

## **SUMMARY RECORDS**

### **FIRST MEETING**

**Monday, 22 January 2007, at 09:35**

**Chairman:** Dr F. ANTEZANA ARANÍBAR (Bolivia)

**1. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA:** Item 1 of the Provisional agenda (Documents EB120/1 and EB120/1(annotated))

The CHAIRMAN declared open the 120th session of the Executive Board and welcomed two new members: Dr Salehi of Afghanistan and Dr Smith of Denmark. He invited the Board to consider the provisional agenda.

Dr NYIKAL (Kenya), speaking on behalf of the Member States of the African Region and supported by Dr RAHANTANIRINA (Madagascar) and Dr SUWIT WIBULPOLPRASERT (Thailand), proposed that the item entitled “Public health, innovation, and intellectual property: towards a global strategy and plan of action”, which currently appeared under item 9 “Matters for information”, should be moved to item 4 “Technical and health matters”.

Dr BUSS (Brazil), supported by Dr SUWIT WIBULPOLPRASERT (Thailand), suggested that the item entitled “Commission on Social Determinants of Health” should likewise be moved from item 9 to item 4.

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

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the European Community, recalled that since 2000 the Commission had attended sessions of the Executive Board as an observer, an arrangement which did not prejudice the possible conclusion of a general agreement on cooperation between WHO and the European Commission in the future. However, under Rule 4 of the Board’s Rules of Procedure, observers were not automatically allowed to attend meetings of committees or other subdivisions of the Board, including drafting or working groups. He therefore asked the Board to allow the Commission to attend and participate in such meetings, without a vote, in matters falling within the competence of the European Commission. He was referring particularly to the item on public health, innovation and intellectual property, but also other items.

Dr AGWUNOBI (United States of America) asked which items the European Commission wished to speak on.

Ms HALTON (Australia), supported by Dr SUWIT WIBULPOLPRASERT (Thailand), said that in the past it had been understood that, when the representative of the European Commission

---

<sup>1</sup> See page 61.

spoke on an issue on behalf of the European Community, individual Member States of the European Union would refrain from speaking on the same matter.

Professor PEREIRA MIGUEL (Portugal) said that he would speak on behalf of either the Community or the European Union, since the country currently holding the presidency, Germany, was not currently represented on the Board. He agreed that in such circumstances Member States of the European Union or the Commission would not usually make statements of their own.

The CHAIRMAN said that he took it that the Board wished to allow the European Commission to participate as an observer in meetings of subcommittees and other subdivisions of the Board subject to the conditions agreed upon by the Board.

**It was so agreed.**

## **2. ORGANIZATION OF WORK**

The CHAIRMAN said that meetings should not run late. It should not be necessary to invoke Rule 28 of the Rules of Procedure, which limited the time for which members were allowed to speak. The preliminary daily timetable (document EB120/DIV/2) provided for discussion of item 5, the draft Medium-term strategic plan, including Proposed programme budget 2008–2009, on Thursday 25 January and Friday 26 January. He took it that the Board wished to follow that timetable, and to review the situation on Thursday morning if necessary.

**It was so agreed.**

## **3. REPORT BY THE DIRECTOR-GENERAL: Item 2 of the Agenda (Documents EB120/2 and EB120/40)**

Dr NORDSTRÖM (Assistant Director-General), speaking in his capacity as former Acting Director-General, recalled the challenge posed by the untimely death of Dr Lee and thanked Member States and staff for their excellent response. Key decisions had been reached at the Fifty-ninth World Health Assembly, including those on: early voluntary compliance with the International Health Regulations (2005); HIV/AIDS, particularly the new five-year strategy towards universal access; endorsement of the Global Strategy for the Prevention and Control of Sexually Transmitted Infections; approval of the Eleventh General Programme of Work 2006–2015; and the launch of the Global Health Workforce Alliance.

Collaboration with United Nations partners had included work with UNFPA in the area of sexual and reproductive health; continued cosponsorship of UNAIDS; discussions with the United Nations High Commissioner for Human Rights; and the close relationship with UNICEF with a focus on poliomyelitis, immunization and child survival. WHO had participated in United Nations reform, particularly through the High-level Panel on System-wide Coherence, which had emphasized the role of the specialized agencies. Two major areas of increased cooperation with the World Bank were malaria and the strengthening of health systems. For the first time, WHO had been formally invited to participate in the G8 Summit, which had resulted in some 60 recommendations for global health. More recently, WHO, UNAIDS, the Global Alliance for Vaccines and Immunization and the Global Fund to Fight AIDS, Tuberculosis and Malaria had sent a joint letter to the Chancellor of Germany on the importance of keeping health high on the G8 agenda, and the German Government had responded positively.

Policy guidelines were being drawn up on WHO's engagement in partnerships. A Memorandum of Understanding had been concluded with the Roll Back Malaria Partnership that covered arrangements for WHO's hosting of the secretariat and clarification of the role of WHO's Global Malaria Programme. With the Global Alliance for Vaccines and Immunization, WHO had launched the International Finance Facility for Immunisation. It had also been a partner in the launch of the International Drug Purchase Facility (UNITAID) and had signed a Memorandum of Understanding on the hosting of its secretariat. Technical cooperation with the Global Fund had been stepped up.

WHO had participated in high-level discussions with pharmaceutical companies, in order to review improved access to paediatric antiretroviral treatment. A US\$ 25 million agreement had been signed with a major pharmaceutical company in order to fight neglected tropical diseases. Discussions had continued with the food and non-alcoholic beverage industries as part of the Global Strategy on Diet, Physical Activity and Health. Consultations with representatives of the alcoholic beverage industry and the agricultural and trade sectors had examined ways of reducing the harmful effects of alcohol.

All the regional committees had focused on chronic noncommunicable diseases and the growing epidemic of obesity. Following the adoption of resolution WHA58.22 on cancer prevention and control in 2005, the Secretariat in 2006 had consolidated its cancer-control activities and had issued the first of six modules offering guidance to governments and health planners. Progress had been made with implementation of the Global Strategy on Diet, Physical Activity and Health and the adoption of a European Charter on Counteracting Obesity. By the end of 2006 there had been 142 States Parties to the WHO Framework Convention on Tobacco Control, and US\$ 125 million had been donated by a private individual for tobacco control activities. Considerable progress had been made in implementing resolution WHA59.25 on prevention of avoidable blindness and visual impairment, particularly in the Eastern Mediterranean Region.

In the area of communicable diseases, a new strategy had been put in place to fight some of the most neglected tropical diseases. The International AIDS Conference (Toronto, Canada, 13–18 August 2006) had highlighted WHO's key role in treatment and prevention and in providing care and support to those living with HIV/AIDS. A new malaria strategy focused on the use of bednets, effective treatment and greater emphasis on vector control. A task force of 100 experts had been assembled to react to the recent discovery of extensively drug-resistant tuberculosis. An independent review of the Global Polio Eradication Initiative had concluded that the number of poliomyelitis-affected areas was at its lowest in history, with just four areas in four countries continuing to be endemic.

In the implementation of the International Health Regulations (2005), more than half all Member States had nominated national focal points. In response to outbreaks of avian influenza, WHO had launched more than 30 field missions with its partners in the Global Outbreak Alert and Response Network. A capacity-building programme to develop a new influenza vaccine had been launched, and the Influenza Pandemic Task Force had met for the first time in September 2006 in order to advise on the level of pandemic threat.

In the areas of sexual and reproductive health and child health, senior WHO staff had participated in the Special Session of the Conference of African Union Ministers of Health (Maputo, 18–22 September 2006). A comprehensive plan of action had been adopted. At the fifty-sixth session of the Regional Committee for Africa (Addis Ababa, 28 August–1 September 2006) a joint WHO/UNICEF/World Bank Strategy for Child Survival in the African Region had been adopted.

The Commission on Social Determinants of Health had continued its work. A report,<sup>1</sup> as well as guidelines on air and drinking-water quality, had been published. A set of International Child Growth Standards had been issued. A strategy to integrate gender analysis and actions into WHO's work had been drafted.

---

<sup>1</sup> Prüss-Üstün A, Corvalán C. *Preventing disease through healthy environments: towards an estimate of the environmental burden of disease*. Geneva, World Health Organization, 2006.

The Organization had responded to health emergencies, for example in Lebanon. However, the situation in the Democratic Republic of the Congo, Iraq and Darfur (Sudan) continued to give cause for concern. WHO had also reviewed and improved its emergency standard operating procedures for dealing with national disasters.

Strengthened health systems would be discussed later. The Global Health Workforce Alliance was an important element in the field of human resources. WHO was examining, with the Global Alliance for Vaccines and Immunization, ways of linking immunization to the strengthening of health systems. Through its prequalification activities, the Organization had expanded its response to partners such as UNICEF, the Global Fund and UNITAID. The first session of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property (Geneva, 4–8 December 2006) had made good progress.

The results-based management system had underpinned the General Programme of Work. The six-year draft Medium-term strategic plan 2008–2013, which clearly set out objectives, expected results and related costs, was being submitted to the Executive Board.

WHO had been fully funded in the biennium 2004–2005, but imbalances remained between areas of work and the Organization's different offices. Responses had included closer monitoring and producing standardized financial reports; negotiating with partners in order to improve alignment; setting up an advisory group on financial resources; and creating Organization-wide corporate accounts for smoother transfer of resources.

In the area of human resources, contract reform was under consideration. All managers were involved in the Global Leadership Programme. The scheduled introduction in 2008 of the global management system would provide a modern environment with appropriate support. In 2006, a Department of Communications had been set up at headquarters.

Faced with the unusual circumstances of May 2006, he had set three priority targets for the Organization: to maintain WHO's high-level technical work; to manage the election process efficiently and transparently; and to continue management reforms. Thanks to the cooperation of WHO's staff and Member States, those targets had been met.

The DIRECTOR-GENERAL thanked Dr Nordström for his admirable management of the Organization. She recalled that, upon taking up her post, she had promised staff that she would continue reforms at WHO, but would not introduce changes that would cause upheaval or disrupt the continuity needed by staff and the programmes. She was discussing with Regional Directors improvements to the Organization at all levels, including country offices. Much had already been achieved. At headquarters, the organizational structure still needed some fine-tuning, and she would seek to amplify the impact of WHO activities and to bring related programmes closer together.

The present outlook for health was optimistic. The ambitious target for the reduction of measles mortality – 50% by the end of 2005 – had been surpassed. Measles mortality had dropped by 60%. In Africa, the region with the heaviest measles burden, the death rate had been reduced by an impressive 75%. Moreover, the Measles Initiative was delivering a range of other life-saving and health-promoting interventions, including bednets in order to prevent malaria, vitamin A in order to boost immunity, deworming tablets, poliomyelitis vaccination and tetanus vaccination of pregnant women. The Initiative was a model of what could be achieved through integrated service delivery.

She had identified six issues that would guide the future work of the Organization. Two addressed fundamental health needs: health development and health security. Two were strategic: strengthening of health systems and use of better evidence in order to shape strategies and measure results. The last two were operational: reliance on implementing partners and improved organizational performance across all programmes and at all levels.

The relevance and effectiveness of WHO's work should be measured by its impact on people, in particular on women and on the people of Africa. In considering the health of women, it was important to take into account their role as agents of change. Increasing women's household income led to improvements in their own health and that of their families and communities. It was important not to forget the links between poverty and health in Africa. Poor health anchored large populations in

poverty, while better health allowed them to work their way out of poverty and spend resources on something other than illness.

Malaria caused immense suffering in large parts of the world, but did the greatest harm in Africa. The disease caused high mortality and created a huge burden of debilitating illness that impeded human progress. Interventions were increasing. Public-private partnerships showed promise in bringing together resources from different sectors for the people of Africa.

Neglected tropical diseases also took their heaviest toll in Africa, and disproportionately affected the health of women: WHO estimated that at least 300 million women had been severely and permanently disabled as a result of such diseases. Fortunately, there were excellent initiatives, partnerships and interventions for addressing them.

Communicable diseases, especially AIDS, tuberculosis and malaria, were significant impediments to development in Africa. Chronic diseases were also on the rise there and elsewhere. In low- and middle-income countries, such diseases were a further serious impediment to development. Health systems could not manage both the intermittent emergencies caused by infectious diseases and the demands and costs for chronic care. The consequences of chronic diseases could be catastrophic. Nevertheless, as a WHO report<sup>1</sup> had made clear, excellent opportunities for prevention – by far the best option – were available, as were a broad range of cost-effective interventions. WHO must continue to convince health leaders in all regions that addressing chronic diseases was part of the development agenda.

Health and security would be the theme for World Health Day in 2007 and the topic for the world health report in both 2007 and 2008. The 2007 report would focus on dangers to health arising from how populations interacted internationally. Severe acute respiratory syndrome had shown how much the highly mobile, interconnected and interdependent world of today had become more vulnerable to health threats. Shocks to health – whether from emerging infectious diseases, natural disasters or environmental change – could easily become major shocks to economies, societies and business continuity around the globe. As 2008 would mark WHO's sixtieth anniversary and the thirtieth anniversary of the Declaration of Alma-Ata, the world health report for 2008 would focus on primary health care and its role in strengthening health systems. It would also address health security: community access to the prerequisites for health, including enough food, safe water, adequate housing and sanitation, and essential health care. Every country as a matter of good governance should meet those crucial public health prerequisites.

She was setting measurable performance objectives for herself. She must lead by example, and must be held accountable by Member States, and measurement of performance was the foundation of accountability. She expected similar accountability of staff at all levels.

Turning to the Board's agenda, she noted that one item, the draft Medium-term strategic plan 2008–2013, which included the Proposed programme budget 2008–2009, covered the work of WHO in its totality. Under Technical and health matters, the first item was poliomyelitis. Its eradication was one of the Organization's most important areas of unfinished business. The Advisory Committee on Polio Eradication had concluded that it was technically feasible to interrupt poliovirus transmission worldwide, but operational and financial obstacles remained. A high-level consultation would be convened in late February 2007. The expected outcome would be a set of targets that had to be met in order to interrupt transmission in the four remaining countries where the virus was endemic. The consultation would also consider the funding required. Its conclusions would be communicated to the Health Assembly in May.

While single-disease initiatives had their place, synergies that would yield multiple results should be pursued. Recent years had witnessed unparalleled growth in the number of partnerships, initiatives and funding agencies devoted to public health. Funding from private foundations and other sources was unprecedented, and never before had health been so high on development and political

---

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

agendas. WHO had a great responsibility to channel all health activities and funds in ways that would bring measurable benefits to countries and their populations.

Avoiding duplication of effort was as important as guarding against fragmentation. An integrated primary health care approach could interrelate programmes and thus amplify their impact. The need for integrated approaches was borne out by three repeated themes in reports and resolutions: health systems, evidence for measuring impact and access to essential care. Strengthening health systems and services was crucial in combating numerous diseases and delivering outcomes. Measuring those outcomes required evidence and monitoring. The report on tuberculosis control (document EB120/8) provided a model for monitoring operational performance and its impact. When the global tuberculosis targets had been set in 1991, no system had existed for measuring the global burden of the disease, but currently, thanks to monitoring, it could be said with confidence that tremendous progress had been made. In order to measure performance and results, reliable information was needed. Even the most basic data on morbidity and mortality depended on well-functioning health systems.

The third recurring issue was equitable access to essential care, including medicines, other commodities and the information needed in order to avoid or minimize health risks. Gender was one factor that affected access to care, and she therefore welcomed the draft strategy on gender, women and health (document EB120/6). The report on rational use of medicines, including better medicines for children (document EB120/37), noted that children suffering from HIV/AIDS, tuberculosis and malaria often lacked access to fixed-dose medicines because the pharmaceutical industry had no strong market incentive to produce them. Lack of essential paediatric medicines, including antibiotics, hindered progress towards some Millennium Development Goals. Issues of access and equity reinforced her commitment to primary health care.

With regard to performance, United Nations reform was on the agenda, and WHO would be an active participant. As the United Nations agency with the strongest country presence, the Organization was well placed to contribute to the reform agenda.

With regard to avian influenza and the related pandemic threat, the fact that the world had lived under the threat of an influenza pandemic for more than three years demonstrated the tenacity of the H5N1 virus. As long as that virus continued to circulate in birds, the threat of a pandemic would persist. Although avian influenza was still essentially a disease of birds, experience had shown that when it occurred in humans it was extremely virulent. Of the 267 human cases confirmed to date, 161 had been fatal. More human deaths had occurred in 2006 than in the previous years combined; the case-fatality rate for that year had been 70%. The message was clear: the international community must not lower its guard. Although countries were much better prepared, they had to continue their efforts.

The CHAIRMAN, commending the Director-General's comprehensive and forward-looking report, thanked the Assistant Director-General for his efforts as Acting Director-General. He also congratulated the Deputy Director-General on his appointment.

Mr SHA Zukang (alternate to Dr Qi Qingdong, China) said that he was gratified to note the continuity in WHO's work since the appointment of the new Director-General. Remarkable progress had been made in dealing with major communicable diseases.

The possibility of an avian influenza pandemic had commanded attention worldwide. Bringing avian influenza under control would require the joint efforts of the public health and animal health sectors. Member States should improve information sharing between the two sectors with a view to early identification and effective control of the disease. Close collaboration between WHO and other international organizations such as FAO would strengthen the fight against the virus.

HIV/AIDS and tuberculosis were being brought under global control through government attention, improved prevention and control policies and better access to treatment, although the spread of disease had not been reduced. In addition, other communicable diseases, such as schistosomiasis and hepatitis, still posed severe threats to human health. Moreover, the social and economic effects of chronic ailments, such as cardiovascular disease and diabetes, were particularly damaging in developing countries, where the double burden of communicable and noncommunicable diseases had

caused increasingly serious public health problems. The international community expected WHO to give a stronger lead in public health matters, and to take proactive measures in order to curb the spread of disease and improve health and quality of life, which were the foundations of human progress.

China supported a higher programme budget for the increasing needs of global health. More funds should be allocated to primary health care in the programme budget.

Dr ALLEN-YOUNG (Jamaica), speaking on behalf of the member countries of the Caribbean Community, said that it was an exciting time for health-systems development, particularly integrated primary care. She welcomed the Director-General's priorities and the emphasis placed on the health of women and the people of Africa. Not only the Director-General but also Member States should be held accountable for the attainment of performance objectives. The Community pledged its continued support for WHO's objectives.

Dr SHINOZAKI (Japan), recalling the Director-General's address to the staff on 4 January, agreed that the Organization should be guided by the principle of "Reform yes, upheaval no". Drastic changes were intolerable but ways of managing the Organization more effectively and efficiently should be considered.

As the number of confirmed human cases of avian influenza was still increasing, the threat of an epidemic remained a concern. Most Member States were preparing for a potential pandemic. Unresolved issues included production capacity and the sharing of information on the virus. The situation was likely to remain serious for the foreseeable future.

He welcomed the emphasis placed on maternal and child health, in view of the alarming number of deaths among women and newborns as a result of preventable complications. Pneumonia and diarrhoea were still the main causes of death in children aged under five years, almost equivalent in impact to HIV/AIDS, tuberculosis and malaria. Insufficient international attention was being given to maternal and child health.

Japan had always put health at the top of its cooperation agenda, advocating a holistic approach with wide-ranging assistance. It was fully committed to supporting WHO's activities under the able leadership of the Director-General.

Dr NYIKAL (Kenya), speaking on behalf of the Member States of the African Region, welcomed the Director-General's statement that the Organization should be judged on its impact on the health of the people of Africa and the health of women, which she had identified as key indicators of WHO's performance. He also supported the six identified core areas; Member States were responsible for achieving those objectives and for allocating sufficient resources. The African Region thus endorsed the draft Medium-term strategic plan 2008–2013 and the proposed increase in the programme budget for the biennium 2008–2009.

He welcomed the increase, in absolute terms, of the proposed budget allocation for the African Region, and the proposed increase in the share of the budget for the five regions of WHO. He noted with concern, however, the proposed percentage decrease in the budget allocation for the African Region and asked how that could be reconciled with the priorities set by the Director-General.

Technical and health matters of significant interest to the African Region were on the agenda, including public health, innovation and intellectual property. In that regard, he favoured early implementation of the global strategy and plan of action, and provision of a medium-term framework based on the recommendations of the WHO Commission on Intellectual Property Rights, Innovation and Public Health. He commended the focus on primary health care in strengthening health systems.

Dr BUSS (Brazil) expressed initial agreement with the ideas on modernization of the administration contained in the Director-General's report. She had highlighted the strengthening of "value systems", and it was appropriate that health systems should be under discussion again. The primary health care approach must emphasize equity, universal access, intersectoral linkages and social control, all of which determined and justified the actions to be taken. He welcomed the decision

to make primary health care and its role in strengthening health systems the subject of the world health report 2008.

WHO must manage the enormous interest in health and potential for solidarity, together with the international resources available, so as to ensure lasting improvements and not overburden recipient countries. He agreed that it was for WHO to set the international health agenda and to fulfil its mandate as the directing and coordinating authority on health.

He approved the new design of the draft Medium-term strategic plan 2008–2013. WHO needed to refocus on its essential functions in order to restore its leading role in harmonizing and coordinating global health activities, revitalize the principle of strengthening countries' institutional capacity in public health, and re-establish the position of WHO within the reforming United Nations system.

Since 1948, Brazil had participated in the work of WHO, placing emphasis on policies that promoted multilateralism in health, social issues and a stronger guiding role for WHO. It had helped to establish the Commission on Social Determinants of Health. His President believed that social policies underpinned development, in terms of improving people's living conditions. With Kenya, Brazil had promoted the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, convinced that the international community already had the technological and financial resources to extend access to treatments regarded as a global public good. The commercial interests of the few should not outweigh the need for access to medicines of a billion men, women and children the world over.

Professor CHEW Suok Kai (Singapore) welcomed the Director-General's address, in particular her call to maintain guard against avian influenza and to strengthen health-care systems, especially primary health care. Singapore would host the high-level panel debate on global health security to be held as part of World Health Day 2007.

Dr CÓRDOVA VILLALOBOS (alternate to Mr Bailón, Mexico) reaffirmed his country's commitment to WHO and its priorities such as universal coverage, access to medicines, health promotion and disease prevention strategies in order to detect and treat chronic degenerative diseases, infectious illnesses and emerging diseases.

Dr SUWIT WIBULPOLPRASERT (Thailand) expressed the hope that the new Director-General would not be subject to political pressures but would be given the freedom to take appropriate decisions for global health. He strongly supported her six key ideas, in particular the goals of improving women's health and strengthening health systems and primary health care. Trends in global health care, such as horizontal and vertical approaches, should be woven together in order to create a strong, integrated system.

He expressed appreciation for her past work as an Assistant Director-General in expanding the global capacity for influenza vaccine production, which should be continued as a matter of national security rather than a commercial, demand-driven concept. He also supported the proposed increase in the programme budget; Thailand would be willing to increase its contribution.

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the Member States of the European Union, in the name of the German Presidency, said that the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and Ukraine aligned themselves with the declaration.

He commended WHO's efforts regarding human and avian pandemic influenza, which had led to successful meetings in Beijing, Vienna and Bamako. The Union also supported the pandemic influenza strategic action plan and was committed to improving collaboration between WHO, FAO and OIE.



The estimated global shortfall of nearly 4.3 million doctors, midwives, nurses and support workers as revealed in *The world health report 2006*<sup>1</sup> should sound the alarm for all stakeholders. WHO's global strategy to prevent and control sexually transmitted infections and its goal of providing universal access to HIV prevention and treatment would be valuable contributions to improving the health of men, women and young people.

In February 2006, the first session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control had been held in Geneva. He congratulated WHO for demonstrating that global tobacco control had acquired a distinct shape and structure.

Drawing attention to the Director-General's six priority areas and the structural reform process, he welcomed an approach based on integrated primary health care in strengthening health systems, which should facilitate dealing with noncommunicable diseases. It was important to assess the impact of WHO's performance on the health of, especially, people in Africa, as well as of women and other vulnerable groups. Health development was fundamental to combating HIV, malaria and tuberculosis, and to increasing access to essential medicines. WHO should therefore not confine its efforts to achieving the Millennium Development Goals. He had been encouraged by the Organization's work with its United Nations partners on reforms that would improve their combined effectiveness, particularly at country level. The 2005 World Summit had reinvigorated the process and WHO should participate in achieving objectives and in assessing additional potential for the sake of a well-coordinated approach. The International Health Regulations (2005) would enter into force in 2007. Countries should be assisted in building capacity for prevention, preparedness, response and rehabilitation in order to deal with health emergencies more effectively. The forthcoming stakeholder consultation on eradication of poliomyelitis would be an important step in that direction.

Results-based management would serve as a useful starting point for institutional reform under way throughout the United Nations system. WHO should focus on quality, and should use its comparative strengths. He welcomed the proposed internal review. The necessary assistance would be provided.

Ms HALTON (Australia) welcomed the Director-General's six key areas, and the emphasis placed on the people of Africa and women. Men and women faced different health challenges, and fully operative health systems should reflect the needs of both sexes.

WHO would require creative responses and adaptability. She welcomed the emphasis placed on accountability, performance and management as well as the commitment to United Nations reform. However, a proliferation of players with a declared interest in health issues, including donors, specialized agencies and even international celebrities, would require more flexibility and responsiveness from WHO if it was to remain relevant in an encroaching environment.

Mr RABGYE (alternate to Dr Wangchuk, Bhutan) said that not only were communicable diseases taking their toll in the region but the burden of noncommunicable diseases was also increasing. He welcomed the emphasis on integrated delivery of services, primary health care approaches, and on health and gender issues.

Mr MIGUIL (Djibouti), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that developing countries expected positive outcomes under WHO's new leadership, despite budget limitations. The health situation of many African and Eastern Mediterranean countries presented innumerable difficulties, particularly concerning maternal and child health, the determinants of health, equitable access to basic health services, and links between health and the environment. Also, Afghanistan, Iraq and Lebanon were experiencing conflicts. WHO should particularly assist the Regional Office in its efforts to meet those countries' needs. Decades of regional instability had prompted Djibouti to foster cooperation between the countries concerned, including the convening of a

---

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

conference on health (Djibouti, 27–30 November 2006). The meeting had also served as a bridge-building exercise between the African and Eastern Mediterranean Regions. He asked WHO for technical support to build on those initiatives. WHO, in close collaboration with the World Bank and other United Nations specialized agencies, needed to combat malaria, tuberculosis and AIDS more effectively. Those and other diseases were threatening economic development in the Region.

He favoured further administrative decentralization to the regional level in order to apply the strategies outlined by the Director-General. His Region pledged its support for the recommendations and goals that would shape the Organization's future work.

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

## SECOND MEETING

Monday, 22 January 2007, at 14:05

**Chairman:** Dr F. ANTEZANA ARANÍBAR (Bolivia)

**1. REPORT BY THE DIRECTOR-GENERAL:** Item 2 of the Agenda (Documents EB120/2 and EB120/40) (continued)

Mr DE SILVA (Sri Lanka) said that one of the Secretariat's functions was to provide technical expertise to Member States in order to ensure global health security. The technical expertise shown by the Director-General in heading the programme to combat avian influenza and her proven ability to translate such expertise into action left no doubt that she would advance the Organization in the work for which it was intended.

WHO was not primarily a donor organization: it had a different role to play. He welcomed the Director-General's references to health-system development, which should receive more attention. Antiretroviral medicines and other treatments could never be provided free of charge to Member States, but WHO should strive for a lowering of the prices of pharmaceutical items and to ensure that national health systems were given proper emphasis.

The Director-General's commitment to transparency and accountability must filter down through all levels of the Organization; Member States would give their full support to that tremendous task. Many programme activities had been carried out with funding allocated to, for example, work on communicable and noncommunicable diseases, but the question was whether the results were commensurate with the moneys spent. Accountability and transparency depended on both needs assessment and performance.

Dr TANGI (Tonga) said that, as the member for the smallest country on the Executive Board, he felt entitled to pledge the support of all small countries for the Director-General. Success and failure in the six areas she had highlighted would depend greatly on the efforts made at country level, as demonstrated by the experience with tuberculosis control: even after a five-year extension, that target had only been achieved by one region. It was particularly important, therefore, to focus on activities at ground level and to bear that in mind in setting targets for poliomyelitis control at the forthcoming high-level consultations.

The CHAIRMAN, speaking as the member for Bolivia, acknowledged the Director-General's message of hope and confidence in a better future including improved health, especially for poor people, women and children. Her vision was of equity and social justice. Although both the haves and the have-nots seemed to have more today than in the past, the gap between them had in fact widened.

The Executive Board, having nominated Dr Chan as Director-General, reiterated its confidence in her.

Ms EPHREM (Canada)<sup>1</sup> welcomed the Director-General's focus on its core global health functions. With multilateral and bilateral agencies, development banks, private foundations and public-private partnerships having all become influential players, WHO must capitalize on its comparative strengths and set priorities. The reform momentum must be sustained and the changes

---

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

introduced by the Secretariat in recent years institutionalized at all levels. WHO must also expand its harmonization efforts in order to achieve stronger results on the ground. Canada supported the six priority areas and welcomed the emphasis on women and the people of Africa.

The DIRECTOR-GENERAL thanked the Board for the broad support expressed for the six important areas she had outlined. The Organization had to learn how to work with partners, within and outside the United Nations system, how to be more responsive and more accountable, and to deliver results at country level. She welcomed the support for using improvements in the health of women and the people of Africa as indicators of WHO's performance. That approach would not necessarily be manifested in new programmes or departments; on the contrary, it would help to promote robust cost-cutting and ensure that synergies were developed from existing programmes.

The Secretariat, starting with herself as chief technical and administrative officer, would be accountable to Member States for delivering results in implementing the agreed-upon global public health priorities. At the same time, as the members for Jamaica and Tonga had indicated, Member States must be accountable for implementing programmes agreed upon jointly.

She appealed to Member States to lend their strong support to WHO in the months and years ahead. That was the only way to provide a platform on which the Organization could work with outside partners and achieve the goals agreed and priorities set in the interests of improving the health of the world's people.

## **2. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 3 of the Agenda (Document EB120/3)**

Ms HALTON (Australia), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, introduced the report and commended the success of its fifth meeting. Her objective in chairing the Committee had been to pursue greater transparency, in line with the shared ambition of the late Director-General, the former Acting Director-General and the new Director-General. It was much clearer what the Organization had done, was doing and intended to do, all in the interests of world health. As a result, a dialogue could be instituted about WHO's current efforts and future directions.

The Committee had begun with a review of management reforms at WHO, with a particular focus on the global management system, on which the Secretariat's briefing had been illuminating. Committee members had emphasized the sharing of experience of the global management system and, above all, the monitoring of results. When management changes were instituted, computer systems brought both risk and opportunity. The Secretariat needed to proceed with caution, with due regard for the agenda to be delivered.

The Committee had also looked in detail at the procedure whereby the Secretariat authorized publications carrying WHO's logo, and had discussed the importance of the disclaimer. Concern about protecting WHO's reputation for technical excellence had been expressed, and the need for oversight of the clearance and release of documentation had been emphasized. The Committee had requested an outline of publications policy, including the language question and access to materials produced by WHO. A report on the Director-General's review of publications policy should be submitted to the Committee at its sixth meeting in May 2007 and could subsequently be forwarded to the Executive Board.

The Committee had considered a report on the monitoring of the Eleventh General Programme of Work and requested that an overview of all evaluation, assessment and review procedures relating to it should be submitted to its seventh meeting in January 2008 in order to ensure alignment between policy and practice. The Committee had examined the performance assessment of the Programme budget 2004–2005 and endorsed a revised process for the biennium 2006–2007 whereby discussions would be held on the basis of a summary of the performance assessment report. The review would be validated once the full report was available in all languages.

The Committee had welcomed the growth in the programme budget from US\$ 3313 million to US\$ 3670 million, which reflected confidence in the Organization. The balance between voluntary and assessed contributions had led the Committee to request that mechanisms to improve alignment of resources should continue to be examined and put in motion. The Director-General had stated clearly that WHO's services could not be bought in exchange for financial contributions, and that it must therefore confine itself to working only in areas that had been agreed to be important for world health.

The Secretariat's detailed position on each of the reports of the Joint Inspection Unit issued during 2005 and 2006 had provided greater oversight of the Organization's work. The Committee had welcomed the greater transparency and accountability as well as the Director-General's commitment to the United Nations reform process and results-based management. The Committee had requested adequate staffing for the Office of Internal Oversight Services, given its increasing workload. The dedication of WHO's audit staff to ensuring that the Organization's priorities were being delivered had been noted, and minor changes had been requested for future reports.

Dr AGWUNOBI (United States of America) concurred on the importance of protecting the WHO brand. His Government had brought the issue of WHO's publication policy to the Committee because WHO's reports and documents were relied on the world over. Those publications must represent the best possible science and quality, with clear rules for the use of WHO's logo. The Director-General's report on publication policy should establish a clear and reliable process for review and should express her commitment to applying that policy consistently and transparently across the entire Organization.

Dr SUWIT WIBULPOLPRASERT (Thailand), referring to paragraph 27 of the report, said that the number of governing body resolutions must be reduced if their implementation was to improve. He urged the Secretariat to prepare its report as soon as possible. The Organization's reputation for technical excellence must be protected. Years earlier, as a doctor practising in rural Thailand, he had accepted WHO's reports or recommendations without hesitation. Having worked with the Organization, he was more circumspect, aware that wording might have been influenced by the positions of particular Member States. WHO's publications should be based on evidence and good science and without bias. The proposed oversight process must not jeopardize the timeliness of publications.

Dr NYIKAL (Kenya) said that documents issued by WHO were taken very seriously and that there must not be any question about their evidence base. He asked whether WHO's publications were subject to peer review.

The DIRECTOR-GENERAL agreed that WHO's brand and reputation for technical excellence must be protected. She would report to the Board on a policy that would ensure the proper prior review of publications. She assured the Board that WHO's publications would be credible and free from the influence of any Member State or industry and that the review process would be transparent, fair and accountable to all.

Dr KHALFAN (Bahrain) emphasized that academics and scientists should enjoy freedom of expression, and press freedom should always be respected.

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

**Draft resolutions deferred from the Fifty-ninth World Health Assembly and the 118th session of the Executive Board:** Item 4.12 of the Agenda

**Smallpox eradication: destruction of variola virus stocks** (documents EB120/11, EB120/11 Add.1 and EB120/39)

The CHAIRMAN said that, in order to save time, some Board members had suggested setting up a drafting group to discuss the draft resolution on smallpox eradication under item 4.12. He took it that, in the absence of any objection, the Board agreed to that suggestion.

**It was so agreed.**

(For adoption of the resolution, see summary record of the eleventh meeting.)

**Poliomyelitis: mechanism for management of potential risks to eradication:** Item 4.1 of the Agenda (Documents EB120/4 Rev.1 and EB120/4 Rev.1 Add.1)

Mr MIGUIL (Djibouti) said that in the Eastern Mediterranean Region political commitment had enabled rapid progress to be made towards the eradication of poliomyelitis. By 2003, only three countries, Afghanistan, Egypt and Pakistan, were reporting cases and only 113 cases had been reported that year. Regrettably, eradication efforts had since been disrupted by political and security issues. The armed conflict in Afghanistan had impeded access during immunization campaigns on both sides of the border with Pakistan. The cessation of preventive campaigns because of limited resources had resulted in the virus spreading from Nigeria to Sudan in 2004 and subsequently to Yemen and Somalia; in Sudan and Yemen, great effort and expense had halted the epidemics. The armed conflict in Somalia had changed the epidemiological situation and disrupted the planned supplementary immunization campaign.

The Governments of Afghanistan and Pakistan were synchronizing immunization campaigns and Saudi Arabia had taken measures to prevent the further spread of wild poliovirus from its present reservoirs.

He welcomed the draft resolution but proposed that in paragraph 3(2) the words “and presently polio-free countries at high risk of re-infection” should be added after the word “circulating”, in order to prevent a recurrence of the lowering of immunity that had resulted in 2004 and 2005 from the loss of support for supplementary immunization activities in high-risk countries.

Dr HANSEN-KOENIG (Luxembourg) welcomed the Organization’s commitment to eradicating poliomyelitis. She supported a sustainable immunization programme and therefore the draft resolution. Recalling the laborious negotiations before adoption of the International Health Regulations (2005), she asked for clarification of the procedure for the drafting of an additional annex to those Regulations, as indicated in paragraph 9 of the report.

Ms TJIPURA (alternate to Dr Shangula, Namibia), speaking on behalf of the Member States of the African Region, said that the persistent endemic transmission of wild poliovirus in Nigeria had accounted for 94% of all confirmed cases in the Region in 2006. Wild poliovirus had been imported into Angola, Democratic Republic of the Congo, Ethiopia, Kenya, Namibia and Niger from the areas that remained endemic. The Regional Committee for Africa, at its fifty-sixth session, had endorsed the regional strategic plan for the Expanded Programme on Immunization (2006–2009), which urged Member States in the Region to sustain certification-level surveillance and to establish outbreak-response systems. It had requested the Regional Director to continue to advocate measures for the eradication of poliomyelitis with political leaders and opinion makers.

