budget and Administration Committee<sup>2</sup> had indicated that it should be made clear that the objective of the General Programme of Work had changed from that of its predecessors. It should be a strategic framework for both WHO and its partners, and indicate clearly the progression from the broad aims of the General Programme to the more specific objectives of the medium-term strategic plan and the biennial programme budgets. The Programme, Budget and Administration Committee had suggested a procedure for the revision of the document.

Endorsement of the General Programme of Work by the Health Assembly would enable it to be used as a framework for the preparation of the medium-term strategic plan and the biennial programme budgets and as a basis for dialogue between WHO and its partners. The layout of the document would be improved to make it easier to read. A process would be put in place to monitor and evaluate progress towards the objectives of the General Programme and ensure its continued relevance throughout its lifetime.

The CHAIRMAN invited Board members to bear the following points in mind in their comments. The Secretariat needed a clear idea of members' views in order to revise the General Programme of Work accordingly. The Board needed to agree on a procedure for transmitting it to the Health Assembly, for instance by delegating the responsibility for approving the final version to the Programme, Budget and Administration Committee, as had been suggested. Document EB117/16 contained a draft resolution on which members might wish to comment.

Professor PEREIRA MIGUEL (Portugal) said that a consultation among Member States of the European Region had taken place in Copenhagen on 10 and 11 January 2006, the conclusions of which were reflected in the report of the Programme, Budget and Administration Committee,<sup>2</sup> and whose official report would be submitted to the Secretariat. Member States had discussed the overall balance of the document in relation to WHO's core functions as laid down in the Constitution. The key normative and standard-setting functions, exemplified by the WHO Framework Convention on Tobacco Control, the International Health Regulations (2005) and the work of the Commission on Social Determinants of Health, had not received adequate consideration. Those were issues which only WHO could deal with and examples of the added value that the Organization provided. The General Programme resembled more an advocacy document than a genuine programme of work. He asked for his comments to be taken into account, and welcomed the suggestion that the Programme, Budget and Administration Committee should review the next draft.

Mr SAMOU (alternate to Dr Al-Keeb, Libyan Arab Jamahiriya), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the extensive and transparent consultation process. The General Programme of Work was well structured, laid down a comprehensive global health agenda, provided a good analysis of current gaps in health services (although it had omitted some issues, such as nutrition), and acknowledged the changing roles and responsibilities of health ministries and their partners at country level. The proposed global health agenda provided broad strategic directions for the 10 priority areas identified. It should form the basis

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<sup>1</sup> Document EB117/INF.DOC./3.

<sup>2</sup> Document EB117/3.

for the medium-term strategic plan for the period 2008-2013, recognizing existing technical and financial capacities and resources, especially in the countries with the greatest needs.

The final section, on the evolution of WHO, should acknowledge WHO's past and present achievements and explicitly spell out the lessons that had to be learnt. WHO's role as the "directing and co-ordinating authority on international health work", as stated in Article 2(a) of the Constitution, was more crucial than ever, owing to the emergence of new partners and new alliances, and he called on all members of the Board to support WHO in the fulfilment of that important mandate. He supported the draft resolution.

Dr PHOOKO (Lesotho), speaking on behalf of the Member States of the African Region, commended the preparation of the General Programme of Work, particularly the extensive regional consultations. The General Programme attempted to identify the global health challenges, the advantages WHO could offer compared to other organizations, the gaps in existing resources, the opportunities that presented themselves and the steps needed over the next decade. It had far-reaching implications for the way WHO and its partners would fulfil the Organization's mandate. Its message must be clearly understood by other agencies of the United Nations system, development partners and nongovernmental organizations.

He expressed concern that the General Programme had not been finalized, even though the period to which it applied had already begun. It needed more work but must be completed as soon as possible. Many of the African States' concerns were reflected in document EB117/INF.DOC./3, but he particularly emphasized the need to define global health problems and indicate the respective roles of WHO and other partners in tackling them. The General Programme must respond to the concerns and expectations of the end-users of health services.

The section on the global health agenda should deal with synergy with related organizations and development partners, which was essential in order to avoid duplication and promote cooperation among the increasing number of stakeholders. The final text should define the relationship between the General Programme of Work, the medium-term strategic plan and the biennial programme budgets. He supported the suggestion that the Secretariat, together with the Programme, Budget and Administration Committee, should finalize the General Programme of Work for submission to the Health Assembly in May 2006.

Mr GUNNARSSON (Iceland) said that the Eleventh General Programme of Work, in its current form, lacked clarity. However, when considered together with the medium-term strategic plan, the budget and other relevant documents, it constituted a useful guidance tool. More information was required on WHO's role compared to that of partner organizations, and on its strengths and weaknesses. Fewer and more specific priorities were required. Greater linkage might be provided between the General Programme of Work and the future scenarios in public health that the Board had considered at its seminar in Reykjavik. He approved of the proposed process to be followed, which would result in a better document for submission first to the Programme, Budget and Administration Committee and then to the Fifty-ninth World Health Assembly. He endorsed the draft resolution.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) asked that the comments of the members of the Programme, Budget and Administration Committee and the Board should be taken into account in the revision of the Eleventh General Programme of Work. He expressed concern that, although the analysis in paragraph 139 of the General Programme of Work, relating to the need to ensure an adequate health workforce, was consistent with the problems identified in paragraph 42, the priorities described in paragraphs 142 to 144 were not adapted to the problems of the international migration of health professionals. Those priorities needed greater substance and clarity, and should take into account resolution WHA57.19 on international migration of health personnel.

He proposed that paragraph 1 of the draft resolution be amended to read: "APPROVES the Eleventh General Programme of Work, 2006-2015 after the finalization of the Eleventh General

Programme of Work by the Programme, Budget and Administration Committee in its extraordinary session in February 2006”.

Dr BOTROS SHOKAI (Sudan), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the clear presentation of the General Programme and endorsed the comments made by the member for the Libyan Arab Jamahiriya.

Mr IWABUCHI (alternate to Dr Shinozaki, Japan) acknowledged the extensive consultations. He agreed that WHO's mission was increasingly influenced by social, economic and political factors outside the traditional public health domain, but called for realism about how much the Organization could undertake. WHO should concentrate on what it did well, and the Programme of Work should be more specific in identifying what its tasks should be. The Organization should focus on its original mandate.

Dr ANTEZANA ARANÍBAR (Bolivia) commended the draft Programme of Work but agreed that clarifications were necessary. The chapter on the changing global environment should emphasize poverty, increasing risks to health and the politicization of health. The section on health systems needed strengthening: the effectiveness of the international declarations and agreements (paragraphs 45 and 46) was questionable; it was concrete actions that would improve health systems. He commended the chapter on challenges to, especially inequities in, health. He welcomed the inclusion of health security within the global health agenda but intersectoral analysis was needed. He endorsed the draft resolution.

Ms GILDERS (alternate to Mr Shugart, Canada) commended the drawing up of the Eleventh General Programme of Work. The Programme should state clearly and concisely WHO's top priorities that would lead to a global health agenda and help the Organization to make the difficult choices that financial and human resources demanded. It should also facilitate the budgetary process, given the dependence on voluntary funding, by articulating work priorities that stem from WHO's core functions. She echoed the request made by several members for a clear definition of WHO's role in achieving global health and of those areas where its work represented value added compared to the work of other parties.

She endorsed the proposal for further review of the document and suggested that the Board's comments be used as criteria for determining whether the Programme of Work should be submitted to the Fifty-ninth World Health Assembly. Even if it were not perfect, the document should be submitted to the Health Assembly, as the decade 2006-2015 had already commenced. She endorsed the draft resolution, on the understanding that the Programme of Work would provide a more succinct vision of WHO's work priorities.

**The meeting rose at 19:00.**



## **NINTH MEETING**

**Friday, 27 January 2006, at 09:10**

**Chairman:** Ms J. HALTON (Australia)

### **PROGRAMME AND BUDGET MATTERS:** Item 5 of the Agenda (continued)

**Eleventh General Programme of Work, 2006-2015:** Item 5.1 of the Agenda (Documents EB117/16, EB117/16 Add.1, and EB117/INF.DOC./3) (continued)

The CHAIRMAN asked the Secretariat to clarify the proposed procedure for the approval of the draft Eleventh General Programme of Work and the relevant draft resolution.

Mr BURCI (Legal Counsel) said that the Board might wish to delegate authority to the Programme, Budget and Administration Committee to examine the draft Eleventh General Programme of Work at an extraordinary session in February to ensure that the document had been revised in accordance with its conclusions. The Committee could then finalize and approve the relevant draft resolution, on behalf of the Board, for submission to the Health Assembly.

Dr BRUNET (alternate to Professor Houssin, France) pointed out that document EB117/INF.DOC./3 summarized some but not all of the points raised in the consultations of Member States of the European Region, and he asked had the views of other Member States or regions been taken into account? Furthermore, it was not clear, from procedure outlined by the Legal Counsel, whether the draft resolution to be considered by the Programme, Budget and Administration Committee was the one currently before the Board, or whether there was to be a second resolution in which the Board would delegate authority to that Committee, clearly specifying its mandate.

Mr BURCI (Legal Counsel) said that the draft resolution contained in document EB117/16, as amended in the course of the Board's discussions, could be forwarded to the Programme, Budget and Administration Committee to serve as the basis for its approval, on behalf of the Board, of a final draft resolution that would be submitted to the Health Assembly. The Board would not need to adopt a formal resolution to give a mandate to the Programme, Budget and Administration Committee. The Chairman's summing up, which would appear in the summary records, would set out the terms of reference that the Board wished to give to the Committee and would suffice.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland)<sup>1</sup> said that Member States of the European Region had welcomed the opportunity to consider the entire draft document, rather than just a draft executive summary. Although the results of those consultations had been made widely available to all Member States, it was not clear whether that was the case for the other consultations referred to in document EB117/INF.DOC./3. Transparency was a prerequisite for ensuring the support of Member States.

As the Director-General had said, the development of the Eleventh General Programme of Work provided an opportunity to look into the future and to elaborate WHO's role within the United Nations reform agenda. The Director-General had already recognized the need for change through the introduction of results-based management. By continuing its programme of reform and using its core

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

mandate and advantages compared to other organizations to strengthen operational relations with other agencies, and avoid duplication of effort, WHO would be in a strong position to provide the necessary leadership on global health issues. The General Programme of Work, in whatever form it finally emerged, would be a key instrument in that process.

The General Programme needed radical redrafting. The next version should contain an unambiguous statement setting out its purpose, provide a clear vision of global health, and identify WHO's role in the increasingly complex global architecture. It should consider WHO's core mandate and strengths in order to strike a better balance between global normative and standard-setting instruments and the provision of technical support. It should provide an assessment of WHO's performance and take greater account of the need for flexibility to meet unexpected challenges against the background of funding uncertainties and reliance on voluntary contributions. The revised document should also give consideration to synchronizing the terms of the General Programme of Work and the mid-term strategic planning process.

The Programme, Budget and Administration Committee might also consider the merit of launching the General Programme of Work as part of a package of proposals with the mid-term strategic plan and the next Proposed programme budget, so that Member States could see how those documents, the new approach and the strategic resource allocation principles fitted together in practice.

The discussions and clarifications had been useful, but he sought assurance that the next draft of the General Programme of Work would be available to all Member States to enable them to contribute to the next debate either as observers at the meeting or through their regional representatives.

The CHAIRMAN confirmed that the revised version of the document would be available to all Member States; the February meeting of the Programme, Budget and Administration Committee would be open to all Member States as observers.

Dr STEIGER (United States of America),<sup>1</sup> endorsing the comments of the representative of the United Kingdom, said that the Eleventh General Programme of Work, as it stood, fell short as a strategy and needed a radical change of focus and direction. Coordination among and between United Nations agencies and other international bodies with mandates touching on health would be an important part of the document, and he accordingly supported the call for a clear delineation of WHO's strengths and a clear assessment of its performance in several areas. WHO was not a human rights body. Care should be taken not to deviate from the language of its Constitution by using expressions such as "the right to health" and "rights-based approaches". The process suggested was acceptable, but support for the draft resolution could not be contemplated until a further revision of the document became available.

Mr XING Jun (China)<sup>1</sup> agreed in principle with the contents of the General Programme of Work and draft resolution and that the document should be considered further by the Programme, Budget and Administration Committee in February.

Implementation of the Programme would depend on factors such as economic and social development, resources, disease outbreaks and other emergencies. WHO should use its advantage compared to other organizations to strengthen communication and cooperation with Member States and other parties in order to make the best use of the Programme. The world health situation might change significantly over the next 10 years, and the Programme would have to be adjusted accordingly. The Secretariat should therefore enhance its monitoring and evaluation of the Programme's implementation and keep Member States regularly informed. As implementation would depend on elements outside the health sector, WHO should also make the relevant international

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

agencies and institutions aware of the Programme's content and coordinate its strategies with others with a view to achieving the Millennium Development Goals.

