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)[1] 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.

[1] 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)[1] 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.

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

Ms EZHLOVA (Russian Federation)[1] 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

[1] 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. Maintainance 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.[1] 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.

[1] 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,[1] 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

[1] *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.