She proposed that, in paragraph 1(1) of the draft resolution, the words “for regularly updating the Head of State or Government on programme progress and requirements” should be deleted and that the words “state/provincial and district” should be replaced by “all”. Paragraphs 2(1) and 2(2) could be condensed, but clarification of their meaning as currently drafted would be useful. She questioned whether a national from a country in which poliomyelitis was endemic who travelled through another country would have to provide proof of immunization. She welcomed the introduction of days of tranquillity during conflicts so that immunization against poliomyelitis and other preventable diseases could be conducted.

Professor PEREIRA MIGUEL (Portugal) endorsed the draft resolution. The report should have specified that, in areas endemic for wild poliovirus and countries where the virus had been reintroduced, vaccination policies and epidemiological surveillance should be reinforced. In countries at risk of importing the wild virus, epidemiological surveillance, vaccination of people travelling to areas where the virus was present, surveillance of travellers coming from areas in which the virus was present, and vaccination of less protected groups, including immigrants, should be reinforced.

Portugal had implemented WHO’s strategy for global poliomyelitis eradication and a post-eradication action plan had been incorporated into its national programme. Because of its relations with countries of sub-Saharan Africa, his country had increased verification of the vaccination status of its population and vaccination coverage, especially in disadvantaged communities, mainly immigrants, susceptible to the disease. Following WHO’s guidelines, Portugal used a vaccine with inactivated virus.

Important measures for eradicating the disease included vaccination in areas endemic for wild poliovirus and in countries where the virus had been reintroduced; epidemiological surveillance in countries at risk of importing wild virus; vaccination of travellers to risk areas; and surveillance of travellers from such areas.

Dr QI Qingdong (China) supported WHO’s analysis of the epidemiological situation of poliomyelitis and its recommendations. He proposed adding a new paragraph after the third preambular paragraph that would read: “Realizing that travellers from areas where poliovirus is circulating may pose a risk of the international spread of the virus”. In order to improve the quality of the Secretariat’s technical support, he further suggested the addition, in paragraph 3(1), after the words “still prevalent”, of the words “as well as to Member States at a high risk of importing viruses ...”.

Dr SOMSAK AKKSILP (adviser to Dr Suwit Wilbulpolprasert, Thailand) said that eradication of poliomyelitis was technically feasible, but required political commitment from the four Member States in which wild poliovirus remained endemic, and without which global efforts to eradicate the disease would fail. Welcoming the draft resolution, he suggested that, in order to obtain a strong commitment to interrupt transmission of wild poliovirus from those four countries, the words “especially the four endemic countries” should be added after the words “Member States” in paragraph 1.

In paragraph 2(2), the phrase “areas in which poliovirus is circulating”, was open to interpretation regarding the scope of interventions, for example, whether they should be applied nationally or subnationally. The International Health Regulations (2005) defined an affected area as a geographical location specifically for which health measures had been recommended by WHO. As it was difficult for Member States to distinguish between travellers from areas in which poliovirus was circulating and travellers from other States in which it was not, complete vaccination coverage could not be guaranteed. Interventions for countries with large populations could be costly, and further advice would be helpful.

Dr SHINOZAKI (Japan) supported immunization of travellers from areas in which wild poliovirus was circulating in order to interrupt its transmission globally. In Japan, work on laboratory containment according to the current edition of WHO’s global action plan for laboratory containment of wild polioviruses was in progress. In the post-eradication era, a strategy dealing with release of

poliovirus into the community should be considered. In order to maintain the poliomyelitis-free status of the Western Pacific Region, bilateral cooperation had been initiated in the area of vaccines for preventable diseases, including poliomyelitis and measles, which would contribute to the global eradication of the former. Since the number of cases in the four countries that remained endemic for wild poliovirus had not decreased, a new target year and road map for global eradication of poliomyelitis would be needed.

Dr YUBA (Mali) said that the eradication of poliomyelitis was of great concern not only to the countries that remained endemic but also to their neighbours such as Mali. She welcomed the rapid application of the measures in resolution WHA59.1 which had enabled recent outbreaks to be contained and substantial progress to be made in preparing for the post-eradication era. That included the draft third edition of WHO's global action plan for laboratory containment of wild polioviruses, and the review by the Advisory Committee on Polio Eradication of the standard operating procedures for the stockpile of monovalent oral poliomyelitis vaccines in the era following eradication and cessation of use of oral vaccine.

Financing was needed in order to interrupt endemic poliovirus transmission, prepare for the post-eradication era and manage the risks of re-emergence of poliomyelitis in that era. She supported the draft resolution and urged the international community to increase its commitment to the global eradication of poliomyelitis. Although the vaccination of travellers from countries in which poliovirus was circulating was not consistent with her country's policy, such measures were needed in order to prevent the international spread of wild poliovirus.

Dr CAMPBELL FORRESTER (alternate to Dr Allen-Young, Jamaica) recalled that in 1982 the Caribbean had been the first subregion to eradicate poliomyelitis. The last case of the disease in the Region of the Americas had been recorded in Peru in 1991, and the Region had been certified poliomyelitis-free in 1994. Since then, Jamaica had established and strengthened a system of surveillance of acute flaccid paralysis. Efforts were being made to reverse the decline in vaccination coverage over the past six years, and to raise the coverage rate from the 80% level in late 2006 to 95%. The last "catch-up" campaign had been conducted in 1996, targeting children aged one to six years. In accordance with WHO's advice, oral poliomyelitis vaccine was still being used in the subregion, despite concerns about vaccine-associated paralytic poliomyelitis. The requirement for travellers from endemic countries to show proof of adequate vaccination had been endorsed by Caribbean countries, thus managing the risk of importation of communicable diseases, including poliomyelitis and measles, through the Declaration of the Caribbean EPI Managers in support of Cricket World Cup Activities (Paramaribo, 17 November 2006), the Cup being an event that was expected to attract many visitors to the region. Strengthened surveillance was needed for timely identification, notification and investigation of suspected cases of those diseases. Sanctions for persons or facilities failing to report should be regulated under public health laws. Vaccination of Caribbean nationals travelling to countries in which poliomyelitis was endemic was encouraged.

Coverage levels should be raised to at least 95% for each birth cohort and complacency among young parents about children's vaccination had to be overcome. The lack of community health workers and outreach programmes was a serious constraint. Also important were sensitive surveillance, good stool-sampling technology, high levels of immunization and averting vaccine-associated cases. Comprehensive containment activities and accurate reporting could prevent possible use of the wild poliovirus by bioterrorists. Highly vocal and visible groups lobbying against vaccination must be countered through the media and effective and sustained public education. A smooth transition from oral poliovirus vaccine to inactivated poliovirus vaccine would be needed after poliomyelitis-free status had been globally certified.

The member countries of the Caribbean Community supported the draft resolution. The Secretariat should ensure timely reporting and documentation of containment activities by laboratories, provide support to countries for dealing with anti-vaccination groups, raise public awareness of vaccine safety, and seek additional funds for global eradication. In particular, vaccination coverage should be raised quickly in Nigeria, where most recent cases had been reported. Stricter



guidelines for laboratory containment of wild poliovirus should be shared with all countries, including those where transmission continued, and containment should be monitored by independent experts. Expanded Programme on Immunization activities, including the introduction of new vaccines and technologies, should also be supported.

Dr CORDOVA VILLALOBOS (alternate to Mr Bailón, Mexico) endorsed the need for international consensus on policies to manage the risks of re-emergence of poliomyelitis. Mexico supported WHO's eradication efforts and had been declared poliomyelitis-free in 1994. Surveillance for poliomyelitis and acute flaccid paralysis was being strengthened in response to the risk of reintroduction of the virus and re-emergence of the disease. Vaccination coverage with oral poliomyelitis vaccine was high; in addition, intensive campaigns were conducted during national health weeks. Mexico would introduce a pentavalent vaccine including inactivated poliomyelitis vaccine into its national immunization programme from 2007. Oral vaccine would still be used in intensified campaigns. He supported the draft resolution.

Dr VOLJČ (Slovenia) observed that the eradication of smallpox and the excellent progress made towards eradicating poliomyelitis showed WHO's unique role and strength. The re-emergence of poliomyelitis in some countries underlined the importance of achieving high levels of immunization through efficient vaccination.

The last serious outbreak of poliomyelitis in Slovenia had occurred in 1957. Despite vaccination coverage of more than 95%, an outbreak of nine cases, none of which had proved fatal, had been recorded in 1979. None of those affected had been vaccinated, and it was not certain whether the outbreak had been vaccine-related or due to wild poliovirus. Even with high coverage, some children could remain unvaccinated. Slovenia, like other countries, had experienced organized opposition to vaccination from a movement, which included some medical doctors and attracted some media support, that accused the country's health authorities of endangering children's health. A growing number of parents had to be persuaded to allow their children to be vaccinated. Member States were responsible for implementing successful vaccination programmes, but such movements could cause a serious decline in coverage. WHO should remain alert to that danger and be ready to intervene as necessary. He supported the draft resolution.

Dr AGWUNOBI (United States of America), commenting that his country was the largest financial contributor to the poliomyelitis eradication initiative, stated that eradication was feasible. Member States must remain focused on the goal of eradication and must garner the human and financial resources necessary at the national and global levels. Every country must reduce risks of importation and ensure the capacity to detect rapidly and respond effectively to circulating poliovirus. Leadership at the highest level in countries of Africa, the Middle East and Asia was essential in order to improve supplementary and routine vaccination coverage and surveillance for acute flaccid paralysis.

The reintroduction of poliovirus remained a major concern for all Member States. Recommendations by his country's Centers for Disease Control and Prevention set out in its "Yellow Book",<sup>1</sup> and by WHO<sup>2</sup> required vaccination for travellers to poliomyelitis-endemic countries. Ensuring that all travellers from endemic countries were fully immunized might also be effective. A standing recommendation to that effect established under the International Health Regulations (2005), which would enter into force in June 2007, could provide the means. The Regulations would require the immediate notification of poliomyelitis. Before that date, Member States should respect that requirement on a voluntary basis and should remain vigilant for imported wild poliovirus.

The United States wished to be included as a sponsor of the draft resolution.

---

<sup>1</sup> Centers for Disease Control and Prevention. *Health information for international travel, 2005-2006*. Atlanta, Georgia, US Department of Health and Human Services, Public Health Service, 2005.

<sup>2</sup> *International travel and health 2005*. Geneva, World Health Organization, 2005.

Dr SADASIVAN (Singapore) said that transmission of wild poliovirus in the four remaining endemic countries would be interrupted only with additional support from WHO and political commitment at the highest level in the countries concerned. He therefore supported the draft resolution. The International Health Regulations (2005) would provide an effective means of preventing the reintroduction of wild poliovirus in countries where it was currently not endemic.

Mr DE SILVA (Sri Lanka) recalled that Sri Lanka had recorded its last case of poliomyelitis in 1993 and was continuing surveillance, particularly in the light of risks from neighbouring endemic countries, India and Pakistan. Targets, including vaccination coverage, had been achieved, even in areas of conflict, through political leadership and with support from nongovernmental organizations. He supported the draft resolution.

Mr RABGYE (alternate to Dr Wangchuk, Bhutan) welcomed the proposed consultation in February 2007 to advance eradication in the remaining countries endemic for poliomyelitis. Those countries had the political will to achieve eradication but required further coordinated financial and logistic support in order to implement routine immunization programmes and immunization days. He supported the draft resolution.

Dr SALEHI (Afghanistan) reassured the Board that his country was fully committed to interrupting transmission of wild poliovirus and the global eradication of poliomyelitis. His President had established a national poliomyelitis action group which would enable the Office of the President to oversee implementation. Afghanistan was collaborating with Pakistan, implementing simultaneous vaccination campaigns on both sides of the border. Political support had included the administration of a dose of oral poliovirus vaccine by the Minister of Health of each country to a child from the other country. He supported the draft resolution with the amendment to paragraph 3(2) proposed by the member for Djibouti.

Professor AYDIN (Turkey) noted that the Advisory Committee on Polio Eradication had emphasized that the four remaining countries endemic for poliomyelitis constituted a continuing risk to all poliomyelitis-free areas until transmission had been completely interrupted. WHO should provide support for strengthened immunization requirements for travellers to and from endemic areas. Financial and security concerns in some endemic areas were hampering implementation of programmes. He supported the draft resolution.

Mr KENNY (Rotary International), speaking at the invitation of the CHAIRMAN, said that he was encouraged by the dedication of Member States and the progress made. Egypt and Niger were no longer poliomyelitis-endemic countries; 2006 had seen the lowest number of poliomyelitis-affected areas in history; new tools and strategies had been introduced in the targeted areas. Within two decades, cases had been reduced by 99%, five million cases of paralysis had been prevented, and 250 000 paediatric deaths from poliomyelitis had been averted. Yet progress was fragile. Failure to eradicate poliomyelitis would result in an estimated 10 million paralysed children in the next 40 years and would jeopardize the world's US\$ 4500 million global investment in the initiative.

Officials in poliomyelitis-endemic and other poliomyelitis-affected countries should prioritize poliomyelitis eradication. Through its global network of community volunteers, who had immunized more than 2000 million children in 122 countries, and its contribution of more than US\$ 650 million, Rotary International remained committed to eradicating the disease.

Dr OMI (Regional Director for the Western Pacific) said that experience had shown that the most difficult part of the eradication process was elimination of the last foci of transmission of wild poliovirus, which required extraordinary efforts relevant to each situation. The remaining endemic countries had already done much to contain transmission, with strong support from the international community, including Rotary International. However, the virus continued to circulate, and there was a danger that fatigue on the part of donors and the countries concerned could hamper further progress.

There was a need for renewed efforts by the Member States affected and global commitment and solidarity from the international community. On behalf of the Regional Directors of the three regions that had already been certified free from poliomyelitis, the Region of the Americas and the European and Western Pacific Regions, he said that they were ready to provide any support required in order to complete the task of eradication, including the secondment of staff to affected areas.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean) welcomed that offer of support. Two countries in his Region remained endemic, although only two cases had been reported in December 2006. Fatigue among those working the field, their political leaders and donors was an obstacle. He had visited the countries concerned in order to stress the need for eradication. The coverage of the Expanded Programme on Immunization in the four poliomyelitis-endemic countries, in particular in affected areas, was not up to the standard required for eradication. Routine and campaign immunization activities must be fully supported. Although sensitive surveillance systems for acute flaccid paralysis had been established, there was still a need for adequate supplies of vaccines, and greater funding was still needed in order to safeguard the investments made in eradication. Security and days of tranquillity were needed. All Member States must combine their efforts. Rumours of adverse effects of vaccination must be dispelled, and the fact that the same vaccines and sound technology were in use the world over must be publicized. Had smallpox not been eradicated, the response to HIV/AIDS would have been a much more complicated matter, since vaccination of an HIV-positive person could result in fatal vaccinia.

Dr HEYMANN (Representative of the Director-General for Polio Eradication) thanked the members of the Board on behalf of the spearheading partners of the Global Polio Eradication Initiative – WHO, UNICEF, the Centers for Disease Control and Prevention in the United States of America and Rotary International – for their continued support. Since late 2006, each of the four poliomyelitis-endemic countries had strategies for dealing with the disease. Afghanistan and Pakistan had synchronized their immunization activities across borders; India, a country with a dense population and poor sanitation in the areas where poliomyelitis remained, was vaccinating children under two years of age in those areas; Nigeria's measures included "Immunization Plus Days" where interventions added to poliomyelitis vaccination would strengthen health systems.

He welcomed the proposed amendments to the draft resolution. Concerns regarding the international spread of the poliovirus as a result of travel to and from areas where poliomyelitis was endemic would be fully reflected. Travel from such areas would also be addressed under the International Health Regulations (2005). A report would be made to the Health Assembly on the forthcoming consultation to establish indicators of the interruption of transmission of wild poliovirus by the end of the next two-year period. Preparations were being made for a post-eradication era in order to ensure the safe storage or destruction of wild or Sabin polioviruses after poliomyelitis had been certified as eradicated. The poliomyelitis surveillance network should remain as a legacy of eradication and be broadened so as to include diseases that required continued surveillance. The infrastructure for poliomyelitis eradication would be fully applied in routine immunization programmes. WHO would continue to mobilize the US\$ 570 million still needed for the activities in 2007–2008, and was confident that it could continue to count on its financial partners to see the eradication of poliomyelitis through to the end.

Mr BURCI (Legal Counsel), responding to the question by the member for Luxembourg, said that the annexes to the International Health Regulations (2005) were an integral part of those Regulations. The addition of an annex would therefore be equivalent to amending the Regulations. The Health Assembly would have to take a decision to launch negotiations on a new annex; a working group or similar body would have to be established in order to negotiate the text and report back to the Health Assembly. The Health Assembly could adopt the annex, which would enter into force 24 months after its adoption subject to the conditions set out in the Regulations.

The DIRECTOR-GENERAL emphasized that the eradication of poliomyelitis was an item of unfinished business and concerted efforts were needed. She thanked the poliomyelitis-free countries for their achievements, the four poliomyelitis-endemic countries for their efforts, and the key partners and other donors. The Secretariat's determination to eradicate poliomyelitis was also demonstrated through the willingness of the Regional Directors of the poliomyelitis-free regions to deploy resources in the three regions where poliomyelitis remained endemic. The eradication of poliomyelitis would constitute a gift in perpetuity to generations of children all over the world, and she thanked countries for their solidarity and their commitment to achieving that goal.

The CHAIRMAN said that a revised draft resolution would be prepared incorporating the suggested amendments and considered at a later meeting.

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

**Malaria, including proposal for establishment of World Malaria Day:** Item 4.2 of the Agenda (Documents EB120/1(annotated), EB120/5 and EB120/5 Add.1)

Dr ALLEN-YOUNG (Jamaica) described her country's recent experience of having eradicated a disease and then seeing it re-emerge. The last local case of malaria had been reported in Jamaica in 1961 and since 1965 her country had been declared free of the disease with recently fewer than 10 imported cases of malaria annually. However, in 2006, a first case had been detected, a second in October and a third in November. Local transmission was occurring, in a small area in Kingston. An emergency operations centre had been established without hiding the problem. Jamaica's strategy had been early detection and prompt treatment, with epidemiological and entomological surveillance. There had been timely public information and education, with community mobilization and intersectoral collaboration. Cases had peaked in December at 43 per week, dropping to 18, most in the 20–39-year age group. The 255 confirmed cases had been adequately treated with no reported death.

The local transmission of a disease that had been eradicated more than 40 years earlier had shocked Jamaica. Effective global surveillance had been essential for early detection. Implementation of the International Health Regulations (2005), international cooperation and the strengthening of health systems had been vital. Jamaica had received technical assistance from sources including PAHO, the Caribbean Epidemiology Centre, and health ministries. She could state that malaria was not endemic on the island, that the outbreak had been localized in Kingston and that transmission had peaked in late November to mid-December 2006. The situation was under control. Continued surveillance would identify and enable treatment of any sporadic cases and enhanced vector-control activities. Through collaboration with PAHO the local situation would be further evaluated. She urged countries that had already eradicated malaria to remain vigilant and strengthen surveillance systems. She supported the proposal for the establishment of World Malaria Day.

Dr SALEHI (Afghanistan), speaking on behalf of the countries of the Eastern Mediterranean Region, supported the proposal to establish World Malaria Day on 25 April. Malaria and its transmission were poorly understood by those at risk. More people were travelling to regions in which malaria was endemic. Cases among travellers were often fatal. A World Malaria Day would help malaria-free countries to prevent the reintroduction of malaria, improve measures to protect travellers and manage imported malaria.

He welcomed the draft resolution. However, countries with a high malaria burden were unlikely to achieve the target of an 80% coverage rate for planned interventions by 2010, set by the Health Assembly in resolution WHA58.2, because the funds pledged for malaria control had not materialized. Countries with small health budgets, weak health systems or a shortage of human resources might need more innovative approaches in order to deal with complex emergencies.

He commended WHO's increased vector-control interventions, including indoor residual spraying, with emphasis on sustainability and access for affected communities. However, many

countries lacked properly trained entomologists and vector-control teams. WHO should support and encourage funding for short- and long-term training at all levels.

In the Region, many countries, including the Islamic Republic of Iran and Iraq, were embarking on malaria elimination. In Sudan, a local malaria-free initiative was in progress in Khartoum and Gezira Provinces. Member States needed support from partners such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and training from WHO in the necessary expertise. WHO could improve capacity for malaria elimination through cross-border coordination and interregional cooperation. Staff with malaria control expertise should be decentralized to the country level.

Dr SHINOZAKI (Japan), welcoming the draft resolution, said that malaria had been endemic in Japan in the past, and could well re-emerge. Since 2000, his country had been strongly committed to global malaria control through the Global Fund to Fight AIDS, Tuberculosis and Malaria and support to affected countries, such as the distribution of insecticide-treated bednets. Technical support favoured by WHO included indoor residual spraying with DDT, a compound regulated by the Stockholm Convention on Persistent Organic Pollutants. Countries should examine sustainability and the possible emergence of resistant mosquitoes. He urged the Secretariat to establish a monitoring system for that intervention, in conjunction with the secretariat of the Stockholm Convention. WHO should expand activities to combat malaria, further the training of medical entomologists, promote hygiene programmes at community level, support studies of insecticide resistance, and adopt ecological mosquito control. The best approach would need varied expertise, secure funding and guaranteed human resources.

Dr SOMSAK AKKSILP (adviser to Dr Suwit Wibulpolprasert, Thailand) said that his country's malaria control programme, a major public health initiative, operated in both low-endemic and high-endemic areas. Authorized use of antimalarial medicines licensed since 1985 was normally restricted to government health facilities. Two medicines in common use, artesunate and mefloquine, were restricted to public pharmacies. Every year in May, preceding the seasonal peak for malaria, a "malaria week" promoted public awareness.

He welcomed the draft resolution, but queried the scope of the term "market", the mention of prequalified antiretroviral medicines and the meaning of "artemisinin monotherapies" in paragraph 1(3). He suggested adding, at the end of paragraph 4, the sentence "In addition, a report on both obstacles encountered and progress achieved in malaria control should inform the general public to reflect the social accountability of the government".

Dr AGWUNOBI (United States of America) said that the statistics highlighted the need for global malaria control, especially for women and young children. Vulnerable populations were uneducated about malaria protection. A World Malaria Day would not in itself reduce the global burden of infection. More attention should be given to the provision of life-saving antimalarial medicines, the distribution of long-lasting insecticide-treated bednets and intermittent preventive treatment in pregnancy. He strongly supported indoor residual spraying with DDT and other insecticides. The Malaria Initiative launched by his country's President supported the use of DDT and other insecticides in carefully-controlled household-spraying campaigns in target countries in Africa. Artemisinin-based combination therapies were the most effective in treating malaria. However, he did not support a ban on malaria monotherapies, as long as those medicines met international standards for quality, safety and efficacy. Regulatory issues relating to the fixed-dose combination therapies needed more discussion. Funding should focus on procuring medicines known to be safe and effective. Fixed-dose combination therapies could simplify treatment regimens and prevent the development of drug resistance.

The United States Government was the largest donor to malaria control, through the President's Malaria Initiative and its contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria. All countries should increase support for global malaria control with stronger financial and political commitment. He urged affected countries, especially in Africa, to increase their spending on malaria control.

He would submit some proposed amendments to the draft resolution in writing.

Dr YOUNG (Mali), speaking on behalf of the Member States of the African Region, said that malaria was a major public health problem in the Region. Malaria killed a million children every year, and endangered 30 million pregnancies. In Africa, malaria accounted for 25% of household costs and was a major economic and social burden. Increased resistance to antimalarial medicines had led most African countries to adopt more effective but more costly treatments such as artemisinin-based combination therapies. Some countries, including Mali, had been promoting the use of insecticide-impregnated bednets and intermittent preventive therapies using sulfadoxine-pyrimethamine for pregnant women. High costs, inadequate health systems and shortages of human resources were preventing the coverage of vulnerable populations. She called for increased transborder measures, improved monitoring and evaluation systems, and public-private partnerships. Available artemisinin-based therapies and pharmacovigilance systems were insufficient, and access to health services fell short, especially in remote and rural areas. The international community must be made aware of the acute shortage of funds and other resources for malaria control. She supported the draft resolution, especially the proposal to establish a World Malaria Day.

Dr CORDOVA VILLALOBOS (alternate to Mr Bailón, Mexico) recalled that the grave consequences of malaria impeded economic growth, reduced productivity and perpetuated poverty. Mexico had reduced the incidence of malaria through a focalized treatment strategy, also used elsewhere in the Americas, which lessened reliance on insecticides. The draft resolution should emphasize community participation in malaria control, reduce the use of insecticides and ensure choice of environmentally acceptable and scientifically sound insecticides.

Dr QI Qingdong (China) said that the international community must be mobilized to deal with malaria. WHO had coordinated the work of international agencies in that area, including the Roll Back Malaria Partnership. He welcomed the emphasis in the draft resolution on waiving taxes and tariffs for bednets, medicines and other products needed for malaria control.

A World Malaria Day would draw the attention of governments and the international community to the problem, and would raise public awareness for self-protection. However, the date should be reconsidered, because 25 April in China was the national day for child immunization. An April date would be unsuitable for China and its neighbours, where the peak season for malaria was from April to October.

The gradual promotion of artemisinin-based combination therapies required the right conditions. However, according to Chinese experts there was no specific evidence of resistance to artemisinin monotherapies in *Plasmodium falciparum*. By comparison with artemisinin monotherapy, the combination therapies did not shorten bouts of malaria or increase the effectiveness of treatment. Moreover, the combination therapies were far more expensive than monotherapy products. Before opting to promote combination-therapy products, WHO should step up its monitoring of artemisinin-based antimalarial treatments and should set up a longer-term timetable for halting the use of monotherapies.

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the European Union and its 27 Member States and in the name of the German Presidency, welcomed WHO's efforts to bring together global, regional and national malaria prevention and control through the Global Malaria Programme. Effective antimalarial medicines and long-lasting insecticide-treated bednets were global public goods, for access to which participatory discussion and innovative financing methods were required. Developing countries should expand local capacity to produce and distribute medicines and bednets. He stressed the role of pharmaceutical research and building of evidence through initiatives such as the Medicine for Malaria Venture and the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. Cooperation and exchanges between countries and regions were also valuable.

He supported the draft resolution, but proposed a new preambular paragraph after the third preambular paragraph, to read:

“Welcoming the contribution to the mobilization of resources for development by voluntary innovative financing initiatives taken by groups of Member States and in this regard noting the International Drug Purchase Facility (UNITAID), the International Finance Facility for Immunization, and the commitment to launch a pilot project within the Advance Market Commitments Initiatives”.

That wording reproduced paragraph 5 of the United Nations General Assembly resolution 61/228, on malaria.

Paragraph 1(3) should be amended to read:

“to withdraw from the market or withdraw the marketing authorization for oral artemisinin monotherapies, and to promote the marketing authorization of artemisinin-combination therapies, to implement policies that prohibit the production of counterfeit (antimalarial) drugs and assure that financing bodies cease to procure those monotherapies or other medicines, including prequalified antiretroviral medicines, from manufacturers that continue to market artemisinin monotherapy products”.

Paragraph 1(4) should be deleted, in order to avoid any conflict with the corresponding resolution already adopted by the General Assembly of the United Nations at its most recent session.

The wording used in paragraph 2(1) should be replaced by a formulation such as:

“to provide support to countries in expanding combination therapies that are appropriate for the local resistance situation, including artemisinin-based combination therapies where necessary, use of long-lasting insecticide-treated bednets, and integrated vector-control measures that may include indoor residual spraying with appropriate and safe insecticides as indicated by WHO and in accordance with the Stockholm Convention, and using monitoring and evaluation systems, including the country database, as developed by WHO”.

The following wording should be inserted at the end of paragraph 3(1):

“and to provide technical guidance for the management of malaria control activities in refugee camps and complex emergencies”.

He recommended the deletion of paragraph 4. He saw no added value in establishing a World Malaria Day. The reference to it in the preamble should also be deleted.

Mr DE SILVA (Sri Lanka) expressed full support for the draft resolution. Since 1990, the incidence of malaria in his country had been reduced from 400 000 cases annually to a few hundred. He appreciated the technical support provided through the Roll Back Malaria Partnership. He suggested that all previous programmes for combating malaria should be appraised in terms of the investment made in them.

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

**The meeting rose at 17:45.**

### **THIRD MEETING**

**Tuesday, 23 January 2007, at 09:40**

**Chairman:** Dr F. ANTEZANA ARANÍBAR (Bolivia)

**Following an open meeting at 09:00, the meeting resumed in public session at 09:40.**

#### **1. STAFFING MATTERS:** Item 7 of the Agenda

**Appointment of the Regional Director for the Eastern Mediterranean:** Item 7.1 of the Agenda (Document EB120/23)

Dr SAHELI (Libyan Arab Jamahiriya), Rapporteur, read out the following resolution adopted by the Board during the open meeting:<sup>1</sup>

The Executive Board,  
Considering the provisions of Article 52 of the Constitution of WHO;  
Considering the nomination made by the Regional Committee for the Eastern Mediterranean at its fifty-third session,

1. REAPPOINTS Dr Hussein A. Gezairy as Regional Director for the Eastern Mediterranean Region as from 1 October 2007;
2. AUTHORIZES the Director-General to issue to Dr Hussein A. Gezairy a contract for a period of five years from 1 October 2007, subject to the provisions of the Staff Regulations and Staff Rules.

The CHAIRMAN congratulated Dr Gezairy on his reappointment.

Dr GEZAIKY (Regional Director for the Eastern Mediterranean) said that he was honoured to be reappointed and grateful for the trust placed in him. He pledged to rise to the task. He reflected on the progress that had been made in the Region, for example in controlling communicable diseases and health-sector reform. The principle of primary health care would continue to guide change in health systems; partnerships with the private sector, civil society and nongovernmental organizations would be promoted. Challenges for the future included the increasing burden of chronic, noncommunicable diseases, workforce shortages and communicable diseases, including maximizing immunization coverage against vaccine-preventable diseases and the emergence of new diseases. The Region's Community-Based Initiative would be continued, primary health care strengthened and prevention promoted, especially for diseases of women and children.

The DIRECTOR-GENERAL congratulated Dr Gezairy on his reappointment and commended his leadership, wisdom and experience, and work on prevention and control of many diseases, including the eradication of poliomyelitis.

---

<sup>1</sup> Resolution EB121.R2.



Dr KHALFAN (Bahrain), supported by Dr AL-EISSAWI (Iraq) and Dr SALEHI (Afghanistan), congratulated the Regional Director on his reappointment, acknowledging his contribution to the Gulf Cooperation Council and his knowledge and experience.

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

**Poliomyelitis: mechanisms for management of potential risks to eradication:** Item 4.1 of the Agenda (Documents EB120/4 Rev.1 and EB120/4 Rev.1 Add.1) (continued from the second meeting, section 3)

The CHAIRMAN informed the Board that a revised version of the draft resolution, with a drafting modification to paragraph 3(5), would be issued the following day.

(For adoption of the resolution, see summary record of the fourth meeting.)

**Malaria, including proposal for establishment of World Malaria Day:** Item 4.2 of the Agenda (Documents EB120/5 and EB120/5 Add.1) (continued from the second meeting, section 3)

Dr NYIKAL (Kenya) said that the Board must give clear direction on control of malaria, the prime cause of morbidity and mortality in the African Region. Trade-related considerations must not overshadow WHO's chief responsibility, namely the protection of human health, and the Board should be guided by hard scientific evidence alone when examining such issues as resistance to drugs and insecticides. The issue of monotherapy in the case of drug resistance was bad science. Scientific principles must override national trade interests in order to preserve the efficacy of new medicines. Many Africans were denied access to effective antimalarial medicines because of their high cost; that situation must be redressed.

He supported the draft resolution contained in document EB120/5, and the proposed date of 25 April for World Malaria Day, which coincided with Africa Malaria Day. He proposed the following amendments. A new paragraph 1(5) should be added, to read "to provide in their legislation flexibility to use compulsory licensing, in accordance with the TRIPS agreement, to increase access to antimalarial medicines, diagnostics and prevention technologies". A new subparagraph should be added between existing paragraphs 3(2) and 3(3), the new text reading:

to bring together the WHO Global Malaria Programme, the Roll Back Malaria Partnership, the Global Fund to Fight AIDS, Tuberculosis and Malaria, academics, small and large pharmaceutical and biotechnology companies, interested Member States, medical research councils and foundations in a standing forum to improve coordination between the various players in the war against malaria.

Paragraph 4 should be divided into two subparagraphs, whereby the current paragraph would become paragraph 4(1) and a new paragraph inserted as paragraph 4(2), to read: "the World Malaria Day shall be the culmination of year-long intensified community-based malaria prevention activities in malaria-endemic areas".

Dr VOLJČ (Slovenia) linked global warming with malaria. Diseases such as malaria and their vectors might spread, as a result of climate change, to areas in which they had not previously been endemic. Anopheles mosquitoes had already been found on the Slovenian coast; they were not at present carriers of *Plasmodium spp.*, but, from an epidemiological standpoint, in time malaria would occur if global warming continued. Countries bordering malarious areas should institute preventive entomological surveillance. He supported the draft resolution.

Dr SADASIVAN (Singapore) said that malaria was a global scourge still causing millions of preventable deaths, yet awareness of the disease as a global problem remained low. He supported the

establishment of a World Malaria Day in order to promote awareness and understanding. However, countries endemic for the disease must also implement policies and strategies recommended by WHO. He supported the draft resolution.

Dr AGWUNOBI (United States of America) said that some of the proposed amendments to the draft resolution appeared to conflict with one another. He suggested that the resolution should be referred to a drafting group.

Dr KOCHI (Global Malaria Programme), responding to the comments on artemisinin monotherapy, stressed that the world could not afford to lose artemisinin to drug resistance. If plasmodia became resistant to artemisinin, malaria control efforts would regress two decades. WHO was consequently advocating the use of therapies that combined artemisinin with other antimalarials. There were already signs that artemisinin resistance was emerging in some parts of the world, notably in the border region between Cambodia and Thailand. In the coming week, WHO would be holding informal consultations with the Cambodian and Thai Governments in order to review the situation and make recommendations. As to whether the monotherapy ban would apply to both the private and the public sectors, the answer was "yes".

On the issue of indoor residual spraying and the use of DDT, he welcomed the suggestion by the member for Japan regarding the establishment of a monitoring system. In October 2006, WHO had held a meeting of experts with UNEP, and one recommendation had been that the two organizations should set up a system to monitor DDT use; a memorandum of understanding was being drawn up. Regarding the comments made on behalf of the European Union, he agreed that indoor residual spraying and DDT should be part of an integrated vector-management strategy.

WHO was developing guidelines for malaria elimination that would include recommendations for handling malaria outbreaks in formerly malaria-free areas. Once the guidelines were completed, as scheduled for the first quarter of 2007, training programmes would be organized in accordance with the suggestion by the member for Afghanistan.

The CHAIRMAN said that either the draft resolution could be referred immediately to a drafting group or the Secretariat could be asked to prepare a revised version for discussion at a future meeting, whereupon a drafting group could be formed, if necessary.

Dr AGWUNOBI (United States of America) said that either option would be acceptable to him.

Dr NYIKAL (Kenya) said that it would be preferable for the Board to examine a revised version of the draft resolution and then decide whether a drafting group was needed.

The CHAIRMAN accordingly requested the Secretariat to revise the draft resolution, reflecting all the comments and suggestions put forward. The item would thus remain open.

**It was so agreed.**

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

**Tuberculosis control: progress and long-term planning:** Item 4.3 of the Agenda (Documents EB120/8, EB120/8 Add.1 and EB120/8 Add.1 Rev.1)

Dr GWENIGALE (Liberia), speaking on behalf of the Member States of the African Region, said that, although Africa had only about 11% of the world's population, it accounted for an estimated 25% of tuberculosis cases reported each year. It also bore the highest HIV/AIDS burden in the world, and was seeing an increasing number of HIV/tuberculosis coinfections; many of those cases were resistant to second-line tuberculosis medicines. The Regional Committee for Africa had declared tuberculosis an emergency and had called for accelerated control actions, as had the Special Summit of

the African Union on HIV/AIDS, Tuberculosis and Malaria (Abuja, 2–4 May 2006). However, the challenges posed by coinfection and resistance to second-line medicines could not be addressed without additional technical and financial support from WHO. He appreciated the importance that had been given to tuberculosis and related problems through their inclusion on the Board's agenda and supported the draft resolution contained in document EB120/8.