Dr NORDSTRÖM (Assistant Director-General) said that the purpose of the Eleventh General Programme of Work was to review world health and look to the future. Document EB117/INF.DOC./3 summarized the consultations with Members States of the European Region, with civil society and with bilateral partners. Other regional consultations had already been taken into account in preparing the draft Programme. The outcomes of all the regional consultations were already available on WHO's web site, and would be taken into account during the redrafting process.

The Secretariat might include some of the initial work on future public health scenarios, as suggested by the member for Iceland. It could undoubtedly improve the layout of the final document in order to make it easier to read.

There was no contradiction between WHO's global normative work and the provision of technical support in developing countries. On balance, however, he agreed that the global normative work should be positioned more strongly in the document.

The comments on the importance and changing role of health ministers in a multisectoral environment, and that the Programme of Work should respond to countries and individuals in greatest need had been noted; there had been comments that health went beyond the conventional health sector. Although WHO did not have overall responsibility for human rights or environmental issues, it did have a role in ensuring that the health aspects and the implications of more cross-cutting issues of importance to health were well captured. The comments by the member for Lesotho on the need to develop mechanisms to achieve the necessary synergies and derive benefit from them had also been noted.

He accepted that the document needed to define the role and strengths of WHO more precisely and to assess its future expectations within the United Nations system against the background of reform.

Indeed, the General Programme of Work, the medium-term strategy and the Programme budget had to be seen as a package. However, the Programme was not a workplan for the Secretariat: it provided the strategic direction, the medium-term strategic plan set the objectives, and the Programme budget defined the expected results and financial resources available.

Members had raised the issue of priorities. WHO's mandate made it difficult to decide, without guidance from Member States, that one health problem was more important than another. He welcomed the essential discussion of the Organization's core functions and the calls for greater clarity on WHO's strengths. Core functions could not be performed in the same way for all health issues as the expected results and resource implications differed. Greater clarity about WHO's role and the expected results for certain health problems would ensure the right priorities, permit clearer budgeting and costing, and therefore achieve better value for money.

The CHAIRMAN said that the Board had given the Programme, Budget and Administration Committee clear messages. The document must reflect more fully the results of all the consultations and the Board's discussions. It should be more succinct, with a sharper focus and clearer purpose than the current version. The role of the document and core mandate of WHO should be stated more clearly. The relation between the General Programme of Work, the medium-term strategic plan and the Programme budget should be clarified so that there was no doubt that the Programme was part of a package. There should be greater clarity about matters considered by WHO as global health issues, about gaps, strengths and weaknesses, about the challenges and opportunities to be faced, about WHO's position in that scenario, and about the role and importance of other parties. The need for greater flexibility to deal with changing circumstances, and to ensure that language was consistent with WHO's mandate had also been emphasized.

She had noted support for the delegation of authority from the Board to the Programme, Budget and Administration Committee for consideration of the revised General Programme of Work. If the new version of the document did not meet the Board's requirements it would not be approved. The

draft resolution would only be considered by the Committee if the revised version of the General Programme of Work was approved.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) asked whether the Board would be delegating to the Programme, Budget and Administration Committee the responsibility for approving the report.

The CHAIRMAN, replying in the affirmative, explained that the Board had the legal authority to do so. The Board was delegating two decisions: whether to approve the revised Programme of Work and, if so, whether to adopt the draft resolution contained in document EB117/16.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) asked what the implications of the Committee's not approving the General Programme of Work would be for the medium-term strategic plan and the Programme budget, and what alternatives would then be open to WHO.

Ms GILDERS (alternate to Mr Shugart, Canada) asked when the revised text would be issued, as that would affect the timing of the process, including consultations by Member States within their own governments.

Dr BUSS (Brazil) endorsed the concerns of the member for Thailand. The General Programme of Work had to be adopted in 2006; if it was not, would the Programme budget remain valid?

Mr BURCI (Legal Counsel) said that, if the Committee was not entirely satisfied with the revision, it could give clear instructions to the Secretariat to prepare a final draft for consideration by the Health Assembly. If the latter was not in a position to adopt a new General Programme of Work in 2006, it could decide provisionally to extend the General Programme of Work, 2001-2005, supplemented by additional indications from the Health Assembly, until a new General Programme of Work was adopted. Failure of the Health Assembly to adopt a General Programme in 2006 would not invalidate the Programme budget, which had already been adopted for the biennium 2006-2007.

Dr NORDSTRÖM (Assistant Director-General), responding to the question on timing, said that in order for the report to be issued for the Health Assembly, it would have to be translated into all six official languages by early April 2006. The Secretariat expected to issue the revised version of the report one week in advance of the extraordinary meeting, on 24 February 2006, of the Programme, Budget and Administration Committee, but did not have the capacity to produce it in all six languages for the Committee and again for the Health Assembly. Efforts would nevertheless be made to produce it in more than one language for the Committee. Following the Committee's meeting, the text would be given its final revisions in light of the Committee's comments and forwarded to the Health Assembly.

Dr SHANGULA (Namibia) endorsed the procedure outlined by the Chairman.

Dr BUSS (Brazil) also endorsed the proposed procedure but noted that the handling of the translation was not the same as that agreed the previous day for the draft resolution submitted by his country and Kenya.

The CHAIRMAN asked whether the Board would accept the proposed procedure whereby the Secretariat would incorporate the input provided at the meetings of the Board and the Programme, Budget and Administration Committee, and in informal consultations. The responsibility for considering the revised Programme would be delegated to the Committee which, if the document was acceptable, would then consider the draft resolution and forward both the document and the draft resolution to the Health Assembly.

In response to a question by Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand), she said that the Committee would be responsible for amending the draft resolution, if necessary.

In the absence of any objection, she took it that the Board endorsed the procedure outlined.

**It was so agreed.**

**Mr Khan took the Chair.**

**Guiding principles for strategic resource allocations, including validation mechanism:** Item 5.2 of the Agenda (Documents EB117/3 and EB117/17)

The CHAIRMAN said that document EB117/17, containing draft guiding principles for the strategic allocation of resources throughout the Organization, had been prepared in response to a request made by the Board in May 2005.<sup>1</sup> Details of the proposed validation mechanism were set out in the annex to the document; the Programme, Budget and Administration Committee had reported on them in document EB117/3.

Ms HALTON (Australia), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee's considerations had been greatly facilitated by the Secretariat's detailed briefings, which had given members a better understanding of certain technical aspects of the validation mechanism. It was not a resource allocation mechanism. Its purpose, which was not always clear from the documentation, was to provide an additional means of assessing whether resources were going to the right place. The statistical method produced a broad range of values for assessing the budget allocations but did not dictate the resources allocated within regions.

The Committee had discussed in detail the statistical foundation of the mechanism and whether all the elements on which the mechanism was founded were accurate, well chosen and adequately reflected the concerns of Member States regarding the relative needs of countries. Some Committee members had suggested the possibility of changing the weighting for least developed countries so as better to reflect the relative need. No consensus had been reached on that suggestion, but on balance, there had been consensus that the validation mechanism was a good approach.

Mr BAILÓN (Mexico) said that the Latin American countries emphasized the importance of an efficient, open system for evaluation of resource allocation. They were concerned about disparities in regional weighting but supported the increased resources to the least developed countries. Areas within developing countries with a high poverty index should also be considered least developed regions and care should be taken that regions like Latin America and the Caribbean received sufficient support. Furthermore, in analysis and decision-making on resource allocation, special account could be taken of the fact that countries of the Region of the Americas had to pay two contributions, to PAHO and WHO. Those countries should make constructive proposals on the allocation of resources.

Dr SINGAY (Bhutan), speaking on behalf of the Member States of the South-East Asia Region, referring to paragraph 22 of document EB117/3, said that there had been consensus in the Programme, Budget and Administration Committee on the guiding principles, but not on the validation mechanism. He noted that Principle 2 of the guiding principles affirmed that resource allocation should be based on equity and support of countries in greatest need, particularly the least developed countries. However, not all least developed countries were included in deciles 1 and 2: those from his Region were scattered over deciles 3 and 4, which were weighted 2.9 and 2.2, respectively.

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<sup>1</sup> Document EB116/2005/REC/1, summary record of the third meeting.

Health equity meant equal treatment for equal needs. He accordingly urged the Board to abide by the definition of least developed countries adopted by the United Nations in 1971 and by Principle 2, by putting all least developed countries into decile 1.

Professor PEREIRA MIGUEL (Portugal) recalled the statement in the Programme, Budget and Administration Committee's report (document EB117/3, paragraph 23) that, overall, there had been a consensus among members on the validation mechanism. PAHO had already gained useful experience in using that kind of model. Countries in the European Region saw the model as a well balanced way of dealing with health indicators.

Dr ACHARYA (Nepal) said that the countries of the South-East Asia Region had met four times to discuss the guiding principles for strategic resource allocation, and a clear conception of those had emerged. He supported the member for Bhutan in emphasizing the principles of equity and support for countries in greatest need, in particular the least developed countries, and called for equal treatment among deciles.

Mr RAMATSOARI (alternate to Dr Phooko, Lesotho), speaking on behalf of the Member States of the African Region, acknowledged with appreciation the incorporation of Principle 2, which had been put forward by the Regional Committee for Africa. The vital mechanisms for efficient resource allocation as presented in document EB117/17 could be made easier to understand. The engagement component should be reduced. Contrary to the indication in paragraph 21 of the report by the Programme, Budget and Administration Committee, the African Member States considered that its removal would increase the dollar figures for the needs-based component. The Secretariat should also draw up clear guidelines for the implementation of the guiding principles and validation mechanism. The areas in greatest need and regions with high disease burden should be accorded greater priority in allocations, and the least developed countries should remain a priority.

In his report to the Executive Board at its 113th session,<sup>1</sup> the Director-General had emphasized strengthening national health systems in order to explain the shifting in resources to countries. WHO had increased allocations to countries and regions under the 2004-2005 Programme budget from 66% to 70% and was pushing to reach 75% for the 2006-2007 biennium. That commitment should serve as an overarching guideline for resource allocation and its spirit should be reflected in the document. Adherence to the guiding principles, particularly Principle 2, would ensure that the African Region and other regions in greatest need were better placed to face their daunting challenges.

Dr OROOJ (alternate to Mr Khan, Pakistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, supported the Director-General's efforts to decentralize WHO, a process that would affect coordination and operations, and result in more being expected from the regional and country offices. The validation mechanism must take that fully into account and must ensure equity in regular budget and extrabudgetary resources. He was concerned that the share of headquarters remained constant, while the share of the regions depended on the model selected. Decision WHA57(10) on regional budget allocations had requested the Director-General to draw up guiding principles that took into account equity, efficiency and performance, and to provide support to countries in greatest need. However, if the proposed validation mechanism, an average of the four proposed models, had been applied in the 2006-2007 biennium, the African, Eastern Mediterranean and South-East Asia regions (the three least developed in terms of life expectancy, income, education and other health and socioeconomic indicators) would have received US\$ 127 million less in resources than was the case. The African Region, the poorest and neediest, would have lost more than US\$ 62 million of its budget for the biennium. The validation mechanism, in providing indications for

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<sup>1</sup> Document EB113/2.

resource allocation, should not inadvertently compromise the letter and spirit of the Health Assembly decision.

The suggested indicators for assessing country health needs were another area of concern. Indicators such as life expectancy, per capita income and education improved only gradually over time and reflected only long-term trends in health status. Moreover, there was a two- to three-year time lag in reporting, so that they did not reflect the current situation in many countries. WHO also allocated resources for health needs that were not captured by those indicators, for example for efforts to eradicate poliomyelitis. Like emergency and humanitarian action, those allocations should not be included in the validation mechanism, but treated as a separate component of resource allocation.

The selection of a model to assess country health needs called for careful consideration. The positive correlation between health and education had been extensively demonstrated, with increasing access to education leading to improvements in health. UNDP's Human Development Index, which took education into account, should therefore be used for the validation mechanism. Countries with large populations should be treated fairly; there was a limit to so-called economies of scale. The Member States of the Eastern Mediterranean Region supported the use of the square root methodology for adjustments related to population size.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) welcomed the validation mechanism and the seven guiding principles, in particular Principle 2. However, he endorsed the comments made by the member for Bhutan on Table 1 of the Annex to document EB117/17. All least developed countries should receive equal weighting.

