

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 CHAVANICKUL (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)¹ 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.

¹ 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.¹ 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.

¹ 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 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.