Dr SOMSAK AKKSILP (alternate to Dr Suwit Wibulpolprasert, Thailand) said that failure to reach the global tuberculosis targets for 2000 and the slow progress towards the detection and treatment targets for 2005 reflected inadequate health systems, infrastructure, human resources and capacity to manage programmes. The Global Plan to Stop TB 2006–2015 and WHO's Stop TB strategy, with its six comprehensive elements, provided effective tools for achieving the targets. However, a major obstacle to their implementation was the estimated funding shortfall of US\$ 31 000 million. He urged WHO and its partners to strive to fill the gap.

He welcomed the draft resolution but proposed two amendments. First, given the need to improve health information in order to measure the performance of national tuberculosis programmes, the phrase "and accelerating the improvement of health information systems to serve national programme performance assessment" should be added at the end of paragraph 1(1)(a). Secondly, a new paragraph 2 should be inserted:

- "2. URGES international organizations and development partners:
- (1) to provide support to high-burden countries in expanding the implementation of the Stop TB strategy;
  - (2) to increase and improve funding mechanisms in line with the Global Plan to Stop TB 2006–2015."

Dr SALEHI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, commented that tuberculosis affected some 600 000 people in the Region every year. Most patients belonged to socially and economically productive age groups. In order to stop tuberculosis, the DOTS strategy had been widely expanded, covering some 94% of the population. The treatment rate of 82% was close to the global treatment success target.

In contrast, in many countries of the Region case detection was far below the global target of 70%. Causes lay in the poor quality of DOTS; insufficient number of health-care providers, particularly in the private sector; limited active participation of communities; the increasing incidence of HIV/AIDS; and both multidrug-resistant and extensively drug-resistant tuberculosis.

He therefore supported the comprehensive Stop TB strategy and the Global Plan to Stop TB 2006–2015. The budgetary requirements for tuberculosis control had been identified in the Global Plan, and control activities were being implemented. Nine out of the 10 countries in the Region with high or intermediate incidence of tuberculosis had developed country cooperation mechanisms and were receiving support from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

He endorsed the draft resolution. National implementation of increased control efforts and of long-term plans to stop tuberculosis was necessary, despite the stabilization or decline of the incidence of disease in four out of the six WHO regions in the past decade. Partnership was essential for mobilizing the resources required for long-term plans, such as the Partnership's Global Plan to Stop TB. The draft resolution should urge all Member States to develop effective partnerships, similar to the Eastern Mediterranean Partnership to Stop Tuberculosis, and should reflect WHO's crucial assistance and coordination. Only one third of resource requirements in his Region were currently met – a gap that should be highlighted in the draft resolution. Collaboration with the Global Fund was very important. He commended the report, but stressed improved accuracy in estimating tuberculosis incidence, prevalence and mortality. The draft resolution should request the Director-General to establish mechanisms for reviewing and monitoring those estimates.

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the European Union and its 27 Member States, in the name of the German Presidency, said that the candidate countries Croatia,

The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and Ukraine and the Republic of Moldova aligned themselves with his statement.

He acknowledged WHO's achievements in tuberculosis control and affirmed support for the Stop TB Partnership. He emphasized collaboration with all stakeholders for regional surveillance systems. He was concerned, however, about the dramatic increase in tuberculosis infection rates in the past year in eastern Europe and Africa, where the disease was mainly associated with HIV/AIDS. It was alarming that extensively drug-resistant tuberculosis strains were evolving in countries where there was practically no chance of treatment. That was a priority health issue, and assistance from WHO and the international community should be strengthened.

The European Union and its partners were tackling tuberculosis, its spread and neighbourhood policy instruments. Enhanced collaboration with other programmes, especially those concerning HIV/AIDS, was needed with increased alignment between national health sectors for a more effective international response. He emphasized strengthening national health systems and solutions to the human resource crisis. Regarding access to medicines, he welcomed innovative funding initiatives such as the International Drug Purchase Facility (UNITAID), the International Finance Facility for Immunisation, and a pilot project within the advance market commitments for 2007. WHO had played a key role in the Stop TB Partnership through the Green Light Committee and the Global Drug Facility, supporting access to and safe use of tuberculosis medicines. He supported the draft resolution but requested the addition of the words "and, if affected, consider extensively drug-resistant tuberculosis as a top priority health problem to be tackled immediately as part of the overall strategy of Stop TB" at the end of paragraph 1(1)(b), and the addition of the words "and urgently to strengthen WHO's assistance to countries affected by extensively drug-resistant tuberculosis" at the end of paragraph 2(1).

Speaking as the member for Portugal, he said that his country had achieved the global targets for tuberculosis control, but it still had one of the highest incidences in the European Union. The National Programme for Prevention and Control of Tuberculosis needed to increase early detection capacity, reduce the incidence of tuberculosis associated with HIV/AIDS, and mitigate the high prevalence of extensively drug-resistant tuberculosis. The former President of Portugal, Mr Sampaio, who had been appointed the United Nations Secretary-General's Special Envoy to Stop Tuberculosis, was endeavouring to raise global awareness, secure funds and urge world leaders to strengthen their commitment. The slogan "TB anywhere is TB everywhere", chosen by Mr Sampaio for the 2007 World Tuberculosis Day, should be kept in mind in the collective fight against tuberculosis.

Dr RUIZ MATUS (alternate to Mr Bailón, Mexico) said that the focus of the Mexican Programme for Prevention and Control of Tuberculosis had shifted from a medicalized to a social, holistic approach. Since tuberculosis control was not the responsibility solely of the Government or of medical staff, the DOTS strategy had been reshaped to involve the commitment of society as a whole, including the population at risk. The national programme "Mexico free of tuberculosis" had stepped up detection in health units and the community, especially among vulnerable groups. That had led to better understanding among and organization of health-care personnel and to increased social mobilization. Joint responsibility and the empowerment of the community were crucial to controlling the disease. In connection with the new Stop TB Partnership, his Government had set up the National Committee to Stop Tuberculosis, replicated in each of the country's states. Mexico had participated actively in the elaboration of the Global Plan to Stop TB, as the representative of the Americas.

He supported the draft resolution and joined requests for WHO to increase prevention and control measures.

Dr QI Qingdong (China) commended the Secretariat's work on tuberculosis control and the global progress achieved, but expressed deep concern that the targets for 2005 had not been attained.

China had five million tuberculosis patients, the second highest number in the world, living mainly in rural areas. Remarkable progress had been made by his Government through vigorous measures on tuberculosis control. By the end of 2005, DOTS coverage had reached 100%, the sputum

smear-positive pulmonary tuberculosis detection rate was 79% and the treatment success rate was 91%. China's commitment to the international community was a driving force for better tuberculosis control. State policies had included scientific control strategies and fund-raising initiatives. Challenges remaining included the association with HIV infection, the emergence of multidrug resistance and increased rural-urban migration. China was committed to overcoming those difficulties and, in cooperation with the international community, to achieving the international targets for 2015.

Countries with a high incidence of the disease should include tuberculosis control in national strategic planning and provide the relevant funding, human resources and policy guarantees. He welcomed the objective of "increasing access to quality-assured second-line medicines at affordable prices through the Stop TB Partnership's Green Light Committee" contained in paragraph 1(1)(c) of the draft resolution. He emphasized WHO's role in coordinating, promoting and supporting that initiative. The estimated shortfall in funding for the next 10 years, referred to in the report, could be met through an effective fund-raising mechanism devised by WHO. Developed countries and donor institutions should fulfil their funding obligations in order to meet the targets. He supported the draft resolution.

Dr AL-EISSAWI (Iraq) supported the Global Plan to Stop TB 2006–2015. Its rigorous implementation at global, regional and national levels was essential for all Member States. He emphasized the internationally agreed tuberculosis control strategy (the DOTS strategy) and policies for dealing with multidrug-resistant and extensively drug-resistant strains of the disease. Implementation of the DOTS strategy should continue as the core of the Stop TB strategy and could lead to high treatment-success rates. However, in spite of considerable progress, the report showed that high rates of case detection and treatment success, both globally and within his Region, had nevertheless failed to meet the targets, and more needed to be done. Many countries faced problems in implementing the DOTS strategy, and it was important to improve the quality of DOTS activities in those that had not attained the global targets for case detection and treatment success. Paragraph 1(1)(b) of the draft resolution should be amended to read "rapidly improving the quality of DOTS activities as the first and foremost step in the full implementation of the Stop TB strategy and also to limit the emergence and transmission of multidrug-resistant, including extensively drug-resistant, tuberculosis". He also suggested that the words "particularly for the improvement of quality of DOTS activities", should be inserted after "tuberculosis-control programmes" in paragraph 2(1).

There was a danger that misuse of first-line and second-line tuberculosis medicines could lead to the development of multidrug-resistant and extensively drug-resistant tuberculosis. Recent outbreaks of the latter in South Africa had indicated significant potential impact, and the issue must be addressed. Immediate care should be provided to patients by management systems, including accurate and timely diagnosis, effective treatment, infection control and follow-up. Panic on the part of either health personnel or the public should be avoided.

Dr AGWUNOBI (United States of America) noted the great concern among members of the Board about tuberculosis, in particular the overlap between the tuberculosis and HIV/AIDS epidemics and the emergence of lethal multidrug-resistant and extensively drug-resistant tuberculosis.

He supported the draft resolution, but suggested that the words "and prompt implementation of infection control precautions" be inserted at the end of paragraph 1(1)(b), and that a new paragraph 1(2) be added, to read "to enhance laboratory capacity to provide for real-time drug susceptibility testing of isolates obtained from all persons with culture-positive tuberculosis and promote access to quality-assured sputum smear microscopy", the existing paragraph 1(2) being renumbered as paragraph 1(3). He further suggested that the words "implementing infection control precautions" be inserted after "national tuberculosis-control programmes and" in paragraph 2(1), and that a new paragraph 2(3) be inserted, to read "to assist Member States to develop laboratory capacity to provide for real-time drug susceptibility testing of isolates obtained from all persons with culture-positive tuberculosis", the existing paragraphs 2(3) and 2(4) being renumbered as 2(4) and 2(5).

Dr RAHANTANIRINA (Madagascar) expressed confidence that WHO's continued support would enable Africa to progress towards target 8 of Millennium Development Goal 6, namely to have halted and begun to reverse incidence of tuberculosis by 2015. Implementation of the DOTS strategy in Madagascar had yielded tangible results, with the treatment-success rate increasing from 63% in 2004 to 86% in 2006. The financial viability of the programme urgently needed resource mobilization, since inadequate funding could jeopardize the treatment of multidrug-resistant forms of the disease.

She proposed that the first part of paragraph 2(2) be amended to read "to strengthen WHO's leadership role in the Stop TB Partnership in its coordination of efforts to implement the Global Plan to Stop TB 2006–2015 ..."

Dr INOUE (alternate to Dr Shinozaki, Japan) expressed support for the draft resolution and the amendments suggested. Japan was contributing to global tuberculosis prevention and control through an international training course run by its Research Institute of Tuberculosis. Almost 2000 people from 90 countries had participated since 1963, and many were playing an important role in that area in their own countries. Japan would continue to support tuberculosis prevention and control globally.

Dr NYIKAL (Kenya) welcomed the Global Plan to Stop TB 2006–2015, and expressed support for WHO's leadership in efforts to meet the international targets for tuberculosis control for 2015. Only one country in Africa had achieved the targets for case detection and treatment success for 2005, and South Africa had seen an alarming trend in mortality from extensively drug-resistant tuberculosis, which entailed high treatment costs.

He suggested addition of a new paragraph 1(3) to the draft resolution, to read: "to declare, where appropriate, tuberculosis as a public health emergency and allocate additional resources to strengthen activities to stop the spread of extensively drug-resistant tuberculosis." That text would be in line with the Maputo Declaration of 2005, and would enhance advocacy for better funding.

Dr TANGI (Tonga) pointed out that China, which had one of the highest incidences of tuberculosis, had achieved the targets set for 2005 because of political commitment at the highest level. Tonga had also met the targets, by prioritizing and working towards its objectives. More attention should be paid to research, particularly on drug resistance. It was in the commercial interests of pharmaceutical companies to pursue such research if they were to survive in the market.

Ms MAFUBELU (South Africa)<sup>1</sup> expressed concern at the emergence of extensively drug-resistant tuberculosis in some countries, including her own, and the lack of laboratory capacity for detection in those countries, which could have disastrous consequences. She welcomed WHO's technical assistance to South Africa and the support from her country's partners.

She supported the draft resolution, together with the amendments proposed.

Dr RAVIGLIONE (Stop TB) said that the new Stop TB strategy and the Global Plan to Stop TB 2006–2015 were key elements in meeting the targets in the relevant Millennium Development Goal. Currently, the global success rates for case detection and treatment of cases of tuberculosis were 60% and 84%, respectively. Although progress had been made, much work remained.

Replying to questions raised, he affirmed that the Stop TB strategy covered all the issues that had been identified hitherto. Implementation of the DOTS strategy was a prerequisite for all countries, given that it was almost impossible to treat multidrug-resistant or extensively drug-resistant cases without first having established a basic structure. The old DOTS strategy had been improved by inclusion of an impact measurement element, thereby strengthening health information systems. A task force of experts was considering how accurate information on incidence, prevalence and mortality would be provided. A budget and plan had been drawn up, but the relevant studies would need

---

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

investment. The lack of laboratories, as noted by the member for the United States of America, was a weak point in both the Stop TB and DOTS strategies. Diagnosis and effective services depended on good laboratory systems. Due attention would be paid to the proposed amendments.

Extensively drug-resistant tuberculosis, which was being given high priority, and tuberculosis/HIV coinfection were covered by component 2 of the Stop TB strategy. A plan of action had been launched, which, despite a shortfall in its budget, would assist countries like South Africa that were facing major problems. In response to comments by the member for Mexico, he pointed out that the mobilization of civil society in tuberculosis control was included in component 5 of the new strategy. Without community and primary-care level involvement, global targets could not be achieved. The new strategy included the promotion of research in order to increase the availability of new diagnostics and medicines and also, it was to be hoped, produce a vaccine that would prevent tuberculosis. The Global Plan to Stop TB 2006–2015, underpinned by the new strategy, would be carried out in accordance with Stop TB Partnership principles.

He welcomed the appointment of Mr Jorge Sampaio as the United Nations Secretary-General's Special Envoy to Stop Tuberculosis. He also welcomed the contributions made by bilateral and other organizations, including the Global Fund to Fight AIDS, Tuberculosis and Malaria and the International Drug Purchase Facility, all of which helped to bridge the gap in funding of some US\$ 30 000 million in the Global Plan's budget.

The CHAIRMAN suggested that in view of the large number of amendments that had been proposed, a revised version of the draft resolution should be prepared for the Board's later consideration.

**It was so agreed.**

(For adoption of the resolution, see summary record of the eighth meeting, section 2.)

**Avian and pandemic influenza: developments, response and follow-up, and application of the International Health Regulations (2005):** Item 4.4 of the Agenda (Documents EB120/15, EB120/15 Add.1, EB120/INF.DOC./3 and EB120/16)

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the European Union and its 27 Member States, the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and Ukraine and the Republic of Moldova, welcomed WHO's progress in dealing with avian influenza and increasing pandemic preparedness. Comprehensive surveillance of animal and human influenza and timely, transparent sharing of information and specimens were crucial for an early response. Lack of resources and weak veterinary infrastructure gave cause for concern, and there was need for improved information collection and sharing in affected countries. Rapid implementation of the International Health Regulations (2005) would result in establishment of surveillance systems and rapid reaction mechanisms. From a public health perspective, control at source remained a crucial first line of defence. WHO's strategic action plan for pandemic influenza 2006–2007,<sup>1</sup> supported by the common efforts of governments, international organizations, affected countries and the pharmaceutical industry, would play an important role in increasing vaccine supplies. Properly functioning health-care systems were essential for effective influenza preparedness, since competition between health priorities could hinder the implementation of annual vaccination programmes.

---

<sup>1</sup> Document WHO/CDS/EPR/GIP/2006.2.

In enhancing pandemic preparedness, more information on how WHO proposed to ensure coordination with regional organizations such as the European Union and with international bodies such as FAO and OIE would be welcome.

Speaking as member for Portugal, he said that his country had adopted a contingency plan with specific provisions covering day care and hospital care, public health measures, information systems, vaccines and medicines. Although medicine-related measures were fundamental to pandemic preparedness, WHO should also promote other public health measures. Where only limited stocks of antiviral medicines were available, such measures could play a crucial role in delaying the spread of a pandemic.

Dr AGWUNOBI (United States of America) urged Member States to share important public health information, including virus samples and sequence data, and to report human and animal cases of infection with the H5N1 virus, as well as seasonal and other novel influenza viruses, in a timely and transparent manner. WHO should, as a top priority, provide a clear and coordinated plan of action. In spite of progress, many questions remained.

In December 2006, his Government had formally accepted the International Health Regulations (2005), and their implementation had begun, well in advance of the date for entry into force. He supported the draft resolution.

Dr URBINA (El Salvador) agreed that effective implementation of the International Health Regulations (2005) would greatly improve rapid response to an influenza pandemic. Accordingly, in August 2006, his country had designated a national focal point. He was concerned that up to 2 January 2007 only half the Member States had established focal points. By the time the Regulations entered into force on 15 June 2007 most should have done so. As long as some countries remained outside the network of focal points there would be dangerous weaknesses in the global surveillance system, and the Director-General should urge those countries to designate national focal points in order that coverage could be extended to all areas and territories in accordance with Article 3.3 of the Regulations.

Dr JAKSONS (Latvia) said that in his country sensationalist reporting by the media on avian and pandemic influenza had caused public confusion and led to considerable outlays by the Government on vaccines and medicines. WHO should raise its public profile in order to counteract sensationalist claims, and provide a balanced assessment of the situation that was readily accessible to the public. A prolonged media campaign on the threat of an influenza pandemic could lead to apathy on the part of the public and undermine the likelihood of early detection.

Dr RUIZ MATUS (alternate to Mr Bailón, Mexico) said that his country had implemented a national preparedness and response plan in order to combat a future influenza pandemic. It had collaborated with WHO and other multilateral organizations in its efforts to ensure that antiviral treatments and vaccines were available to all countries on an equal basis. The Government had set up an epidemiological intelligence unit responsible for communications, situation analysis and rapid emergency response and control. The national laboratory network had been strengthened. A strategic reserve of antiviral medicines, individual protection equipment and laboratory equipment had been established, along with a stock of influenza A H5N1 vaccine. A full-scale simulation of an influenza epidemic would test the health system's response capacity.

Mexico was thus fulfilling the requirements of the International Health Regulations (2005) relating to preparedness. However, there was no effective vaccine against all strains of influenza at present, and world production capacity could not meet the potential demand. His Government had signed an agreement with the pharmaceutical industry relating to the transfer of technology and, at a later date, the construction of a vaccine manufacturing plant. He supported the draft resolution contained in document EB120/15.



Dr QI Qingdong (China) welcomed the reports, particularly the information on best practices contained in document EB120/INF.DOC./3. China's efforts to control the spread of avian influenza included integrated mechanisms at all levels for the prevention and control of the disease, including laws, regulations and emergency plans. There had been only 10 outbreaks of avian influenza in mainland China in 2006, a reduction of 67.7% compared with 2005. Fourteen people had contracted avian influenza in 2006, of whom eight had died. To date, there had been no new case for the past four months, and the cure rate had also improved.

China had established effective communication with other countries and international organizations. A pandemic could only be defeated by means of international cooperation. WHO's current stage of pandemic alert, namely phase 3, continued to be justified, and he endorsed the strategic action plan for pandemic influenza 2006–2007. Implementation of the International Health Regulations (2005) would help to control a future pandemic, but all the underlying principles, including the sovereignty of States, protection of human rights and the Charter of the United Nations, must be observed.

Regarding the best practices for the sharing of influenza viruses and sequence data, he noted that, in the interests of biosafety, many countries had severely restricted research into influenza viruses. Those national regulations should be observed in order to prevent viruses escaping into the community. Developing countries were particularly at risk from avian and pandemic influenza: governments, laboratories and individual scientists should work closely with WHO collaborating centres and the Global Influenza Surveillance Network in order to increase capacity in those countries. WHO should draw up a long-term strategy on the sharing of influenza viruses and sequence data. A system should be set up to protect the intellectual property of States that provided influenza viruses, in order to clarify the responsibilities of all parties and prevent the use of viruses for an individual's own research or for commercial purposes without the consent of the supplier State. He would submit proposed amendments to the draft resolution in writing.

Dr NYIKAL (Kenya), speaking on behalf of the Member States of the African Region, commended the Secretariat's work on preparedness for an influenza pandemic, the strategic action plan 2006–2007, implementation of resolution WHA59.2 and the establishment of an event management system at headquarters. More cases of influenza had been reported in 2006 than in 2004 and 2005 combined, although human-to-human transmission was still not a major problem.

Seven African countries had reported cases of avian influenza in the past year: Burkina Faso, Cameroon, Djibouti, Egypt, Niger, Nigeria and Sudan. In Africa, poultry were generally kept in small numbers in people's backyards rather than on large farms, where an outbreak of avian influenza would be easier to deal with, and thus there was often intimate contact between humans and poultry. The Region's health and veterinary infrastructure was weak, and there was insufficient laboratory capacity at biosafety level 3, the level required to handle material infected with the H5N1 strain of the virus.

Nevertheless, many African countries had prepared emergency response plans, which they were implementing with support from WHO, FAO and OIE. The Regional Office for Africa had provided support for both human resources and laboratories. At the fifty-sixth session of the Regional Committee for Africa in August 2006, Member States had committed themselves to increasing national and regional preparedness and response.

He supported the draft resolution, with the addition after paragraph 2(3) of a new subparagraph, reading "to mobilize additional support for Member States with vulnerable health systems to strengthen their systems and improve their state of preparedness". He called upon all States to implement the International Health Regulations (2005) voluntarily, even though they had not yet formally entered into force.

Dr KHALFAN (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed WHO's efforts to increase influenza preparedness in Member States. The countries of his Region had drawn up national preparedness plans for pandemic influenza. However, none currently manufactured seasonal influenza vaccines, and it was unlikely that they would produce vaccines for a pandemic strain of influenza if it emerged in the near future, since they

lacked the necessary infrastructure and capacity. They also lacked the necessary epidemiological and laboratory capacity for implementing the International Health Regulations (2005).

The draft resolution urged Member States to exchange viral and biological materials related to novel influenza viruses, but it did not state how developing countries were to have access to pandemic influenza vaccines early enough to save lives. Paragraph 2(3), relating to production capacity and access to influenza vaccines, required further elaboration. Each region should receive a share of all vaccines produced, proportionate to its population, although special treatment should be accorded to countries where the pandemic first emerged and those where the pandemic strain was isolated.

**The meeting rose at 12:30.**

## **FOURTH MEETING**

**Tuesday, 23 January 2007, at 14:05**

**Chairman:** Dr F. ANTEZANA ARANÍBAR (Bolivia)

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

**Avian and pandemic influenza: developments, response and follow-up, and application of the International Health Regulations (2005):** Item 4.4 of the Agenda (Documents EB120/15, EB120/15 Add.1, EB120/16 and EB120/INF.DOC./3) (continued)

Dr HANSEN-KOENIG (Luxembourg) requested an update on implementation of resolution WHA58.3 on revision of the International Health Regulations (2005), in particular, information on the status of any reservations expressed by Member States. She requested that a report should be provided to the Health Assembly containing an overview of implementation of the Regulations, an update on guidelines for the implementation and evaluation of Annex 2, and guidelines on land crossings.

Ms HALTON (Australia) said that as experts Board members understood that the behaviour of a virus was unpredictable. Unfortunately, it was not always easy to convince people, and particularly governments, that the risk of a pandemic was real and represented a significant danger. She warned that some governments seemed to be showing signs of “preparedness fatigue”. The Board must continue to reinforce the message that preparedness was essential. One senior government official had compared the threat of an avian influenza pandemic to the much-heralded fears of the late 1990s that the advent of the new millennium would cause computer systems to collapse, a danger that had not materialized. Board members knew that at some point a virus with a devastating impact could emerge, although they could not be sure when. For that reason, it was vital to continue to advocate vigilance. In that context, she applauded the draft resolution, and in particular paragraphs 1(2) and 1(4), which called on Member States to share novel influenza virus samples and epidemiological information in a routine and timely manner. She emphasized the coordinating role of the WHO Global Influenza Surveillance Network in protecting against seasonal and potential pandemic influenza. WHO must also continue its role of advocacy and leadership in the area of animal health, which necessarily had an impact on human health. Member States must continue to be prepared. She welcomed the attempts made by several countries to subject their response procedures to trials: her country’s Exercise Cumpston ’06 had proved instructive to both the Government and observers from other countries in the Region. Australia would continue its commitment to development and capacity building in the Asia-Pacific region in order to prevent and control emerging infectious disease outbreaks. Australia was also implementing the International Health Regulations (2005).

Dr AKIZUKI (alternate to Dr Shinozaki, Japan) expressed satisfaction that WHO was supporting immediate compliance with the International Health Regulations (2005). Guidelines would help Member States to understand and implement the Regulations. The Secretariat should continue consultations and share information with Member States about those guidelines.

In view of the importance of increasing vaccine-production capacity and sharing information on influenza viruses, she supported the draft resolution. She expressed satisfaction that Member States’ urgent concerns about limited vaccine production capacity were being addressed by the Secretariat; smooth and timely sharing of information was essential for producing a pandemic vaccine. The routine sharing of seasonal influenza virus functioned smoothly, but certain problems in information sharing still needed to be overcome. She urged all members to support the draft resolution.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that ideally influenza virus specimens should be shared for the purpose of producing publicly available vaccines and antiviral products. Sharing virus samples or information should be based on equality of access to vaccines and antiviral medicines. WHO should not become a broker for pharmaceutical companies wishing to acquire viruses. The lack of sufficient vaccine-production capacity should be treated as a national security issue. The current capacity of 400 million doses fell far short of the number that would be needed in a pandemic, and developing countries were likely to be hardest hit.

He welcomed the draft resolution, but proposed two amendments. A new paragraph 2(5) should be inserted to read: “to investigate and implement all possible options to ensure that pandemic influenza vaccine and antiviral drugs will be a global public health good which can be accessible by all, for example to mobilize adequate funding in order to compensate for the cost of research and development of the pandemic influenza vaccine and antiviral drugs”. A new paragraph 2(6) should read: “to report to the Health Assembly through the Executive Board on the situation of pandemic influenza and global preparedness on an annual basis”.

Dr SADASIVAN (Singapore) shared concerns about the prospect of a human influenza pandemic. Although the current outbreak of H5N1 avian influenza had not yet led to sustainable human-to-human transmission, it might do so in future, as the virus mutated. Given that devastating potential, he applauded WHO’s efforts in leading the global community in preventing and preparing for an influenza pandemic, and taking the necessary steps to respond to one. The Secretariat and Member States must continue preparations with vigour.

Tackling transnational infectious diseases such as avian influenza required sharing essential epidemiological and research data with WHO and the global community. Notwithstanding worries about intellectual property rights, commercial opportunities and academic credit, the common health threat disregarded national boundaries and necessitated close working relationships based on trust and respect. Singapore would contribute to the global fight against a possible pandemic, among other things, by participating in research activities and providing laboratory reference services.

He supported the draft resolution and the amendments proposed by Thailand. Epidemiological and research information must be shared in a timely manner. He therefore proposed adding the words “in a timely manner” at the end of paragraph 2(4) of the draft resolution.

Professor AYDIN (Turkey) expressed support for the draft resolution and the proposed amendments. He stressed that Member States should support implementation of the goal of increasing vaccine-production capacity and access to pandemic influenza vaccines. WHO should keep the international community informed about the results of research on influenza viruses, including the H5N1 strain. An outbreak in Turkey in January 2006 had been brought under control and the focus had been eliminated through WHO’s expertise and support. Lessons from that experience were being shared globally. He emphasized rapid clinical and epidemiological investigation of human infections and the timely and transparent sharing of findings with WHO and the international community. WHO should coordinate international surveillance of seasonal influenza viruses and viruses with pandemic potential.

Mr CAMPOS (alternate to Dr Buss, Brazil) said that his country had done a great deal to be prepared for a new influenza pandemic. An interministerial commission had been set up, and a national plan formulated, together with contingency plans for all 27 federal states. That process had enabled Brazil to bring its legislation into line with the International Health Regulations (2005) and improve its national health surveillance system. Brazil’s system was well equipped to cope with a health emergency, and WHO’s technical assistance had enabled it to undertake mathematical modelling and a simulation exercise. Brazil would increase the number of its reference laboratories from three to eight. A production factory in São Paulo was ready to produce vaccines, including an H5N1 vaccine, if necessary. The migration of birds into Brazil was monitored at 18 strategic sites. Immunization coverage against common influenza was good, particularly for people over 60 years of

age. CD-ROMs were being distributed to health professionals, in order to facilitate recognition of and response to cases of avian influenza. He supported the draft resolution.

The CHAIRMAN, speaking in his capacity as the member for Bolivia, said that all countries faced the risks of avian influenza and pandemic influenza, and compliance with the provisions of the International Health Regulations (2005) was a moral obligation, if not a legal one. Information should be shared with medical professionals and the general public, and presented so as to be readily understood and inspire public confidence in the authorities' preparations for a potential pandemic.

Cooperation between countries at every level of development should be promoted so that those that had neither the financial nor the technological capacity had access to stocks of pandemic vaccines and were helped to establish or increase domestic manufacturing capacity.

Mr PAREDES-PORTELLA (FAO) welcomed the reports and WHO's efforts to minimize the risk of the emergence of a pandemic virus. Close cooperation already existed between FAO and WHO in that area. At the international level, FAO was active in communicating the risks of avian influenza and was developing interagency coordination in order to tackle the disease. The FAO-OIE Global Strategy for the Progressive Control of Highly Pathogenic Avian Influenza, currently being revised to take account of the evolving situation, aimed to prevent and control the disease through increased surveillance, early detection and reporting and immediate response.

At the regional level, FAO was developing the Subregional Network of National Laboratories and Collaborating Centres, established in 2004. Such centres were currently operational in Africa, Asia, eastern Europe and the Caucasus, Latin America and the Caribbean. FAO had assisted countries in developing national strategies, building capacity and supporting their surveillance and response systems. The Emergency Centre for the Control of Transboundary Animal Diseases in Bangkok had coordinated a part of FAO's pathogenic avian influenza control programme.

The decrease in highly pathogenic avian influenza outbreaks had reduced the number of human cases but the situation in such countries as Egypt and Indonesia was worrying, and the virus was also still circulating in several regions, particularly in South-East Asia and parts of Africa. FAO would concentrate on revising the FAO-OIE Global Strategy; conducting epidemiological studies in Africa; investigating the role of wild birds and vaccination strategies; researching the socioeconomic and rehabilitation aspects; and encouraging participatory approaches at village level. It would strengthen its regional and country emergency centres and regional animal health centres.

Dr HEYMANN (Acting Assistant Director-General) thanked members for their technical and financial support of WHO's preparations for a potential pandemic of avian influenza. The International Health Regulations (2005) had served as a rallying point for the Secretariat with Member States. In the African Region the integrated disease surveillance networks, and in the Western Pacific and South-East Asia regions the Asian and Pacific Surveillance of Emerging Diseases Network, were being used to plan for the implementation of the Regulations. Establishment of national IHR focal points and designation of WHO contact points, essential for the early implementation of the Regulations, had also led to renewed collaboration with Member States.

The global influenza preparedness plan would reduce human exposure to the H5N1 virus, strengthen the early warning system, intensify rapid containment operations, build capacity to cope with a pandemic, and coordinate global scientific research and development. He endorsed the emphasis placed by the member for Thailand on the global pandemic influenza action plan, which, if fully implemented, would resolve the problem of vaccine shortage through the transfer of vaccine technology and production from industrialized to developing countries. Six out of 11 applications received for transfer of influenza vaccine production technology would be developed into full proposals, with seed funding from WHO.

The threat of an avian influenza pandemic had stimulated international coordination. In the near future FAO, OIE and WHO would examine a surveillance and response plan, which would enable closer cooperation. WHO was also participating in the United Nations System Influenza Coordination

Programme. In 2006, health ministry officials had discussed the risk-communication aspect of avian and pandemic influenza preparedness, and a second meeting would be held in February 2007 in Cairo.

He welcomed the proposed amendments to the draft resolution relating to best practices for the sharing of influenza viruses. Those practices should ensure that, as with the routine sharing of seasonal influenza viruses, the most appropriate vaccines for pandemic viruses would be available if required.

Human cases of avian influenza appeared to be decreasing. Since avian influenza in humans was a zoonotic disease, its incidence would decrease if the preventive measures applied to animals were effective. However, as the member for Australia had warned, the risk of a pandemic remained as long as the H5N1 virus circulated anywhere, and made a constant state of preparedness essential.

As requested by the member for Luxembourg, more information about the implementation of the International Health Regulations (2005) would be submitted to the Sixtieth World Health Assembly.

The DIRECTOR-GENERAL re-emphasized vigilance in the face of the continuing threat of pandemic influenza. The outbreak of the H5N1 virus infection in animals, its geographical spread and its ability to affect humans and other species were unprecedented. No government could withstand the political pressure that it would bear for being unprepared or not protecting its people. Pandemic influenza was WHO's top priority and she would support preparedness activities at country level for as long as the threat continued.

The risk of pandemic influenza was real and needed to be addressed, and Member States were strongly advised to devote resources to preparing for that threat, even though that might mean diverting resources from other needy health areas such as HIV/AIDS, tuberculosis and maternal and child health. WHO was not "crying wolf", and predictions of a potential pandemic were based on solid evidence. Tracking the virus required Member States to share clinical specimens and viruses in a timely manner.

Some members had expressed concerns over access to medicines and vaccines. WHO would develop its action plan and ensure that, through North-South and South-South cooperation, the capacity for vaccine production was increased and research and development activities on antiviral agents enhanced. She acknowledged the vital contribution made by the pharmaceutical industry and its social responsibility and goodwill with respect to pandemic influenza.

Another priority for WHO was the implementation of the International Health Regulations (2005), which, by providing support to resource-poor countries, would give the world better defences against the H5N1 virus and other emerging infections that might result in public health emergencies of international concern.

The CHAIRMAN said that the amended draft resolution would be submitted to the Board members at a later meeting.

(For adoption of the resolution, see summary record of the tenth meeting.)

**Poliomyelitis: mechanism for management of potential risks to eradication:** Item 4.1 of the Agenda (Documents EB120/4 Rev.1 and EB120/4 Rev.1 Add.1) (continued from the third meeting, section 2)

The CHAIRMAN drew attention to a revised version of the draft resolution contained in document EB120/4 Rev.1, incorporating amendments proposed by members, which read:

The Executive Board,  
Having considered the report on eradication of poliomyelitis,<sup>1</sup>

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:

The Sixtieth World Health Assembly,  
Having considered the report on eradication of poliomyelitis;  
Recalling resolution WHA59.1, urging Member States in which poliomyelitis is endemic to act on their commitment to interrupting transmission of wild poliovirus;  
Recognizing that the occurrence of endemic poliovirus is now restricted to geographically limited areas in four countries;  
Recognizing the need for international consensus on long-term policies to minimize and manage the risks of re-emergence of poliomyelitis in the post-eradication era;

**Recognizing that travellers from areas where poliovirus is still circulating may pose a risk of international spread of the virus;**

Noting that planning for such international consensus must commence in the near future,

1. URGES all Member States where poliomyelitis is still prevalent, **especially the four countries in which poliomyelitis is endemic:**

- (1) to establish mechanisms ~~for regularly updating the Head of State or Government on programme progress and requirements~~, to enhance political commitment to, and engagement in, poliomyelitis eradication activities at ~~state/provincial and district~~ **all** levels, and to engage local leadership and members of the remaining poliomyelitis-affected populations in order to ensure full acceptance of, and participation in, poliomyelitis immunization campaigns;
- (2) to intensify poliomyelitis eradication activities in order rapidly to interrupt all remaining transmission of wild poliovirus;

2. URGES all Member States:

- (1) to protect against importations and international spread of wild polioviruses by reviewing and, if appropriate, updating national policy to recommend full immunization against poliomyelitis for travellers ~~from~~ **to** areas in which poliovirus is circulating;
- (2) to revise national policy and legislation on immunization of travellers from ~~areas~~ **countries** in which poliovirus is circulating in accordance with temporary or standing recommendations which may be established under the International Health Regulations (2005) once they enter into force;
- (3) to reduce the potential consequences of importation of wild poliovirus by achieving and maintaining routine immunization coverage against poliomyelitis greater than 90% and, where appropriate, conducting supplementary poliomyelitis immunization activities;
- (4) to strengthen active surveillance for acute flaccid paralysis in order rapidly to detect any circulating wild poliovirus and prepare for certification of poliomyelitis eradication;

---

<sup>1</sup> Document EB120/4 Rev.1.