He remained unconvinced of the need for an engagement component of 2%, which would amount to between US\$ 60 million and US\$ 70 million, or US\$ 350 000 per Member State. Its introduction was designed to cover the administrative costs of engaging with all Member States. However, WHO was de facto serving all Member States through its normative function, even if some had no WHO presence. Scarce resources should not be given to those with already adequate resources. Similarly, he questioned the proposed engagement component in respect of territories and areas under the jurisdiction of Member States, set out in paragraph 12 of the Annex to document EB117/17. The engagement component should be deleted and the 2% of resources transferred to the needs-based component. Such a move would highlight the need to use scarce resources more effectively.

Dr BRUNET (alternate to Professor Houssin, France) commended the efforts made to prepare the guiding principles and validation mechanism, which had been motivated by the need for equity and support for the neediest countries. The mechanism should enable evaluation of the medium-term strategic plan and the Programme budget. France welcomed the inclusion in the results-based indicators of a needs-based component, enabling equitable distribution of resources in accordance with need. That was important in the European Region, where countries' needs varied enormously. The engagement component of 2% was essential, given the regional costs of basic functions. For example, governance expenditures were higher for regions with many countries. The component should be retained.

Three questions required further clarification. First, what would be the consequences of failing to comply with the validation mechanism, for example if Member States adopted budgets that did not conform to the proposed ranges of allocations? Were there procedures for making adjustments and would the budgetary and financial rules have to be changed? Secondly, how did WHO intend to guarantee the proposed fixed component of 43%, given that some 70% of the Organization's total resources currently derived from voluntary contributions and that proportion might well increase. Thirdly, how would coordination and consistency between the various instruments proposed – the 15 strategic objectives of the medium-term strategic plan, the Programme budget, the guiding principles for resource allocation and the validation mechanism – be ensured? The implications of the proposals for resource allocation and the validation mechanism for human resources policy, methods of recruitment and staff mobility should also be clarified.

Dr KHALFAN (Bahrain) questioned whether the mechanism would bring the desired results, as its application would actually lead to decreased allocations to the African and Eastern Mediterranean regions, two of the neediest regions. The Director-General should reconsider the matter and the validation mechanism should be redesigned.

Dr BOTROS SHOKAI (Sudan) endorsed the views of the members for Bahrain, Bhutan, Lesotho, Nepal, Pakistan and Thailand and urged the Board, at the current session, to consider and agree to the proposals made by the member for Pakistan.

Dr TANGI (Tonga) said that the presentation at the recent meeting of the Programme, Budget and Administration Committee and the comments at the start of the present discussion by the Chairman of the Committee had clarified many aspects of the guiding principles and the validation mechanism. The least developed countries should not all be treated equally as their health needs differed considerably. The implementation of resolution WHA51.31 on regular budget allocations to regions had resulted in reduced allocations to the Western Pacific Region. Removing the proposed engagement component for the many territories and areas over which Member States had jurisdiction would result in further reductions. Therefore it should be maintained. He endorsed the comments made by the member for France.

Mr IWABUCHI (alternate to Dr Shinozaki, Japan) acknowledged the difficulty of designing resource allocation procedures that would satisfy all Member States. The Programme, Budget and Administration Committee had reached a general consensus on the guiding principles and use of the validation mechanism, but further clarifications were needed. As the member for France had noted, it might be difficult to allocate resources in accordance with Principle 3, given that some two thirds of WHO's resources were extrabudgetary. Such funds were often made available on a different fiscal schedule from that of WHO, and partner organizations might have little flexibility with regard to their technical or geographical focus, so that they would be unable to comply with the Principle. He requested further clarification of the move from a resource-based to a results-based approach to resource allocation, referred to in paragraph 12 of document EB117/17. There was no sense in seeking to attain results without a solid resource base. Organizations must prioritize their activities in the light of available resources. Did the new results-based approach mean that desired results would henceforth determine the resources that each Member State and partner agency must contribute?

Mr SHIRALIYEV (Azerbaijan) endorsed the comments made by the member for France and supported the guiding principles and validation mechanism in their present form. The slight increase for the European Region was needed, owing to its widely contrasting needs. Resources were scarce in many countries of the Region, especially those in economic transition. The health authorities of Member States looked to WHO for resources and moral support in order to improve public health.

Mr GUNNARSSON (Iceland) expressed concern that the report on the guiding principles and validation mechanism by the Programme, Budget and Administration Committee had not been accepted by all members of the Board, nor even by some who were also members of the Committee. The Committee's review procedures could be reconsidered. Everyone agreed that resources should be largely directed towards those in greatest need. It was important to enable countries to make the economic transition that Iceland had once experienced. To design a mathematical method for resource allocation that would satisfy all Member States would be impossible. A broadly acceptable solution was essential. Adjustments and refinements could render it more equitable, the main goal of the process. Without agreement at the current session, WHO would have to revert to implementation of resolution WHA51.31, which few Member States wanted. He saw no alternative to endorsing the report of the Programme, Budget and Administration Committee, which reflected its consensus.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand), referring to the comment made by the previous speaker, observed that no consensus had been reached.



Paragraph 22 of document EB117/3 stated that the validation mechanism provided significantly more weight to countries in greatest need, but did not single out least developed countries as a particular group; some such countries, namely, those that would be assigned to deciles 3 and 4, did not fall within the applied definition of countries in greatest need. The validation mechanism therefore did not comply with Principle 2. The Board had two alternatives: either it should follow the principles strictly, which meant that the least developed countries had to be treated equally by being assigned to decile 1 – and that was his country's position; or it had to delete Principle 2 – or at least the reference therein to least developed countries – since that principle could not be complied with.

With regard to paragraph 12 of the Annex to document EB117/17, he reiterated that Thailand could not accept the proposed arrangements for an engagement component in respect of territories and areas under the jurisdiction of Member States; any health actions in those territories were the responsibility of the Member States that had jurisdiction over them and were not the responsibility of WHO. To apply that arrangement would be to give scarce resources to countries that already had adequate resources. The engagement component should be deleted.

The CHAIRMAN pointed out that all Member States concurred with the principle of allocating resources equitably and in support of countries in greatest need, and that there could therefore be no question of deleting Principle 2. It was important to find a way of treating all the needy countries equitably.

Professor FIŠER (Czech Republic) expressed confidence that the intention had been to ensure an equitable approach that took into account the needs of the least developed countries. The seemingly minor changes proposed could have undesirable effects. The proposed package could be endorsed without further change.

Dr HANSEN-KOENIG (Luxembourg) welcomed the endorsement by the Programme, Budget and Administration Committee of the focus on countries in greatest need, in particular the least developed countries, and the inclusion of all sources of funds. She supported the proposed model for resource allocations in its entirety, and endorsed the appeal by several members to retain the engagement component: it was obvious that the financial burden was greater for a region that had to serve 52 countries and work in four languages than for regions that did not incur those higher administrative costs. She endorsed the statement by the member for Iceland; the Board should accept the model proposed, but consensus appeared unlikely. The Board should consider how to proceed.

Dr NORDSTRÖM (Assistant Director-General) said that there appeared to be consensus on the guiding principles for strategic resource allocations and the introduction of the validation mechanism. There was also broad agreement that the Organization should move from a resource-based to a results-based management approach. There must also be a clear understanding of the total resources available.

The results-based approach was already being applied to the elaboration of the medium-term strategic plan for 2008-2013 and the next Proposed programme budget. There would be a more detailed costing of both strategic objectives and the expected results needed to achieve those objectives at the country, regional and global levels. The validation mechanism would be used to determine the validity of the results-based resource requirements. If they were found to be invalid, that would indicate that the Organization had not been responding properly to the needs and priorities of Member States. He was confident that sufficient resources would be forthcoming to enable the Organization to honour its Programme budget; the Secretariat was strongly committed to raising further resources through voluntary contributions.

The validation mechanism was a compromise formula, based on the best knowledge of various experts, for supporting countries in greatest need. Its three components had been developed to reflect the nature of the work of the Organization. The ranges derived were purely conceptual and did not constitute actual resource allocations. The needs-based component took into account the socioeconomic indicators – life expectancy, gross domestic product and UNDP's Human Development Index – that most appropriately identified the countries in greatest need. The reference in Principle 2 to

“least developed countries” was intended to pinpoint the most needy countries, and was not a reference to the countries officially classified as “least developed” by the United Nations.

The Board could either accept the proposed approach and validation mechanism as they stood, as a compromise, thereby enabling the Organization to focus on the strategic objectives and the results to be achieved, with the guidance of Member States, or else defer consideration of the topic, pending further consultations, until its 118th session.

The DIRECTOR-GENERAL observed that WHO's role needed to be seen in a broad context. The Organization was not a fund or a development agency but a specialized agency of the United Nations that worked alongside other organizations in the United Nations system, the World Bank, bilateral donors, the European Commission and other bodies, to promote health. WHO supported many least developed countries that were struggling to devote sufficient resources to health and poverty-reduction activities, but it should not pretend to have sufficient resources to be able single-handedly to reduce poverty. The resources available to the Organization, when compared to national health budgets, or the overall resources of other institutions such as the World Bank, were small; moreover, two thirds of its budget was made up of voluntary contributions, which could not be guaranteed. In that context, he thanked the small number of countries that each year made ever-greater unearmarked voluntary contributions to the Organization's budget. Bilateral and multilateral donors expected the Organization, as an agency specialized in health matters, to provide considerable technical support to the countries to which they donated funds.

It had to be accepted that no one mathematical formula would resolve all the issues with which the Organization was faced. He therefore urged the Board to accept the proposed approach and the guiding principles, which would allow WHO sufficient room for manoeuvre, rather than deferring a decision on the subject pending further, and possibly unproductive, discussions. Stressing the need for a flexible response capacity, he assured Board members that, whenever special needs or emergencies arose, WHO would rise to the challenge and mobilize the necessary funds.

Dr SHANGULA (Namibia), thanking the Director-General for his reassuring words, said that that there was no alternative to the current proposal. He therefore implored the Board to endorse the proposed approach. It would not be possible to find a resource allocation formula that would satisfy all. However, during the implementation phase, weaknesses would be identified and the formula could be adjusted accordingly.

Dr KHALFAN (Bahrain) said that it would be helpful if the Secretariat could provide a table showing the effect of the validation mechanism on the distribution of resources to individual countries. The Board was being asked to make a decision without knowing what its implications might be. The trial and error process might lead the Organization to a position from which there was no return.

Dr NORDSTRÖM (Assistant Director-General) reiterated that the validation mechanism did not allocate resources or specify resources for individual countries; those would be determined by the programme budget process and would be dealt with within the different regions.

Dr SINGAY (Bhutan) pledged his country's support for any decision that might be demanded of the Director-General in an emergency. WHO's role as a specialized agency and the technical assistance it provided were highly valued by bilateral and multilateral agencies. That was one of the main reasons why he had suggested that all least developed countries should be grouped in one decile, because assigning them to different deciles would result in differential treatment and lead to difficulties, especially in the mobilization of external resources. The system for classification of least developed countries adopted by the United Nations should be retained and their status periodically reviewed.

The CHAIRMAN noted that, while all were agreed that support had to be given to countries in greatest need, there was no consensus about the way to do so. He therefore suggested that

consideration of the matter should be postponed until the 118th session of the Board and that the Programme, Budget and Administration Committee should reconsider the issue in the meantime.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) said that the merit of the validation mechanism was the application of a  $\pm 10\%$  relative range to the average, which provided the Director-General with the flexibility to spend money across programmes and across regions, having regard to the uncertainty of voluntary contributions. He proposed that, if the Board wished to retain the wording of Principle 2, on which there appeared to be a consensus, all least developed countries should receive equal treatment by being placed in decile 1; if not, the words “in particular least developed countries” would need to be deleted. He further proposed that the engagement component should make up 1% rather than 2% of the total. He was prepared to accept that territories and areas under the jurisdiction of Member States should be factored in the engagement component at the level of 50% of a Member State.

Dr NORDSTRÖM (Assistant Director-General) reiterated that the ranges within the validation mechanism would serve as a yardstick and nothing more. The removal or reduction of the engagement component would make very little difference – only about  $\pm 3\%$  – in terms of ranges or averages across the regions. He assumed that the proposal was prompted by a matter of principle or by political considerations. Including all least developed countries in the first decile would make a small difference in terms of averages, although less in terms of ranges, the main consequence being that the average for the African Region would be decreased by 0.8%, and that for the South-East Asia Region increased by 1.1%. The figures could be adjusted accordingly.

Dr ANTEZANA ARANÍBAR (Bolivia), stressing the importance of moving ahead with the agenda, observed that most Board members, without experts immediately available to examine the figures in detail, were approaching the guiding principles and validation mechanism from a conceptual, strategic viewpoint. The Board should have confidence in the Director-General’s ability to apply the guiding principles, and authorize the Secretariat to proceed, provided that the Board – and the Programme, Budget and Administration Committee – was kept informed and held further discussions at its next session. There should be no further delay.

Dr BOTROS SHOKAI (Sudan) said that the validation mechanism did not adequately reflect the guiding principles. If no consensus was reached at the current session, she favoured submitting the matter to the Health Assembly in May 2006, rather than delaying until the 118th session of the Board. Otherwise, the matter would not be discussed by the Health Assembly until 2007.

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

## **TENTH MEETING**

**Friday, 27 January 2006, at 14:10**

**Chairman:** Mr M.N. KHAN (Pakistan)

**later:** Ms J. HALTON (Australia)

**later:** Mr M.N. KHAN (Pakistan)

### **1. PROGRAMME AND BUDGET MATTERS:** Item 5 of the Agenda (continued)

**Guiding principles for strategic resource allocations, including validation mechanism:** Item 5.2 of the Agenda (Document EB117/17) (continued)

The CHAIRMAN stated that informal consultations had taken place since the morning meeting.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) proposed that, following consultations and in the interest of seeking a consensus on how best the validation mechanism could comply with guiding principle 2, on which there was agreement, the matter should be referred to the Programme, Budget and Administration Committee at its session preceding the Fifty-ninth World Health Assembly and then submitted to the Board at its session in May 2006.

Dr GASHUT (alternate to Dr Al-Keeb, Libyan Arab Jamahiriya), Mr MAHMOOD (alternate to Dr Ali Mohammed Salih, Iraq) and Dr KHALFAN (Bahrain) supported that proposal.

Dr MIHAI (adviser to Dr Iliescu, Romania) supported earlier speakers who had drawn attention to the disparate levels of development within the European Region, and to the consequent need for a fairer allocation of funds.

Dr SADRIZADEH (Islamic Republic of Iran) said that the outcome of adopting the modelling formula would be that WHO headquarters would receive 28% of resources, more than had been promised, and the African, South-East Asia and Eastern Mediterranean regions would receive less. The principles should be reviewed and refined in line with the Board's discussions and WHO's decentralization policy. After revision by the Secretariat, the principles should be submitted via the Programme, Budget and Administration Committee to the Fifty-ninth World Health Assembly.

Mrs MTSHALI (South Africa)<sup>1</sup> acknowledged the work of the Programme, Budget and Administration Committee in facilitating the Board's deliberations. Some issues not fully dealt with in the Committee would inevitably come up in the Board.

She asked what were the status and constitutional responsibility in WHO of territories and areas within the jurisdiction of Member States and whether that responsibility, if any, matched the ideas and proposals contained in paragraph 12 of document EB117/17.

She endorsed previous statements about the least developed countries, and commended earlier improvements to the guiding principles, especially the inclusion of Principle 2.

Ms HALTON (Australia), speaking as Chairman of the Programme, Budget and Administration Committee, agreed with the proposal by the member for Thailand to refer the item to the Committee

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

and the Board at its subsequent session. Contentious issues remained and not all the complexities had been dealt with in detail at the current Board session. Preliminary work should be done ahead of the Committee meeting in order to engage all interested parties informally, and to collect all information and comments in order to focus the Committee's meeting before consideration by the Board. The previous speaker's comments would be among those discussed by the Committee.

The CHAIRMAN said that the Secretariat should likewise be requested to provide all the information sought by the members for Bahrain, Bhutan and others as input to the deliberations of the Committee and the Board. He took it that the Board wished to refer the item to the Programme, Budget and Administration Committee at its next meeting, for subsequent further consideration by the Executive Board at its 118th session.

**It was so agreed.**

**Real Estate Fund: progress report:** Item 5.3 of the Agenda (Document EB117/18)

Mrs SCHAER BOURBEAU (Switzerland)<sup>1</sup> said that, as the host country, which had recently granted an interest-free loan to finance the construction of a new building for WHO and UNAIDS, Switzerland attached particular importance to the report. She welcomed WHO's intention to pursue a coordinated approach to real estate questions, and in particular the forthcoming elaboration of a 10-year capital master plan covering all construction, renovation and security needs. She endorsed the concern about the impact of budget cuts on building maintenance, and stressed the need for all international organizations to set aside the necessary resources to ensure the maintenance of their property.

**The Board noted the report and endorsed the plan of action.**

**2. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD:** Item 3 of the Agenda (Document EB117/3) (continued from the first meeting, section 3)

Mr AITKEN (Director, Office of the Director-General) drew attention to paragraph 48 of the report, referring to a recommendation by the Committee to the Board concerning the periodicity of Committee meetings.

Ms HALTON (Australia), speaking as Chairman of the Programme, Budget and Administration Committee, said that the Board's approval was sought for the proposal to authorize extraordinary meetings of the Committee to deal with urgent matters. She specified that such meetings could be convened by the Board only, and not by the Committee of its own accord.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) supported that proposal given the Board's earlier decision on agenda item 5.1 authorizing the Committee to consider revision of the draft Eleventh General Programme of Work in February 2006 on behalf of the Board.

Mr AITKEN (Director, Office of the Director-General) read out the following proposed decision:

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

**Decision:** The Executive Board, having noted the report of its Programme, Budget and Administration Committee,<sup>1</sup> decided to amend the Terms of Reference of the Committee as set out in the annex to resolution EB114.R4, by adding the following sentence at the end of the paragraph entitled “Periodicity of meetings”: “The Board may decide to convene extraordinary meetings of the Committee in order to deal with urgent matters that fall within the terms of reference of the Committee and that need to be considered between regular meetings of the Committee.”

**The decision was adopted.<sup>2</sup>**

**The Board noted the report.**

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

**Earthquake in south Asia: WHO’s response:** Item 4.1 of the Agenda (Document EB117/30) (continued from the second meeting)

The CHAIRMAN, speaking as the member for Pakistan, said that, on the basis of the Board’s previous discussion of item 4.1 of the agenda, Pakistan wished to propose a draft resolution, which read:

The Executive Board,  
Having considered the report on the earthquake in south Asia: WHO’s response,<sup>3</sup>

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

The Fifty-ninth World Health Assembly,  
Aware of the adversity due to natural and man-made disasters suffered by the people of the world;

Noting that the resilience of the nations and communities affected by crises is being eroded by the extreme pressures they face on a daily basis and over a protracted period;

Concerned that emergency preparedness in many countries is weak and that existing mechanisms may not be able to cope with large-scale disasters such as the earthquakes in Bam, Islamic Republic of Iran, and, most recently, in northern India and Pakistan, the earthquakes and tsunamis in south Asia and the hurricane Katrina in the United States of America;

Appreciating the progress made, particularly in the Eastern Mediterranean and South-East Asia regions with regard to emergency response to the south Asian earthquake;

Recalling Article 58 of WHO’s Constitution, which specifies the establishment of a special fund to meet emergencies and unforeseen contingencies, to be used at the discretion of the Board,

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<sup>1</sup> Document EB117/3.

<sup>2</sup> Decision EB117(2).

<sup>3</sup> Document EB117/30.

1. EXPRESSES its sympathy, support and solidarity for the victims of disasters;
2. ENCOURAGES Member States further to strengthen national emergency preparedness and response programmes through legislative, technical, financial and logistical measures;
3. REQUESTS the Director-General to take the necessary steps:
  - (1) to provide the necessary technical guidance and support to Member States for building their health sector emergency preparedness programmes at national and local levels;
  - (2) to create a global database and an interregional network of trained and equipped health professionals and institutions that are ready to respond to emergencies and crises;
  - (3) to establish a special emergency solidarity fund, whose resources can be mobilized in the immediate aftermath of emergencies and crises and to which all Member States would contribute;
  - (4) to establish several regional hubs for logistics and supply management, which would serve for immediate mobilization of vital supplies in emergencies and crises;
  - (5) to support the development and strengthening of regional centres for emergency disaster preparedness and response;
4. FURTHER REQUESTS the Director-General to report to the Sixtieth World Health Assembly on progress in implementing this resolution.

Mr GUNNARSSON (Iceland) said that it was crucial that the Organization was able to respond to emergencies without delay. The efforts made to deal with an emergency on the spot during the first 24 hours were critical: after that, it was important to receive assistance from outside.

He supported the draft resolution in general, but could not accept the need for a special emergency solidarity fund. Many colleagues would be reluctant to approve yet another fund. He proposed that paragraph 3(3) should be amended to read: “to endeavour to ensure that WHO, within its mandate, is able to respond in the immediate aftermath of emergencies and crises”, and suggested the addition of a new paragraph, to read: “URGES Member States to support WHO to enable it to address immediately, within its mandate, humanitarian health crises”.

Dr BUSS (Brazil) supported the amendments proposed by the member for Iceland. It was important that the Board should express its sympathy with the victims of natural disasters, and his country would always be willing to provide material assistance. The resolution should include reference to the coordination of emergency efforts between different bodies in the United Nations system. He suggested adding a new paragraph 3(6) to read: “to act jointly with the United Nations to establish a rapid coordination mechanism with other organizations of the United Nations system”.

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the Member States of the European Union, suggested the insertion of an additional preambular paragraph, to read: “Recalling United Nations General Assembly resolution 60/124 on strengthening the coordination of emergency humanitarian assistance of the United Nations”. In paragraph 3, after “REQUESTS the Director-General”, the words “in cooperation with the Office for the Coordination of Humanitarian Affairs (OCHA), other specialized agencies and the relevant international organizations” should be added. Paragraphs 3(2), 3(3), 3(4) and 3(5) should be deleted and replaced by a new paragraph 3(2) reading: “To explore (and engage in) ways to enhance WHO participation in the overall humanitarian response through existing mechanisms such as the Central Emergency Response Fund (CERF), the

International Search and Rescue Advisory Group (INSARAG) or United Nations Disaster Assessment and Coordination (UNDAC)”.

Dr KAMAL (alternate to Mr Shugart, Canada) accepted all the proposed amendments, and suggested adding a further preambular paragraph, to read: “Recalling resolution WHA58.1 on health action in relation to crises and disasters;”. Cooperation, timely leadership and the role of the Office for the Coordination of Humanitarian Affairs should all be emphasized. There was also a need to explore potential synergies between the regional hubs for logistics and supply management which existed both in and outside the United Nations system.

Dr SINGAY (Bhutan) fully supported the draft resolution.

Ms TSUJISAKA (alternate to Dr Shinozaki, Japan) emphasized the importance of action by WHO in emergency situations. She supported the draft resolution, but considered that the implications of the proposed fund and the regional hubs referred to in paragraph 3 called for further consideration. In that sense, she agreed with the amendments proposed by the member for Portugal.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) supported the draft resolution, but did not favour establishing another fund because of the bureaucratic implications. Although the amendment proposed by the member for Iceland was useful, it emphasized the vertical relationship between the Secretariat and its Member States rather than the horizontal relationship between Member States themselves, which could be more important in crises and emergencies. Additional wording could be inserted in the operative part of the resolution, urging Member States to support one another in times of disaster. The texts proposed by the members for Portugal and Iceland, should be considered carefully because of possible inconsistencies.

Mr PHAM HONG NGA (alternate to Mrs Le Thi Thu Ha, Viet Nam) strongly supported the draft resolution. A solidarity fund would enable WHO to react within hours after a disaster struck. Time was of the essence in responding to an emergency, and pre-positioned supplies in strategic locations were essential. The proposed fund could be effectively managed by the Secretariat.

Dr ABDULLA (alternate to Dr Botros Shokai, Sudan) strongly supported the draft resolution and the actions requested of the Director-General in paragraph 3. He suggested setting up a working group to seek consensus on the establishment of an emergency fund.

The CHAIRMAN observed that consultations could take place electronically.

Ms HALTON (Australia) willingly supported a resolution calling for the Board’s sympathy and solidarity with the victims of the south Asia earthquake and disasters in general. The Secretariat’s responses to recent disasters had been rapid and better than in the past, but there was still room to improve responsiveness, especially in terms of the operational platform.

The last preambular paragraph of the draft resolution recalled the Constitution’s reference to a special fund to meet emergencies and unforeseen contingencies. She pointed out that resolution WHA58.1 already provided guidance to Member States and the Director-General on priorities for future action to improve the collective response to crises and disasters. Paragraph 3(6) of that resolution requested the Director-General “to adapt, redesign where necessary, and secure adequate resources for effective work in the area of emergency preparedness and response, and other areas of work involved in the Organization-wide response to crises”. There was thus no need for a further resolution on funding mechanisms for that purpose. Moreover, Article 58 of the Constitution was intended to establish, within the biennial programme budget, a budget allocation for contingencies, which could include emergencies. She suggested deleting the last preambular paragraph of the draft resolution together with paragraph 3(3). Paragraphs 3(4) and 3(5) could be combined to read: “to support, as appropriate, the development and strengthening of regional centres for emergency disaster



preparedness and response, including several regional hubs for logistics and supply management, which would serve for immediate mobilization of vital supplies in emergencies and crises". In paragraph 4 the words "through the Executive Board" should be added after "Sixtieth World Health Assembly".