(5) to prepare for the long-term biocontainment of polioviruses by implementing the measures set out under phases 1 and 2 in the current edition of the WHO global action plan for laboratory containment of wild polioviruses;<sup>1</sup>

3. REQUESTS the Director-General:

(1) to continue to provide technical support to the remaining Member States where poliomyelitis is still prevalent in their efforts to interrupt the final chains of transmission of wild-type poliovirus, **and to Member States at high risk of an importation of poliovirus;**

(2) to assist in mobilizing financial resources to eradicate poliomyelitis from the remaining areas where poliovirus is circulating, **to provide support to countries currently free of poliomyelitis that are at high risk of an importation of poliovirus, and** to minimize the risks of re-emergence of poliomyelitis in the post-eradication era;

(3) to continue to work with other organizations of the United Nations system on security issues, through mechanisms such as “days of tranquility”, in areas where better access is required to reach all children;

(4) to initiate the process for a potential standing recommendation, under the International Health Regulations (2005), on the immunization against poliomyelitis of travellers from areas where poliovirus is circulating;

(5) to submit proposals to the Sixty-first World Health Assembly with a view to minimizing the long-term risks of reintroduction of poliovirus or re-emergence of poliomyelitis in the post-eradication era, by establishing international consensus on the long-term use of poliomyelitis vaccines and biocontainment of infectious and potentially-infectious poliovirus materials.

The CHAIRMAN said that, in the absence of any objection, he took it that the Board wished to adopt the draft resolution.

**The resolution, as amended, was adopted.<sup>2</sup>**

**Prevention and control of noncommunicable diseases: implementation of the global strategy:**  
Item 4.5 of the Agenda (Documents EB120/22 and EB120/22 Add.1)

Dr RUIZ MATUS (alternate to Mr Bailón, Mexico) said that health services needed to disseminate scientific evidence that would enable citizens to protect their own health. Information and self-care were the keys to prevention and control of chronic noncommunicable diseases, which in Mexico were appearing at increasingly younger ages, making treatment more costly. In order to tackle chronic degenerative diseases, Mexico would be launching in February 2007 a strategy integrating all its health institutions and emphasizing prevention. His country would take measures consistent with the global strategy in order to reduce chronic diseases. He supported the draft resolution.

Dr CAMPBELL FORRESTER (alternate to Dr Allen-Young, Jamaica) said that Jamaica had implemented a health promotion and protection strategy which included healthy lifestyles and activities to prevent violence.

She supported the draft resolution, subject to amendment. In addition to communicable and noncommunicable diseases, injuries and violence represented a third burden, and a new preambular paragraph should therefore be inserted to read: “Bearing in mind the triple burden of infectious and

<sup>1</sup> Document WHO/V&B/03.11 (second edition).

<sup>2</sup> Resolution EB120.R1.



chronic diseases and injuries faced by many countries". A new subparagraph should be added to paragraph 1 in order to urge Member States "to implement a line item for chronic disease prevention and control in the annual health budget as a core policy implementation step". The words "and to strengthen primary health systems to respond to chronic noncommunicable diseases" should be inserted at the end of paragraph 1(4). Paragraph 2(5) should include a reference to the need to increase health and wellness programmes in the workplace. A new subparagraph should be added to paragraph 2 requesting the Director-General "to encourage dialogue with international, regional and national nongovernmental organizations, and donor and technical agency partners to increase support and resources and partnerships for chronic disease prevention and control".

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the European Union and its 27 Member States in the name of the German Presidency, and with the support of the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Ukraine and the Republic of Moldova, welcomed the importance given to the prevention and control of noncommunicable diseases and the need for higher priority to be given by the Secretariat and the Member States. The draft resolution, and the proposed action plan, had the potential to accelerate implementation of the global strategy on noncommunicable diseases. An outline of the action plan should form part of the report to the Sixtieth World Health Assembly in May 2007. That would enable a completed action plan, whose focus should be on risk factors for noncommunicable diseases and which could build on existing strategies relating to risks and diseases, to be submitted to the Board at its 122nd session in January 2008. The plan should include policies, strategies and activities, ranging from health promotion and disease prevention to the role and responsibilities of health systems. Member States could enhance their capacity to deal with noncommunicable diseases by focusing national health systems on primary health care, and reviewing legislative and regulatory mechanisms with a view to including measures to combat those diseases.

He supported the draft resolution, subject to certain amendments. The words "including on mental health" should be added at the end of the second preambular paragraph, and "the environment" should be inserted after "development," in the fifth preambular paragraph. Two new subparagraphs should be added at the end of paragraph 1, to read: "(6) to ensure that the national health systems are adequately organized in order to tackle the serious challenges caused by noncommunicable diseases; this implies a particular focus on the primary health care", and "(7) to consider possibilities to profit by national legislative or regulatory mechanisms with the aim to prevent and control noncommunicable diseases". In paragraph 2(1), "On the basis of the presented outline" should be inserted before "to prepare", and "where needed for elaboration" should be inserted before "intensified implementation". "This action plan should be presented to the Sixty-first World Health Assembly" should be added at the end of that paragraph. In paragraph 2(5), "in particular" should be added after "private sector". A new paragraph 2(8) should be added, to read: "to ensure that the work on prevention and control of noncommunicable diseases is given appropriately high priority, including in terms of resources". Paragraph 2(8) would become 2(9) and should be amended by replacing "Health Assembly" with "Sixty-third World Health Assembly" and adding "including progress on the action plan" after "diseases".

Speaking as the member for Portugal, he emphasized implementation of the Global Strategy on Diet, Physical Activity and Health, the WHO Framework Convention on Tobacco Control and, in the European Region, the European Strategy for the Prevention and Control of Noncommunicable Diseases, which Portugal promoted. His country also fully intended to implement the European Charter on Counteracting Obesity, which covered intersectoral synergies, partnerships with the private sector and civil society, and interventions for schools and the workplace.

Mr MIGUIL (Djibouti), speaking on behalf of the countries of the Eastern Mediterranean Region, said that noncommunicable diseases currently represented 52% of the disease burden in the Region and that figure could rise to 60% by 2020. Most of the diseases were linked to lifestyle and socioeconomic status and involved multiple risk factors, including tobacco use and diet. The Health

Assembly resolutions relating to the prevention and control of noncommunicable diseases had strengthened chronic disease management and were the basis for national prevention and control. The report highlighted strengthening of integrated, broad-ranging action. Implementation of the draft resolution would necessitate acceleration of the implementation of the earlier resolutions.

The total of 35 million deaths from chronic diseases in 2005 was double that for all infectious diseases, maternal and prenatal conditions and nutritional deficiencies combined. That epidemic could be halted, since the conditions took decades to become fully established and had their origins early in life. Treatment required long-term, systematic prevention, integrating responses to noncommunicable diseases with those to acute infectious diseases.

The global initiative in 2005 for the treatment of chronic diseases had originated in the Region and was based on lessons from the “3 by 5” initiative, the Global Alliance for Vaccines and Immunization, Roll Back Malaria and the Global Fund to Fight AIDS, Tuberculosis and Malaria. The initiative would include the identification of gaps in access to and availability of cost-effective medicines, strategies for influencing price and managing availability, and improved access and affordability. Also in 2005, the Regional Committee, at its fifty-second session, had established a regional strategy for the prevention and treatment of noncommunicable diseases. The Region’s Joint Statement on the Control of Chronic Diseases (2006) called on Member States to prioritize chronic diseases and commit themselves to WHO’s goal for prevention, to reduce risk factors and to integrate management of chronic disease into primary health care.

Prompt and strengthened involvement by WHO was needed through advocacy, programme prioritization, increased funding commensurate with the global burden, and application of innovative instruments for prevention and control especially suited to the needs of the developing countries, where 80% of those diseases occurred. The draft resolution targeted a saving of 36 million lives by 2050.

Dr JAKSONS (Latvia) said that Gaining Health: the European Strategy for the Prevention and Control of Noncommunicable Diseases could form the basis for establishing best practices across WHO, giving it the opportunity to act as “one Organization”. The strategy covered psychological and socioeconomic factors, prevention and health promotion, and cost-effective and evidence-based interventions. Society should create health-supporting environments in order to facilitate healthy choices, such as healthy foods in schools. Poverty was a factor in susceptibility to noncommunicable diseases and inequalities in health must be reduced. Health systems should be easier to use, with more accessible primary health care and medicines. Financing mechanisms and cost-effective health promotion had a role. Ageing created further challenges in the provision of support to people living with chronic diseases. The foundations of health were laid down in early life, which complicated the search for solutions.

He supported the draft resolution as amended by the member for Portugal, but emphasized that the Board must evaluate the action plan.

Dr SUPAKIT SIRILAK (adviser to Dr Suwit Wibulpolprasert, Thailand) reported that mortality from noncommunicable diseases in Thailand exceeded that from communicable diseases and injuries across all age groups except those under five years. Those diseases accounted for eight of the 10 leading causes of loss of disability-adjusted life years in men and women; the major risk factors were misuse of alcohol, tobacco use, obesity and hypertension. Since 2001, 2% of tax revenue from sales of alcohol and tobacco had been allotted to the Health Promotion Fund. Increased taxation on alcohol and tobacco had led to reduced consumption by young adults.

He supported the draft resolution but pointed out that the target for reduction of death rates was ambitious, especially for developing countries. It was difficult to assess mortality rates, since registration of cause of death was often inaccurate and more than half all deaths occurred outside

hospital. The World Bank Group's disease control priorities in developing countries provided guidance for cost-effective action plans.<sup>1</sup>

Professor AYDIN (Turkey) supported the draft resolution as amended by the member for Portugal. Obesity was a major public health challenge of the twenty-first century and a leading cause of noncommunicable diseases. Unless the necessary measures were taken, it would pose a growing threat to future generations. The WHO European Ministerial Conference on Counteracting Obesity (Istanbul, Turkey, 15–17 November 2006) had agreed on rapid action in order to reach WHO's goals of reducing obesity and chronic diseases, particularly among children and adolescents. WHO's action plan for prevention and control of noncommunicable diseases should be in line with the conclusions of that Conference.

Dr TANGI (Tonga) said that, in view of the impact of noncommunicable diseases on the global disease burden, the issue should be placed on the agendas of the Executive Board and Health Assembly every year. The Director-General's focus on the health of women and the people of Africa was welcome. In Tonga, steps taken in the area of noncommunicable diseases included the establishment by legislation of a health promotion foundation, which would be financed by 5% of revenue drawn from taxation on tobacco and alcohol. He supported the draft resolution.

Dr NYIKAL (Kenya), speaking on behalf of the Member States of the African Region, said that for a long time noncommunicable diseases had been erroneously viewed as affecting only the rich, and that had had far-reaching negative effects on people and health systems in Africa. The increase in noncommunicable diseases in Africa, coupled with the disproportionate burden of communicable diseases, had raised levels of premature mortality and reduced quality of life. That complex double burden of disease stretched the weakened health systems and scarce resources in the Region. The diagnosis and treatment of noncommunicable diseases was costly and could not be supported effectively by current health budgets owing to the competing demands of communicable diseases. About 80% of all deaths from noncommunicable diseases, most of which were preventable, continued to occur in countries with low and middle incomes, despite cost-effective interventions. As noncommunicable diseases, once contracted, stayed with people for life, Africa could not wait for that silent epidemic to grow. It required cost-effective, early support in implementing prevention and control strategies for noncommunicable diseases.

He supported the draft resolution and proposed that in paragraph 1(2), the words "where appropriate to national circumstances" should be deleted; a new paragraph 1(4) should be added, that would read: "to increase budgetary provisions that are dedicated to the prevention and control of chronic noncommunicable diseases"; a new paragraph 1(5) should be added to read: "to consider implementing international agreements and increasing support for global initiatives that will contribute to achieving the target of reducing death rates from chronic noncommunicable diseases by 2% per year for the next 10 years"; and the words "every two years" should be inserted at the end of paragraph 2(8).

Dr AGWUNOBI (United States of America) said that chronic diseases were the leading cause of death and disability in his country, with 90 million lives adversely affected by those diseases in any given year. However, they were also some of the most preventable, and often the risks could be reduced. The Secretariat's focus on data collection and surveillance of chronic diseases and their underlying behavioural risk factors was the right approach. Member States should strengthen their capacity to measure the growing disease burden, particularly prevalence, impact across populations and age groups, and economic impact. Prevention should target three main risk factors: tobacco use, unhealthy diet and lack of physical activity. The information provided by the Secretariat must always

---

<sup>1</sup> Jamison DT, Breman JG, Measham AR, (editors). *Disease control priorities in developing countries*. Washington DC, World Bank, and New York, Oxford University Press, 2nd edition, 2006.

be based on evidence and reflect the best science available. The draft resolution should be precise and distinguish between alcohol use and the harmful use of alcohol. It should also reflect that, although the common major risk factors were the same for men and women in all regions, there were variations across regions. His proposed amendments would be submitted in writing.

Mr RAMOTSOARI (Lesotho) said that noncommunicable diseases deserved more attention in many developing countries, including his own, where the focus was on HIV/AIDS, tuberculosis and malaria. Most noncommunicable diseases were lifestyle-related and therefore preventable. He supported the draft resolution.

Ms HALTON (Australia) said that, in moving from strategy formulation to implementation, it must be ascertained which actions could be taken by all players, national and regional administrations, medical professionals, and individuals. Noncommunicable diseases would not have the immediate, catastrophic effect of an infectious disease pandemic, but they could have a devastating effect on the fabric of societies. Following the adoption of the WHO Framework Convention on Tobacco Control and the Global Strategy on Diet, Physical Activity and Health and the discussions on the harmful use of alcohol, the focus should henceforth be on individual responsibility. She supported the draft resolution, but would submit in writing minor drafting suggestions to highlight the importance of supporting countries and health systems and of engaging with, educating and supporting individuals and families to make healthy choices in their daily lives.

Mr HIWAL (alternate to Dr Al-Eissawi, Iraq) said that a national strategy to combat noncommunicable diseases had been underpinned by a nationwide STEPwise survey in Iraq in 2006, in collaboration with WHO. The measurement data and blood samples derived from the survey, which had been collected house-to-house by more than 400 trained fieldworkers in dangerous circumstances, had shown that 66.9% of the Iraqi population were obese or overweight, indicating an unhealthy diet. Almost four million Iraqis (40.4% of the population) suffered from hypertension and about one million (10.4%) from diabetes; 3.7 million (37.5%) had high cholesterol levels, and about two million (21.9%) were smokers. The findings were similar to those obtained in a comparable survey in Jordan in 2005. In order to assess the magnitude of the problem and draw up a plan of work, the survey ought to be repeated every three to five years and the data compared with those from neighbouring countries and the region as a whole.

Mr DE SILVA (Sri Lanka) said that diabetes and cardiovascular diseases were leading causes of disability and death in his country. His Government, with technical support from WHO, was implementing the WHO Framework Convention on Tobacco Control; it planned to implement a policy for the prevention and control of noncommunicable diseases. Sri Lanka had provided free health care for all since independence in 1948. Prevention and care for those suffering from noncommunicable diseases would be scaled up through the many primary health care facilities. Recent legislation should reduce tobacco and alcohol consumption by controlling the sale, advertising and promotion of alcohol in public places. It was an offence to sell alcohol to anyone below the age of 21 years; more than five million rupees had been collected in fines in the three weeks since the legislation was passed.

Mr CAMPOS (alternate to Dr Buss, Brazil), supporting the draft resolution, said that in his country, noncommunicable diseases, especially diabetes and cardiovascular diseases, had reached catastrophic levels. Primary health care relied on 26 000 primary health teams and reached about 70% of the population. The national strategy for health promotion could change dietary and exercise habits among the population and reduce the burden of noncommunicable diseases. A media campaign had encouraged better diet and more exercise. Brazil was implementing the WHO Framework Convention on Tobacco Control; it was also working to reduce the number of traffic accidents. The national commission on social determinants of health had enlisted the help of national sporting and artistic celebrities in order to broaden the vision of health.

The CHAIRMAN, speaking as the member for Bolivia, said that, although some diseases were in themselves noncommunicable, one result of globalization was that certain lifestyles and their effects had become all too communicable. Rather than adding more years to an individual's lifespan, it was a matter of improving the quality of life itself. Tobacco use, faulty nutrition and a lack of physical exercise were factors in noncommunicable diseases. Education was crucial, because habits acquired in childhood were hard to shake off.

Mr DEL PICÓ (Chile)<sup>1</sup> said that he could accept the draft resolution, but would have welcomed more specific proposals for countries that had learnt how to deal with noncommunicable diseases to lend support to those that had not, especially in drawing up national plans of action. His country was willing to share its experience with countries in the Region of the Americas, and provide training for health-care teams.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN, recalled his organization's mandate to improve the health of the world's people by raising standards of nursing practice and strengthening the contribution of nurses to health systems at all levels. Nursing personnel engaged in the care and rehabilitation of sufferers from chronic conditions were essential for reducing the major risk factors for chronic diseases and enabling the global strategy to succeed. The nursing workforce must be strengthened in order to lessen the burden of chronic diseases and implement the global strategy. He welcomed the Director-General's commitment to primary health care and the integrated management of diseases, and reaffirmed his organization's strengthened commitment to partnership with WHO.

Professor NORRVING (International Stroke Society), speaking at the invitation of the CHAIRMAN, said that stroke was the second leading single cause of death, with 5.8 million fatal cases a year, a substantial part of the burden of noncommunicable disease. Some 40% of strokes occurred in people under the age of 70. There were around 15 million new stroke cases every year, and some 55 million people, two thirds of them in low- or middle-income countries, had suffered a stroke at some time. Many stroke sufferers had long-lasting disabilities, including cognitive impairment and dementia. The burden of stroke was likely to increase as a result of demographic changes, urbanization and increased exposure to the major risk factors. By 2025, about 80% of all strokes would occur in people living in low- or middle-income countries. However, stroke was largely preventable. At least two thirds of strokes were attributable to a few risk factors linked to lifestyle. He supported WHO in encouraging healthy lifestyles and cost-effective measures for secondary prevention. The Society collaborated with headquarters and regional offices, and was developing technical tools and promoting surveillance of stroke. In most regions of the world, accurate contemporary data on stroke were still scanty.

The European Stroke Strategies Consensus Conference on Stroke Management (Helsingborg, Sweden, 22–24 March 2006) had adopted the Helsingborg Declaration 2006 on European Stroke Strategies, setting nine new targets to be achieved by 2015, including prevention, appropriate care in stroke units, the provision of acute phase therapies to dissolve blood clots, and improved functioning and survival. He urged priority action to strengthen the prevention and control of stroke.

Ms ALDERSON (World Heart Federation), speaking at the invitation of the CHAIRMAN, said that her organization's mission was to prevent and control heart disease and stroke. Cardiovascular disease caused an estimated 17.5 million deaths annually and was the leading cause of death worldwide. More than 80% of those deaths occurred in countries with low and middle incomes. Countries had to acknowledge the threat of cardiovascular and other chronic diseases and take action without further delay.

---

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

International and regional action plans would translate the Global Strategy on Diet, Physical Activity and Health into specific policy interventions and monitoring mechanisms, but such measures needed greatly increased funding. Taken together, WHO's programmes on chronic disease and tobacco control represented only 2.6% of the Programme budget 2006–2007, and she urged a larger share for chronic diseases. Her organization, together with strong leadership from WHO, would make it possible to strengthen national action plans.

Dr LHOTSKA (Consumers International), speaking at the invitation of the CHAIRMAN and also on behalf of the International Baby Food Action Network, said that both organizations supported the Global Strategy on Diet, Physical Activity and Health. In Europe, noncommunicable diseases represented 77% of the disease burden when expressed in disability-adjusted life years. In 2005, her organization had conducted a pilot survey on the implementation of the Global Strategy. The responses of 40 governments showed varied progress. Recommendations had been made covering: national measures to regulate marketing practices; transparent food labelling; responsible food production; government consultation with public interest organizations, in order to devise strategies for implementation of the Global Strategy; increased resources; and initiation of work by WHO on an international code for the marketing of food and beverages for children.

Immediate steps could include reduction in television viewing time and promotion of breastfeeding. In the United States of America both had proved to be cost-effective interventions for dealing with the childhood obesity epidemic. Neither measure, however, was mentioned in the report or the draft resolution. Unfortunately, dialogue with the private sector, referred to in paragraph 2(5), often created complex conflicts of interest.

Mr HENDRICKX (International Diabetes Federation), speaking at the invitation of the CHAIRMAN, said that his organization was the global voice of the estimated 246 million people, or 6% of the world's population, who suffered from diabetes. Each year, there were an estimated seven million new cases, with the greatest burden in developing countries. A resolution on diabetes, adopted by the United Nations General Assembly,<sup>1</sup> had designated 14 November, the current World Diabetes Day, as a United Nations Day to be observed every year from 2007. He encouraged Member States to formulate national policies for the prevention and treatment of diabetes. In the budget proposals soon to be considered by the Board, funding for noncommunicable diseases should be significantly increased.

Mr CHAN (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that promotion of multidisciplinary health-care teams and recognition of the role of all health-care professionals, including pharmacists, should be elements in the prevention and management of noncommunicable diseases. Collaboration was important to ensure patients' adherence to long-term therapy.

Pharmacists, as the most accessible health-care professionals, could identify unhealthy lifestyles and promote services such as smoking cessation support, behavioural counselling, monitoring and education. His organization would encourage pharmacists' associations to integrate pharmacy services into national programmes for the prevention and control of noncommunicable diseases.

Mr RIGBY (International Association for the Study of Obesity), speaking at the invitation of the CHAIRMAN, said that the European Charter on Counteracting Obesity, adopted in November 2006, included food and nutrition because they were central to any action plan to combat noncommunicable diseases. Strategies must protect children against dietary causes of chronic diseases. Recent WHO consultations had identified the need to reduce the marketing of unhealthy products to children and WHO's action plan should encourage that.

---

<sup>1</sup> Resolution 61/225.

The CHAIRMAN noted that proposals by Member States not represented on the Board had to be supported by a Board member in order to be considered. Speaking as the member for Bolivia, therefore, he supported the proposal made by the representative of Chile.

Dr DANZON (Regional Director for Europe), speaking on behalf of all the Regional Directors and regional offices, underlined the subject's importance. The European Strategy for the Prevention and Control of Noncommunicable Diseases, adopted in September 2006, would be followed up by a plan of action. Noncommunicable diseases and their prevention must be addressed as part of primary health care. The cost of long-term treatment of such diseases was high, hence the fund-raising campaign launched by the Regional Director for the Eastern Mediterranean. He emphasized the need for coherence between the Charter adopted by the European Ministerial Conference on Counteracting Obesity and global, regional and national approaches to the treatment and prevention of noncommunicable diseases.

Dr LE GALÈS-CAMUS (Assistant Director-General) thanked all the speakers for their suggestions and comments. The report would be revised to take into account the more precise wording suggested by the European Union and the United States. As the member for Australia had said, it was not a matter of creating a new strategy but of building on those already adopted by the Health Assembly. The work already done on tobacco control, diet and physical activity and harmful use of alcohol would be put to use in designing the action plan.

The latest scientific findings and the use of the diverse experiences of countries would be used to orient the plan strategically. She concurred with the remarks of the Regional Director for Europe on coordination among the regional and country offices.

In response to a comment by the CHAIRMAN, she confirmed that the draft resolution would be amended and submitted for later consideration.

The DIRECTOR-GENERAL said that the facts spoke for themselves as to the importance of the subject. The discussion had been robust and rich, with agreement to prioritize the action plan, which she would do. The Secretariat would support Member States' efforts to prevent noncommunicable diseases. As the member for Tonga had requested, some aspects of the issue would be discussed at future sessions of the Executive Board and Health Assembly. She thanked members for their advice and guidance.

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

**The meeting rose at 17:15.**

## **FIFTH MEETING**

**Wednesday, 24 January 2007, at 09:05**

**Chairman:** Dr F. ANTEZANA ARANÍBAR (Bolivia)

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

**Oral health: action plan for promotion and integrated disease prevention:** Item 4.6 of the Agenda (Document EB120/10)

The CHAIRMAN drew attention to a draft resolution on oral health: action plan for promotion and integrated disease prevention, proposed by Brazil, China, Djibouti, Ethiopia, France, Japan, Kenya, Lesotho, Libyan Arab Jamahiriya, Madagascar, Mali, Mexico, Namibia, Rwanda, Sri Lanka and Sudan, together with its financial and administrative implications, which read:

The Executive Board,

Having considered the report on oral health: action plan for promotion and integrated disease prevention,<sup>1</sup> and the report on prevention and control of noncommunicable diseases: implementation of the global strategy,<sup>2</sup>

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:

The Sixtieth World Health Assembly,

Recalling resolutions WHA22.30, WHA28.64 and WHA31.50 on fluoridation and dental health, WHA36.14 on oral health in the strategy for health for all, WHA42.39 on oral health; WHA56.1 and WHA59.17 on the WHO Framework Convention on Tobacco Control; WHA58.22 on cancer prevention and control; WHA57.14 on scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS; WHA57.16 on health promotion and healthy lifestyles; WHA57.17 on the Global Strategy on Diet, Physical Activity and Health; WHA58.16 on strengthening active and healthy ageing; WHA51.18 and WHA53.17 on prevention and control of noncommunicable diseases, and WHA58.26 on public-health problems caused by harmful use of alcohol;

Recognizing the important role of oral health for health in general and for quality of life;

Emphasizing the need to incorporate programmes for promotion of oral health and prevention of oral diseases into national programmes for the integrated prevention and treatment of chronic diseases,

---

<sup>1</sup> Document EB120/10.

<sup>2</sup> Document EB120/22.



1. URGES Member States:
  - (1) to adopt measures to ensure that oral health is incorporated into national policies for the integrated prevention and treatment of chronic noncommunicable diseases;
  - (2) to provide coverage for the population with essential oral-health care, and to ensure within the framework of enhanced primary health care for chronic noncommunicable diseases the availability of national oral-health systems that should be directed towards disease prevention and health promotion for poor and disadvantaged populations, in collaboration with integrated programmes for the prevention of chronic noncommunicable diseases;
  - (3) for those countries that have not yet established systematic water fluoridation programmes, to develop and implement national fluoridation programmes, giving priority to equitable strategies such as the automatic administration of fluoride, for example, in drinking water, salt or milk, and to the provision of affordable fluoride toothpaste;
  - (4) to take measures to ensure that prevention of oral cancer is an integral part of national cancer-control programmes, and to encourage the involvement of oral-health professionals or personnel with special training in oral health and specialized in detection, early diagnosis and treatment;
  - (5) to develop and implement programmes for the prevention of oral disease associated with HIV/AIDS, the promotion of oral health and quality of life for people living with HIV, that involve oral-health professionals or staff who are specially trained in primary health care, applying primary oral-health care;
  - (6) to develop and implement the promotion of oral health and prevention of oral disease for children as an integral part of national healthy schools programmes;
  - (7) to develop and implement, in countries affected by noma, national programmes to control the disease within national programmes for the integrated management of childhood illness and for the reduction of malnutrition and poverty, in line with internationally agreed health-related development goals, including those contained in the Millennium Declaration;
  - (8) to incorporate an oral-health information system into health surveillance plans so that oral-health objectives are in keeping with international standards, and to evaluate progress in promoting oral health;
  - (9) to strengthen oral-health research and use evidence-based oral-health promotion and disease prevention to consolidate and adapt national oral-health programmes and to encourage the intercountry exchange of reliable knowledge and experience of community oral-health programmes;
2. REQUESTS the Director-General:
  - (1) to raise awareness of the global challenges to improving oral health, the specific needs of low-income countries and of poor and disadvantaged population groups;
  - (2) to ensure that the Organization, at global and regional levels, provides advice and technical support, on request, to Member States for the development and implementation of oral-health programmes within integrated approaches to monitoring, prevention and management of chronic noncommunicable diseases;
  - (3) continually to promote international cooperation and interaction with and among all actors concerned with the implementation of the oral-health action plan, including WHO collaborating centres for oral health and nongovernmental organizations.

<b>1. Resolution</b> Oral health: action plan for promotion and integrated disease prevention	
<b>2. Linkage to programme budget</b>	
<b>Area of work</b>	<b>Expected result</b>
Health promotion	1. Increased guidance for integrating health promotion into health plans, including healthy diet, physical activity, ageing and oral health
Surveillance, prevention and management of chronic, noncommunicable diseases	1. Support provided to countries for framing policies and strategies for prevention and management of chronic, noncommunicable diseases at national level, including integration of primary and secondary prevention into health systems  5. Improved quality, availability, comparability and dissemination of data on chronic, noncommunicable diseases and their major modifiable risk factors
<b>3. Financial implications</b>	
(a) <b>Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)</b> US\$ 3 230 000 between 2008 and 2013	
(b) <b>Estimated cost for the biennium 2006–2007 (estimated to the nearest US\$ 10 000, including staff and activities)</b> US\$ 1 040 000	
(c) <b>Of the estimated cost noted in (b), what can be subsumed under existing programmed activities?</b> US\$ 1 040 000	
<b>4. Administrative implications</b>	
(a) <b>Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant)</b>	
Implementation of the resolution will require participation of all levels of the Organization, with activities focused on low- and middle-income countries. There will be a particular emphasis on the 23 countries that account for 80% of the burden of chronic, noncommunicable diseases in low- and middle-income countries.	
(b) <b>Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)</b>	
No additional staffing requirements are foreseen.	
(c) <b>Time frames (indicate broad time frames for implementation and evaluation)</b>	
Implementation will take place from 2007 to 2013.	

Professor PEREIRA MIGUEL (Portugal) said that an important focus of the global strategy on oral health was on reducing common risk factors for oral and chronic diseases. Health systems should seek to improve oral health according to the different risks and needs of populations, particularly low-income groups, which had the highest incidence of oral disease, by promoting the role and capacity of primary health care. His country's National Programme for Oral Health targeted children under 16 years and pregnant women. It aimed to reduce the prevalence of oral diseases and promote equity of care through work at primary care level in health centres and other institutions, including schools. He supported the proposed draft resolution.

Dr RUIZ MATUS (alternate to Mr Bailón, Mexico) said that oral health was a priority for Mexico, which for 20 years had been implementing preventive strategies, notably salt fluoridation, a

programme that had a high coverage rate and had reduced the incidence of dental caries in children aged 6 to 10 years. Oral health was also being promoted through schools. Each year, prevention was emphasized during national oral health week with the participation of health and educational institutions, civil society and the private sector. Nevertheless, poor oral health remained a serious problem in Mexico and the Region of the Americas, and he supported the action plan proposed in the draft resolution.

Dr RAHANTANIRINA (Madagascar), speaking on behalf of the Member States of the African Region, said that oral diseases were a public health problem in Africa. Oral pathologies varied across the Region, depending on the degree of exposure to different risk factors, which included unhealthy environments and behaviours, insufficient fluoride exposure, severe malnutrition and infectious diseases such as HIV/AIDS, measles and malaria.

The regional oral health strategy for 1999–2009 prioritized prevention and the elaboration of national strategies. The number of national programmes had risen to 36 in 2006, and the regional noma programme covered nine countries in 2006 compared with one country in 2001. Obstacles to the promotion of oral health in the Region included a shortage of oral health personnel, inequitable access to oral health services, lack of accurate epidemiological information on oral health, lack of public awareness, and poor investment in oral health at regional and country levels.

The action plan on oral health would integrate prevention of oral health problems with prevention of chronic diseases by addressing their common risk factors. It sought to provide oral health services and systems in the context of primary health care. She emphasized the needs of poor and disadvantaged populations, and urged the Board to adopt the draft resolution.

Dr AKIZUKI (alternate to Dr Shinozaki, Japan) said that good oral health was necessary for maintaining good general health and quality of life. It was closely related to lifestyle factors such as smoking, diet, physical activity and sleep. Prevention and early diagnosis of oral health problems should be strengthened and promoted, including routine checkups and raising awareness of the determinants of oral and general health. WHO should promote the sharing of experiences.

Dr QI Qingdong (China) said that China supported the action plan proposed and wished to cosponsor the draft resolution. Oral diseases were an important public health issue, but not enough attention was paid to them, especially in low- and middle-income countries. In China, for example, there was little awareness of the importance of oral health, and dentists were in short supply. The adoption of the draft resolution should focus attention on oral health and help to reduce the burden of oral disease.

Dr ALLEN-YOUNG (Jamaica) said that her country had significantly reduced its index for decayed, missing or filled teeth in children under 10 years of age through salt fluoridation since 1984. Gains had been made in child oral health, but the ageing of the population in the Caribbean region was giving rise to new risks, as evidenced by the increased prevalence of periodontal disease and associated noncommunicable diseases. Many health conditions had the same genesis, which had implications for health-service delivery. Oral health services should be delivered through a horizontal, integrated primary health care approach.

She suggested that the Secretariat's report should have included information on best practices. A further subparagraph should be added to paragraph 2 of the draft resolution, reading "to communicate to the United Nations Children's Fund (UNICEF) and to other United Nations agencies with health-related activities the need to include oral health as an integral part of their programmes".

Ms HALTON (Australia) said that she would submit in writing some minor amendments to the draft resolution, aimed at reflecting the existence of different areas of responsibility for oral health and differing degrees of national government involvement in different countries.

Dr SOPIDA CHAVANICHKUL (adviser to Dr Suwit Wibulpolprasert, Thailand) said that the periodic national oral health surveys recommended by WHO should include additional data on consumption of sugar and sweets, oral care behaviour and access to oral services. Such information would be useful in the formulation, monitoring and evaluation of oral health policy. Her country's success in tobacco control over the past 20 years highlighted the valuable role of the oral health profession in reducing tobacco use. Studies had shown that one of the most effective deterrents to smoking was illustrations on cigarette packets showing the oral health damage caused by tobacco use.

Thailand was concerned about the problem of fluorosis, the prevalence of which reached 50% in some parts of the country. Before implementing a national fluoridation programme, countries should assess the natural fluoride concentration in groundwater supplies and fluoride intake through dental products. Hence she proposed that subparagraph 1(3) of the draft resolution should be amended to read: "for those countries with no access to natural fluoride that have not yet established systematic fluoridation programmes, to develop and implement national fluoridation programmes ...".

Thailand supported oral health promotion in schools and the provision of oral health care in primary health care services. That required sufficient oral health personnel, particularly auxiliary personnel. Studies had shown that services provided by auxiliary personnel were effective and often more appropriate than dentists' services. Moreover, auxiliaries could increase access to oral health services for rural populations. Yet in many countries, including her own, dentists outnumbered dental auxiliaries. Accordingly, she proposed that the draft resolution be amended by the addition of a new paragraph 1(7) reading "to scale up the training of dental nurses, dental hygienists and other auxiliary personnel and to ensure the equitable distribution of such personnel at the primary care level, with proper back-up by dentists through appropriate referral services".

Evidence from the national oral health survey in Thailand had indicated that most oral health problems occurred in preschool children. She therefore proposed that paragraph 1(6) of the draft resolution should be amended to read: "to develop and implement the promotion of oral health and prevention of oral disease for preschool and schoolchildren as an integral part of national health-promoting schools".

She supported the amendments proposed by the member for Jamaica.

Dr SAHELI (Libyan Arab Jamahiriya), speaking on behalf of the countries of the Eastern Mediterranean Region, said that in order to meet the challenges posed by oral diseases and related problems, public health administrators and decision-makers needed the tools, capacity and information to assess and monitor health needs, choose intervention strategies, design policies and improve oral health programmes.

The countries of the Region had made great strides in oral health promotion, which was an integral part of broader health initiatives in most Member States. However, often access to oral health services remained limited, and diseased or damaged teeth were often left untreated or extracted.

He supported the draft resolution, which should build on the 10 priority areas identified in The world oral health report 2003.<sup>1</sup> It should incorporate requests to WHO for more financial and human resources in oral health promotion and assistance in the surveillance of oral diseases.

Dr TANGI (Tonga), highlighting the alarming increase in the incidence of dental caries in schoolchildren, said that Tonga had prioritized oral health in its national programmes. Water fluoridation had been introduced, and a fluoride mouthwash programme had been set up in primary schools across the country. Small islands and developing countries faced difficulties in building human resources capacity in the area of oral health. Tonga wished to be included as a cosponsor of the draft resolution.

---

<sup>1</sup> Document WHO/NMH/NPH/ORH/03.2.

Mr RAMOTSOARI (Lesotho) said that Lesotho experienced many problems arising from oral health manifestations of HIV/AIDS, oral trauma and oral cancer, and recognized the importance of oral health in the context of public health policies. Greater access to, and equity of, oral health services must be ensured for disadvantaged and rural populations, notably by means of decentralization. Promotion of oral health could ensure early diagnosis and care, and monitoring of oral manifestations of HIV/AIDS should be strengthened. Education campaigns should combat alcohol misuse and smoking, which were major causes of oral trauma and oral cancer. He emphasized WHO's role in assisting developing countries and supported the draft resolution.

Dr VOLJČ (Slovenia) said that hitherto oral health had been given insufficient attention by the medical community. In the light of the Secretariat's report, Slovenia would incorporate oral health into its strategy for prevention of noncommunicable diseases. Attention would be given to oral mucosal lesions, in particular atrophies, oral pre-cancers and oral-cavity cancers.

Several decades earlier, a system for preventing dental caries, from kindergarten to the end of high school, had been implemented in Slovenia and significantly reduced the frequency of dental caries. However, new legislation had encouraged dentists specially trained in preventive work with children to turn to the private sector, thus weakening primary health care provision. Slovenia would collaborate with other European countries that had achieved similar results on the basis of mixed public/private health systems.

Mr DE SILVA (Sri Lanka) said that oral cancers constituted some 35% of all cancers in Sri Lanka. His Government had promoted oral health through outreach programmes for rural populations, and each year more than 100 dentistry graduates were involved in integrating oral health into school health programmes. Sri Lanka had hosted the scientific session of the Commonwealth Dental Association in 2006, at which valuable discussions had been held on cost-effective provision of community health care.

Dr OGWELL (alternate to Dr Nyikal, Kenya) said that it was crucial to integrate oral health plans and activities into those of general health systems, at both planning and service delivery levels, particularly community interventions modelled on primary health care. Kenya's Health Sector Strategic Plan was based on a cost-effective and preventive, rather than a curative, approach.

Service effectiveness required trained, supported and motivated personnel, yet issues relating to human resources had not been addressed in the report; nor had it highlighted the existing shortfall in WHO's capacity to deliver technical support to Member States. The inadequate staffing of WHO's Oral Health Programme, both at headquarters and in the regional offices, needed to be addressed urgently. Moreover, the report had failed to adequately recognize key partners in oral health. Member States should refer to the Global Goals for Oral Health 2020, jointly developed by WHO, the FDI World Dental Federation and the International Association for Dental Research, which constituted a valuable tool for setting clear and measurable objectives in oral health-care delivery.

He broadly supported the draft resolution, but proposed the following amendments: the fourth preambular paragraph should be amended to read "Acknowledging the intrinsic link between oral health and general health and quality of life" and the addition of new sixth and seventh preambular paragraphs, to read: "Aware that the importance of the prevention and control of noncommunicable diseases has been highlighted in the Eleventh General Programme of Work 2006–2015" and "Appreciating the role that partners like the FDI World Dental Federation and International Association for Dental Research have played in improving oral health globally". He also proposed the addition of three new subparagraphs in paragraph 1, to read "to take measures to ensure that evidence-based approaches are used to incorporate oral health into national policies for integrated prevention and control of noncommunicable diseases"; "to address workforce planning and human resources for oral health as part of every national plan for health"; and "to increase budgetary provisions that are dedicated to the prevention and control of oral and craniofacial diseases and conditions". A new subparagraph should be added in paragraph 2, which would read: "to strengthen WHO's technical

leadership in oral health by expanding the oral health programme in terms of funding and staffing at both the headquarters and regional offices”.

Dr AGWUNOBI (United States of America) supported the integration of oral health into broader health systems and programmes. Sound public health approaches, including disease prevention, health promotion and disease surveillance, were key elements of oral health programmes. He endorsed the draft resolution, with certain amendments: in paragraph 1(2), the words “and to ensure” and the preceding comma should be deleted, as well as the word “national” before “oral-health systems”. In paragraph 1(9), the word “national” should also be deleted.

Mr CAMPOS (alternate to Dr Buss, Brazil) said that in his country oral health was a key issue. Eighty per cent of family health teams included professional dentists, numbering 12 000 in all. Under a personal initiative taken by the President, who had grown up in a poor region of Brazil without any access to dental care, 400 specialist dental surgery centres had been established across the country.

Dr AERDEN (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, emphasized the strategic principles in the report, notably oral health as an integral part of general health, the reduction of risk factors such as tobacco use, the promotion of healthy nutrition with reduced sugar consumption, and the prevention of dental caries through oral hygiene and appropriate use of fluoride. It was also important to tackle the pandemic of untreated childhood caries observed in many low- and middle-income countries, and to acknowledge and strengthen the role of women in health promotion.

Skilled and motivated oral health professionals should be integrated into every national health plan. Regrettably, in many countries, oral health was not integrated into primary health care and was thus not available to or affordable by most disadvantaged populations. She urged equal access to basic oral health care and disease prevention for all peoples. Technical support was available from WHO and the Federation for implementation of adequate, affordable oral health care at realistic costs at all levels of primary health care. She reaffirmed the efficacy, cost-effectiveness and safety of optimal daily fluoride use. Toothpaste and other proven fluoride agents should be made affordable and accessible through measures such as the reduction or removal of taxation.

The Federation strongly recommended the adoption of the draft resolution.

Ms LEHNERS (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, and speaking also on behalf of the International Baby Food Action Network, expressed appreciation for the report’s recognition of the role played by breastfeeding in promoting health, including oral health, as expressed in The world oral health report 2003.<sup>1</sup> She endorsed the emphasis on the link between oral health and healthy diet, particularly lower consumption of sugars, as called for in the Global Strategy on Diet, Physical Activity and Health. However, the Global Strategy for Infant and Young Child Feeding should have emphasized the link between good oral health and breastfeeding. That would offer greater potential for coordinated approaches throughout the life-cycle, improving overall health and preventing diseases and their underlying causes, including those directly related to oral health.

Dr BARNARD (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN and on behalf of the International Association for Dental Research, urged the Board to include on the agenda of the Sixtieth World Health Assembly the strengthening of oral health research and the use of evidence on oral health promotion and disease prevention.

---

<sup>1</sup> Document WHO/NMH/NPH/ORH/03.2.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean) endorsed the comments of the member for Thailand on fluorosis. He also agreed that having a high ratio of dental professionals to oral hygienists and auxiliary dental workers could lead to problems. Because there had traditionally been little communication between WHO and dental training institutions, many of those institutions were not taking into account the importance of prevention and of community-based education. That issue should be addressed.

Dr LE GALÈS-CAMUS (Assistant Director-General) said that, with regard to monitoring and regular evaluation, an absence of data did not imply that there were no problems. The example given by the member for Thailand demonstrated the importance of regular evaluation. Suggestions for a more exhaustive and comprehensive monitoring system would be followed up to the extent possible.

She stressed the role of prevention, especially in relation to the main risk factors including noncommunicable diseases. As oral health was related not only to those diseases, an integrated approach could be beneficial, increasing the effectiveness and durability of treatment in the context of limited resources. It was important to share experience of best practices and keep the focus on the most vulnerable sections of the population.

The term “oral health systems” was currently used to designate both formal and informal health-care services; it was not intended to imply the promotion of health systems designed specifically for one condition or set of conditions. The report would be unambiguously revised for the Health Assembly.

She underlined the need for interaction between all interested parties, including nongovernmental organizations, in the area of oral health, and the vital role of WHO collaborating centres.

The DIRECTOR-GENERAL said that oral health had clearly been a neglected condition. However, effective tools and examples of best practice for prevention and promotion existed and should be applied. Those measures were affordable provided that they built on existing scientific knowledge. Failure to act would result in high financial costs as well as high costs in terms of patient suffering.

The CHAIRMAN said that a revised version of the draft resolution incorporating the many amendments would be submitted for consideration at a later stage.

**It was so agreed.**

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

**Health systems, including emergency-care systems:** Item 4.7 of the Agenda (Documents EB120/27, EB120/27 Add.1, EB120/38 and EB120/38 Add.1)

The CHAIRMAN drew attention to the draft resolution contained in paragraph 17 of document EB120/27.

Dr NTAWUKULIRYAYO (Rwanda), speaking on behalf of the Member States of the African Region, recognized that, in Africa, weak and poorly functioning health systems formed the principal obstacle to achieving the health-related Millennium Development Goals. Priority health problems, such as HIV/AIDS, malaria and tuberculosis depended on efficient and effective systems, whose strengthening was crucial for innovation through community involvement, contractual retention of health personnel, and establishing universally accessible health insurance in all African countries.

In view of the renewed awareness of the importance of health systems and calls for support in that area, strategic orientations for the African Region had been published.<sup>1</sup> One orientation was the strengthening of functional health systems, particularly at community and district levels. That would require action by WHO at country level, and the sharing of experiences with the support of the Organization.

Revitalized primary health care, as endorsed by the Regional Committee for Africa, in resolution AFR/RC56/R6, should promote community participation, strengthen cooperation and improve quality and coverage of essential services. All partners involved ought to be aware that health systems should always be regarded as a whole, so that any intervention contributed to the implementation of each country's strategic plan and more efficient use of resources.

Dr ILIESCU (Romania) supported the draft resolution. The strengthening of health systems would help to solve health issues worldwide. A high number of deaths could be prevented by establishing emergency-care systems. The action proposed in the draft resolution would have a significant impact, particularly in low- and middle-income countries, where preventable death rates were rising and where trauma-care systems were often non-existent. New and improved systems were needed ever more urgently, and could be introduced through better use of existing resources.

Dr JAKSONS (Latvia) suggested that the draft resolution should invite Member States to determine a time frame for the provision of emergency care outside medical institutions, which could be used to measure the development of emergency-care systems.

Dr CAMPBELL FORRESTER (alternate to Dr Allen-Young, Jamaica) said that support for health systems must be a priority for WHO, as a means of ensuring equitable, efficient, high-quality, sustainable and responsive health care.

Families and communities should be central in health systems. The new primary health care approach was based on equity, solidarity and the right to the highest attainable level of health, incorporating health promotion, management and integrated care. It represented the most cost-effective way of achieving health outcomes for most of the population and for vulnerable groups, and she recalled the Declaration of the Americas on the renewal of primary health care, issued in 2005.

The strategies of "health for all" could be reorientated in order to meet current population needs and to reduce inequities in health.

She proposed that the words "an integrated health delivery system and plays an important role in" be inserted after "is an essential part of" in the sixth preambular paragraph of the draft resolution. She further proposed that in paragraph 2, three new subparagraphs be added, reading:

to ensure a strategic approach to the strengthening of emergency care services in the context of the overall health care delivery system;  
to ensure the inclusion of health promotion approaches and interventions;  
to identify and include support programmes and improvements in working conditions of health-care providers serving in emergency services.

Mr DE SILVA (Sri Lanka), supporting the draft resolution, said that in Sri Lanka both curative and public health services were free as they were seen as an investment. By working within a strict policy framework, his country had achieved high targets. Life expectancy, for instance, stood at 71 years for men and 75 years for women, and the percentage of the population older than 60 years was the highest in South-East Asia. Sri Lanka had formulated an overall health development strategy

---

<sup>1</sup> *Strategic orientations for WHO action in the African Region, 2005–2009*. Brazzaville, WHO Regional Office for Africa, 2005.



covering the next 10 years. Providing free health care when faced with an ageing population was a major challenge.

Dr OTHMAN (alternate to Dr Al-Eissawi, Iraq), speaking on behalf of the countries of the Eastern Mediterranean Region, observed that no health system could cope with the large number of incidents Iraq had experienced in recent years. In general, throughout the Region, the prevalence of injuries and their consequences was rising, particularly in middle- and low-income countries. Effective trauma management at the prehospital and hospital stages could be crucial in minimizing the impact and after-effects of injuries. The issue was pertinent in the Region, as it was commonly afflicted by civil strife, wars and natural disasters. Because of restricted access to primary care services, emergency services were also being used for non-urgent cases. There was consequently a need both to strengthen primary care and to assess the quality of emergency medical services, particularly with respect to: competence of staff; capital cost of services; enhancement of intersectoral collaboration; attainment of targets, for example, response times; strategic planning and standards; and design and construction of emergency care departments. The value of research, both in obtaining such information and in general, should be emphasized and also included in the draft resolution.

Recalling resolution WHA57.10 on road safety and health, he requested that the draft resolution take account of some specific issues: the plight of low- and middle-income countries; focusing WHO's efforts on simple life-saving techniques, together with lower-cost methods of establishing effective trauma care systems; involving multiple sectors in trauma response, particularly in prehospital settings; working with the private sector in order to identify less costly, life-saving equipment and technology, as with HIV/AIDS treatment; and increasing WHO's investment in trauma-care systems, their planning, management and evaluation, and documenting the experience for the benefit of low- and middle-income countries. From Iraq's experience, he stressed trauma management at the community level through a first-aid approach; the incorporation of trauma management in primary health care; and sustainable monitoring and evaluation of trauma-care systems, with appropriate indicators and standards.

Dr AGWUNOBI (United States of America) agreed that health systems were vital in ensuring that resources allocated for health were used wisely and efficiently. A thorough review of the performance of countries' health systems showed policy-makers the effectiveness and level of care the system provided. The Secretariat could help Member States to develop evidence-based methods for measuring and evaluating their health systems. He welcomed emergency care as a component of national care systems. While primary prevention should reduce the burden of trauma, the strengthening of trauma and emergency services would reduce morbidity and mortality from injury and violence. In strengthening national services for emergency care and trauma, Member States should ensure that both hospital and prehospital care were included.

He supported the draft resolution, but requested that "services" be replaced by "care" throughout where it appeared in phrases such as "emergency-care". The objective was to highlight the notion that responsibility lay with the wider care community, including citizens, rather than exclusively with service providers.

Dr SUPAKIT SIRILAK (adviser to Dr Suwit Wibulpolprasert, Thailand) said that his Government recognized the importance of health-care systems. Without advocating a particular structure, it believed that a health system should ensure equitable access to high-quality, affordable and cost-efficient health care. It should also be sustainable through optimal application of primary care with proper referral systems and policies for health promotion and disease prevention. He supported the Secretariat's continuing work with Member States and international partners to attain national and international health-related development goals.

Services for emergency care and trauma needed adequate infrastructure and training capacity. The inclusion of the following wording at the end of paragraph 2(9) of the draft resolution would reflect the need for the necessary funding: "including financial mechanisms and management methods,

to ensure that a core set of trauma and emergency-care services are equally accessed by all people who need them”.

Dr SMITH (Denmark) proposed that in paragraph 2(2) of the draft resolution the words “ministries of health” should be replaced with “authorities responsible for prehospital care”, in order to reflect national differences.

She welcomed the continuing consultations in 2007 which aimed at producing a global strategy for strengthening health systems, a top priority – particularly for Member States in the developing world. The strategy should focus on practical interventions, such as motivating and equipping health workers and designing systems that were relevant. It should also take into account organizational and management theories, public–private partnerships, epidemiology, and health economics. WHO must also examine collaboration in the global health arena, including with the World Bank. The United Kingdom of Great Britain and Northern Ireland associated itself with her statement.

Dr BUSS (Brazil) emphasized the Secretariat’s role in developing Member States’ health systems. However, the international community should review its policy on support to developing countries. Considerable resources were being allocated for the treatment of HIV/AIDS and other diseases, but the lack of properly structured health systems in some countries meant that resources were being wasted. In future the international community should provide support for countries’ health systems, including recruitment of personnel and primary care facilities. With functioning systems in place, other resources would have more impact. Therefore, document EB120/38 should have referred to WHO’s resumption of its role of providing support for establishing sustainable health systems based on primary health care.

Brazil had a national prehospital system for trauma and emergency care. It was centrally controlled and could locate the best care for particular health problems. Most of the requirements in the draft resolution had already been met in most cities and states. Brazil possessed an integrated, free and universal system in which patients could obtain whatever level of care they needed through either the emergency department or primary-care facilities.

Mr RAMOTSOARI (Lesotho) said that health care in Lesotho had worsened so much that the health gains of the past 20 years could not be sustained. The situation had been exacerbated by the loss of health workers to diseases such as HIV/AIDS and tuberculosis. Primary health care services had been most affected, particularly in rural areas. The Government was decentralizing its services, among them primary health care, which should benefit health service delivery. Since local structures involved local communities, health priorities would be decided by the people. Attracting, training and retaining health workers would be important in reducing the disease burden. Such incentives as good working conditions, adequate staff housing and meeting other basic needs were essential to retaining health workers in remote and rural areas. In common with other developing countries, Lesotho was unable to provide good working conditions and that, too, affected emergency health-care services. He supported the strengthening of health systems.

Professor PEREIRA MIGUEL (Portugal) said that the Portuguese national health service reflected WHO’s principles and was committed to the measures outlined in document EB120/38. Member States should define the operation and management of the health sector through intersectoral processes. In order to attain the common objective of improved health, governments must also manage sectors cooperating with health, notably their operational processes, structures and management.

Particular attention had to be given to finding innovative ways of using existing resources and the services of other players, such as nongovernmental organizations and the private sector, and accommodating changes in public policy and administration. Poor people would more likely benefit from those reforms if other sectors were involved. Intersectoral work on determinants of health must be coordinated.

He supported the draft resolution. Strengthening the links between trauma and emergency-care services and involving the community in prehospital care, as mentioned by the member for the United States, would definitely bring public health benefits.

Ms HALTON (Australia) highlighted the importance of well-functioning, robust and integrated health systems, a prerequisite for efforts to combat HIV/AIDS and noncommunicable diseases and to respond to major health problems and extraordinary situations. Australia therefore sought to ensure that action to strengthen health systems was provided for in the aid it gave to developing countries, since stronger health systems also helped towards achieving other development goals. Although health systems differed between countries, they should all be effective and efficient, make optimal use of resources, and provide wide-ranging coverage for all groups of people, regardless of income, place of residence or personal health status.

The Secretariat should work with all relevant partners in strengthening health systems. She worked at OECD as well as WHO, and greatly valued the partnership between the two organizations; other speakers had highlighted the importance of collaboration with the World Bank, the Asian Development Bank and other institutions.

She supported the draft resolution, with a minor amendment which she would submit in writing.

Dr NYIKAL (Kenya), supporting the comments of the member for Lesotho, said that the quality of emergency care was a yardstick for the health system as a whole. In the African Region, the quality of emergency care was impaired by the inherent weaknesses of national health systems.

He proposed amending the draft resolution by adding two new subparagraphs at the end of paragraph 2. New subparagraph 10 should read: “[URGES Member States] to ensure that strengthening of health systems is a core objective of all health initiatives”, which would include health initiatives aimed at specific diseases. New subparagraph 11 should read: “to create incentives designed to train and retain health-care workers in employment”. In paragraph 3, a new subparagraph should be added after the existing paragraph 9, reading “[REQUESTS the Director-General] to provide support to Member States to establish or strengthen quality management programmes in health care”, since quality management often did not receive sufficient attention in health initiatives.

Dr TANGI (Tonga) agreed that creating a health system that could cope with new threats, introduce innovations and thus manage existing problems more effectively was a major challenge. He welcomed WHO’s efforts to address emergency care, an area in which the partnership between WHO and health professionals working in hospitals had been underexploited.

Better prehospital care could indeed reduce preventable death and disability. Trauma patients were most likely to die either immediately after their accident or in the ensuing 10 days. In the former case, improvements in road safety engineering and ambulance services would reduce mortality. The second peak in mortality was due to adverse events in hospital, which should be addressed.

In the draft resolution, the term “emergency care services” covered inputs from various sources, including health workers, ambulance services, road engineering experts and people present at the scene of an accident, and was preferable to “emergency care”. “Emergency care” was much more general in meaning.

Dr KOIKE (alternate to Dr Shinozaki, Japan), observing that efforts to strengthen health systems by increasing primary health care provision must be relevant and effective, called upon WHO to provide further guidelines and benchmarks. Trauma and emergency-care services were needed to deal with the consequences of violence and traffic injuries and with natural disasters such as earthquakes and tsunamis. He supported the draft resolution and suggested that the concept of emergency care in disasters and relevant health systems strengthening should be added to the text.

The CHAIRMAN, speaking as the member for Bolivia, said that the report on health systems contained in document EB120/38 gave a full account, with guidance for action. A well-functioning health system could achieve a high degree of sophistication where necessary. All health programmes

had to work together in order to achieve sustainability, promote development and strengthen the health system as a whole. The potential contribution of primary health care was not necessarily obvious to aid donors and should be better publicized, because it was what aid recipients really wanted. A sound health system was a prerequisite for an effective emergency response. The danger was that, as soon as the emergency disappeared from the television screens, emergency provision would disappear as well. He supported the draft resolution.

Dr ASLANYAN (Canada)<sup>1</sup> welcomed the information provided by the Secretariat, but called for a stronger focus on health-system performance, performance measurement and the development of indicators. Canada's support for strengthening health systems in developing countries included efforts to prevent and control the core diseases associated with poverty. In 2006 his Government had committed additional funds to that purpose in Africa. Relevant WHO partners should ensure effective collaboration between "programme" and "systems" activities nationally, regionally and globally.

Professor MIKHAILOVA (Russian Federation)<sup>1</sup> observed that the strengthening of health systems was one of the seven priority areas of the global health agenda contained in the Eleventh General Programme of Work 2006–2015, but it was not specifically mentioned in the draft Medium-term strategic plan 2008–2013 or Proposed programme budget 2008–2009. The need to strengthen health systems, as opposed to promoting health in general, could be stated more explicitly for the benefit of policy-makers and ministers of finance who were not health experts.

The report on health systems (document EB120/38) listed many problems and possible solutions. Although it reflected consensus-building across the Organization, there were inconsistencies: the Secretariat seemed to justify its positions by citing different arguments. For example, the section on the changing problems facing health systems referred both to the need for introducing changes in treatment and to the changes in government policy on the decentralization of health care. Instead of explaining how to strengthen health systems, the report listed the "building blocks" that made up a health system (paragraph 8), a list that was incomplete. It indicated the purposes that the building blocks were meant to serve, with no explanation of how they were to be created, and stated that they clarified essential functions, without specifying those functions. Paragraph 10 referred to "each part" of a health system but did not say what the parts were. Criteria for evaluating health systems were not mentioned. The report should be reviewed by independent experts and restructured to separate the issue of health systems in general from WHO's role in strengthening health systems at country level.

Dr VIZZOTTI (Argentina)<sup>1</sup> said that, almost 30 years after the adoption of the Declaration of Alma-Ata, many countries in the Region of the Americas and elsewhere had made great progress in the social and health fields, but millions of people still lacked the goods and services they needed for optimum development. Current challenges included ageing populations, urban sprawl, changing lifestyles, environmental deterioration and social conflict. It was important to protect the gains achieved in health status and life expectancy and to ensure equitable enjoyment of the fruits of scientific and technological progress.

Following a regional consultation initiated by PAHO in 2003, the Member States of the Region had re-committed themselves to primary health care and its incorporation into national health systems. Health and other sectors would contribute to comprehensive and equitable human development, facing various challenges, including those established in the Millennium Declaration.

His Government had called upon WHO, PAHO, UNICEF, the Inter-American Development Bank, the World Bank, the Ibero-American Summit General Secretariat and other institutions to support an international conference on strengthening primary health care and health systems (Buenos Aires, 13–18 August 2007). Its objectives were to promote global, regional and subregional

---

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

partnerships in order to strengthen primary health care, overcome barriers to access to health, strengthen national health systems, protect human security, and pave the way to achievement of the Millennium Development Goals. Themes would include human resources for health and “equity in health and financing”, and a political and technical declaration, “Buenos Aires 30/15: from Alma-Ata to the Millennium Declaration” would be presented. He invited Member States to attend and make it a milestone in global commitment to primary health care and the right to health as fundamental prerequisites for social inclusion and development.

Ms KEITH (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, welcomed the focus on Africa, women and health systems, and pledged her organization’s support and cooperation. She welcomed the greater focus on health systems in the Eleventh General Programme of Work 2006–2015. Document EB120/38 would have benefited from reference to previous resolutions, such as resolution WHA58.31 on working towards universal coverage of maternal, newborn and child health interventions, in order to remind all stakeholders of their pledge to make every woman and child count. Few African countries had reached national budget targets for health pledged in Abuja in 2001, and none of the G8 countries had kept their 30-year-old promise to invest 0.7% of their national budgets in aid. The document should also have referred to the report in 2006 on global health partnership principles to the High-level Forum on Health Millennium Development Goals; global health resources should support national health priorities and their effectiveness should be measured by their ability to strengthen national health systems. Global partnerships, developed countries and the private sector should implement previous resolutions, such as resolution WHA57.19 on international migration of health personnel. In paragraph 18, the term “affordable” should be replaced by “equitable” or “pro-poor”, since affordability was relative. The aim was to focus on equity of access and use of health-care services by those in most need. The organization’s research indicated that making essential health care free at the point of access was cost effective, and so reduced poverty. WHO should support more operational research into pro-poor health financing. Save the Children would work with WHO in its new strategy for health systems.

Referring to the draft resolution, she suggested the insertion in paragraph 2(9) of a reference to prevention policies in addition to legislation, in order to reduce death from trauma. Adequate investment in primary health-care systems would prevent many childhood deaths. Greater reference could be also made to emergency preparedness plans.

Dr DANZON (Regional Director for Europe) agreed that solid, sustainable health systems were at the heart of WHO’s priorities. Health systems illustrated the Organization’s comprehensive vision of health, integrating in a horizontal approach the different contributions of technical areas of work, and gave substance to the concept of the “intersectoral” dimension of health. There could be no progress in health systems if health alone was addressed: it was an area in which partnerships were especially important. Development aid for health systems as a whole, and not simply for a specific sector, was also important.

The Regional Committee for Europe was working in areas such as the quality of health systems and patient safety, in cooperation with the European Union; the financing of health systems; and health worker migration. The Regional Office had instructed that all its technical programmes should be designed in order to develop health systems, and that consultancy and support should be confined to those Member States with health systems clearly able to benefit. A relevant ministerial conference would be held in 2008.

Health systems provided an opportunity for WHO to demonstrate its unity, effectiveness and performance, and its capacity for innovation by sharing responsibility between the regions and headquarters, and between the regions themselves. He pledged his commitment and that of the other regional directors to that issue, in the same way that commitment had been pledged to the issue of poliomyelitis. The two issues naturally went hand in hand.

Dr EVANS (Assistant Director-General) explained that document EB120/38 was concerned with developing an Organization-wide strategy for health systems; with regard to the comment by the

member for Rwanda that health systems must be addressed as a whole and to the question by the representative of the Russian Federation, the idea contained in paragraph 10 was that, in addition to looking at the specific building blocks of health systems defined in paragraph 9, it was necessary to look at how those blocks interacted. The paragraph would be redrafted for greater clarity. The comments about reference to previous resolutions and declarations related to health systems would be taken into account, as would the request by the member for Denmark for the strategy to be practical with regard to the common denominators of health systems – communities, districts and facilities – would be fully considered. He had noted the comments on learning and research.

WHO could not work on health systems in isolation, and the Organization would continue to cooperate with partners such as the World Bank and OECD, benefiting from their particular strengths. The question of how global health partnerships or development assistance, often targeted towards specific problems such as HIV/AIDS and tuberculosis, could strengthen health systems as a whole, was covered by the second pillar of the strategy. It was an area in which WHO had relative advantages. WHO had been working with the Global Alliance for Vaccines and Immunization on strengthening health systems. Health systems could not be strengthened from within the health-care sector itself, and he acknowledged the need for intersectoral action, a key plank of primary health care. The ability to engage with other actors in the context of wider public-sector reforms was becoming a crucial competence of health ministries. The Commission on Social Determinants for Health had specifically focused on the mechanisms for intersectoral action, and would make recommendations in that area. He concurred with the member for Australia that one size did not fit all cases; there were lessons to be learnt from diversity.

Dr LE GALÈS-CAMUS (Assistant Director-General) said that members' comments would be acted on. The aim of the report and draft resolution was to save the lives of many victims of violence and trauma by means of simple, effective and low-cost interventions. The issue of preventing violence and trauma would be reported on subsequently to the Board. She recalled the recently published guidance on surgical care, essential trauma care and prehospital trauma-care systems, referred to in paragraph 8 of the report. Additional guidelines on mass-casualty incidents were being drawn up. The participation of many international experts from all parts of the world, including low-income countries, would ensure that the guidelines were based on the best available data. Better organization was needed within the Secretariat in order to meet the increasing demand from Member States in that area. Capacity and expertise would be strengthened in the weeks ahead, particularly in the area of essential trauma and emergency-care services and prehospital care. A revised version of the draft resolution could be submitted to the Board for consideration later.

The CHAIRMAN agreed to that suggestion and drew the Board's attention to the need to consider, together with each draft resolution, the accompanying financial and administrative implications. A realistic assessment of the figures proposed – which were optimistic – was necessary.

The DIRECTOR-GENERAL thanked all participants for their constructive comments and suggestions, which would be given full consideration, and for the support pledged by the different regions. Strengthening health systems through integrated primary health care was a top priority for the Organization. Thirty years on from Alma-Ata, the principles of primary health care remained relevant: equity of access; affordable services based on need; multisectoral engagement; and community ownership, participation and sustainability. The concept of an integrated approach to primary health care did not mean, however, a return to the health-for-all agenda of three decades before. In the context of global public health in the twenty-first century, it was necessary to hold extensive, dynamic consultations in the subsequent biennium with Member States and other partners, in order to decide on relevant and effective models and she acknowledged the different proposals made. Her objective was to design performing and creative models that would suit the diverse development of Member States, and maximize the impact and synergy of programmes. She would work closely with all the parties concerned.

The CHAIRMAN, speaking as the member for Bolivia, welcomed the renewed focus on primary health care. Adapted to the twenty-first century, it could allow countries with limited resources to strengthen other parts of their health-care systems.

(For adoption of the resolution, see summary record of the ninth meeting, section 2.)

**The meeting rose at 12:40.**

## **SIXTH MEETING**

**Wednesday, 24 January 2007, at 14:10**

**Chairman:** Dr B. SADASIVAN (Singapore)  
**later:** Dr F. ANTEZANA ARANÍBAR (Bolivia)

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

**Gender, women and health: draft strategy for integrating gender analysis and actions in the work of WHO:** Item 4.8 of the Agenda (Documents EB120/6 and EB120/6 Add.1)

Dr CAMPBELL FORRESTER (alternate to Dr Allen-Young, Jamaica) said that the family and reproductive health strategy for the Caribbean, developed by PAHO and the Caribbean Community in 2001, included strategic directions for gender health, with goals relating to both sexes. The empowerment of women was an effective way of combating poverty, hunger and disease, but issues relating to men's health, such as their reluctance to contact health services and their risk of chronic diseases, should also be addressed. In some Caribbean countries, the number of deaths among young men from violence, road traffic incidents and HIV/AIDS was higher than among women. Health services tended to focus on maternal and child health and were not necessarily gender friendly. In Jamaica, for example, the prevalence of prostate cancer was one of the highest in the Region of the Americas.

She endorsed the strategic directions proposed and the draft resolution contained in the report, but suggested the addition, in paragraph 2, of two new subparagraphs that would read: "to place emphasis on training, sensitization and promotion of gender, women and health" and "to ensure that gender-friendly health services are incorporated into all levels of health-care delivery".

Dr SMITH (Denmark), speaking on behalf of the members for Latvia, Luxembourg, Portugal, Romania and Slovenia and on behalf of Austria, Belgium, Canada, Finland, France, Iceland, Netherlands, Norway, Sweden, Switzerland and the United Kingdom of Great Britain and Northern Ireland, said that the draft strategy should have referred to the need for indicators as a prerequisite for adequate monitoring, and had a sharper focus on the specific technical areas of WHO's work related to gender and health, including sexual and reproductive health. Given the emphasis that the Director-General had placed on women's health, however, specific action in that area would undoubtedly be incorporated in the plan of action once the strategy had been approved.

Gender and health were inextricably linked to sexual and reproductive health and interrelated social and cultural factors, including gender-based violence. Reference might therefore have been made in paragraph 18 of the report to the International Conference on Population and Development (Cairo, 1994), partnerships, and the 2005 World Summit Outcome.<sup>1</sup>

Collaboration and division of labour with partners such as UNFPA, UNICEF and UNAIDS also needed clarification in the plan of action, in order to ensure a coherent approach to maternal and child health, including the feminization of the HIV/AIDS epidemic and prevention of mother-to-child transmission of HIV.

The draft strategy also lacked reference to progress, experiences, lessons learnt and previous or future challenges in implementing gender policies. Progress in implementing the strategy should

---

<sup>1</sup> United Nations General Assembly resolution 60/1.



therefore be reported to the Health Assembly on a regular basis, in order to ensure optimum conditions for incorporating gender in the mainstream of WHO's activities.

In the draft resolution, the words "the Programme of Action of the International Conference on Population Development (ICPD, Cairo, 1994)" should be inserted after the word "recalling" at the beginning of the second preambular paragraph; the words "including in the area of reproductive and sexual health in accordance with WHO's 2004 reproductive health strategy" should be added at the end of paragraph 2(2); the words "to develop indicators and" should be inserted before "to monitor" at the beginning of paragraph 3(2); paragraph 3(3) should be amended to read "to support and sustain incorporation of a gender perspective into the mainstream of WHO's policies and programmes, including through recruiting staff with specific responsibility and experience on gender and women's health"; and in paragraph 3(7), the phrase "on a regular basis" should be inserted after "and report".

Dr AGWUNOBI (United States of America) applauded the Director-General's focus on women's health and looked forward to a bold, comprehensive strategy that would have a significant impact on women's health throughout the world. The draft resolution however, did not reflect that broader vision. The report outlined some good first steps, but fell far short of expectations. He therefore proposed that the draft resolution should be amended to reflect that broader strategy, rather than offering a piecemeal approach to women's health, and that it should be resubmitted for the Board's consideration at its 121st session in May 2007.

Dr QI Qingdong (China) endorsed the report's analysis and incorporation of gender issues into the mainstream of WHO's work. The concept of gender equality and promotion of women's health had in recent years attracted much attention: women were a vulnerable group, and in many countries their right to health had been given too few safeguards. Gender equality was an expression of social equity. The Chinese Government had long striven to integrate gender equality into all political, economic and social areas, and to give priority to women's health. Chinese women's rights were being safeguarded in health care, education, employment, marriage and reproductive health, and their status was thus improving. The constraints to gender equality should be identified and overcome. Gender equality was linked to equity in health care. WHO should adjust its existing policies and programmes, respond to specific needs, promote gender equality and improve women's health status.

He supported the draft resolution.

Ms PAWENA TARNSONDHAYA (adviser to Dr Suwit Wibulpolprasert, Thailand) welcomed WHO's commitment to addressing health inequalities by integrating gender perspectives into its programmes. UNDP's *Human development report 2006*,<sup>1</sup> in reviewing progress towards achieving the Millennium Development Goals, indicated that gender equality had been promoted, but that the health status of women still needed to be improved. There was insufficient information on gender inequity in health and access to health care, and too few sex-disaggregated data. Gender analysis was needed in health-information systems at global and national levels.

She supported the draft resolution, confident that the strategies proposed would reduce gender discrimination in health education, information and services, and welcomed the Director-General's emphasis on women's health.

Professor MACHADO (alternate to Professor Pereira Miguel, Portugal) expressed concern over the possible discriminatory nature of the strategy and the terminology used in the report. Although the title of the report was "Gender, women and health", in some places it referred to women and health and in others to gender and health. A coherent approach to gender and health should therefore include strategies that related to men's as well as women's health.

---

<sup>1</sup> *Human development report 2006. Beyond scarcity: power, poverty and the global water crisis*. New York, UNDP, 2006.

Her Government had introduced programmes on gender equality and domestic violence. Specifically, she mentioned the national health institute's activities on gender and health, the outcomes of which would be available in 2007.

She supported the draft resolution and suggested that, in paragraph 3(3), the Director-General should also be requested to train managers with the aim of integrating gender equality and equity into the decision-making and implementation process.

Dr SALEHI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the strategy and applauded its aim of enhancing the Secretariat's capacity to analyse gender and sex in health and provide support to Member States for formulating and implementing gender-responsive health strategies. Paragraph 2(1) of the draft resolution urged Member States to include gender analysis in their strategies, which pointed to the need for joint capacity building. The inclusion of Member States as both partners and recipients in the process of meeting the strategic objectives should therefore be made more explicit.

He supported the distinction between equality and equity, so that males and females had equal opportunities to secure good health. Social conditions should facilitate positive health outcomes.

The references in paragraphs 6 and 8 of the report to "women and men" implied that the strategy would address only the health of adults; it should be amended to refer to all age groups.

Females had borne the brunt of health inequities, but male vulnerabilities arising from social expectations should also be addressed. Males and females should be partners in health, and he was therefore concerned by the reference in paragraph 18 to the strategic objectives for women's health and, in paragraph 3(3) of the draft resolution, to the recruitment of staff with expertise on gender and women's health.

Making senior WHO staff accountable for integrating gender perspectives into WHO's programmes would ensure that the gender strategy was taken seriously and integrated into all areas of work. Process and outcome indicators for monitoring implementation of the strategy were needed.

He supported the draft resolution and strategy.

Dr RUIZ MATUS (alternate to Mr Bailón, Mexico) said that his Government was introducing a gender perspective in its policies, especially social policies. He supported the draft resolution, which reflected Mexico's principles of equality of opportunity and its commitments to international agreements, including those mentioned in paragraph 3 of the report.