She could accept the amendments proposed by the member for Portugal, which were not inconsistent with the wording suggested by the member for Iceland.

Dr ACHARYA (Nepal) supported the draft resolution as amended by the member for Iceland.

Ms BLACKWOOD (United States of America)<sup>1</sup> said that the third preambular paragraph should include a reference to hurricane Rita as well as to hurricane Katrina, and she suggested inserting at the end of paragraph 2 the words "including through a focus on building community resilience". She welcomed the emphasis placed by some members of the Board on cooperation with the Office for the Coordination of Humanitarian Affairs and other responsible United Nations agencies, and agreed with the member for Portugal that the issues raised in paragraph 3 warranted closer examination.

The CHAIRMAN, speaking as the member for Pakistan, expressed his appreciation of the Board's solidarity with victims of disaster. When an emergency struck, it fell to the Director-General to take the appropriate action, whether or not resources were immediately available, and to seek the Board's approval as necessary. He drew strength in that regard from Article 58 of the Constitution.

Mr AITKEN (Director, Office of the Director-General), noting that the draft resolution enjoyed broad support, said that it might, however, not be possible to incorporate the various proposed amendments in time for it to be adopted at the current session. He suggested that the Secretariat should take on that task and circulate an electronic version of the draft resolution to members of the Board for review. The revised resolution might then be submitted to the Fifty-ninth World Health Assembly.

**It was so agreed.**

#### **4. FINANCIAL MATTERS: Item 6 of the Agenda**

**Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution:** Item 6.1 of the Agenda (Document EB117/19)

The CHAIRMAN noted that the item had already been discussed by the Programme, Budget and Administration Committee, and that the Committee's report was contained in document EB117/3.

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

**External and internal audit recommendations: tracking of implementation:** Item 6.2 of the Agenda (Document EB117/20)

The CHAIRMAN said that the report gave an example of the presentation of the proposed tracking document. Members should also refer to the report of the Programme, Budget and Administration Committee, contained in document EB117/3. As there were no comments, he took it that the Board accepted the proposed tracking programme.

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

**It was so agreed.**

**5. STAFFING MATTERS:** Item 7 of the Agenda

**Human resources: annual report:** Item 7.1 of the Agenda (Documents EB117/21, EB117/21 Add.1 and EB117/21 Add.1 Corr.1)

The CHAIRMAN recalled that the Programme, Budget and Administration Committee had considered the item.

Mr BAILÓN (Mexico), speaking on behalf of Member States in Latin America and the Caribbean, welcomed the report on staffing contained in document EB117/21 Add.1. For the sake of transparency and equitable geographical distribution in staffing, account must be taken of each Member State's financial contribution, population and membership. He urged the Organization to step up the recruitment of professional staff from developing countries, and recruit staff from unrepresented or underrepresented countries. He strongly supported the proposal of the Programme, Budget and Administration Committee that the Secretariat should compile a report differentiating between, on the one hand, the number of staff appointed to internationally-recruited posts through a competitive process following the issuance of a vacancy notice and, on the other, the number of direct appointments made by the Director-General. He attached equal importance to the Committee's proposal to include information on the mother tongue and language proficiency of staff. When addressing public health issues, it was necessary to take account of the various approaches and academic traditions in the world, and to respect multilingualism and multiculturalism and the need for access to information. The report should be available in time for the forthcoming Health Assembly.

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

**Report of the International Civil Service Commission:** Item 7.2 of the Agenda (Document EB117/22)

The CHAIRMAN explained that the item had also been discussed the previous week by the Programme, Budget and Administration Committee, and reference should therefore be made to the Committee's report.<sup>1</sup>

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

**Confirmation of amendments to the Staff Rules:** Item 7.3 of the Agenda (Documents EB117/23, EB117/23 Add.1 and EB117/23 Add.2)

The CHAIRMAN invited the Board to consider the two draft resolutions contained in document EB117/23.

**The resolutions were adopted.<sup>2</sup>**

**Statement by the representative of the WHO staff associations:** Item 7.4 of the Agenda (Document EB117/INF.DOC./1)

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<sup>1</sup> Document EB117/3.

<sup>2</sup> Resolutions EB117.R10 and EB117.R11.

Ms LALIBERTÉ (representative of the WHO staff associations) said that the staff associations sought to be active contributors to the process of establishing an institutional framework that was fair and equitable and in keeping with the standards and practices of the United Nations system. In May 2003 agencies of the system had signed a Declaration of Collective Understanding regarding a common human rights approach to both their work and the institutional governance of the system. She drew attention to a one-hour work stoppage that had taken place at headquarters on 30 November 2005 as a result of a breakdown in communication between headquarters staff and management. Surveys had pointed to a lack of trust in senior management and the work stoppage reflected disquiet that staff had been excluded from the decision-making process in respect of conditions of service and from the most critical phases of the strategic direction and competency review. There had been documented cases of abuse of discretionary decision-making in respect of recruitment and promotions, high levels of harassment and an ineffective internal justice system.

One key concern had been the refusal to reconsider or abolish the “four years and out” rule, due to be implemented in June 2006, whereby 280 staff, mostly women, on short-term contracts would have to leave the Organization after four years’ service. Short-term contracts had been prioritized in 2002 to enable the Organization to develop an effective system for human resources planning, and had not been intended to perpetuate a situation in which staff performed regular tasks without benefiting from regular conditions of employment. The headquarters staff association did not oppose downsizing or transfer of resources to regions and countries, but expected a human resources planning system that would convert short-term contracts into regular or fixed-term positions and relocate staff in keeping with technical cooperation demands and country focus strategy, taking into account gender balance and with clear procedures for mobility and rotation. Organization-wide, 45% of staff were serving under short-term contracts, many of which would expire in 2006.

She called for a comprehensive proposal on integrating gender considerations in all policies and programmes. She expressed concern about the systematic rehiring of retired staff; a policy on the matter was needed. Consideration should be given to changing the Staff Rules to give recognition to staff for time served in the Regional Office for the Americas and PAHO, and service contracts should be introduced in the regional offices for Europe and the Americas.

The role of the staff associations was to promote internal due process, fairness and a work environment that was based on good practices and rewarded integrity and mutual respect. They requested the Board to provide guidance to the administration on updating the guiding principles on staff/management relations so as to promote WHO as an employer of choice with an ethical and supportive work environment. There should be a fair, consistent and accountable process, and a jointly agreed mechanism for ensuring the upholding, monitoring and evaluation of the guiding principles; a clear policy should be defined and regulations streamlined in all the regions to avoid rehiring retired staff; and consideration should be given to the request for a moratorium until January 2007 on the application of the “four years and out” rule so that implementation of a human resources planning proposal could be discussed.

Dr BUSS (Brazil) said that the proposals for a strengthening of dialogue and more constructive relations were reasonable. He supported the request for a clear policy and a streamlining of regulations on the issue of rehiring of retired staff, observing nevertheless that the experience of such staff could be useful to the Organization in some situations. He welcomed the Director-General’s democratic approach in making possible a permanent and constructive dialogue, and suggested that the Board should consider the points raised at its 118th session. It would be important to assess the financial implications of the request for a moratorium on the application of the “four years and out” rule.

Dr BRUNET (alternate to Professor Houssin, France) expressed concern at the tone of the statement presented. Management sometimes had to take decisions that could have difficult consequences for staff, but it was important that staff understood the reasons for such decisions. Relations between management and staff in an organization had to be based on mutual respect. The Board could assist the Director-General by referring the budgetary implications of the requests made to the Programme, Budget and Administration Committee for consideration.

He expressed confidence that the administration was able to solve the problems raised, but urged that they should be considered with the seriousness they deserved. Good human relations were a precondition for a well-functioning and effective organization.

Professor FIŠER (Czech Republic) endorsed the views expressed by the member for Brazil: the current tension between staff representatives and the administration could not be beneficial for WHO. The Director-General should pursue dialogue with the staff associations in order to find a reasonable compromise that would improve the working atmosphere in the Organization.

Dr TANGI (Tonga) said that it was his impression that most staff were proud to be members of the Organization and worked for it unstintingly. While agreeing with the comments made by the member for France, he would be concerned to see the development of confrontational, union-style relations. Problems should be resolved by senior management and staff through dialogue.

Mr OLDHAM (alternate to Mr Shugart, Canada), affirming that human resources were of paramount importance for WHO, said that special emphasis should be placed on dialogue between management and staff during the period of profound change the Organization was undergoing. He supported the suggestion by the member for France that the budgetary issues raised should be referred to the Programme, Budget and Administration Committee.

Mr GUNNARSSON (Iceland) said that his own management experience had shown him the difficulties of balancing staff expectations and management imperatives to cut costs. It was to be expected that the transfer of resources from headquarters to the regions would be difficult for staff, but the decision to make that transfer had to be implemented.

He reminded those present that they had been appointed by their governments to lead the Organization, and that personnel matters had been entrusted to senior managers. Despite the deep sympathy that he and other members of the Board felt for staff, governments did not expect members to become involved in personnel matters.

Mr HENNING (Human Resources Services) said that the Secretariat welcomed and valued the participation of the staff associations in the consultative process concerning personnel policy or conditions of service, as enshrined in the Staff Rules and Staff Regulations. The Global Staff/Management Council's guiding principles had been further refined and reinforced, and agreed upon by all parties. He expected to submit to the Board at its session in May 2006 a proposal on contract reform in line with the recommendation of the International Civil Service Commission to the United Nations General Assembly, and therefore considered it appropriate to suspend any further action during 2006 on service appointments. With respect to the issue of reciprocity with PAHO, the Board would have noted the proposed change to the Staff Rules whereby PAHO's staff transferred to WHO would no longer be required to undergo a probationary period. Concerning retired staff, measures had been put in place to limit the recruitment of retirees, and to identify new or existing talent, particularly from unrepresented and underrepresented countries.

Over the past year, each department in headquarters had gone through a review of strategic direction, functions, high-level structure and human and financial resources, in order to align the work of departments with the parameters of the Programme budget 2006-2007. Several regional offices were expected to go through a similar process. The review process had led to reduction in numbers of staff in some headquarters programmes and in the inappropriate use of short-term contracts for long-term functions. In order to manage those changes, the Secretariat had introduced several measures to support staff through the process. They included the publication of safety net guidelines for all affected staff; the establishment of in-placement and out-placement services, complemented by time off for job search activities for fixed-term and long-serving short-term staff; special measures for retention of internal candidates for short-term assignments; implementation of a mechanism for separation by mutual agreement; institution of special measures for those affected by the maximum 44-month policy for temporary contracts; strengthening of the reassignment process; and

establishment of a task force on staff support. Furthermore, staff representatives were members of the Coordinating Team and Monitoring Working Group of the strategic direction and competency review process, and participated as observers if and when departments went through a review of staff and conducted a matching exercise.

**The Board took note of the statement by the representative of the WHO staff associations.**

**Ms Halton took the Chair.**

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

**Intellectual property rights, innovation and public health:** Item 4.10 of the Agenda (Document EB117/9) (continued from the eighth meeting, section 3)

Dr SHANGULA (Namibia) said that the informal group set up to discuss the draft resolution on a global framework on essential health research and development, which he had chaired, had agreed on the text of some paragraphs and had placed square brackets around others on which there was no agreement or for which further information was required. The text would be distributed to Board members, and the group recommended that it should be submitted to the Fifty-ninth World Health Assembly.

The CHAIRMAN suggested that the item remain open until the text of the draft resolution prepared by the group was available.

**It was so agreed.**

(For adoption of the resolution, see section 9 below.)

**7. OTHER MANAGEMENT MATTERS:** Item 8 of the Agenda

**Reports of committees of the Executive Board:** Item 8.1 of the Agenda

- **Standing Committee on Nongovernmental Organizations** (Documents EB117/24 and EB117/24 Add.1)

Dr ACHARYA (Nepal), speaking in his capacity as Chairman of the Standing Committee on Nongovernmental Organizations, described the outcome of the Committee's consideration of applications from three nongovernmental organizations for admission into official relations with WHO and whether official relations with some others should be maintained. In particular, concerning Corporate Accountability International, it had recommended that the Board should defer a review until that body had presented a written response to the allegations made. He drew attention to the draft resolution and the draft decision contained in paragraphs 29 and 30 of document EB117/24. He expressed appreciation of the work of the applicant organizations and of those whose activities had been reviewed.

The CHAIRMAN invited the Board to consider the draft resolution contained in paragraph 29 of document EB117/24.