Adoption of the draft resolution by the Board at the present session could lead to its adoption by the Sixtieth World Health Assembly, thereby promoting gender equality and equity in health across the world. A gender perspective countered the discrimination and disadvantages faced by women, and the negative attitudes of men towards their own health, which resulted in premature deaths. WHO should bring gender into the mainstream in order to improve women's access to health services and deal with issues such as violence against women, the care of family members living with chronic diseases, and the increased numbers of women working outside the home, which was changing traditional patterns of care.

He supported the draft resolution as a first step in formulating appropriate gender-sensitive strategies.

Dr RAHANTANIRINA (Madagascar), speaking on behalf of the countries of the African Region, welcomed efforts to attain Millennium Development Goal 3, "Promote gender equality and empower women". Although progress had been achieved in implementing the resolutions adopted at the International Conference on Population and Development (Cairo, 1994) and the Programme of Action from the Fourth World Conference on Women (Beijing, 1995), a gender perspective in policies would improve women's health, in particular those at risk of HIV infection and AIDS. Biological and social differences between men and women affected their behaviour in seeking treatment and the responses of the health system. The area of work on women's health in the Programme budget 2006–2007 had focused efforts and should enable Member States to adopt suitable policies.

In the African Region in 2003, WHO had defined 40 gender indicators and had supported four countries (Burkina Faso, Mauritania, Nigeria and Zimbabwe) in undertaking a gender analysis for their programmes on HIV/AIDS and sexual and reproductive health. In 2004, WHO had strengthened implementation of a gender perspective in health at country level. October 2005 had seen the integration of a gender perspective in an action plan for six regional economic communities, which included definition of priorities and the roles of WHO and the African Union, and, in 2006, tools for analysis. Those tools should be put to effective use with WHO's support.

She supported the draft resolution, with the amendments proposed by the member for Denmark, but also proposed that the words "every two years" should be added at the end of paragraph 3(7), in order to ensure regular monitoring.

Dr AKIZUKI (alternate to Dr Shinozaki, Japan) welcomed the Director-General's action for the attainment of gender equality and the empowerment of women in improving health status and reducing poverty. Analysis of gender differences should take account of local cultural and social values. Gender equality and equity were promoted in Japan's cooperation programmes in order to strengthen reproductive health services and the capacity of female health workers.

Ms HALTON (Australia) remarked that, as soon as the question of gender was raised, interventions by women members, alternates and advisers increased. If women spoke more often on other matters, the debate on gender equality and equity would no longer be necessary. However, just as strong men die early, as women took on higher roles in the workplace, their health patterns might become more like those of men, whereas the aim should be to improve the health status of everyone.

She had observed no significant improvement in gender equality and equity. She supported the draft strategy and the draft resolution but shared the disappointment expressed by the member for the United States; the draft strategy failed to chart the next steps and needed to reflect concerns relating to males as well as females. The term "unfair disparities in health" mentioned in paragraph 9 of the report needed clarification. Australia recognized the importance of gender equality and equity, and encouraged WHO to continue its efforts in that area.

Professor AYDIN (Turkey) welcomed WHO's efforts to bring gender analysis into the mainstream of its management and the integration of gender equality and equity in health into country cooperation strategies, medium-term strategic objectives and the programme budget. The determinants of health in men and women should be analysed, in order to show whether the existing differences were avoidable, and to establish appropriate policies, norms and standards. He supported the proposed actions.

Mr DE SILVA (Sri Lanka) said that Sri Lanka had good social indicators for the region, including access to education and health and in terms of the gender development index. However, domestic violence against women and their participation in the political process were causes for concern. The 1993 Sri Lanka Women's Charter incorporated non-discrimination and set policy for gender equality and equity. Legislation to help to prevent domestic violence had been enacted in 2005, and the Ministry of Women's Affairs was working to establish a national commission to eliminate gender-based discrimination. Life expectancy for women in Sri Lanka, a low-income country, had risen from 55 years in the 1950s to the current level of 76 years, and maternal mortality had fallen to 34 per 100 000 births in 2006. The policy environment and socioeconomic and service factors had contributed to that progress. He endorsed the report.

Dr TANGI (Tonga) agreed that WHO should look ahead and examine the impact of the current high proportion of female students attending medical and nursing schools, and the obstacles to raising the proportion of women on the staff of WHO. He supported the draft resolution but asked whether funds would become available to cover the estimated shortfall of US\$ 3.65 million indicated in document EB120/6 Add. 1.

Dr AGWUNOBI (United States of America) said that, if the Board wished to proceed at the present session, he would propose some amendments to the draft resolution. Paragraph 1 should be deleted. In paragraph 2(4) the term “women’s and men’s contribution to health care” needed to be clarified and the words “both remunerated and unremunerated” should be deleted. In paragraph 3(1), “to ensure that the Secretariat is capable of, and responsible for, assessing” should be replaced by “to assess”. In paragraph 3(2), “global and regional levels” should be replaced by “at the WHO Secretariat and regional levels” to make it clear that the accountability called for was within the Secretariat. Paragraph 3(3) should be amended as proposed by the member for Denmark. Several of the amendments proposed previously raised concerns and he expected an opportunity to discuss them in greater detail.

Mr HIWAL (alternate to Dr Al-Eissawi, Iraq) said that inequity in health was present at the community level, especially in remote areas, where WHO must support action. Gender inequities were multisectoral. Any plan should concentrate on the social determinants of health and health education strategies in order to overcome entrenched attitudes. Gender equality and equity must be a part of sustainable development.

Dr SMITH (Denmark) said that she was pleased that the member for the United States of America considered the matter important and that it should not be further delayed. The Director-General would ensure that the strategy, which related to gender mainstreaming within the Secretariat, would be implemented satisfactorily.

Dr HANSEN-KOENIG (Luxembourg) recalled that the Board had requested a strategy and plan of action at its 116th session in 2005<sup>1</sup> and that the item had been withdrawn from the agenda of the 117th session in 2006. However, the Director-General had clearly articulated her priorities, which included women’s health, one aspect of which was gender equity and equality. She supported the amendments proposed by the member for the United States of America. The draft resolution could be improved. The proposed actions represented only the first step and it was necessary to look to the future. WHO should not find itself being accused of merely paying lip-service to gender equity and equality. She supported the strategy and the draft resolution.

Professor MACHADO (alternate to Professor Pereira Miguel, Portugal) endorsed the comments made by the member for Denmark. It was important to consider the potential consequences of the high proportion of females (70%) currently training in health care, as they would subsequently represent the majority in those professions.

Mr DEL PICÓ (Chile)<sup>2</sup> supported the draft strategy. Member States needed to promote intersectoral communication. Surveys would identify the unpaid work done in the home, help to change perceptions and strengthen the role of women, the main health carers in society. Demographic and epidemiological changes increased demand for health care, and adequate support services, financial reward and social benefits should be provided for the carers, of whom about 90% were women. Cultural change was needed as health policy had placed women in a supportive role with no part in decision-making. The disaggregation of data by sex, social class and ethnicity should also be encouraged.

---

<sup>1</sup> Document EB116/2005/REC/1, summary record of the second meeting.

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

Ms MAFUBELU (South Africa)<sup>1</sup> reiterated her position, stated at the Board's 116th session, that a strategy and plan of action for gender mainstreaming would give both political visibility to that area of work and a strong mandate to the Director-General.<sup>2</sup> The draft resolution, which she supported, should refer in paragraph 3(2) to implementation at country level, through country offices, as well as at global and regional levels. Paragraph 3(7) should indicate the submission date of the first progress report. Reports should be submitted every two years. She endorsed the draft strategy and plan of action.

Mrs SHARAPOVA (Russian Federation)<sup>1</sup> said that implementation of national health-care projects would be impossible in the Russian Federation unless gender was taken into account. Men were better off than women economically, but had a shorter life expectancy. The high mortality rate among men of working age made it difficult for women to remarry, resulting in large numbers of single-parent families. In order to resolve the demographic and gender difficulties, legislation had been enacted for additional state assistance to families with more than one child. A new council on gender issues promoted gender equality with a view to ensuring a gender approach in national politics. The national strategy would ensure equality of rights and opportunities for men and women. She supported the draft strategy and plan of action.

Ms BELLO DE KEMPER (Dominican Republic)<sup>1</sup> endorsed the need to take into account in planning and health policies, the unpaid work done by women, and their role in the home, child health and care of the elderly. In countries with a high incidence of HIV/AIDS, those tasks had to be done by older women.

Mrs NGAUNJE (Malawi)<sup>1</sup> said that gender was not simply about women, but about equal opportunities for men and women. Men were often seen as the heads of the household, whereas women were the centre of the home and usually the primary health carers, although they received no payment for their work. In Africa, owing to the HIV/AIDS pandemic, girls became responsible for the care of their siblings from a very early age, and grandmothers often looked after their own and other people's grandchildren in the community. Malawi welcomed the Director-General's focus on the health of women and the people of Africa, and supported the draft resolution.

Dr BUSS (Brazil) endorsed the draft resolution and urged that the views expressed by the representative of Chile should be reflected in the text.

Ms TELLIER (UNFPA), speaking at the invitation of the CHAIRMAN, welcomed effective strategies on gender, women and health for the success of WHO's interventions and collective success within the United Nations system. Gender mainstreaming was important for the achievement of all the Millennium Development Goals, notably the improvement of maternal health, reduction of child mortality, and combating HIV/AIDS, malaria and other diseases. However, gender inequalities in income, decision-making and social status made women vulnerable to poverty and poor health. In the developing world, poor sexual and reproductive health remained a leading cause of death and disability among women and girls. Equal access to reproductive health was one of seven key actions identified in the 2005 World Summit Outcome as necessary to empower women and achieve gender equality. Men and women must be treated with dignity, and interventions tailored to their respective needs. Men and boys must be engaged as partners in order to end gender discrimination and violence and to improve the health and status of women.

The draft strategy was relevant to collective work such as the Partnership for Maternal, Newborn and Child Health and the Maputo Plan of Action for the Operationalisation of the

---

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

<sup>2</sup> Document EB116/2005/REC/1, summary record of the second meeting.

Continental Policy Framework for Sexual and Reproductive Health and Rights 2007–2010. She welcomed the focus on sex-disaggregated data and gender analysis.

**Dr Antezana Aranibar took the Chair.**

Ms LEHNERS-ARENDT (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN and on behalf of the International Baby Food Action Network, praised the draft strategy. The Beijing Declaration and Platform for Action (Beijing, 1995) called for, among other things, governments to promote public information on the benefits of breastfeeding, to enable mothers to breastfeed their infants and to eliminate discriminatory practices by employers. Breastfeeding contributed to the health of the child and maternal health. She urged all governments to implement the Platform for Action.

Mrs KEITH (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, welcomed the draft strategy, and called for a plan of action to implement it. Partners should be urged to cover the funding shortfall. In paragraph 8 of the report, the words “policies and” should be inserted after “to design health”. In the third sentence of that paragraph, the words “This could entail” should be amended to read “This should entail”. WHO must revisit plans and resolutions in order to ensure that they adequately addressed gender issues. The last sentence of paragraph 8 should read: “Efforts need to include women and men, to ensure effective change over time, but changes must be measured in improved health outcomes for women, to ensure the mainstreamed programmes are addressing present gender inequities”. If programmes were focused solely on women, there was a danger that social norms that perpetuated gender inequity would be overlooked or left unchanged.

She supported the guiding principles set out in the document, and requested simple implementation tools and indicators of change over time. The Secretariat should support Member States in analysing legal, political, economic and social factors that encouraged gender inequality in health as a baseline for measuring change. User charges for health services must be eliminated in order to ensure equal access to such services for women. Resources were needed for reporting research findings. WHO should encourage the entry of more women into formal education and increase equity within health service utilization.

In the draft resolution, paragraph 2(3) should urge Member States to collect and analyse sex-disaggregated data and gender research on issues specific to countries. Paragraph 3(7) should call for a mid-term evaluation in 2010.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN, welcomed the report, and drew attention to the data in the annual report on human resources (document EB120/24 Add.1) showing the low representation of nurses within the Organization: 1.5% of the professional staff. Women’s lack of gender equality was fuelling the HIV/AIDS pandemic, especially in sub-Saharan Africa, where women and girls accounted for over 60% of those living with HIV/AIDS, and for 76% of individuals in that category within the 15–24 year age group. The Millennium Development Goals emphasized the promotion of gender equality and the empowerment of women as effective means of combating poverty, hunger and disease, and of stimulating sustainable development. He supported the establishment of a United Nations agency specifically for women, with operational capacity.

Ms WOODS (International Women’s Health Coalition), speaking at the invitation of the CHAIRMAN, welcomed the draft strategy, which built on work already done within the Organization. Sex and gender must be subjected to rigorous analysis in all WHO’s policies, programmes and projects. Gender mainstreaming was the key to eliminating gender-based health inequalities. Changing the title to “Strategy for integrating gender analysis and actions into the work of WHO” would convey greater purpose. Additional staff should be recruited, and the strategy would need monitoring and evaluation. The entire Organization should be engaged in gender action. She observed that only 23% of the members of WHO’s expert committees were women. The report should include an explicit

statement that violations of women's human rights also violated their right to health. Mention should also be made of the International Conference on Population and Development (Cairo, 1994). The reference to the allocation of resources for both mainstreaming and specific programming for women and girls should be stronger. A time frame should be included for reporting on the implementation of the strategy, with an evaluation at midpoint or in 2010.

Mrs PHUMAPHI (Assistant Director-General) explained that the title of document EB120/6 was the same as the agenda item; the title of the strategy itself referred to the various ways in which the Organization intended to integrate gender analysis and action into its work, in response to the Board's request to the Director-General at its 116th session. The plan of action provided a detailed response to the questions that members had raised. A baseline gender assessment was needed in order to establish accountability mechanisms, monitoring and evaluation procedures as well as a time frame for implementing the different parts of the strategy. Tools had been developed for mainstreaming gender into health promotion and tested in some Member States, including Madagascar. They could be applied as soon as the governing bodies reached a decision on the strategy. In the report, the term "women and men", which was intended to denote also girls and boys, had been preferred to the more impersonal "females and males". The suggestions and concerns regarding the draft resolution would be reflected in an amended text.

The DIRECTOR-GENERAL said that she appreciated members' strength of feeling on women and health. The Secretariat's report had been prepared before she took office, in response to the request made by the Board at its 116th session. The integration of gender analysis and action into WHO's work contributed to issues of women and health. More details concerning the priorities for that area of work, which she had outlined when taking office, would be made available at the forthcoming Health Assembly.

(For adoption of the resolution, see summary record of the ninth meeting, section 2.)

**Progress in the rational use of medicines, including better medicines for children:** Item 4.9 of the Agenda (Documents EB120/7, EB120/7 Add. 1, EB120/37 and EB120/37 Add. 1)

The CHAIRMAN explained that the draft resolution contained in document EB120/7 took account of the Board's discussion of the item at its 118th session.<sup>1</sup> Document EB120/37 contained a report and draft resolution on improving access for children to essential medicines. The Board would decide whether to take the two draft resolutions together or separately.

Dr ALLEN-YOUNG (Jamaica), supported by Dr NTAWUKULIRYAYO (Rwanda) and Dr GASHUT (alternate to Dr Saheli, Libyan Arab Jamahiriya), favoured taking the two draft resolutions together, in view of the synergy between them.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that to combine the second draft resolution with the first, which had already been discussed at a previous session of the Board, would complicate matters unduly. The new draft resolution should be dealt with on its own merits.

Dr NTAWUKULIRYAYO (Rwanda) said that the question underlying both draft resolutions was how to manage medication in an appropriate and cost-effective way. A separate question, in a world ravaged by epidemics of HIV/AIDS, malaria and tuberculosis, was how to make the right medicines available to children, through joint action by governments, the pharmaceutical industry and WHO. Procedural issues were unimportant.

---

<sup>1</sup> Document EBSS-EB118/2006/REC/1, summary record of the third meeting, section 1.

Professor MACHADO (alternate to Professor Pereira Miguel, Portugal) said that the reports could be discussed together, but that the draft resolutions should be considered separately.

Dr ALLEN-YOUNG (Jamaica) said that she would accept the consensus for discussing the draft resolutions separately, even though, as a pharmacist, she saw rational use of medicines as a general concept with subsets.

The CHAIRMAN suggested taking the approach proposed by the member from Portugal.

**It was so agreed.**

Dr NTAWUKULIRYAYO (Rwanda), speaking on behalf of the Member States of the African Region, highlighted the main issues raised in the report. The irrational use of medicines was a major problem worldwide, contributing substantially to the emergence of resistance to antibiotics, the rapid spread of communicable diseases, the emergence of side-effects and prescription errors and wastage of scarce resources, all of which had an adverse impact on public health and national economies. Many policies and strategies aimed at improving the use of medicines were not put into effect properly.

The Secretariat had been providing support to Member States through the medicines strategy for 2004–2007. Results included development and revision of national lists of essential medicines, standardization of therapeutic guides, generation and dissemination of information on essential medicines, establishment of pharmaceutical and therapeutical committees, training of health workers on good practices for prescription and dispensing, and establishment of laboratories for analysis and mechanisms for follow-up and evaluation of rational use of medicines.

Close cooperation between prescribers and dispensers must be fostered and supported, starting at the training stage, at all levels of health care. The challenges were spreading antimicrobial resistance and the lack of sufficient resources to implement strategies for promoting the rational use of medicines. Nevertheless, a partnership between governments, WHO and the pharmaceutical industry would be central to the development of new methods for countering antimicrobial resistance and providing appropriate formulations for children of all ages and for all diseases, especially infections resulting from HIV/AIDS, tuberculosis and malaria. He supported the draft resolution.

Professor MACHADO (alternate to Professor Pereira Miguel, Portugal) supported the two draft resolutions proposed. Several medicines used for children were prescribed off-label. A research strategy must be elaborated, and the European Medicines Agency would have an important role in defining rules and considering the ethical aspects of paediatric research. Because of the financial interests of the pharmaceutical industry, some formulations specific to children, such as syrups or drops, had been removed from the market. Yet when mothers were advised to crush pills, it was difficult to administer correct doses. Medicines that were available in paediatric formulations were not always the most rational to use. The draft resolution on better medicines for children contained in document EB120/37 should make reference to paediatric formulations and paediatric research.

In the draft resolution on the rational use of medicines contained in document EB120/7, the bracketed preambular paragraph that began “Recognizing the perverse incentive of itemized fee for service ...” should be deleted. She requested evidence in support of the bracketed sentences in preambular paragraphs 7 and 13.

Promoting the rational use of medicines depended on a proactive attitude by national health authorities. Well-prepared technical staff and reliable information systems were required. A prerequisite for the rational use of medicines was a sustainable health system.

Dr ALLEN-YOUNG (Jamaica), speaking on behalf of the member countries of the Caribbean Community, supported the draft resolutions. In the sixth preambular paragraph of the draft resolution contained in document EB120/7, the bracketed phrase should be deleted or reworded, as the promotion of rational use of medicines was unrelated to the question of equitable access to essential medicines. She agreed with the deletion of the bracketed preambular paragraph beginning “[Recognizing the



perverse incentive ...”; if it referred to dispensing by physicians, that should be stated and the practice discouraged. It might be that the ability to provide medicines that saved lives could not be denied to practitioners, but in that case a strategy should be considered that limited dispensing to life-saving circumstances; that would reduce the incentive to sell or prescribe medicines simply because they were in stock. The requirement for continuing professional development should be extended to pharmacists who reviewed prescriptions before dispensing and to nurses who had to administer medicines in hospital settings. Experience indicated that those persons were the “firewalls” between prescriptions and patients.

She suggested the inclusion in paragraph 1 of the draft resolution contained in document EB120/37 of a reference to the responsibility of parents or guardians. Member States should be encouraged to make adults – those with ultimate responsibility for bringing children into the health-care system – aware of the need to access essential medicines: that was not solely a function of governments. Since most Member States in the developing world did not develop new medicines, paragraph 1(4), which referred to rapid licensing of medicines, should be amended in order to include a reference to the requirement that paediatric dosage forms must be included in submissions for registration. In the recent malaria outbreak in her country, no paediatric dosage form had been available. Tablets that had been crushed or masked in syrup were unpalatable for adults; all the more so for children. Submission of paediatric dosage forms should accordingly be a prerequisite when new or essential medicines were being licensed.

She supported the two draft resolutions, given that therapeutic outcomes could not be guaranteed without the right medicine, available at the right price and in the right quantity, and administered to the right patients, including children.

Dr GASHUT (alternate to Dr Saheli, Libyan Arab Jamahiriya), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that irrational use of medicines was an ongoing tragedy. The developing countries spent, on average, up to 40% of their annual health budget on medicines. WHO’s estimates indicated that more than half those medicines were wasted through improper prescription and use. Probably, no more than 25% of people in developing countries benefited from their access to medicines. Yet irrational use of medicines was not addressed as a public health issue at national level. She supported the draft resolution on rational use of medicines. There was much international concern about lack of access to medicines, but the use of medicines was not high enough on the political agenda. Member States, international partners and the Director-General must make it a priority.

Regarding the draft resolution in document EB120/7, she recalled the earlier version considered at the Board’s 118th session, which had proposed that WHO should support the establishment of national programmes and multidisciplinary bodies in order to promote rational use of medicines. That reference had been deleted from the latest version, probably because of resource implications. That change was not warranted and she proposed that that point should be reinstated. Only a sustainable health-system approach would have meaningful impact in line with recommendations made by the Second International Conference on Improving Use of Medicines (Chiang Mai, Thailand, 30 March – 2 April 2004.)

Work on better medicines for children and appropriate dosage formulations for existing essential medicines for paediatric use must be intensified. The off-label use of adult dosage formulations of common medicines must be minimized. The issue justified a separate draft resolution, rather than being part of the draft resolution on rational use of medicines.

Dr WANGCHUK (Bhutan) said that under WHO’s Action Programme on Essential Drugs Bhutan had started using lists of essential medicines based on safety, effectiveness and good quality, with considerable benefits. The incidence of microbial resistance had been reduced and expenditure on medicines was much lower than that on non-drug items. Rational use of medicines had become an integral part of Bhutan’s health system. The essential medicine programme needed to be revitalized, given the changing trading environment. That required greater capacity for national bodies such as drug regulatory authorities. WHO’s leadership was still necessary in order to ensure access to

affordable essential medicines in the remotest areas. As a small, landlocked country, Bhutan had high overhead costs for medicines. He supported the draft resolution on rational use of medicines and considered that the draft resolution on better medicines for children required further, separate deliberation.

Ms SRIPEN TANTIVESS (alternate to Dr Suwit Wibulpolprasert, Thailand), referring to the report on better essential medicines for children, said that UNDP's *Human development report 2006*<sup>1</sup> indicated that children under 15 years of age accounted for 31% of the world's population; the need for health technologies and medicines for children was great.

In Thailand, when no ready paediatric formulation was available, hospital pharmacists would use adult dosages in order to formulate paediatric dosages, sometimes inaccurately. Moreover, despite an effective programme on prevention of perinatal transmission, the HIV epidemic in Thailand had left several thousand children living with HIV. Universal access to antiretroviral therapy had been introduced in Thailand in 2003, but the lack of dosage formulations and strengths of antiretroviral medicines for children caused problems. The Government's pharmaceutical laboratory had been urged to develop paediatric antiretroviral formulations, and syrups were being produced. The use of two or more monotherapies in accordance with standard practice guidelines for HIV/AIDS created problems in terms of compliance with antiretroviral treatment. She endorsed the draft resolution on better essential medicines for children.

Irrational use of medicines resulted in unnecessary spending, adverse reactions, drug resistance and health implications. The report in document EB120/7 had stressed the need to tackle a problem common to developed and developing countries alike. She welcomed the draft resolution, including the bracketed text. Evidence showed that private providers had incentives to maximize profits that resulted in irrational use of medicines, diagnostics and other therapeutics. The square brackets around the text in the seventh preambular paragraph should therefore be deleted.

Ample evidence suggested a correlation between financial incentives to providers and prescribing behaviour in both the public and private sectors, irrespective of a country's income level. A study in the Republic of Korea had shown that fee-for-services payments led to overprovision and distortion because physicians had an incentive to provide more services with greater profit margins. Thailand's experience had pointed to similar conclusions. In both countries, the findings had resulted in health-care financing reforms for minimizing the negative impact of incentives for paid services systems. On the basis of the evidence, she supported the deletion of the square brackets from the thirteenth and fourteenth preambular paragraphs.

The incorporation of an essential medicines list into the benefit package of existing or new insurance funds had been found to be effective in curbing the irrational use of medicines. Several developed countries used product cost and effectiveness assessment mechanisms in order to ensure rational and efficient use of medicines. Accordingly, she proposed deleting the square brackets in paragraphs 1(3) and 1(6). The significant number of Internet sites that provided biased information about medicines suggested a need for governments to introduce regulatory mechanisms for Internet sales of pharmaceutical products. She therefore recommended deleting the square brackets from paragraph 1(5). Likewise, a strong hospital drug and therapeutic committee was needed to act as a gatekeeper in promoting the rational use of medicines. Accordingly, she recommended the deletion of the square brackets from paragraph 1(7).

Mr DE SILVA (Sri Lanka) said that three groups of stakeholders were involved in the rational use of medicines: manufacturers and pharmaceutical companies, prescribers and pharmacists, and consumers or patients. No doctor would want to prescribe medicines irrationally, and no patient would want to take unnecessary medication. The irrational use of medicines was, however, profitable for the

---

<sup>1</sup> *Human development report 2006. Beyond scarcity: power, poverty and the global water crisis*. New York, UNDP, 2006.

powerful pharmaceutical industry. The ethical issues in the rational use of medicines had not been properly addressed: it was the responsibility of doctors and pharmacists to ensure that patients were given the correct medicine, regardless of any incentive designed to influence their decision. He recalled the legacy of Professor S. Bibile, in line with whose views the Government was following a strict policy of prescribing only generic drugs. With the assistance of WHO, Sri Lanka would establish an independent regulatory authority. In the area of the rational use of medicines the Director-General would have to stand up to the pharmaceutical companies. He assured her of Sri Lanka's support.

The CHAIRMAN paid tribute to Professor Bibile, who had pioneered the concepts of essential drugs and the rational use of medicines.

Dr SMITH (Denmark) supported the draft resolution contained in document EB120/7. However, the focus on better medicines for children in document EB120/37 should be broadened in order to cover the lack of access worldwide to medicines evaluated specifically for paediatric use. Two new subparagraphs should be added. A new paragraph 1(3) should urge Member States "to collaborate in order to facilitate the innovative development, the formulation, the regulatory approval, the provision of adequate product information and the rational use of paediatric medicines and of medicines authorized for adults but not approved for use in children." A new paragraph 2(1) should request the Director-General to "to ensure that all WHO programmes, including but not limited to the Essential Medicines Programme, contribute to the attainment of the equal right of children to have appropriate medicines available".

Dr AKIZUKI (alternate to Dr Shinozaki, Japan) said that unresolved problems of paediatric medicines included standard dosages, administration and safety. In order to promote evidence-based prescribing, scientific information on efficacy and safety should be disseminated to health workers. Japan had assisted its pharmaceutical industry and medical community in promoting the clinical development of medicines for children. Japan's approach could prove useful at the international level. She supported the draft resolution contained in document EB120/37.

Promoting the rational use of medicines required a comprehensive approach including human resources development, strengthening of health systems, information for consumers, and pharmaceutical policy measures in areas such as safety and monitoring of promotion of medicines. She supported the draft resolution contained in document EB120/7.

Ms HALTON (Australia) recalled Australia's expertise and experience in the rational use of medicines, adding that a significant proportion of her working week was devoted to the issue. The benefits of investing in the rational use of medicines had been proven. She emphasized appropriate dispensing and use of prescription medicines, which needed a close partnership between prescribers, pharmacists and patients. She did not support the inclusion of the proposed preambular paragraph of the draft resolution contained in document EB120/7 that began "[Recognizing the perverse incentive of itemized fee for service ...]", but proposed some amendments to the preceding paragraph, which she would provide to the Secretariat.

She found it perplexing that the number of children in the world had not served as an incentive to gather the information that would allow health practitioners to be confident that the medicines they prescribed for children would be used effectively and efficiently. She endorsed the comments made by the member for Jamaica about the practice of crushing pills, which could significantly change the mode of administration. She proposed the addition of a new paragraph 1(1), the wording of which she would provide to the Secretariat as well as amendments to the wording of the existing paragraph 1(1), which might overcome the problem to which the member for Jamaica had drawn attention, namely that few Member States themselves developed medicines.

Dr AGWUNOBI (United States of America) supported the rational use of medicines by medical prescribers and patients. He recognized the human and financial costs associated with medication errors and irrational use of medicines. The consequences of inappropriate or less than optimal use of

medicines were often morbidity and mortality. WHO should work carefully to identify the most evidence-based and practical ways for promoting the rational use of medications to physicians and pharmacists in both the public and private sectors. He was concerned that the report in document EB120/7 appeared to promote a one-size-fits-all solution, in the form of a government-run national medicines programme to promote the rational use of medicines. Member States should develop programmes and policies based on their own unique national contexts.

Medicines for children was an extremely serious issue. All countries shared a pressing need for better medicines for children. Using ineffective, unsafe or improperly dosed medication in children often resulted in morbidity and mortality, with adverse developmental consequences. More information was needed on the following: frequency of use of medications in children, evidence-based guidance on treatment of nearly all paediatric diseases, paediatric prescribing, age-appropriate dosage forms and strengths, and safety. WHO's initiatives should be integrated with building capacity in order to provide the best possible paediatric care. WHO's work on better medicines for children should form part of children's health care in general, and should be kept separate from its work on the rational use of medicines.

He did not support the inclusion of any of the wording enclosed in square brackets in the draft resolution contained in document EB120/7.

With regard to the draft resolution contained in document EB120/37, he proposed that the beginning of paragraph 1(1) should be amended to read: "to promote the development of appropriate medicines for the diseases that affect children, ..."; and that in paragraph 1(2) the words "as appropriate" should be added after the word "inclusion" and the words "and reduce" deleted before the word "prices". Paragraph 2(1) should be deleted in its entirety and similarly the last two phrases of paragraph 2(3), which would then end with the words "these guidelines".

He requested clarification of the extent to which the budgetary implications of the two draft resolutions were covered by the Proposed programme budget 2008–2009.

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

**The meeting rose at 17:35.**

## **SEVENTH MEETING**

**Thursday, 25 January 2007, at 09:10**

**Chairman:** Dr SUWIT WIBULPOLPRASERT (Thailand)

**later:** Dr F. ANTEZANA ARANÍBAR (Bolivia)

### **PROGRAMME AND BUDGET MATTERS:** Item 5 of the Agenda

**Draft Medium-term strategic plan, including Proposed programme budget 2008–2009**  
(Documents EB120/17, MTSP2008–2013/PPB2008–2009 and MTSP2008–2013/PPB2008–2009 Corr.1)

- **Draft Medium-term strategic plan 2008–2013**
- **Proposed programme budget 2008–2009**

Ms HALTON (Australia), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, said that the agenda item was most significant to the work of the Organization. The Committee commended the Secretariat's work on the draft Medium-term strategic plan 2008–2013, which reflected the new approach to planning and budgeting in a comprehensive and accessible way. The Committee's discussion had been particularly informative as to ways of further improving the layout of the document. Rather than making recommendations, the report of the Committee, addressing the item under consideration, in document EB120/3, paragraphs 19 to 28, had requested the Board to take note of the specific details contained therein.

Regarding the draft Medium-term strategic plan, the Committee had considered it important to recall the relationship between the General Programme of Work, that plan, the programme budget, and the expected results, as illustrated in Annex 2 to document EB120/3. It had asked the Secretariat to clarify that relationship and produce a document readily comprehensible to all Member States. It had requested clarification also on budgetary increases, particularly in relation to the five identified priority areas. In addition, comments had been made about the content and formatting of the strategic objectives listed in paragraph 25. Some Member States also intended to submit written comments to the Secretariat on the formulation of those objectives, so changes could be expected. The proposed costs for the current biennium – and basis of the budget – together with estimates for the second and third bienniums should be summarized, and the estimated cost of the entire strategic plan should be aggregated.

Turning to the Proposed programme budget, some Member States had welcomed, and others had expressed concern about, the increases in assessed contributions. Some Member States had indicated their preference for zero nominal growth. For the current year, however, the resources brought into the Organization had actually been greater than first expected, bringing to light the difference between assessed and voluntary contributions. The balance between the objectives set and funding available, particularly through increases in voluntary contributions, must consequently be considered. Some Member States had expressed concern at the proportionate decrease in funding. That decrease, however, had related to the share rather than the aggregate of the funds available. The allocation for all the regions had been within the range proposed in the validation thresholds.

How the budget had been established, the role of WHO in global health, and governance across the three levels of the Organization had also been discussed. Acknowledging the budgetary implications of, and insufficient resources available for, governing body resolutions, the Committee had highlighted the need to reduce their number and asked the Secretariat to submit proposals in that regard to the Board. Moreover, the Committee felt that the funding aspects, as opposed to the content,

of the draft capital master plan should be included in the Proposed programme budget, rather than as a separate item.

The DIRECTOR-GENERAL said that she had participated in developing the draft Medium-term strategic plan and Proposed programme budget 2008–2009, and had endeavoured to ensure that the strategic plan was in line with WHO's six core functions and priorities, drawing on the Eleventh Global Programme of Work. She was open to suggestions for incorporation in the programme and budget to be submitted to the Sixtieth World Health Assembly.

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the European Union and its 27 Member States, in the name of the German Presidency, said that the candidate countries Croatia, The former Yugoslav Republic of Macedonia, Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and Ukraine and the Republic of Moldova aligned themselves with his statement. The European Union welcomed the highly informative draft Medium-term strategic plan and Proposed programme budget. It strongly favoured a continued focus on the Organization's core functions, endorsing the Director-General's view that WHO should not follow a "full menu" approach. It should perform the activities for which it was uniquely suited and remain a leading international standard-setting health organization.

The draft plan, a tool for results-based management, would facilitate comparisons over time and between regional offices and headquarters, and make the Organization's work more transparent. Reducing the number of strategic objectives, in order to avoid fragmentation and duplication, might enhance the plan and achieve the crucial objective of strengthening health systems.

In the five main areas proposed in the Eleventh General Programme of Work, there should be more emphasis on global health security in both the strategic plan and programme budget for 2008–2009. Insufficient importance had been given to sexual and reproductive health, one of the major issues in the prevention of HIV/AIDS and sexually transmitted infections, and to access to medicines. Those topics were central to attainment of the Millennium Development Goals and should be clearly reflected in the budget. The prevention and control of noncommunicable diseases and health promotion should be prioritized, and the relatively low regular budget allocation to the European and African regions was a matter of concern.

All areas of work and strategic objectives should have a strong evidence base. He looked forward to the Director-General's report on publications policy to the governing bodies; the Organization's reputation as a standard-setting agency must not be jeopardized by questions about consistency.

The strategic objectives should be prioritized. Greater clarity and accuracy was necessary throughout the document, in particular with respect to two issues in the Proposed programme budget: how the Organization would prioritize its work if it failed to obtain the expected resources; and, in that case, how it intended to adapt its human resources policy at all levels of the Organization to the new priorities. Several Member States had made that point at the fifty-sixth session of the Regional Committee for Europe; its omission from the current draft strategic plan was deplorable.

Enhanced cooperation between WHO and other organizations in the United Nations system in the context of United Nations reform needed to be reflected in the strategic objectives. He encouraged more collaboration with UNAIDS, and expected information on how WHO would follow up the Global Task Team's recommendations and effect the division of labour among UNAIDS cosponsors. Cooperation with ILO, the World Bank, WTO and FAO in the areas of social protection, health systems, and nutrition and food safety would avoid duplication and reduce costs.

Mr RAMOTSOARI (Lesotho), speaking on behalf of the Member States of the African Region, supported the draft Medium-term strategic plan and Proposed programme budget. He also supported the proposed increase of 8.6% in expected expenditure from assessed contributions in 2006–2007 (document EB120/17, Table 1) in order to sustain financing of the Proposed programme budget. The increasing disease burden in the African Region required additional investment in health.

The Director-General, having decided to focus on Africa, would be judged by WHO's impact on the health of people there, as well as on women's health globally.

Voluntary contributions, mostly earmarked for specific projects, accounted for almost 80% of the Proposed programme budget, thereby compromising the Director-General's flexibility in allocating resources and WHO's efficiency and effectiveness, since time was consumed in managing thousands of contracts, replanning, budgeting and reporting to donors. He appealed to all Member States, foundations and other agencies making voluntary contributions not to restrict the Director-General in the allocation of resources.

According to Table 3 in document EB120/17, headquarters still received a large share of the programme budget compared with regional offices. WHO's presence in countries remained limited, and he encouraged decentralization. He noted with concern that the proposed distribution had reduced the African Region's allocation by 0.5%, while other regions had seen an increase, a fact that had not been explained by the Chairman of the Programme, Budget and Administration Committee. The Director-General should allocate 30.8% of the programme budget, the maximum allowed under the validation mechanism, to the African Region, in order to make her personal commitment to Africa absolutely clear.

Dr AL-EISSAWI (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, supported the draft Medium-term strategic plan, WHO's accountability framework and performance management system and the Director-General's goals and commitment to "attaining results for health".

He supported the Proposed programme budget, which indicated an increase of 16% over expected expenditures, reflecting Member States' need for technical and financial support from WHO. Balancing assessed and voluntary contributions would preserve the identity of WHO and the responsibility and guidance of WHO's work by Member States.

Ms BLACKWOOD (alternate to Dr Agwunobi, United States of America) commended the draft Medium-term strategic plan and Proposed programme budget. More continuity with previous programme budgets, particularly that for 2006–2007, and more baseline information would have been desirable.

She did not agree that Member States' assessed contributions should be progressively increased to achieve the balance between assessed and voluntary contributions. Greater growth in voluntary resources over regular budget resources was likely for the foreseeable future. Her Government pursued a budget policy of zero nominal growth for all international organizations, advocating budgetary discipline, efficiency in implementation and programme prioritization. She therefore did not support the substantial increase in the draft Proposed programme budget 2008–2009, especially following the increase agreed for 2006–2007, and urged the Director-General to present a duly revised programme budget to the Health Assembly.

Regarding the proposal for negotiated core contributions, the Secretariat was free to explore such funding on the understanding that different donors had different requirements for the use of resources made available to WHO. With regard to the integrated 10-year capital master plan, she requested that one consolidated proposal should be submitted for Member States' consideration, rather than two separate assessments.

Dr SADASIVAN (Singapore) said that the 16 strategic objectives set out in the draft Medium-term strategic plan needed significant resources. The Proposed programme budget was aligned with WHO's priorities. He expressed satisfaction that US\$ 900 million, more than 20% of the total, had been allocated to fighting communicable diseases.

Global eradication of poliomyelitis was feasible and should become one of WHO's hallmark achievements. Expressing satisfaction at the channelling of resources towards communicable disease surveillance and pandemic preparedness, he suggested that WHO should set more immediate targets in such areas, since nobody knew when or where a pandemic might begin. He favoured providing

Member States with technical assistance to strengthen their health workforces, both by increasing numbers of health-care professionals and by improving the skill mix.

The draft strategic plan was broad and ambitious, and WHO should constantly review the 16 priorities in order to meet targets and streamline overlapping initiatives.

Dr QI Qingdong (China) said that integrating the draft strategic plan, which covered three bienniums, with the Proposed programme budget was a useful measure. The Eleventh General Programme of Work had been well integrated with the Millennium Development Goals, summing up and putting into practice the lessons learnt over 60 years. The document under consideration was innovative in both form and content, and the short-term strategic goals were set out clearly. He supported the approach, which increased the predictability and continuity of future work.

His Government had always supported an appropriate increase in the programme budget adapted to growing needs. WHO had a unique role in global health matters and, in order to respond to increasing health challenges, it needed a programme budget in keeping with its position, including reasonable increases in funding.

The strategic directions proposed in the draft strategic plan were comprehensive and clear. He emphasized traditional medicine, which strengthened the physical constitution, cured difficult diseases, and formed an important feature of human culture and civilization. Under WHO's leadership, the role of traditional medicine in prevention and promotion should be better understood, recognized, emphasized and strengthened. Blindness was mentioned in the draft strategic plan and he stressed the undue psychological and economic burden it placed on sufferers and their communities, particularly since 75% of cases were preventable. WHO should take the lead in global blindness prevention.

Mr ABOUBAKER (alternate to Mr Miguil, Djibouti) requested greater predictability of extrabudgetary funding and its gradual alignment with the programme budget, and an increase in the proportion of non-earmarked funds compared with funds which were subject to over-restrictive conditions. The programme budget should be the basis for allocating extrabudgetary funds. He also requested that more extrabudgetary resources should be allocated for measures to fight noncommunicable diseases.

Dr RAHANTANIRINA (Madagascar) reiterated concern that the Proposed programme budget showed a 0.5% decrease in the share allocated to the African Region by comparison with 2006–2007. That seemingly insignificant figure would cost lives in a Region with high death rates from malaria, HIV/AIDS, malnutrition and other conditions, particularly among women and children. The proportion of the programme budget allocated to the African Region should increase, not decrease. Investment in health in the Region was needed in order to achieve socioeconomic development objectives.

Dr SHANGULA (Namibia) echoed concern at the decrease in the share of funds allocated to the African Region, a move that eroded the principle agreed by the Health Assembly several years earlier. He requested the Board to restore the previous ratio in order to avoid protracted negotiations during the Sixtieth World Health Assembly. At country level, a decrease in WHO's activities as a result of limited funds was already being seen.

Dr SMITH (Denmark) said that an overall increase of 8.6% in the level of assessed contributions was optimistic, bearing in mind the outcome of discussions on the budget at recent Health Assemblies. A clear view was needed of the budgetary requirements for fulfilling WHO's core mandate, in the absence of adequate guidance on adjustment mechanisms, if voluntary contributions failed to materialize. Despite the new validation mechanism, the proposed distribution of regular budget funds appeared to follow historical perspectives. Were all the regions receiving their fair share of the total budget under the new validation procedure? In order to maintain its credibility, WHO, with its global responsibility for normative technical work, ought to derive the bulk of its funding from assessed contributions. The growing imbalance between the regular budget and voluntary



contributions could adversely affect WHO's priorities and undermine the governing bodies' leading role. The issue of negotiated voluntary contributions would need to be further discussed. Another concern was the lack of clarity regarding allocation of funding to the regional offices during the 2008–2009 biennium. Predictable funding would allow them to perform priority tasks and retain qualified staff.

The Government of Belgium associated itself with her statement.

Dr JAKSONS (Latvia) endorsed the statement made by the member for Denmark. The Board had approved an approach to the strategic allocation of resources based on countries' needs and priorities followed by validation of outcomes. Voluntary contributions should not be used for long-term, planned investment in health systems development. He stressed the role of WHO in providing regular support and coordinating donors for health reforms.

Budget resources should be used cost-effectively and within a strict time frame. Mechanisms were also needed for redistributing the resources in cases where the expected outcomes could be shown not to have materialized. Further consideration should go to deciding which of WHO's core functions should be centralized or decentralized, and how resources would be allocated on that basis.

Dr INOUE (alternate to Dr Shinozaki, Japan) said that document EB120/17, together with the draft strategic plan and Proposed programme budget, illustrated the link between the longer-term strategy and the two-year budget cycle and presented baselines and targets that would facilitate monitoring. Although there was a need for negotiated voluntary contributions, countries had different relative strengths and areas of interest. Voluntary contributions had served to balance, harmonize and align WHO's interests, as well as donors' accountability (in some cases to taxpayers), in order to ensure sustainability. He welcomed the dialogue between the Secretariat and Member States on the future of voluntary contributions.

Dr NYIKAL (Kenya) emphasized that voluntary contributions increased operational costs, promoted rigidity and inhibited the establishment of coherent health systems. Their manner of delivery also made it virtually impossible to implement national strategic plans. Strategic objectives 10, 11 and 13 were long-term objectives that could not be met through unpredictable, voluntary contributions. He appealed to donor countries and Member States not to use voluntary contributions as a tool for manipulating WHO. Countries had specific interests, but sometimes it was hard to discern whether the interests of the donors or the recipients were more important. That was an area needing further consideration.

Dr TANGI (Tonga) said that, given the plethora of resolutions adopted by the Board in recent years, it would be prudent in future to consider the financial implications before adopting any further resolutions.

Budgetary resources should be allocated on the basis of need. As Minister of Health for Tonga, he accepted that WHO funding would only cover 10% of his health programmes and that additional support would have to be raised from donors.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand), referring first to the report of the Programme, Budget and Administration Committee (document EB120/3), specifically paragraph 23, said that the Committee should have reached consensus on the amount of the proposed budget increase. Increases ranging from nil to 8.6% had been suggested. A proportionate decrease in assessed contributions could result in most funding coming from earmarked voluntary contributions. Possible ways of avoiding such an imbalance would be to increase assessed contributions over the next biennium in line with escalating health needs, and to keep earmarked voluntary contributions to a minimum as they tended to distort priority programme areas. Such contributions must be in line with the programme budget and medium-term strategic plan. When additional funding was raised, it must be used to improve the execution of WHO's programmes and result in effective health gains, particularly among women worldwide and the people of Africa.

Turning to the draft strategic plan, he supported the recommendation made by the member for Denmark regarding resource allocation. With regard to the Proposed programme budget, he concurred with the comments recorded in paragraph 25 of document EB120/3, particularly with reference to strategic objectives 3, 12 and 13. Strategic objectives 1, 2 and 16 accounted for more than half the total budget. The amount left for other strategic objectives was woefully inadequate, particularly the proportion allocated to noncommunicable diseases, which, on the evidence, were the major cause of death and disability in most countries. The allocation for strengthening health systems, including information systems and service delivery, would not ensure effective malaria, HIV/AIDS and tuberculosis control services and surveillance for acute infections. Focused resource allocation needed to recognize that primary care should be the vital function of all health systems.

He supported the proposed increase of 8.6% in assessed contributions and called for a revised Proposed programme budget 2008–2009 to be prepared for consideration by the Sixtieth World Health Assembly.

**Dr Antezana Aranibar took the Chair.**

Mr SHIRALIYEV (Azerbaijan) observed that many recommendations for budget allocations related to specific regions or countries. It would be better to follow the recommendations of the Programme, Budget and Administration Committee, which had analysed medical and socioeconomic priorities throughout the world.

Dr SALEHI (Afghanistan) welcomed the draft strategic plan. The Eastern Mediterranean Region had some of the worst health statistics in the world. Maternal mortality in his own country stood at 1600 maternal deaths per 100 000 live births, and one child in four died from a preventable disease before his or her fifth birthday.

He shared the views expressed by the members for Djibouti and Iraq, and endorsed the Proposed programme budget 2008–2009. Resource distribution between regions should reflect the validation mechanism for strategic resource allocation.

Dr MATHESON (New Zealand)<sup>1</sup> commended the transparency and accountability of the budgeting process. However, he would welcome further guidance in several areas. The reports under consideration gave details of the mortality and suffering associated with a particular disease or condition. However, there was no technical advice available that might help the Board to set overall priorities in terms of the burden imposed by one disease compared with another, the populations affected by various diseases or disease etiology. He also sought more information about health trends and forecasts. The Board's decisions would have an impact over the next 10 years, and should be based on predictions as well as information about the past.

Global annual expenditure on health amounted to US\$ 3 000 000 million, whereas WHO expenditure was only some US\$ 3700 million. The question was how the Organization should best use that small resource to reduce the global disease burden. He called for more information about the interrelationships between programmes. For instance, the Board had been informed that poverty was the main reason for the rising rates of tuberculosis, while the lack of rational policies on use of medicines was the main reason for the increasing resistance to anti-tuberculosis medicines. He would like more general information about the actions the Organization was taking, rather than information on specific technical aspects.

Mr VAN DER HOEVEN (Netherlands)<sup>1</sup> said that his country, as one of the 10 largest contributors to the United Nations budget, was concerned about the growing imbalance between regular budget and voluntary contributions. WHO was the international organization with global

---

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

responsibility for normative work and technical assistance in the field of health. In the interests of its credibility and integrity, a significant proportion of the budget should be financed through assessed, rather than voluntary, contributions. WHO was becoming no more than a United Nations fund financed by a small group of donors, which was not a desirable development.

The Secretariat had proposed an increase of 16% in the regular budget for 2008–2009, which included an increase of 8.6% in assessed contributions. Any increase in the budget should be financed by an increase in assessed contributions of at least the same percentage, otherwise the imbalance would only worsen. He therefore objected to the Director-General's budget proposals. The current Netherlands voluntary contribution was aligned with WHO's priorities, and he welcomed the proposed introduction of a system of negotiated voluntary contributions.

Mrs NGAUNJE (Malawi)<sup>1</sup> said that the burden of disease in Africa continued to rise, and more resources must be allocated to it if the Millennium Development Goals were to be achieved. Regional and country offices should be strengthened, but some country offices were currently reducing their level of activity because of limited resources. She did not support the proposed reduction of 0.5% in the budgetary allocation to the Regional Office for Africa.

Ms HALTON (Australia), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, said that members' comments would be a valuable addition to the discussion within the Committee and would help the Secretariat in revising the budget documentation.

Dr NORDSTRÖM (Assistant Director-General) said that the Secretariat had noted the comments, and would use them to create a longer-term, more strategic, more transparent and more accountable approach. He had also noted the specific comments on subjects such as health systems, health security and disease outbreaks, sexual and reproductive health, noncommunicable diseases and collaboration with other agencies of the United Nations system.

The Board had welcomed the approach outlined in the Medium-term strategic plan, namely, a single integrated budget approved by the governing bodies and financed by means of assessed contributions, negotiated core voluntary contributions and specific voluntary contributions. The Secretariat would continue its dialogue with both Member States, in order to agree upon a reasonable level of assessed contributions, and donors of specific voluntary contributions. When revising the budget documentation, it would also take into account comments on the validation mechanism. However, the latter analysed what had already been done, and was not a tool for budget allocation.

A more detailed explanation of the suggested increase in the budget would be provided, including the differences between the Proposed programme budget and previous budgets, the reasons an increased budget had been requested and its expected results, the cost increases faced and the areas in which activities would be reduced.

The DIRECTOR-GENERAL said that she was heartened by members' broad support for the draft Medium-term strategic plan. The process of budget preparation was difficult; one could not please everyone. The Organization had to operate effectively within the limits of the resources at its disposal, and it would be necessary to exercise discipline in many areas.

She would finalize the Proposed programme budget for submission to the Health Assembly, bearing in mind the main areas highlighted during discussions with the governing bodies, which also reflected the priorities she had declared at the time of her election. She had discussed with the Regional Directors the best way to allocate resources. Clearly, not everyone would be happy with all the decisions made, but the process would be transparent and accountable.

Once resources had been allocated, it would be necessary to decide in detail how programmes could be implemented using those resources. Cross-cutting activities and synergies between

---

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

programmes would be necessary. The Regional Directors had undertaken to introduce cross-regional activities in areas such as poliomyelitis eradication. There was a new enthusiasm for the concept of “one WHO” – a transparent, accountable Organization that would produce results.

She had noted the suggestion by the member for Latvia; if programmes were not implemented in accordance with the agreed timetable, it should be possible for her or the Regional Directors to take back the relevant resources and transfer them to other projects. That, too, was an aspect of budget discipline.

Many speakers had commented on the large number of resolutions adopted by the governing bodies, all of them with resource implications. Clearly, she could not implement all those resolutions unless the necessary resources were forthcoming: if they were not, she would need to give some programmes priority over others. That was her job as the chief administrative and technical officer of the Organization, and she would do that job, although she was aware that it would not necessarily make her popular.

Another aspect of budget discipline was the need to make a collective decision about areas that would be given lower priority if the resources to implement them were not available. The Organization could not continue indefinitely to do more work with fewer resources without compromising quality. She would work with the Regional Directors, Assistant Directors-General and Directors of Programme Management to improve WHO’s performance, guided by the recommendations of the Board.

The CHAIRMAN invited the Board to consider the draft Proposed programme budget 2008–2009 beginning with the strategic objectives outlined on pages 118–134 of the document.

### **Strategic objectives 1–5**

Dr AGWUNOBI (United States of America) said that he would submit technical comments on the strategic objectives in writing.

Dr NTAWUKULIRYAYO (Rwanda) queried the use of the words “mental disorders” in the definition of strategic objective 3. He preferred the more general term “mental health”. The problems that were arising throughout the world – for example, the genocide in his own country and the conflicts in Afghanistan, Iraq and Lebanon – and their effects on mental health should be given more serious consideration by the Organization. Mental health was fundamental to health strategy and policy in Rwanda, which had to deal with the psychological trauma suffered by people who had experienced genocide as children. Similarly, strategic objective 5 dealt with the immediate health consequences of conflicts, without taking into account the related physical and psychological trauma.

Dr KHALFAN (Bahrain) expressed his concern that the prevention of blindness and visual impairment was not included specifically in the draft Medium-term strategic plan and Proposed programme budget, but more generally under chronic noncommunicable conditions in strategic objective 3. Recalling that in resolution WHA59.25 the Director-General had been requested to give priority to prevention of avoidable blindness and visual impairment and, more specifically, to include it in the strategic plan and programme budget, he suggested that it should receive an appropriate budget allocation. WHO enjoyed strong global partnerships in that area; interventions were highly cost effective, and WHO should lead by example when it came to committing funds.

Dr ALLEN-YOUNG (Jamaica) suggested that, instead of trying to prioritize issues at the current meeting, members might engage in dialogue with country offices upon their return. Priorities set out in the draft strategic plan and Proposed programme budget could be adjusted to their national plans. In that way, there would be a “trickle-down” effect, from WHO to the regions and, in turn, to the countries.

Dr VOLJČ (Slovenia), referring to the comments made by the member for Rwanda, said that, if he had understood correctly, the draft strategic plan and Proposed programme budget, including the

strategic objectives, had been prioritized in accordance with the needs and wishes of Member States. He was not in favour of broadening the objectives. Health in general was the “golden thread” binding together all the proposed activities and objectives.

Dr TANGI (Tonga) endorsed the comments made by the member for Bahrain concerning the prevention of blindness, which should be given suitable coverage in objective 3. He expressed doubt that the recommended budget increases would materialize. The Director-General would therefore have to address the issue of budget reallocation. More funds should be allocated to strategic objective 3 than those currently assigned under the draft Proposed programme budget.

Mr HIWAL (alternate to Dr Al-Eissawi, Iraq) highlighted school health services, which received inadequate attention and insufficient budget allocations. About one third of the population of all communities attended school of some kind. The success of all health programmes could be measured by the effectiveness of school, and ultimately community, health services.

Professor PEREIRA MIGUEL (Portugal) observed that population ageing was placing an increasingly heavy burden on society in Europe and in other regions. More should therefore be allocated under strategic objective 4 for the promotion of active and healthy ageing.

Dr LE GALÈS-CAMUS (Assistant Director-General) said that the use of the term “mental disorders” rather than “mental health” in strategic objective 3 reflected an emphasis on the delivery of care and services for people with such conditions. That did not mean that the promotion of mental health would be neglected. It might, perhaps, not be sufficiently visible, but mental health promotion was part of strategic objective 3. The mental health of victims of emergencies, disasters and crises was addressed more specifically under strategic objective 5, in particular under indicator 5.3.3. Regarding blindness prevention, it was covered under strategic objective 3, specifically expected result 3.5 and indicators 3.2.5 and 3.3.5, all of which dealt with the prevention of visual impairment, including blindness.

### **Strategic objectives 6–9**

The CHAIRMAN said that, there being no comments, he would take it that members were in agreement with strategic objectives 6, 7, 8 and 9.

### **Strategic objectives 10–14**

Mr HIWAL (alternate to Dr Al-Eissawi, Iraq) said that he saw no reference under strategic objectives 10–14 to health economics, which was currently a key issue, nor to total quality management. The latter was fundamental to effective monitoring and evaluation.

Dr NYIKAL (Kenya) commended the linking of the strategic objectives in the draft Proposed programme budget 2008–2009 with the areas of work for 2006–2007. Referring to strategic objective 14, he said that health-care financing was a big challenge. In many countries, including Kenya, out-of-pocket expenditure accounted for a major share of total spending on health, which effectively meant that most poor people had little or no access to health services. He welcomed the increase of 40% in the allocation for the activities covered under strategic objective 14; however, that allocation represented only 2% of the overall budget proposal for 2008–2009, which was insufficient. In the battle against poverty, governments needed help in identifying sustainable sources of health financing. Health systems and infrastructure would not improve without consideration of health financing.

Dr EVANS (Assistant Director-General) pointed out that strategic objective 14 comprised six subsections, which taken together related to the overall issue of health economics, addressing such aspects as design of the financial system, mobilization of resources, accounting for expenditures,

measurement of cost and effectiveness of interventions, and strengthening capacity for health financing. He agreed with the member for Kenya that financing of health systems was central to virtually all the strategic objectives. Total quality management was included under strategic objective 10, specifically under indicator 10.2.1; WHO emphasized total quality management and quality assurance in strengthening health systems, as highlighted in document EB120/38 Add.1 and as discussed the previous day.

### **Strategic objectives 15–16**

Dr BUSS (Brazil) suggested strengthening WHO's leadership in health diplomacy, which had assumed increasing importance in the light of transborder health issues such as disease epidemics. Health diplomacy enhanced relations between partners and recipient countries, improved coordination among donors at country level and trained personnel in recipient countries to use resources more effectively. Brazil was developing training programmes in health diplomacy at national and international levels.

Indicators for the strategic objectives should also assess WHO's success in fulfilling its role in international coordination of health efforts.

Dr KHALFAN (Bahrain), recalling that the late Dr Lee had initiated a process to reduce administrative expenses and channel more resources to technical matters at the regional level, requested the views of the Director-General on that issue.

Ms HENDRY (United Kingdom of Great Britain and Northern Ireland),<sup>1</sup> welcoming the draft Medium-term strategic plan, said that a sharper focus to the document before the Board would allow WHO to define its roles and priorities more precisely. She therefore proposed a further compression of the strategic objectives, combining strategic objectives 1 and 2 to read: "to reduce the health, social and economic burden of communicable diseases, including HIV/AIDS, tuberculosis and malaria". In addition, strategic objectives 10, 11, 13 and 14 could be combined to read: "to improve the governance, organization, management, staffing, sustainable financing, accessibility and delivery of health services through supporting an evidence-based health systems approach...". Those modifications would reduce the number of objectives to 11.

Regarding United Nations reform and bearing in mind the Director-General's positive remarks about the pilot country exercise, she proposed adding the words "the United Nations system and other stakeholders" after "countries" in strategic objective 15, which would thus read: "to provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work". She also suggested adding a further indicator under expected result 15.2 entitled: "Number of countries where WHO is taking a full part in the 'One UN' country pilots".

The DIRECTOR-GENERAL said that she had taken note of points raised by members. Responding to the comments made by the member for Brazil and the representative of the United Kingdom, she pointed out that one of her six core areas of work was partnerships, which was very important given the proliferation of global public health partners in the previous 10 to 15 years. In that new landscape, it was extremely important for WHO to identify its comparative strengths and core areas of work, both at headquarters and in the regions. Certainly, WHO should not be duplicating the efforts of other partners. Three questions should therefore be asked before embarking on any initiative: what were the must do's for WHO? what were the can do's? and what were the don't do's?

---

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

She agreed that the area of health diplomacy was gaining increasing importance. In recent years, there had been numerous examples of major public health issues that had required the involvement, not only of ministries of health, but also of ministries of foreign affairs. WHO would be addressing health diplomacy in conjunction with its work in the closely related area of health security.

On the subject of United Nations reform, she appreciated the suggestion put forward by the representative of the United Kingdom and would endeavour to act on it.

Finally, responding to the request by the member for Bahrain, she said that she would carry on the legacy of Dr Lee and strive to reduce the transaction costs of WHO's activities. The Acting Director-General had reduced overheads for all clusters, and she would continue to seek additional savings and greater efficiencies with a view to channelling more resources into technical programmes.

**The meeting rose at 12:30.**

## **EIGHTH MEETING**

**Thursday, 25 January 2007, at 14:05**

**Chairman:** Dr F. ANTEZANA ARANÍBAR (Bolivia)

### **1. PROGRAMME AND BUDGET MATTERS: Item 5 of the Agenda (continued)**

#### **Draft Medium-term strategic plan, including Proposed programme budget 2008–2009 (continued)**

- **Real estate: draft capital master plan** (Documents EB120/18, EB120/18 Corr.1 and EB120/18 Add.1)

Ms BLACKWOOD (alternate to Dr Agwunobi, United States of America) welcomed the preparation of the draft capital master plan and expressed pleasure that the Secretariat was taking a long-term approach to planning for real estate needs. As agreed by the Programme, Budget and Administration Committee, it was essential to determine needs and costings for facilities, set priorities and plan necessary building work in a phased manner in order to spread costs.

Ms HALTON (Australia), speaking as the Chairman of the Programme, Budget and Administration Committee, said that the Committee had requested the Secretariat to include the financial requirements of the capital master plan in the Organization's programme budgets as a single budget line. The Committee had suggested that the proposed expenditure should be spread over the whole period of the plan;<sup>1</sup> it was currently concentrated in the early years. The Committee had welcomed the integrated plan, which provided an insight into the requirements and should permit orderly capital maintenance and replacement.

Mrs SCHAEER BOURBEAU (Switzerland)<sup>2</sup> welcomed the plan, which presented a coordinated approach to the Organization's facilities, identifying needs and setting priorities that would guide activities. Every international organization had to set aside sufficient resources from its budget to cover its infrastructure expenditures. However, cuts in building maintenance, often an early economy measure during times of budgetary constraint, could lead to increased expenditure in the long run as well as security and safety risks. The Real Estate Fund had been underfunded for some time and investment would be needed to redress the situation. Efforts must be made to cover the projected shortfall of US\$ 22 million for capital expenditures in the Proposed programme budget 2008–2009.

Security was becoming increasingly important and the Board needed a better overview of the security measures being taken. The ongoing reforms to ensure greater coordination in the United Nations system might result in further possibilities for savings, for example, joint offices, as mentioned in paragraphs 15 and 16 of document EB120/31, which would be considered later.

The CHAIRMAN suggested that Board members should note the report and request the Secretariat to ensure that the capital master plan was implemented in the best possible way.

**It was so agreed.**

---

<sup>1</sup> Document EB120/3.

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



- **Proposed programme budget 2008–2009** (Documents EB120/17, MTSP2008–2013/PPB2008–2009 and MTSP2008–2013/PPB2008–2009 Corr.1) (continued from the seventh meeting)

Dr INOUE (alternate to Dr Shinozaki, Japan), referring to the increase of 8.6% in the Proposed programme budget 2008–2009 compared with the previous biennium, said that Japan's position was similar to that expressed by the member for the United States of America at the previous meeting, namely that the budgets of all the international organizations should show zero nominal growth. The maintenance of fiscal discipline was an important principle. The need to strengthen WHO's functions in certain areas did not imply automatic approval of a budget increase of such proportions. Budgetary discipline and increases in results were not mutually exclusive. New goals could be achieved by reallocation according to country needs, priorities and expected results; savings could be made through operational efficiency; and support could be sought from partners, including other United Nations organizations. Through its collective wisdom and ongoing management reform, the Organization should be able to make its money work more efficiently and effectively, thereby obviating the need for an increase in the regular budget.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) asked for clarification regarding the implications of zero nominal growth, which constituted negative growth in real terms, once inflation and salary increases had been taken into account. Would reduced expenditure have a major impact on WHO's activities? It was important to understand the consequences of the various proposals before making a decision.

Dr INOUE (alternate to Dr Shinozaki, Japan), acknowledging the concern expressed by the previous speaker, said that it was his understanding that salaries accounted for more than 50% of the programme budget. However, it was not always the case that salaries increased each biennium, since retiring senior staff might be replaced by younger staff at lower salary levels. He requested further information regarding staffing costs and levels. For example, did the 8.6% increase imply that staff numbers would increase?

Dr NORDSTRÖM (Assistant Director-General) said that more detailed explanations of the proposed increase would be provided in due course. In the meantime, he indicated that changes in activities in the five areas identified as requiring an increase accounted for about US\$ 410 million. The main cost increase was the consequence of the depreciation of the United States dollar, which had resulted in losses of US\$ 50–100 million over the past two bienniums. The increases in staff costs were modest at around 2%. However, WHO's contribution to common system security costs had risen significantly from US\$ 6 million in 2004–2005 to US\$ 17 million in 2006–2007, and was set to rise further to US\$ 23 million in 2008–2009. WHO was moving forward and most of the expected results shown in the Proposed programme budget 2008–2009 were therefore new.

Ms HENDRY (United Kingdom of Great Britain and Northern Ireland)<sup>1</sup> welcomed the Director-General's commitment to budget discipline and rigorous prioritization, and the move away from reliance on earmarked voluntary contributions. WHO should take a hard look at its core mandate, identify its priorities and concentrate on those priorities as a way of developing a realistic budget over the six years of the Medium-term strategic plan. The graphic representation of the total proposed increase to 2015 presented to the Programme, Budget and Administration Committee had been received with some surprise by her Government's finance ministry.

She endorsed the view expressed by some Board members that the financing requirements for the capital master plan should be incorporated in the overall budget negotiations. WHO should seek

---

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

other channels of funding, for example the rationalization of overseas estates and accommodation, perhaps with greater support from host countries, before seeking increases in assessed or voluntary contributions from Member States. The United Nations reform process might also offer opportunities for further savings.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) asked whether the Board intended to submit a formal view on the programme budget proposals to the Health Assembly and requested clarification as to the procedures to be followed in developing the proposals further.

The DIRECTOR-GENERAL replied that she would take into account the comments made by members of the Board and would hold further consultations with Member States. She would then proceed with resource allocations in the conventional manner and present the proposals to the Health Assembly. Allocation was never an easy process and it would be impossible to please everyone. She was confident that sufficient resources would be forthcoming to fund the proposed activities.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) pointed out that it was important to consult the least developed countries, where needs were greatest, as well as major contributors.

The DIRECTOR-GENERAL assured the Board that her consultations would be broad-based.

The CHAIRMAN, observing that the Board's comments would be taken into account, said that it would be for the Health Assembly to decide on the level of the Proposed programme budget.

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

**Malaria, including proposal for establishment of World Malaria Day:** Item 4.2 of the Agenda (Documents EB120/5 and EB120/5 Add.1) (continued from the third meeting, section 2)

The CHAIRMAN invited the Board to consider the revised draft resolution on malaria, including a proposal for establishment of World Malaria Day, which read:

The Executive Board,  
Having considered the report on malaria, including a proposal for establishment of World Malaria Day;<sup>1</sup>

**Concerned** ~~Noting~~ that few malaria-endemic countries have made substantial progress towards achieving the **internationally agreed development goals, including those contained in the United Nations Millennium Development Goals Declaration** relating to malaria, **and that a number of countries have not yet met the commitments to increase their national budgets that they made when adopting the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases;**

**Noting** ~~but~~ that valuable opportunities are being created in the form of new tools and better defined strategies, and that **the** momentum for expanding malaria-control interventions, and increasing financial resources at country and global levels, is growing,

---

<sup>1</sup> Document EB120/5.

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>1</sup>

The Sixtieth World Health Assembly,

Having considered the report on malaria, including a proposal for the establishment of World Malaria Day;

Concerned that malaria continues to cause more than one million preventable deaths a year;

**Noting the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Bank Global Strategy and Booster Program; the Bill and Melinda Gates Foundation; the President's Malaria Initiative; and other donors have made substantial resources available;**

**Welcoming the contribution to the mobilization of resources for development of voluntary innovative financing initiatives taken by groups of Members States and, in this regard, noting the activities of the International Drug Purchasing Facility – UNITAID, and the International Finance Facility for Immunisation, and the intention to launch a pilot project within the Advance-Market Commitments initiative;**

Recalling that combating HIV/AIDS, malaria and other diseases is included in the United Nations Millennium Development Goals;

Mindful that the global burden of malaria needs to be decreased in order to reach the Millennium Development Goal of reducing child mortality by two thirds by 2015 and to help to achieve the Millennium Development Goals of improving maternal health and eradicating extreme poverty;

1. URGES Member States:

(1) to apply to their specific contexts the policies, strategies and tools recommended by WHO, and to establish evidence-based national policies, operational plans and performance-based monitoring and evaluation in order to expand coverage with major preventive and curative interventions in populations at risk, and assess programme performance and the coverage and impact of interventions in an effective and timely manner, particularly with use of the WHO country-profile database;

(2) to assign national and international resources, both human and financial, for the provision of technical support in order to ensure that the most locally and epidemiologically appropriate strategies are effectively implemented and target populations are reached;

(3) to withdraw from the market or withdraw the marketing authorization **in both the public and private sectors for oral artemisinin monotherapies i.e. artemisinins used alone without the accompaniment of a partner medicine, and to promote the use of artemisinin-combination therapies, to implement policies that prohibit the production of counterfeit antimalarial medicines;** and assure that financing bodies cease to **provide for procure** those monotherapies or other medicines; ~~including prequalified antiretroviral medicines, from manufacturers that continue to market artemisinin monotherapy products;~~

(4) ~~to waive taxes and tariffs for bednets, medicines and other products needed for malaria control, in order both to reduce the price of these commodities to consumers and to stimulate more competitive trade in these products;~~ **to identify and implement appropriate means to make effective medicines, long-lasting**

---

<sup>1</sup> See document EB120/5 Add.1 for the administrative and financial implications for the Secretariat of the resolution.

**insecticide-treated nets and other products as indicated by WHO available at low cost or free of charge;**

**(5) to provide in their legislation for use to the full of the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to increase access to antimalarial medicines, diagnostics and preventive technologies;**

2. REQUESTS international organizations:

**(1) to provide support to countries in expanding use of artemisinin-based combination therapies that are appropriate for local drug-resistance conditions, integrated vector-management that includes use of long-lasting insecticide-treated nets, and indoor residual spraying with appropriate and safe insecticides as indicated by WHO and in accordance with the Stockholm Convention on Persistent Organic Pollutants, the three main interventions: case management with artemisinin combination therapies, indoor residual spraying, and use of long-lasting insecticide-treated bednets as indicated by WHO, and using monitoring and evaluation systems, including the country database, as developed by WHO;**

**(2) to increase funding to the various financing mechanisms for malaria control, so that they can continue providing support to countries, and to channel additional resources, for technical support to ensure that they can be absorbed and used effectively in countries;**

**(3) to provide support for the development of capacities in developing countries to produce and distribute appropriate medicines and long-lasting insecticide-treated nets;**

3. REQUESTS the Director General:

**(1) to take steps to identify knowledge gaps for malaria control; to provide support for the development of new tools and strategies; to estimate more accurately the global burden of disease and determine trends; to develop new tools and methods for assessing impact and cost-effectiveness of interventions; to build up WHO's current research on malaria, including that of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases; and to provide technical support to countries for conducting operational and implementation research into ways to ensure adequate coverage with antimalarial interventions;**

**(2) to strengthen and rationalize human resources for malaria by decentralizing staff to country level, thus improving the capacity of WHO's country offices to provide support to national health programmes for coordinating partners to prevent and control malaria; and to provide technical guidance for the management of malaria control in refugee camps and in complex emergencies;**

**(3) to bring together WHO's Global Malaria Programme, the Roll Back Malaria Partnership, the Global Fund to Fight AIDS, Tuberculosis and Malaria, academics, small and large pharmaceutical and biotechnology companies, interested Member States, medical-research councils, and foundations in a standing forum in order to improve coordination between different stakeholders in the fight against malaria;**

**(3)(4) to report to the Health Assembly through the Executive Board on progress made in implementation of this resolution;**

## 4. RESOLVES that:

- (1)<sup>1</sup> ~~World~~ Malaria Day **shall** be commemorated annually on 25 April **or on such other day or days as individual Member States may decide**, in order to provide education and understanding of malaria as a global scourge that is preventable and a disease that is curable;
- (2) **Malaria Day shall be the culmination of year-long intensified implementation of national malaria-control strategies, including community-based activities for malaria prevention and treatment in endemic areas, and the occasion to inform the general public on the obstacles encountered and progress achieved in controlling malaria.**

The revised financial implications were:

(a) **Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)** To fulfill WHO’s leadership role in supporting implementation of the revised strategies and directions for malaria control globally, an estimated US\$ 1302.5 million over the 10-year period (including the 2006–2007 biennium) will be required. These costs are in line with the current biennium workplan, and scale-up required under the Draft Medium-term strategic plan and the relevant strategic objectives.

(b) **Estimated cost for the biennium 2006–2007 (estimated to the nearest US\$ 10 000, including staff and activities)** US\$ 137 million plus US\$ 1 million required for global support of World Malaria Day in 2007 and US\$ 250 000 to support the standing forum to improve coordination.

Dr SHANGULA (Namibia) said that the phrase “the President’s Malaria Initiative”, in the third preambular paragraph, should be clarified. He proposed deletion of the words “or other medicines” from paragraph 1(3) as there were areas where antimalarial medicines other than artemisinin-based combination therapies were still in use and proved effective. In order to avoid unnecessary repetition, paragraph 2(3) should be deleted, and the beginning of paragraph 2(1) should be amended to read “to provide support for the development of capacities in developing countries in expanding ...”.

Dr SOMSAK AKKSILP (adviser to Dr Suwit Wibulpolprasert, Thailand) recalled that in the *WHO guidelines for the treatment of malaria*, published in 2006, monotherapy was defined as “antimalarial treatment with a single medicine (either a single active compound or a synergistic combination of two compounds with related mechanisms of action)”. In the interests of clarity, the beginning of paragraph 1(3) should be amended to read: “to prohibit the practice in both the public and private sectors of oral artemisinin monotherapies ...”, as it was the practice itself rather than the marketing of the product that was to be prohibited.