**The resolution was adopted.<sup>1</sup>**

Ms GILDERS (alternate to Mr Shugart, Canada) said that Canada recognized the commitment of nongovernmental organizations working with WHO and their contribution to public health. She stressed the need for transparent relations, and for informing nongovernmental organizations in a timely manner of any concerns relating to their relations with WHO.

The CHAIRMAN invited the Board consider the draft decision contained in document EB117/24.

**The decision was adopted.<sup>2</sup>**

- **Foundations and awards**

**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 to Dr Sa'ad H.S. Kharabsheh (Jordan).<sup>3</sup>

**Sasakawa Health Prize**

**Decision:** The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel, awarded the Sasakawa Health Prize for 2006 to the International Leprosy Union (ILU), India and to the Agape Rural Program (Holistic Community Based Health Development Program) of Puerto Princesa City, Palawan, Philippines. Each laureate will receive US\$ 40 000 for its work in health development.<sup>4</sup>

**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 2006 jointly to the Rafic Hariri Foundation (Lebanon) and to Ms Aminath Jameel, Executive Director, Manfaa Centre on Ageing (Maldives). Each laureate will receive US\$ 20 000 for their outstanding contribution to health development.<sup>5</sup>

**State of Kuwait Prize for Research in Health Promotion**

**Decision:** The Executive Board, having considered the report of the State of Kuwait Health Promotion Foundation Selection Panel, awarded the State of Kuwait Prize for Research in

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<sup>1</sup> Resolution EB117.R12.

<sup>2</sup> Decision EB117(3).

<sup>3</sup> Decision EB117(4).

<sup>4</sup> Decision EB117(5).

<sup>5</sup> Decision EB117(6).

Health Promotion for 2006 to the Early Psychosis Intervention Programme (EPIP) (Singapore). The laureate will receive US\$ 20 000.<sup>1</sup>

**Reports of the Joint Inspection Unit:** Item 8.2 of the Agenda (Documents EB117/25 and EB117/26)

Mr MACPHEE (alternate to Mr Shugart, Canada) noted that an oral report had been given at the Programme, Budget and Administrative Committee meeting because document EB117/26 had not been available. The Board had thus had little time to discuss important topics. He welcomed the detailed report, and suggested that it be carried forward, updated, and discussed at a meeting of the Programme, Budget and Administrative Committee in 2007.

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

**Provisional agenda of the Fifty-ninth World Health Assembly and date and place of the 118th session of the Executive Board:** Item 8.3 of the Agenda (Document EB117/27)

Dr KEAN (Governing Bodies and External Relations) said that, during the current session of the Board, several issues had been proposed for transmittal to the Health Assembly. The Secretariat proposed that under item 12 of the Health Assembly's agenda (technical and health matters) the following should be added: sickle-cell anaemia; implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, to be taken with nutrition and HIV/AIDS as a two-part item on HIV/AIDS; intellectual property rights, innovation and public health; and emergency preparedness and response. Under item 12.12 (implementation of resolutions: progress reports) nursing and midwifery and a subitem on patient safety should be added.

Under item 15 (programme budget and financial matters) it was proposed to renumber the subitems as follows: 15.1, status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution; and 15.2, special arrangements for settlement of arrears. Placing those items first would enable voting rights to be clarified as early as possible in the proceedings. The other items would then follow, namely 15.3, Programme budget 2004-2005: performance assessment; 15.4, financial report and 15.5, amendments to the Financial Rules and Financial Regulations (if any).

Ms GILDERS (alternate to Mr Shugart, Canada) requested that under item 12, after "implementation by WHO of the recommendations of the Global Task Team", the words "and of the Global Steering Committee on Universal Access" should be added.

Professor PEREIRA MIGUEL (Portugal) proposed that consideration of the Global Strategy on Diet, Physical Activity and Health should be moved up the provisional agenda in order to give more attention to health promotion at the Health Assembly. The primary prevention of chronic diseases by promoting a healthy diet and physical activity was of great importance for his and other governments. Moreover, resolution WHA57.17 requested the Director-General to work with other agencies on assessing and monitoring the health aspects of the strategy and to report on its implementation at the Fifty-ninth World Health Assembly.

Ms HUNT (Belize)<sup>2</sup> expressed surprise that the Board had failed to consider an item that her Government had requested for inclusion in the provisional agenda, entitled "Invitation to Taiwan to participate in the World Health Assembly as an observer and consideration of adequate measures to

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<sup>1</sup> Decision EB117(7).

<sup>2</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

facilitate its meaningful participation in relevant meetings and disease control mechanisms of the World Health Organization”. That failure was not only unlawful but unacceptable. The Board had deliberately transgressed the clear provision of Rule 5(d) of the Rules of Procedure of the World Health Assembly, which stated that the Board “shall include in the provisional agenda ... any item proposed by a Member”. Moreover, it disregarded the decision of the highest body of the Organization, thereby establishing a bad precedent that would deprive any Member State of its fundamental and constitutional right to propose any matter it deemed appropriate. The adverse position adopted by the Board could be extremely prejudicial to every Member State. It was for the Health Assembly to decide whether to include an item in its agenda. The Board’s position called in question the Organization’s integrity. It could be suggested that, according to Rule 3 of the Rules of Procedure of the Executive Board, her proposal should be seconded by a member of the Board. There was, however, a contradiction between the rules governing the Health Assembly, which had 192 Members, and those governing the Board, which had only 32 members. The Health Assembly rules should prevail.

It might be argued that, had the proposal been submitted earlier, it would have appeared on the provisional agenda. However, she could find no provision concerning a deadline; if there were a deadline, the Secretariat should bring it to delegations’ attention well in advance. She requested the Director-General to explain his position and asked how, given the ever-increasing possibility of a new pandemic outbreak, WHO proposed to deal with a geographical area that had neither Member nor observer status in the world’s supreme health organization.

Mr BURCI (Legal Counsel) said that the Board acted in accordance with Rules 4 and, especially, 5 of the Rules of Procedure of the World Health Assembly, under which a request in writing by a Member State to the Director-General was included in the provisional agenda whereas proposals made during the Board’s consideration of the provisional agenda of the item had to be approved by the Board. The letter from the Permanent Mission of Belize had arrived, however, only on 24 January, after the provisional agenda of the Health Assembly had been issued, and, moreover, the request therein had been addressed not to the Director-General but to the Board itself. Faced with an unusual situation, the Secretariat had informed the Permanent Mission that it would have to raise the issue directly with the Board at the meeting.

The CHAIRMAN said that she took it that the Board wished to adopt the draft decision contained in paragraph 3 of document EB117/27.

**The decision was adopted.<sup>1</sup>**

The CHAIRMAN said that she took it that the Board wished its 118th session to be convened from 29 May to 1 June 2006 at WHO headquarters, Geneva.

**Decision:** The Executive Board decided that its 118th session should be convened on Monday, 29 May 2006, at WHO headquarters, Geneva, and should close no later than Thursday, 1 June 2006.<sup>2</sup>

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<sup>1</sup> Decision EB117(8).

<sup>2</sup> Decision EB117(9).



**8. MATTERS FOR INFORMATION: Item 9 of the Agenda**

**Expert committees and study groups:** Item 9.1 of the Agenda (Documents EB117/28 and EB117/28 Add.1)

Dr ANTEZANA ARANÍBAR (Bolivia) stressed the importance of the work done by the Expert Committee on Biological Standardization. The importance of vaccine production according to WHO-approved standards had been discussed and continuing success in that area was largely the responsibility of the Committee. He drew particular attention to its work on blood grouping reagents, in view of the threat to safe blood transfusion from HIV infection and other diseases.

**The Board noted the report.**

The CHAIRMAN said that she took it that the Board wished to thank the experts who had given up their time to serve on the expert committees and study groups.

**It was so agreed.**

**Implementation of resolutions: progress reports:** Item 9.2 of the Agenda (Document EB117/29)

**A. Infant and young child nutrition**

Dr GASHUT (alternate to Dr Al-Keeb, Libyan Arab Jamahiriya) noted with some disappointment that the paragraphs neither covered all elements of resolution WHA58.32 nor could be considered as the quadrennial report due at the next session of the Health Assembly. Evidence showed that improved breastfeeding led to a 13% reduction in under-five mortality. The international conference on "Tracking Progress in Child Survival: Countdown to 2015" (London, 13-14 December 2005) concluded that breastfeeding exclusively for six months, and continued breastfeeding with appropriate complementary feeding were essential predictors of progress towards attaining Millennium Development Goal 4 (reduce child mortality). She therefore sought assurances that the quadrennial report would be issued in good time for the review and sufficiently reflect all aspects of the Global strategy on infant and young child feeding.

Dr RAHANTANIRINA (alternate to Dr Jean Louis, Madagascar) said that her country's legislation enshrined most of the provisions of the International Code of Marketing of Breast-milk Substitutes. She asked WHO and interested nongovernmental organizations for technical assistance in implementation. The rate of exclusive breastfeeding for six months had reached 70% compared with only 34% in 1997 while the mortality rate of children under five had dropped from 159 per 1000 in 1997 to 94 per 1000 in 2004, clearly showing the link between breastfeeding and lower mortality rates, but Madagascar needed assistance in raising breastfeeding rates still higher.

Dr SOPIDA CHAVANICHKUL (adviser to Dr Suwit Wibulpolprasert, Thailand) said that most of the report related to the activities of WHO, not those of Member States. It did not satisfy proper reporting requirements and she sought an assurance that a full report would be available to the Health Assembly in May 2006.

Dr BUSS (Brazil) said that his Government had in place a wide-ranging policy of exclusive breastfeeding up to six months and he welcomed the fact that an ever-growing number of States had introduced legislation to that effect. Since the last session of the Board, Botswana and Honduras had done so.

Ms LEHNERS-ARENDT (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, said that her Association had officially endorsed the Global strategy for

infant and young child feeding, which was based on the 1990 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding, a visionary document that had urged governments to set up effective mechanisms for the protection, promotion and support of breastfeeding; to make its maternity facilities baby-friendly; to protect mothers and babies from commercial pressures by implementing the International Code of Marketing of Breast-milk Substitutes; and to create a supportive environment for breastfeeding for working women. An international meeting jointly organized by WHO, UNICEF and interested nongovernmental organizations had agreed that much still needed to be done. She was dismayed that the provisions of the Code, and those of subsequent relevant WHO resolutions, were still being violated. In most instances, such violations occurred in countries that had not yet implemented the Code. She therefore called on Member States to implement the Code in full, as a minimum requirement.

Dr BRONNER (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, said that, serving a vital area of health care, manufacturers fed about 70 million children worldwide with foods designed to meet their specific needs, including infant formulas that were important for babies when they did not receive breast milk or when they would otherwise receive dangerous substitutes. Scientific progress aimed at promoting nutrition was to be welcomed. The industry would continue to be guided by national and international recommendations in the field of infant nutrition and would apply food legislation prescribed for infant food products. Once the results of the WHO Multicentre Growth Reference Study and the associated standards were issued, the industry looked forward to working with national authorities and paediatricians on their application. Her organization welcomed ongoing efforts by WHO to ensure safe and appropriate infant feeding practices in emergencies and in special circumstances, such as when mothers were HIV-positive. The infant food industry applauded the significant strides made by many countries in implementing the International Code, thus improving the health of infants and young children worldwide. National measures through legislation or guidelines, together with transparent monitoring procedures, were the best means of giving effect to the Code.

Dr LE GALÈS-CAMUS (Assistant Director-General) acknowledged that the report was short for such a multifaceted subject, but explained that it had been decided simply to note developments since the previous report. Considerable progress had been made. The results of the Multicentre Growth Reference Study would be published in a few months' time.

**B. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (including impact on national economic development)**

Dr RUÍZ MATUS (alternate to Mr Bailón, Mexico) said that, according to UNFPA, deficiencies in reproductive health were the main cause of morbidity and mortality among women worldwide. The indicators were directly linked with poverty; the issue was therefore one of social justice, ethics and equity, particularly for the most vulnerable groups. His Government had therefore, on the basis of scientific evidence, drawn up integrated programmes, standards and guidelines, with a view to establishing best practices. To hamper women's access to reproductive health services or health information constituted violence against women coping with unwanted pregnancies, unsafe abortions or sexually transmitted infections. Violence against women had serious repercussions for sexual and reproductive health. His Government would strengthen the link between reproductive health and violence against women by engaging key actors and agencies.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) said that, in his country, reproductive health services were available free to everyone as part of the national health insurance package, in accordance with the actions agreed at the International Conference on Population and Development (Cairo, 1994). Particular attention went to family planning services for adolescents. Contraceptive use remained very high. Antiretroviral medicines had been universally

available since 2003. The Medical Council of Thailand had revised its definitions of maternal and fetal health indications for legal abortions in order to minimize the number of unsafe abortions. WHO should work closely with Member States in order to accelerate achievement of the goals of the Cairo Conference.

Dr STEIGER (United States of America)<sup>1</sup> said that his country had disassociated itself from resolution WHA57.12. He noted that, in the section heading in document EB117/29, a phrase had been added in brackets reading: “including impact on national economic development”. Why had the title of the strategy been changed after its endorsement by the Health Assembly?

Mrs PHUMAPHI (Assistant Director-General) thanked Member States for their response to the assessment of the strategy on reproductive health. It was essential to focus on such areas as maternal mortality where progress was still not on course to meet the targets set by the Millennium Development Goals. On the problem of violence against women, WHO had issued a report on the Multi-country Study on Women’s Health and Domestic Violence against Women in November 2005. There was still concern about the high incidence of unsafe abortion and the weakness of strategies for the prevention of sexually transmitted infections, particularly HIV infection. It was to be hoped that the draft global strategy on the prevention and control of sexually transmitted infections would be adopted at the Fifty-ninth World Health Assembly. Country plans could then be drawn up, implemented and followed up.

The two clusters concerned with this topic – Family and Community Health and Noncommunicable Diseases and Mental Health – worked closely together. She assured the member for Madagascar that her appeal for technical assistance in promoting breastfeeding would be answered.

Mr AITKEN (Director, Office of the Director-General), replying to the point raised by the representative of the United States of America, said that the phrase in brackets “including impact on national economic development” did not form part of the official title of the Health Assembly resolution or the strategy, both of which remained as the Health Assembly had adopted them.

Dr STEIGER (United States of America)<sup>1</sup> asked whether any future resolutions were likely to be referred to by titles other than those formally adopted by the Health Assembly.

The DIRECTOR-GENERAL and Mr AITKEN (Director, Office of the Director-General) assured the Board that it would not happen again.

### **C. Family and health in the context of the tenth anniversary of the International Year of the Family**

The CHAIRMAN observed that the Board had no comments on this progress report.

### **D. Health action in relation to crises and disasters**

Dr SÁ NOGUEIRA (Guinea-Bissau), speaking on behalf of the Member States of the African Region, said that, following the Asian tsunami of December 2004 and subsequent crises, including the earthquakes in the Islamic Republic of Iran and Pakistan and the famine in Niger, the Health Assembly, in resolution WHA58.1, had requested the Director-General to strengthen WHO’s capacity for health action in crises on the basis of evaluation of health needs, closing gaps, coordinating health activities, and capacity-building for WHO’s partners.

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

The Member States of the African Region greatly appreciated WHO's activities, which had included the recruitment of 12 country consultants for the Central African Republic, Chad, the Democratic Republic of the Congo, Liberia and Uganda; strengthening health systems in Burundi to facilitate voluntary repatriation of refugees; a project on gender-based violence in crisis situations in the Democratic Republic of the Congo and Liberia; a mortality survey in northern Uganda; the establishment of an early warning system for nutrition and epidemics in Chad and Niger; and participation in the Consolidated Appeal Process and Common Humanitarian Action Plans coordinated by the United Nations.

Financial resources must be mobilized for the many African countries without emergency preparedness or relief plans. WHO should increase its technical support for African countries and improve its cooperation with other international agencies, donor countries and the governments of affected countries.

Dr SOPIDA CHAVANICHKUL (adviser to Dr Suwit Wibulpolprasert, Thailand) thanked WHO for its support to the countries affected by the Asian tsunami. Thailand particularly welcomed technical assistance with the identification of bodies, mass casualty management and mental health rehabilitation.

#### **E. Sustainable health-financing, universal coverage and social health insurance**

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) said that in the context of resolution WHA58.33 he welcomed the emphasis on mobilizing additional funds, using them effectively, efficiently and equitably, and ensuring social protection for poor and vulnerable groups. Thailand had taken 28 years to achieve universal coverage, starting with the poor and gradually extending coverage to older people and children under 12, using a system financed from general taxation. The social health insurance scheme, which had originally applied to enterprises with over 20 employees, was applicable to all enterprises. In order to achieve universal coverage, different partners, including ministries of finance, labour and social welfare, had had to reach a national consensus on social protection for the poor. WHO should work closely with international partners, including ILO.

Dr NYIKAL (Kenya), speaking on behalf of the Member States of the African Region, said that financing was the key to health-care delivery. At the African Summit on HIV/AIDS, tuberculosis and other related infectious diseases (Abuja, 2001) African Heads of State had undertaken to allocate 15% of their national budgets to improvement of the health sector. Most countries had many competing priorities. Traditional health-financing mechanisms, such as direct taxation and support from donors, would not adequately fund health services in developing countries. Much more work was needed to implement resolution WHA58.33. Several African States, including Ghana, Kenya and Nigeria, were developing social insurance systems, and, by the end of 2005, Rwanda had achieved 45% coverage. Social health insurance might be the only way of mobilizing internal resources and still protect the poor.

Dr SINGAY (Bhutan) said that, in response to resolution WHA58.33, his country had established the Bhutan Health Trust Fund, which was already enabling the purchase of vaccines and essential medicines and financing primary health care. It might offer a model for other countries. WHO should support countries in improving their health-care financing policies in line with their socioeconomic development plans, facilitating the exchange of experience in health-care financing between countries, and, with national stakeholders, partners and development agencies, advocating increased investment in health and better resource coordination and utilization.

Dr VON VOSS (Germany)<sup>1</sup> commended the follow-up to resolution WHA58.33. Sustainable health-care financing, including social health insurance, would contribute to the achievement of all the health-related Millennium Development Goals. Germany had supported the partnership between WHO, ILO and the *Gesellschaft für Technische Zusammenarbeit* which had flourished since the International Conference on Social Health Insurance in Developing Countries (Berlin, 5-7 December 2005). The partnership aimed to create synergies through joint assistance, pooling of resources and greater choice of the best technical advisers. The initiative was a model of good practice.

#### **F. The role of contractual arrangements in improving health systems' performance**

Dr ANTEZANA ARANÍBAR (Bolivia), emphasizing the importance of following Health Assembly resolutions, observed a recent trend towards the privatization and outsourcing of health services. WHO could provide valuable support in the form of policies, guidelines and mechanisms. The report described country workshops and other activities, in the Eastern Mediterranean and African regions for example, and plans for 2006-2007, including assessment of innovations in terms of methodology, efficiency and effectiveness. Those activities should be widely publicized.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) said that his country's health insurance system relied exclusively on contractual services in which purchasers, such as the social security or national health security offices, purchased services which were financed by capitation payments or global budgets. Thailand had considerable experience of contracting in health services, in which the roles of purchaser and provider of health care were separated, in order to allow the consumer a choice. Contractual arrangements could increase efficiency and save on costs, but high-quality care should be maintained. He welcomed the workplan for 2006-2007.

#### **G. United Nations reform process and WHO's role in harmonization of operational development activities at country level: interim progress report**

Mr DELVALLÉE (alternate to Professor Houssin, France) welcomed WHO's contributions to the current process of United Nations reform. The Programme, Budget and Administration Committee at its meeting the previous week had discussed two important issues. First, it had noted that the Millennium Development Goals were apparently being given their rightful place in the Programme budget for the biennium 2006-2007 and in the forthcoming Eleventh General Programme of Work. Secondly, the efforts to harmonize WHO's operational activities, in accordance with the Rome Declaration on Harmonization (2003) and the Paris Declaration on aid effectiveness (2005), had already achieved some results, such as the introduction of results-based budgeting and decentralization.

However, little had been done to implement resolution WHA58.25. A first step was the Board's adoption of resolution EB117.R8 on the implementation by WHO of the recommendations of the Global Task Force on Improving AIDS Coordination among Multilateral Institutions and International Donors, the day before. WHO should pursue its efforts within the United Nations system on two levels. First, it should work with UNDP to ensure that the Organization's standards were incorporated into national development strategies and used by other United Nations agencies. The campaign to eradicate poliomyelitis and the Expanded Programme on Immunization were promising examples. Secondly, it should work at country level, particularly in the UNDP country development teams, as had been done for country activities to combat HIV/AIDS. WHO should continue to discuss financing of operational activities, for instance at the next substantive session of the United Nations Economic

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

and Social Council, in order to make the specialized agencies and United Nations funds and programmes more effective by ensuring more predictable long-term financing.

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

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

**Intellectual property rights, innovation and public health:** Item 4.10 of the Agenda (Document EB117/9) (resumed from section 6)

The CHAIRMAN drew attention to the revised draft resolution on a global framework on essential health research and development, which read:

### **[Global framework on] essential health research and development**

The Executive Board,

Having considered current developments regarding access to medicines and the need to develop urgently new medicines and other health care technologies;

Noting the useful work being done by the WHO Commission on Intellectual Property Rights, Innovation and Public Health,

Submits ~~RECOMMENDS~~ to the Fifty-ninth World Health Assembly for its consideration ~~the adoption of~~ the following draft resolution:

The Fifty-ninth World Health Assembly,  
Recalling resolutions WHA52.19, WHA53.14, WHA54.10, WHA56.27, and WHA57.14;

Considering the need to develop ~~paucity of~~ safe, ~~adapted~~ and affordable new medicines ~~developed~~ for such communicable diseases as AIDS, malaria and tuberculosis, and ~~the lack of medicines, vaccines and diagnostics for tropical other~~ other illnesses that primarily affect the world's poorest people;

Recognizing the importance of providing support for the development of treatments for diseases that have small client populations;

Recognizing the importance of making global health and medicines a strategic sector;

Concerned about the need for appropriate, effective and safe health tools for patients living in resource-poor settings;

[Mindful that more than 70% of new drug approvals are for medicines that do not provide incremental benefits over existing ones;<sup>1</sup>]

Considering the urgency of developing new medicines to address emerging health threats such as multidrug-resistant tuberculosis, and other ~~poverty-related~~ and infectious diseases of relevance to developing countries;

Aware ~~that~~ of the need for additional funding for research and development for new vaccines, ~~and other illnesses that disproportionately affect developing countries is~~ insufficient;

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<sup>1</sup> National Institute for Health Care Management Research and Educational Foundation, *Changing Patterns of Pharmaceutical Innovation*, May 2002.

[Recognizing the importance of global public undertakings such as the Human Genome Project, and the increasing relevance of open and accessible public research in advancing science and the transfer of technology;]

[Further aware of the promise of new, open models for the development of medical science, enhanced participation in, and access to, scientific advances, and increased knowledge;]

[Recognizing the importance of public/private partnerships devoted to the development of new essential drugs and research tools, but concerned about the need for governments to set a needs-based priority agenda for health, and to provide political support and sustainable sources of funding for such initiatives;]

Recognizing the importance of public and private investment in the development of new medical technologies;

Considering that a number of developing countries have been strengthening their research and development capacity in new health technologies, and that their role will be increasingly critical, and recognizing the need for continued support for research in and by developing countries;

Recognizing that intellectual property rights are one of several important tools to promote innovation, creativity, and the transfer of technology;

[Recognizing at the same time the importance of providing for a proper balance between intellectual property rights and the public domain, and the need to implement intellectual property rules in a manner that is consistent with the ~~basic human~~ right to the highest attainable standard of health and the promotion of follow-on innovation;]

Taking into account Article 7 of the TRIPS agreement that ~~points out~~ states that “the protection and enforcement of intellectual property rights should contribute to the promotion of technological innovation and to the transfer and dissemination of technology, to the mutual advantage of producers and users of technological knowledge and in a manner conducive to social and economic welfare, and to a balance of rights and obligations”;

Stressing that the Universal Declaration of Human Rights provides that “everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits” and that “everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author”; ~~recognizes the right to protection of interests resulting from any scientific production balanced by the right to share in scientific advancements and its benefits;~~

[Considering that it is imperative to reconcile the public interest in accessing the products derived from new knowledge, with the public interest in stimulating invention;]

[Concerned about the impact of high prices of medicines on access to treatment, and the need to implement intellectual property laws in a manner that reconciles incentives for development of new medicines with the need to promote access to all, consistent with paragraphs 4, 5 and 7 of the Doha Declaration on TRIPS and Public Health;]

Aware of the need for [a new global framework (mechanism) to provide] adequate and sustainable levels of financial support for ~~patient-driven~~ public health search, including in particular for priority medical research; [including the possibility of exploring a new global framework]

~~Bearing in mind a call from 162 scientists, public health experts, law professors, economists, government officials, members of parliament, nongovernmental organizations and others for an evaluation of proposals for a new global framework on medical research and development;~~

[Considering the global appeal on research and development on neglected diseases launched on 8 June 2005 with the support of 18 Nobel Laureates, over 2500 scientists and health experts, academics, nongovernmental organizations, public research institutes,

governments officials and members of parliament, calling for [noting the need for] new policy [rules] [approaches] to stimulate essential research and development in health, especially for the most neglected ~~patients~~ diseases;

Aware of the need to promote new thinking in the mechanisms that support innovation;

Recognizing the importance of strengthening capacity of local public institutions and businesses in developing countries to contribute to, and participate in, research and development efforts,

1. URGES Member States:

(1) to make global health and medicines a strategic sector, to take determined action ~~to direct priorities in~~ to emphasize priorities in research and development ~~according~~ addressed to the needs of patients, especially those in resource-poor settings, and to harness collaborative research and development initiatives involving disease-endemic countries;

(2) [taking into account [the results of the Commission on Intellectual Property Rights, Innovation and Public Health and] existing frameworks, to take an active part, ~~within~~ in cooperation with WHO and ~~with~~ other international actors, [in the establishment of a framework for defining global health priorities], ~~providing in supporting for~~ essential medical research and development ~~predicated~~ [based on the principle of equitable sharing ~~determining~~ of the costs of research and development, and determining incentives to invest in useful research and development in the areas of patients' need and public interest;]

(3) to ensure that progress in basic science and biomedicine is translated into improved, safe and affordable health products – drugs, vaccines and diagnostics – to respond to all patients' and clients' needs, especially those living in poverty, taking into account the critical role of gender and to ensure that capacity is strengthened to support rapid delivery of essential medicines ~~are rapidly delivered~~ to people;

(4) to encourage that bilateral trade agreements take into account the flexibilities contained in the WTO TRIPS Agreement and recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health;]

[(5) to ensure that the report of the WHO Commission on Intellectual Property Rights, Innovation and Public Health is included on the agendas of WHO's regional committees in 2006.]

2. REQUESTS the Director-General:

(1) to establish ~~a~~ an open-ended working group of interested Member States to consider proposals to [establish a global framework for supporting] [strengthen incentives and mechanisms for] needs-driven research, consistent with appropriate public interest issues and taking note of the work [building on the analysis] of the WHO Commission on Intellectual Property Rights, Innovation and Public Health];

(2) to ensure that bilateral, regional and global free-trade agreements and other trade agreements do not jeopardize the flexibilities of the TRIPS agreement and are in accordance with the Doha Declaration on TRIPS and Public Health;

[(3) to submit an annual progress report of the working group of interested Member States [to] beginning with the [Sixtieth] World Health Assembly [(May 2008), if possible] and a final report [with concrete proposals] ~~to~~ through the Executive Board at its 121st session (January 2009) to the Sixty-first World Health Assembly (May 2008); [and to suggest alternative simplified systems for



protection of intellectual property, with a view to enhancing accessibility to health innovations and building capacity for product development, uptake and delivery of new medicines in developed and developing countries;<sup>1</sup>

(4) to ensure that the report of the WHO Commission on Intellectual Property Rights, Innovation and Public Health is included on the agendas of WHO's regional committees in 2006.

Dr SHANGULA (Namibia), speaking as chairman of the drafting group, said that the revised draft resolution was recommended for submission to the Fifty-ninth World Health Assembly. The text in square brackets was open to discussion and that marked as deleted would be deleted from the version submitted to the Health Assembly, as agreed. He drew attention to the fact that the preambular paragraph commencing "Noting that UNDP's *Human Development Report 2005* states that ..." in the earlier draft had also been deleted.

Dr BRUNET (alternate to Professor Houssin, France) recalled that the working group had agreed to insert a footnote in paragraph 1 to extend "Member States" to cover "where possible, regional economic integration organizations".

Mr HOHMAN (United States of America)<sup>1</sup> said that he had no recollection of such a discussion and could not agree to that amendment.

Dr SHANGULA (Namibia) confirmed that he too had no recollection of discussion of a footnote.

Ms KONGSVIK (Norway),<sup>1</sup> referring to the preambular paragraph beginning "Recognizing at the same time the importance of providing for a proper balance ...", recalled that the group had agreed to use the language of the Constitution so that the phrase "basic human right to health" should be replaced by "fundamental human right to health", a view supported by Dr SHANGULA (Namibia).

Mr BURCI (Legal Counsel) noted that the expression "the fundamental right of every human being to the enjoyment of the highest attainable standard of health" would be closer to the language in the preamble of the Constitution.

The CHAIRMAN, in response to a question from Mr HOHMAN (United States of America),<sup>1</sup> confirmed that the entire preambular paragraph under consideration remained in square brackets.

Dr CICOONA (Italy),<sup>1</sup> speaking for the record, confirmed that his notes of the discussions in the drafting group indicated that the insertion of the phrase quoted by the member for France had distinctly been mentioned, even if not necessarily as a footnote.

The CHAIRMAN commented that often in drafting not all comments were necessarily taken up. She understood that the matter would be more fully debated at the Health Assembly.

Dr SHANGULA (Namibia), speaking as the chairman of the drafting group and responding to a question from Ms PRANGTIP KANCHANAHATTAKIJ (adviser to Dr Suwit Wibulpolprasert, Thailand), confirmed that in the third line of paragraph 2(3) the words "if possible and a final report" should be changed to "and, if possible, a final report".

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

The CHAIRMAN invited the Board to consider the revised draft resolution, as amended.

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

Mr AITKEN (Director, Office of the Director-General), responding to a question from Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand), confirmed the procedural aspects relating to consideration of intellectual property and public health at the Fifty-ninth World Health Assembly. It had been agreed that a 12-member committee would be set up, composed of two members of the Executive Board from each Region represented, to be chosen by the members for that Region. The committee would hold a meeting in Geneva – to which all Member States would be invited – to review the report on intellectual property rights, innovation and public health that would be produced in April 2006. That report would be transmitted to the Fifty-ninth World Health Assembly for its views or comments. That committee would not be considering the resolution just adopted by the Board which would go directly to the Health Assembly. The Secretariat itself intended to submit, alongside the report on intellectual property rights, innovation and public health reviewed by the committee, a draft resolution to the Fifty-ninth World Health Assembly, which would take into account the comments made by the 12-member committee.

**Mr Khan resumed the Chair.**

#### **10. MATTERS FOR INFORMATION:** Item 9 of the Agenda (resumed)

##### **Human resources for health development:** Item 9.3 of the Agenda (Document EB117/36)

Ms MAFUBELU (South Africa)<sup>2</sup> commended the report, welcoming the significant progress made in implementing resolution WHA57.19. She asked what progress had been made regarding paragraph 2(6) of that resolution concerning examination of modalities for receiving countries to offset the loss of health workers.

Mr RAMATSOARI (alternate to Dr Phooko, Lesotho), speaking on behalf of the Member States of the African Region, said that the issue of human resources was of great importance to health service delivery, in Africa and beyond, and affected almost all the agenda items addressed by the Board. In September 2005 the United Nations General Assembly had noted that one of the reasons why developing countries, particularly in Africa, would be unlikely to achieve the Millennium Development Goals was their limited human resources. Health indicators such as maternal health and child mortality were considerably worse than in other regions. Those countries would also have difficulty implementing the Eleventh General Programme of Work and governing body resolutions unless the issue of human resources was examined. He expressed support for human resources development advocacy beyond World Health Day 2006. Full implementation of resolutions WHA57.19 and WHA58.17, on international migration of health personnel, was required if developing countries were to meet the challenges. He looked forward to *The world health report 2006* and said that, while the right of health workers to free movement must be respected, both “push” and “pull” factors must be managed in order to limit the impact on health service delivery in Africa. He drew attention to four points. First, development of collaborative partnership and intervention among Member States was urgently needed. Secondly, more health workers needed training, with support from receiving countries. Thirdly, as migration and recruitment raised moral issues, receiving

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<sup>1</sup> Resolution EB117.R13.

<sup>2</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

countries should compensate source countries. Fourthly, WHO should attract staff from those countries that were underrepresented or nonrepresented and who would otherwise migrate elsewhere.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand), commenting on global inequity, said that paragraph 9 in the report highlighted the difficulty of obtaining data and their unreliability. That was because of limited information on the education, retention, posting and morale of health professionals, even in middle-income countries like Thailand. The draft Eleventh General Programme of Work had observed that over the next decade or so there would be a chronic drain of trained health professionals from developing to developed countries. Paragraph 10 indicated that the measures taken so far were having no significant effect, and even though a draft protocol had been prepared that emphasized the roles and responsibilities of receiving and source countries, it seemed unlikely to make a significant impact on the movement of health workers. One country had produced an ethical code, but it applied only to government appointments and not private-sector recruitment of doctors and nurses from Africa. A global effort was required to tackle what amounted to a pandemic of international migration of the resources forming the backbone of countries' health systems. Given the scale of the problem and since the global response required was beyond the capacity of WHO alone, the solution might be to hold a special session of the United Nations General Assembly on human resources.

Dr EVANS (Assistant Director-General), responding to the comments made by the representative of South Africa, recalled that resolution WHA57.19 specifically requested the Director-General to examine international agreements. However, there was no evidence of any issues relating to health worker migration having been raised under mode 4 of WTO's General Agreement on Trade and Services. There were between 12 and 16 instruments, either codes of practice or ethical international recruitment guidelines, recommended by some groups and by international and professional organizations. Bilateral agreements involving explicit discussions between countries on the nature of exchange or the two-way movement of health workers were becoming more popular. Ethical recruitment, codes of practice and bilateral agreements were three international instruments that were receiving attention and would be discussed at a forthcoming policy consultation.

With respect to the comments of the member for Lesotho, the responsibilities of source and receiving countries would also receive significant attention in connection with *The world health report 2006* and more specifically at the consultation addressing migration. Given the complexity of the issue, a broad approach sensitive to many dimensions of health worker migration was needed to minimize ill effects.

Turning to the comments of the member for Thailand, he pointed out that the observatory in Africa was at an early stage of development; its purpose would be to collect more accurate information on the size of current and future migratory flows. With population ageing in the developed countries and demographic changes in the developing countries, migration seemed likely to become more intractable. WHO could not handle the problem on its own, and it needed to make the case for health exceptionality because when health workers left already under-resourced areas the consequences were not just economic. However, since migration was a global phenomenon transcending individual sectors, WHO and its partners, including ILO and IOM, were seeking satisfactory ways of managing the drawbacks of the phenomenon.

**The Board noted the report.**

The CHAIRMAN conveyed the gratitude of the President of Pakistan to WHO for all the support, the goodwill and the words of comfort extended to the Pakistan people in the tragic circumstances of the recent earthquake.

**11. CLOSURE OF THE SESSION:** Item 10 of the Agenda

The DIRECTOR-GENERAL confirmed that WHO's draft protocol for rapid response to pandemic-influenza had been uploaded on to the WHO web site for consultation. He would urgently follow up on the early implementation of relevant provisions of the International Health Regulations (2005) and other preparedness measures. The theme of *The world health report 2007* would be health and security, covering the links with development, how countries could best prepare against the destabilizing effect of unpredictable events and strengthen their health systems in the long term, and the impact of conditions such as HIV/AIDS on social systems. The draft global strategy on prevention and control of sexually transmitted infections would be circulated to Member States for comment within four weeks. He also announced that that morning the Global Plan to Stop TB 2006-2015 had been launched at the World Economic Forum in Davos, Switzerland. It aimed to save some 14 million lives by 2015. Already nearly US\$ 1000 million had been committed.

It had been agreed to hold several consultations and meetings on matters in hand. The Programme, Budget and Administration Committee would meet to review the emendation of the draft Eleventh General Programme of Work, 2006-2015. From mid-February to mid-March, the Secretariat would host an electronic consultation on WHO's role in health research. A date would be chosen in April for the convening of the open-ended working group on smallpox and, later in the month, for the working group on the report of the Commission on Intellectual Property Rights, Innovation and Public Health.

Speaking informally and referring to the statement by the representative of the WHO staff associations, he said that the foremost matter for him was his accountability to the Board and Member States. There were rules for the welfare of staff; he owed them a duty of care, but his overall responsibility was to the Member States. Fundamental staffing dilemmas, such as those that arose when goals had been achieved, had to be faced. About two thirds of WHO's staff were employed in country or regional offices, many working to relieve health crises in emergency situations, and they had not raised that issue. A large proportion of WHO's resources was being channeled to regional and country levels; less funds at headquarters had repercussions on staffing. He and his senior managers were, however, committed to the welfare of the staff; much thought had gone into staff planning, and all parties had engaged in many meetings. He recalled the appreciation expressed for the Organization's rapid responses to recent crises; its credibility and reputation was also reflected in increased funding.

After the customary exchange of courtesies, the CHAIRMAN declared the 117th session closed.

**The meeting rose at 19:05.**

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