Dr AGWUNOBI (United States of America), referring to the fourth preambular paragraph, suggested the deletion of the phrase “and the International Finance Facility for Immunisation, and the intention to launch a pilot project within the Advance-Market Commitments initiative” as he did not see its relevance to malaria. He supported the proposal by the member for Namibia to delete the words “or other medicines” from paragraph 1(3). In order to be consistent with the text of United Nations General Assembly resolution 61/228 on the 2001–2010 Decade to Roll Back Malaria in Developing Countries, Particularly in Africa, the wording of paragraph 1(4) should be amended to read: “to

---

<sup>1</sup> [There were proposals to delete this paragraph and to change the date from 25 April. The text indicated is a possible alternative.]

intensify access to affordable, safe and effective antimalarial combination treatments, intermittent preventive treatment in pregnancies, insecticide-treated mosquito nets, including through the free distribution of such nets where appropriate, and insecticides for indoor residual spraying for malaria control, taking into account relevant international rules, standards and guidelines". Paragraph 1(5) should be replaced with language from resolution WHA59.24 to read: "to take into account the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights", and, in order to allow greater flexibility, the word "standing" should be deleted from paragraph 3(3).

Dr RUIZ MATUS (alternate to Mr Bailón, Mexico), while supporting the draft resolution, recalled Mexico's earlier comments on community participation and mechanisms for vector control which had not been reflected therein. Accordingly, he suggested the incorporation in the text of wording from resolution CD46.R13 of the PAHO Directing Council, urging Member States to "implement integrated approaches to malaria prevention and control through multisectoral collaboration and co-responsible community participation", and to "aim at reducing transmission risk factors through integrated vector management, [and] promote improvement of local and environmental conditions and healthy settings ...".

Professor PEREIRA MIGUEL (Portugal), referring to the comments of the member for the United States, pointed out that the language of the fourth preambular paragraph was consistent with paragraph 5 of General Assembly resolution 61/228. In the interests of clarity, a reference to the origin of the text might therefore be included as a footnote.

Dr NYIKAL (Kenya), noting that the objective of paragraph 1(5) was to increase access to antimalarial medicines, diagnostics and preventive technologies, sought clarification of the amendment proposed by the United States.

Dr AGWUNOBI (United States of America) offered to provide the member for Kenya with an explanation of the rationale behind his proposed amendment in an informal setting before the draft resolution was considered further.

Dr QI Qingdong (China) recalled that China had originally favoured the deletion of paragraph 1(3). It would however, be prepared to accept the text, with the insertion of the word "gradually" before "withdraw from the market".

Dr KEAN (Executive Director, Office of the Director-General) said that, in view of the extent of the new wording proposed, a revised version of the text incorporating the amendments would be prepared for consideration at a later meeting.

**It was so agreed.**

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

**Tuberculosis control: progress and long-term planning:** Item 4.3 of the Agenda (Documents EB120/8 and EB120/8 Add.1 Rev.1) (continued from the third meeting, section 2)

The CHAIRMAN drew attention to a revised version of the draft resolution, which read:

The Executive Board,

Having considered the report on tuberculosis control: progress and long-term planning,<sup>1</sup>

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>2</sup>

The Sixtieth World Health Assembly,

Having considered the report on tuberculosis control: progress and long-term planning;

Noting the progress made since 1991 towards achieving the international targets for 2005, and more recently following the establishment, in response to resolution WHA51.13, of the Stop TB Partnership;

Aware of the need to build on this progress and overcome constraints in order to reach the international targets for tuberculosis control for 2015 set by the Stop TB Partnership – in line with the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration: “to have halted and begun to reverse incidence by 2015” – of halving tuberculosis prevalence and death rates by 2015 compared with 1990 levels;

Noting the development of the Stop TB strategy as a comprehensive approach to tuberculosis prevention and control that incorporates the internationally agreed tuberculosis control strategy (DOTS strategy) and represents a significant expansion in the scale and scope of tuberculosis-control activities;

Welcoming the Partnership’s Global Plan to Stop TB 2006–2015, which sets out the activities oriented towards implementing the Stop TB strategy and achieving the international targets for tuberculosis control for 2015;

Aware of the need to increase the scope, scale and speed of research needed to achieve the international targets for tuberculosis control for 2015 and the goal of eliminating tuberculosis as a global public-health problem by 2050;

Concerned that delays in implementing the Global Plan will result in increasing numbers of tuberculosis cases and deaths, including those due to multidrug-resistant (and extensively drug-resistant) tuberculosis and to the impact of HIV, and therefore in delays in achieving by 2015 the international targets for tuberculosis control and the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

Recalling that resolution WHA58.14 encouraged Member States to fulfil their commitments to ensure the availability of sufficient domestic resources and of sufficient external resources to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration,

1. URGES all Member States:

(1) to develop and implement long-term plans for tuberculosis prevention and control in line with the Global Plan to Stop TB 2006–2015, in the context of overall health development plans, ~~and~~ in collaboration with other programmes (including those on HIV/AIDS, child health and strengthening of health systems), **and through national Stop TB partnerships, [Afghanistan]** with the aim of:

(a) accelerating progress towards the international targets for tuberculosis control for 2015 through full and rapid implementation of the Stop TB

---

<sup>1</sup> Document EB120/8.

<sup>2</sup> ~~See document EB120/8 Add.1 for the administrative and financial implications for the Secretariat of this resolution.~~

strategy, as measured through improved health information systems to serve assessment of national programme performance; [Thailand]

(b) limiting the emergence and transmission of multidrug-resistant tuberculosis, including extensively drug-resistant tuberculosis, by ensuring high-quality **implementation of DOTS by performance of tuberculosis programmes as the first and foremost step in the full implementation of the Stop TB strategy** [Iraq], and by prompt implementation of infection-control precautions; [USA]

(b bis) if affected, immediately tackling extensively drug-resistant tuberculosis as part of the overall Stop TB strategy, as the highest health priority; [Portugal]

(b ter) **enhancing laboratory capacity in order to provide for rapid drug-susceptibility testing of isolates obtained from all persons with culture-positive tuberculosis, and promote access to quality-assured sputum smear microscopy**; [USA]

(c) increasing access to quality-assured second-line medicines at affordable prices through the Stop TB Partnership's Green Light Committee;

(2) to use all possible financing mechanisms in order to fulfil the commitments made in resolution WHA58.14, including that to ensure sustainable domestic and external financing, **thereby filling the funding gaps identified in the Global Plan to Stop TB 2006–2015** ~~for tuberculosis prevention and control~~; [Afghanistan]

(2 bis) **to declare, where appropriate, tuberculosis as an emergency and to allocate additional resources in order to strengthen activities aimed at stopping the spread of extensively drug-resistant tuberculosis**; [Kenya]

2. REQUESTS the Director-General:

(1) to intensify support provided to Member States **in expanding implementation of the Stop TB strategy by** [Thailand] developing capacity and improving the performance of national tuberculosis-control programmes, **particularly the quality of DOTS activities** [Iraq], and by **implementing infection-control precautions** [USA] within the broad context of strengthening health systems in order to achieve the international targets for 2015;

(1 bis) **to strengthen urgently WHO's support to countries affected by extensively drug-resistant tuberculosis**; [Portugal]

(2) to enhance WHO's ~~support for~~ **leadership within** [Madagascar] the Stop TB Partnership in its coordination of efforts to implement the Global Plan to Stop TB 2006–2015 and to facilitate long-term commitment to ~~its~~ sustainable financing **of the Global Plan through improved mechanisms for increased funding**; [Thailand]

(2 bis) **to strengthen mechanisms to review and monitor estimates of impact of control activities on the tuberculosis burden, including incidence, prevalence and mortality**; [Afghanistan]

(2 ter) **to support Member States in developing laboratory capacity to provide for rapid drug-susceptibility testing of isolates obtained from all persons with culture-positive tuberculosis**; [USA]

(3) to enhance WHO's role in tuberculosis research in order to promote the applied research necessary to reach the international targets for tuberculosis control for 2015 and the basic research necessary to achieve the goal of eliminating tuberculosis by 2050; and to increase global support for those areas of tuberculosis research that are currently underresourced;

(4) to report to the Sixty-third World Health Assembly through the Executive Board on:



- (a) progress in implementation of the Global Plan to Stop TB 2006–2015, including mobilization of resources from domestic and external sources for its implementation;
- (b) progress made in achieving the international targets for tuberculosis control by 2015, using the “proportion of tuberculosis cases detected and cured under directly observed treatment, short course (DOTS)” (Millennium Development Goal indicator 24) as a measure of the performance of national programmes, and tuberculosis incidence and “prevalence and death rates associated with tuberculosis” (Millennium Development Goal indicator 23) as a measure of the impact of control on the tuberculosis epidemic.

The revised financial implications were:

**(b) Estimated cost for the biennium 2006–2007 (estimated to the nearest US\$ 10 000, including staff and activities)**

US\$ 260 million: this includes the revised budget of US\$ 235 million for the tuberculosis area of work, and an additional US\$ 25 million required for WHO’s role in laboratory strengthening, tuberculosis-impact assessment, and global support to national responses to the emergence of extensively drug-resistant tuberculosis in 2007.

Dr RUIZ MATUS (alternate to Mr Bailón, Mexico) queried the amendment proposed by Thailand to operative paragraph 1(1)(a) of the draft resolution. The best indicator of progress would be reduced morbidity and mortality, even though health information systems would have to be improved in order to measure those indicators.

Dr AGWUNOBI (United States of America) supported the amendment proposed by the delegation of Afghanistan to paragraph 1. However, not every country had a Stop TB partnership. He proposed inserting the phrase “where appropriate” after “partnerships”.

Dr SHANGULA (Namibia) asked whether the proposed amendment contained in paragraph 1(1)(b bis) was intended to be an alternative to, or additional to, paragraph 1(1)(b). He suggested substituting for the word “tackling” some other term more appropriate to a medical context.

Dr KEAN (Executive Director, Office of the Director-General) suggested “addressing” as an alternative to “tackling”. Paragraph 1(1)(b bis) represented additional text. In the final text, the operative paragraphs of the resolution would be renumbered.

Dr RUIZ MATUS (alternate to Mr Bailón, Mexico) suggested, as an alternative to the amendment to paragraph 1(1)(a) proposed by Thailand, rewording paragraph 1(1)(b ter) to read: “through improving health information services so as to provide instruments for assessing national programme performance and enhancing laboratory capacity ...”.

Dr RAVIGLIONE (Stop TB) suggested that, with the agreement of the member for Thailand, the second part of paragraph 1(1)(a) could be treated as a separate subparagraph.

**It was so agreed.**

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

**Prevention and control of noncommunicable diseases: implementation of the global strategy:**  
Item 4.5 of the Agenda (Documents EB120/22 and EB120/22 Add.1) (continued from the sixth meeting)

The CHAIRMAN invited comments on the amended text of the draft resolution, which read:

The Executive Board,

Having considered the report on prevention and control of noncommunicable diseases: implementation of the global strategy,<sup>2</sup>

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>3</sup>

The Sixtieth World Health Assembly,

Having considered the report on prevention and control of noncommunicable diseases: implementation of the global strategy;

Recalling resolutions WHA53.17 on Prevention and control of noncommunicable diseases, WHA56.1 on the WHO Framework Convention on Tobacco Control, WHA57.17 on Global strategy on diet, physical activity and health, WHA57.16 on Health promotion and healthy lifestyles, WHA58.22 on Cancer prevention and control, and WHA58.26 on Public-health problems caused by harmful use of alcohol, and the many related regional committee resolutions, **including on mental health; [Portugal]**

Deeply concerned that in 2005 chronic noncommunicable diseases caused an estimated 35 million deaths (60% of all deaths globally), that 80% of these deaths occurred in low- and middle-income countries, and that about 16 million deaths occurred among people under 70 years of age;

Noting that the mortality due to chronic noncommunicable diseases is expected to rise by a further 17% by 2015, with serious socioeconomic consequences for Member States, communities and families;

Noting the links between chronic noncommunicable diseases, development, **the environment, [Portugal]** and human security, and their contribution to health inequalities;

Noting that multisectoral responses continue to be limited by lack of awareness about, and appropriate action to reverse, the pandemic of chronic noncommunicable diseases;

Noting that the importance of the prevention and control of chronic diseases has been highlighted in the Eleventh General Programme of Work 2006–2015, which includes the target of reducing death rates from all chronic diseases by 2% per year during the next 10 years;

Noting the increasing evidence on the cost-effectiveness of several simple interventions for prevention and control of chronic noncommunicable diseases;

**Noting the importance of motivating, educating and supporting individuals and families to make healthy choices in their daily lives particularly in relation to diet, physical activity and tobacco use; [Australia]**

---

<sup>1</sup> Resolution EB120.R3.

<sup>2</sup> Document EB120/22.

<sup>3</sup> See document EB120/22 Add.1 for the financial and administrative implications for the Secretariat of this resolution.

Confirming the importance of tackling the major underlying risk factors for chronic noncommunicable diseases in an integrated, comprehensive, multisectoral and step-by-step manner;

Bearing in mind that the response to the ~~double~~ **triple [Jamaica]** burden of infectious diseases, chronic noncommunicable diseases, **and injuries [Jamaica]** faced by many countries and their severe resource constraints requires a strong primary health-care system within an integrated health system;

Recognizing that the implementation of the WHO Framework Convention on Tobacco Control is an essential measure for the prevention and control of chronic noncommunicable diseases;

Recognizing that greater efforts are required globally to promote physical activity, and to improve the quality of food and drink products, including information available to consumers and the way in which **new and healthy [USA]** products are marketed, especially to children;

Recognizing that more information is required on the socioeconomic and developmental impact of chronic noncommunicable diseases and on the outcome of available interventions;

Aware that Member States spend only a small proportion of their health-care budget on prevention of chronic noncommunicable diseases and on public health, and that even a minor increase in that percentage would yield tremendous health and socioeconomic benefits;

~~Recalling that several innovative mechanisms exist for funding national disease-prevention and health promotion programmes; [USA]~~

1. URGES Member States:

(1) to strengthen national and local political will to prevent and control chronic noncommunicable diseases as part of a commitment to achieving the target of reducing death rates from all chronic noncommunicable diseases by 2% per year for the next 10 years, as contained in the Eleventh General Programme of Work 2006–2015;

(2) to establish or strengthen a national coordinating mechanism for prevention of chronic noncommunicable diseases, ~~where appropriate to national circumstances;~~ **[Kenya]** with a broad multisectoral mandate, including mobilization of political will and financial resources, and involving all relevant stakeholders;

(3) to develop and implement a national multisectoral evidence-based action plan for prevention and control of chronic noncommunicable diseases that sets out priorities, a time frame and performance indicators, and that provides the basis for coordinating the work of all stakeholders, **and actively engage civil society; [Australia]**

**(3 bis) to increase budgetary provisions that are dedicated to the prevention and control of chronic noncommunicable diseases, [Kenya] and to implement a line item for prevention and control of chronic noncommunicable diseases in the annual health budget as an essential step in policy implementation; [Jamaica]**

**(3 ter) to consider implementing international agreements and increasing support for global initiatives that will contribute to achieving the target of reducing death rates from chronic noncommunicable diseases by 2% annually for the next 10 years; [Kenya]**

(4) to make prevention and control of chronic noncommunicable diseases an integral part of programmes aimed at strengthening primary health-care systems, **and to strengthen primary health care systems so that they respond to the challenges raised by chronic noncommunicable diseases; [Jamaica]**

- (5) to strengthen monitoring and evaluation systems, including country-level epidemiological surveillance mechanisms, in order ~~to assess the response of health systems and all relevant sectors, including the private sector~~ **to compile evidence to inform policy decisions; [USA]**
- (6) **to ensure that national health systems are adequately organized in order to tackle the serious challenges raised by noncommunicable diseases; which implies a particular focus on primary health care; [Portugal]**
- (7) **to consider possibilities to use national legislative or regulatory mechanisms with the aim of preventing and controlling noncommunicable diseases; [Portugal]**

2. REQUESTS the Director-General:

- (1) **on the basis of an outline contained in the report on prevention and control of noncommunicable diseases**, to prepare an action plan to be submitted to the Sixty-first World Health Assembly that sets out priorities, actions, a time frame and performance indicators for prevention and control of noncommunicable diseases between 2008 and 2013 at global and regional levels, and to provide support **where needed for elaboration**, intensified implementation and monitoring of national plans for prevention and control of chronic noncommunicable diseases, including the further development of an intervention to manage the conditions of people at high risk of such diseases;
- (2) to raise further awareness among Member States of the importance of drawing up, promoting and funding supportive national multisectoral coordination and surveillance mechanisms, and plans for prevention and control of chronic noncommunicable diseases;
- (3) to provide support to Member States, on request, **and to foster partnership, collaboration, cooperation and sharing of best practices among Member States, [Bolivia and Chile]** for incorporating comprehensive chronic noncommunicable disease interventions into national policies and programmes, including health systems policies and programmes, and for expanding interventions, **including strategies to educate and support individuals and families; [Australia]**
- (4) to disseminate to Member States, in a timely and consistent manner, information on cost-effective, core interventions aimed at preventing and controlling chronic noncommunicable diseases;
- (4 bis) **to encourage dialogue with international, regional and national nongovernmental organizations, donors and technical-agency partners in order to increase support, resources and partnerships for prevention and control of chronic noncommunicable diseases; [Jamaica]**
- (5) to encourage dialogue with the private sector **in particular [Australia and Portugal]** in order to increase **the relative demand for, and [Australia]** availability of, healthy foods, promote healthy diets ~~reduce and the marketing and promotion of unhealthy products, [USA]~~ **and increase access to medicines for high-risk populations in low- and middle-income countries, and include health and wellness programmes at the workplace; [Jamaica]**
- (6) to build and sustain contact with the mass media in order to ensure continued prominence in the media of issues related to the prevention and control of chronic noncommunicable diseases;
- (7) to improve understanding of the socioeconomic impact of chronic noncommunicable diseases at national and household levels, ~~and the links to poverty and human insecurity especially [USA]~~ **in low- and middle-income countries;**

**(7 bis) to ensure that the work on prevention and control of noncommunicable diseases is given appropriately high priority, including in terms of resources; [Portugal]**

**(8) to report to the Sixty-third [Portugal] World Health Assembly, and subsequently every two years to the Health Assembly [Kenya] through the Executive Board, on progress in implementing the global strategy on prevention and control of noncommunicable diseases, including progress on the action plan. [Portugal].**

Dr AGWUNOBI (United States of America) said that the technical agencies in his country would favour replacing the term “noncommunicable diseases” by “chronic diseases”. Some chronic diseases, such as cancers of the cervix or stomach, resulted from a communicable virus such as the human papillomavirus, and could not be accurately denominated noncommunicable.

He disagreed with the proposed deletion in paragraph 1(2) of the phrase “where appropriate to national circumstances”. In paragraph 1(3 bis) he suggested a wording such as “to increase, as appropriate, resources for programmes for the prevention and control of chronic diseases”. Paragraph 1(7) should use the language of resolution WHA53.17, paragraph 1(2)(d), namely: “to emphasize the key role of governmental functions, including regulatory functions, when combating noncommunicable diseases”. Generally speaking, when amendments were proposed it seemed desirable to offer alternative wordings which already enjoyed a measure of acceptance in other texts.

Paragraph 2(1) should include the words “through the Executive Board” after “an action plan to be submitted to the Sixty-first World Health Assembly”.

Ms HALTON (Australia) pointed out that national coordinating mechanisms did not necessarily exist in federal States, which had their own budgeting arrangements. She suggested including the words “where appropriate” in paragraph 1(2) after “to establish or strengthen”, and replacing “increase” by “consider increasing” at the beginning of paragraph 1(3 bis). In the same paragraph, the words “where appropriate” should be inserted after “implement a line item”. In paragraph 1(3 ter) she suggested inserting the word “existing” before “international agreements”. Paragraph 2(1) should specify which report was referred to. The words “where appropriate” should be inserted before “health and wellness programmes” in paragraph 2(5), and also before “in terms of resources” in paragraph 2(7 bis).

Dr SMITH (Denmark) agreed with the proposal by the United States to replace paragraph 1(7) with language that had already been agreed in that context. She proposed the deletion, in the thirteenth preambular paragraph, of the phrase “new and healthy” and, in the ninth preambular paragraph, all the text following “daily lives”: it was better to omit all mention of risk factors than to mention only a few. Paragraph 2(5) had lost its focus. She proposed amending the text up to “increase access to medicines” to read: “to cooperate with the private sector committed to reducing the risks of noncommunicable diseases in implementing the strategy and promoting healthy diets”, and adding, after “workplan”, at the end of the paragraph, the words “while ensuring avoidance of potential conflict of interest.”

Dr AGWUNOBI (United States of America), responding to a query by Dr TANGI (Tonga), explained that he had not formally proposed an amendment in connection with the term “noncommunicable diseases”. He merely wished to emphasize that the term “chronic diseases” had a sounder scientific basis.

Dr TANGI (Tonga) said that he found both terms acceptable. Both were used within the Oxford Health Alliance. However, for the time being it would be better to retain the term in general use in WHO.

Dr SHANGULA (Namibia) said that the distinction drawn by the member for the United States between noncommunicable and chronic diseases constituted a grey area. HIV/AIDS, though a communicable disease, was also regarded as chronic in some circumstances, but it would hardly be appropriate to describe it as noncommunicable. It would be best to keep to the language customarily used.

Dr NYIKAL (Kenya) accepted the proposal to reinstate the words “where appropriate to national circumstances” in paragraph 1(2). In paragraph 1(3), he asked whether the phrase “all stakeholders” included brewers and the tobacco industry. It seemed desirable to find a term to encompass protagonists whose activities could be detrimental to health.

Dr SUPAKIT SIRILAK (adviser to Dr Suwit Wibulpolprasert, Thailand), referring to the ninth preambular paragraph beginning “Noting the importance of motivating ...”, proposed adding “and the important role of the government in providing a healthy public policy environment”.

Professor PEREIRA MIGUEL (Portugal) endorsed the comment by Denmark concerning the United States’ proposal for paragraph 1(7).

Mr CAMPOS (alternate to Dr Buss, Brazil) suggested that paragraph 2(5) could be redrafted to include a request to the Director-General to promote and introduce specific policies. He would submit some wording to that effect to the Secretariat in writing.

Dr SHANGULA (Namibia), referring to the ninth preambular paragraph, noted that it seemed to embrace both positive and negative aspects of lifestyle.

The CHAIRMAN said that a new version of the draft resolution, incorporating the proposed amendments, would be available at the following meeting.

**It was so agreed.**

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

**Progress in the rational use of medicines, including better medicines for children:** Item 4.9 of the Agenda (Documents EB120/7, EB120/7 Add.1, EB120/37 and EB120/37 Add.1) (continued from the sixth meeting)

Dr TANGI (Tonga) concurred with comments made at the earlier meeting. He said that the problems associated with the rational use of medicines appeared to be largely the result of people’s attitudes. In large hospitals policies and regulations on prescribing could be readily implemented. Most prescribing difficulties occurred at primary health care level, where doctors had to deal, for example, with distressed parents, or health professionals responded to patient pressure by prescribing antibiotics. There was also the question of how to finance health systems and the inability of poor people to afford good medicines. The member for the United States of America requested the deletion of all the bracketed text in the draft resolution contained in document EB120/7, but had asked for the preambular paragraph beginning “[Recognizing the importance of financing drugs ...]” to be retained. Without a proper policy for the financing of treatment, poor people would stay at home when ill, or resort to inappropriate treatments.

Dr QI Qingdong (China) said that antimicrobial resistance was a grave problem in China. The irrational use of medicines was a waste of scarce health resources, a burden on society and a risk to health. His Government fully supported the intervention measures proposed in the report. Real change needed a holistic approach, with government mechanisms and a standardized code of conduct for health professionals. The public sector must join with nongovernmental organizations and the private

sector in regulating the use of medicines. Medical training in that area should be reinforced and a medicines evaluation system established. China was building a national essential medicines system and hoped to change people's attitudes. It was willing to learn from the experiences of international organizations and other countries.

He supported the draft resolution contained in document EB120/7, but proposed that in paragraph 1(2) the words "and monitor" should be inserted between "to promote" and "the rational use".

Mr CAMPOS (alternate to Dr Buss, Brazil) said that, although the two draft resolutions contained extremely important points, they were so similar that it was hard to see why separate resolutions were necessary.

Dr OGWELL (alternate to Dr Nyikal, Kenya) endorsed the comments by the member for Thailand. The report clearly explained why medicines were not available to children, and those factors persisted, despite numerous Health Assembly resolutions on essential medicines and the rational use of medicines. In Africa and developing countries elsewhere, the situation was compounded by socioeconomic issues. The market was limited because people could not afford to pay for their medicines, nor could governments bear the cost. Children died as a result. Insensitive international trade arrangements exacerbated the situation.

He supported the draft resolution in document EB120/37, but, in order to strengthen it, proposed the addition of a new preambular paragraph, that would read "Concerned that children in developing countries are further disadvantaged by both physical and economic lack of access to essential medicines"; the incorporation of a new paragraph 1(5), to read "to use existing international arrangements to ensure that health-related trade agreements and rights do not restrict children's access to essential medicines"; and in paragraph 2(4), the insertion, of the phrase "fair trade in essential medicines" after the word "ensure".

Mr RAMOTSOARI (Lesotho) supported the amendments proposed to both draft resolutions. Several stakeholders had been identified in the rational use of medicines, and it was important to monitor their activities so that information could be kept up to date. The Health Assembly should receive reports on rational use of medicines on a biennial basis.

Paragraphs 2(6) and 2(5) of the draft resolutions contained in documents EB120/7 and EB120/37, respectively, should be identical, since their message was the same.

Dr GWENIGALE (Liberia) said that rational use of medicines in African countries was impeded by the influx of counterfeit drugs that were convincingly labelled and packaged. Countries were unable to test them because they lacked the necessary laboratories. Some materials arrived labelled in languages that nationals could not understand, and, consequently, could not be correctly prescribed. Some manufacturers used unethical practices, offering medicines for sale at well below the normal price but incorporating only a fraction of the active ingredient; as a result, patients unknowingly took less than the recommended dose. Member States without the capacity to test medicines for their populations must be given support in setting up quality-control laboratories in order to ascertain the quality of imported medicines.

The CHAIRMAN, speaking as the member for Bolivia, said that access to, and rational use of, medicines had long been seen as important within WHO; many resolutions had been passed and programmes launched. Nevertheless, some aspects raised questions, for example, how could medicines for children be tested when clinical trials for children were prohibited? He agreed with the member for the United States that the budget allocated for activities relating to rational use of medicines was very high, far in excess of some countries' annual medicines budget. It should be borne in mind that it was national essential medicines lists that determined which medicines were allowed into a country. They should be based on efficacy, as well as criteria assessed in clinical trials, such as safety and quality. Exchanges between countries concerning their respective lists would be useful.

Any resolution that reinforced efforts to ensure access to, and proper use of, medicines deserved support.

Dr URBINA (El Salvador) said that people's attitudes had changed: self-medication was common either to avoid the cost of consultation or because it offered easier access to medicines, although people were largely unaware that in solving one problem they were creating another. Public information strategies were needed in order to educate people about the products that could safely be taken without a prescription. One of the draft resolutions should address that matter.

Dr SHANGULA (Namibia) supported both draft resolutions but, like the member for Brazil, questioned the need for two such similar texts. He proposed that the words "including better medicines for children" should be deleted from the preamble of the draft resolution in document EB120/7, as that was the subject of the other draft resolution. The two texts should be harmonized so that all issues relating to rational use of medicines were in the first, and those relating to children were in the second.

Mrs VARAVIKOVA (Russian Federation)<sup>1</sup> endorsed the remarks about the danger of confusing what were in fact two separate draft resolutions, each with its own target, budgeting proposals and expected outcomes. The draft resolution on rational use of medicines was of prime importance. Health systems in all countries, irrespective of income level, needed to establish health-system programmes, coordinated by WHO, on rational use of medicines so as to strengthen primary health care. The pharmaceutical industry was often the only accessible source of information on medicines available to practising physicians; however, in order to ensure rational use, physicians needed independent information.

In order to ensure the quality of the programmes implemented by health ministries, WHO should send experts to work with countries on the ground in promoting rational use of programmes. Close collaboration between WHO experts and the staff of national interministerial bodies, and the earmarking of budgetary resources from WHO for financing such programmes, would bring the rational use of medicines within the framework of national safety and the human right to health, including good-quality medical care. She accordingly endorsed the proposal by the member for the Libyan Arab Jamahiriya to reinstate, in paragraph 2 of the draft resolution contained in document EB120/7, the request to the Director-General in an earlier version to expand and strengthen WHO's technical support to Member States in establishing national multidisciplinary bodies in order to monitor medicine use and coordinate the implementation of national rational use programmes.

Turning to the draft resolution on better essential medicines for children contained in document EB120/37, she supported WHO's activities in that area and drew attention to the need to establish and support national and international registers of adverse effects of medicines in children. She proposed that the Board should adopt the two resolutions separately.

Mr POMOELL (Finland)<sup>1</sup> said that medicines developed specifically for the treatment of children, a third of the world's population, either did not exist or were not widely available for many diseases. Children could not, in most cases, be treated as adults so far as the use of medicines was concerned. Medicinal products intended for children must conform to standards for pharmacokinetics, efficacy and safety, and needed appropriate formulation for easy and safe administration. Many medicinal products administered to children had not been evaluated specifically for paediatric use, and therefore had no marketing authorization; they did not meet the same quality, safety and efficacy criteria as medicines for adults.

The lack of appropriate medicines for children was a global problem. It affected countries irrespective of income, impeded attainment of several of the Millennium Development Goals, and failed to respect the rights of the child. Although the problems relating to children's medicines had in

---

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



recent years been recognized by some countries, there had been no comprehensive consideration of the situation, nor a global development plan, hence Finland's proposal of a new item for the Board's agenda.

Mr HILMERSON (Sweden),<sup>1</sup> supported by Dr JAKSONS (Latvia), proposed that, in order to specify the support to be provided to countries by the Secretariat, and to meet China's concerns about monitoring, paragraph 2(2) of the draft resolution contained in document EB120/7 should be amended to read: "to strengthen, as appropriate, WHO's technical support to Member States in their efforts to establish and/or strengthen national programmes to monitor and evaluate medicines use, develop and coordinate the implementation of comprehensive, targeted strategies, including building stronger institutional capacity, to promote the rational use of medicines in both public and private sectors". He urged the Board to retain the text that appeared in square brackets.

Ms NGAUNJE (Malawi)<sup>1</sup> said that, as a result of HIV/AIDS, economic factors and other health issues, young people under the age of 15 predominated in Malawi's population. Their health needs placed a major burden on the country's medical service and families, communities and the nation as a whole. Countries like Malawi could seldom afford a choice of medicines for children and considered itself fortunate that essential medicines were available to children in need. Good research and assessment were most needed, in order to bring about more effective and rational use of medicines for children in Africa, provide a service to children that was urgent and long overdue, and possibly also reduce the side effects and toxicity of unapproved medicines and regimens. She supported WHO's efforts to improve both the quantity and quality of the medicines available for children.

Mr RAJALA (European Commission) said that the European Union's Regulation on Medicinal Products for Paediatric Use would enter into force on 26 January 2007 and, through a package of requirements, rewards and incentives, should lead to a significant increase in the development and authorization of medicines for children. It introduced a reward in the form of six months' extension to the supplementary protection period and a new type of marketing authorization for paediatric medicines. It also contained a provision on European Union funding for research leading to the development and authorization of off-patent medicines for children, which should result in better access to such medicines. By boosting the development and authorization of medicines for children in the European Union, the Regulation would reduce the need for unlicensed and off-label use and thus have a direct and positive impact on their irrational use. The Regulation should also benefit children outside the European Union.

The Commission supported the draft resolution on the rational use of medicines, as rational use was an important element of sound pharmaceutical policies and strategies. In 2005, it had set up a high-level pharmaceutical forum, currently consisting of representatives of all 27 Member States and stakeholders. As well-informed patients had better rates of compliance with their treatments and a better understanding of relevant safety aspects, patient information was clearly an important part of rational use; the forum was looking at ways of producing high-quality, understandable and easily accessible information on diseases and medicines. Relative effectiveness also had an impact on rational use: the forum had therefore stressed the need to devise mechanisms to increase the quality and quantity of data in order to enable relative effectiveness assessments to be carried out at the national level. The existence across the European Union of 27 different pricing and reimbursement systems resulted in wide differences in the availability and cost of medicines, and the forum was looking at ways of speeding up access to medicines while achieving a balance between cost containment and reward for innovation. Rational use of medicines also enhanced patient safety, as more than half all adverse events in health care were caused by medication errors. In order to minimize preventable harm to the patient, medication must be prescribed and administered correctly.

---

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

In 2001, the Commission had launched a strategy to combat the threat to human, animal and plant health of antimicrobial resistance, which included data collection, surveillance, research, awareness-raising and the phasing out of antibiotics for non-medical use in animals. A recommendation on the prudent use of antibiotics, adopted in 2002, was a component of that strategy.

Dr EMAFO (United Nations International Narcotics Control Board) said that the adverse effect of the Internet on rational use of medicines did not appear to be covered in document EB120/7, and that the only reference to cooperation with universities in the draft resolution was in the preamble. Paragraph 1(4) of the draft resolution should be amended to include a reference to cooperation with universities in the training of health professionals in the rational use of medicines. Telemedicine and Internet prescribing facilitated access to medical and pharmaceutical services for large segments of society, but the potential for errors and intentional misuse was considerable. Replacing direct patient-doctor contact with electronic communication in an unregulated manner was problematic. Efforts to regulate the area required close cooperation among countries and relevant international bodies. Paragraph 1(5) dealt with unethical promotion of medicines through the Internet, but failed to address prescription and sale of medicines over the Internet. Those areas needed to be regulated as a matter of urgency, particularly as the quality, safety and efficacy of medicines sold by unregulated Internet prescribers could not be guaranteed.

Dr NOEHRENBURG (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the pharmaceutical industry fully supported the use of facts and data in ensuring that medicines were used appropriately and effectively. Each patient's needs were individual, and individual treatment depended on access to a range of therapies and patient empowerment. As medicines were potent and often complex chemicals, the best care depended on the ability of the health professional to prescribe the best products for their patients' condition; patients with appropriate information could become valuable partners with the health-care providers, thereby improving the quality of care. Government policies should therefore encourage patients' access to health-care information from reputable sources.

The industry had an important role to play in educating medical professionals to prescribe in an informed and rational manner. The industry was often the only source of information on new products, and without that information patients would be denied timely access to innovative medicines. Calls to limit or ban the industry's promotion of medicines were misguided. As of 1 January 2007, the Federation's Code of Marketing Practices, which was binding on all members, had been strengthened.

WHO should support patient-focused health care to promote health, rather than advocating standards of treatment set by budget considerations. Measures implemented without adequate evidence to impose a "one-treatment-fits-all" standard of care resulted in poorer health and greater social costs. The current debate should be used to foster conditions in which prescribers could choose from a portfolio of products in order to suit their patient's specific needs, including those of children.

The incentives provided by the United States and the European Union were effective in bringing many paediatric formulations to market. Paediatric formulations of all antiretroviral agents indicated for children were already on the market and being offered on preferential terms through companies' access programmes.

Promoting proper care included: setting up reimbursement schemes that rewarded innovation; speeding up registration of new and improved medicines; and empowering patients by making them partners in their health care through access to information from responsible sources.

Professor SCHALLER (International Pediatric Association), speaking at the invitation of the CHAIRMAN, said that access to safe and reliable medicines for children worldwide and the rational use of such medicines were essential to child health and survival, and to the attainment of several Millennium Development Goals. In June 2006, paediatricians, clinical pharmacologists and pharmacists had founded the International Alliance for Better Medicines for Children with the aim of making access to safe and effective medicines for all children at country level worldwide a reality. She emphasized basing decisions on medicines for children on documented evidence of disease burdens at

country and regional levels; enlisting the child health, child pharmacology and child pharmacy communities at country and regional levels throughout the world as leaders of that process; ensuring that the unique physiology, metabolism and developmental stages of children were duly considered in all decisions regarding better medicines for children; and working for access to better medicines. She supported the draft resolution, and urged that better medicines for children be considered as an independent initiative.

Mr CHAN (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, urged Member States to reach consensus on establishing national programmes to monitor the rational use of medicines. He expressed concern that, in the revised draft resolution, all references to promoting and implementing national programmes to monitor medicine use had been deleted. The Board should consider retaining a reference to promoting research into the development of national monitoring systems, which were essential for assessing the impact of interventions.

Bearing in mind the guidelines for good pharmacy practice issued by WHO and his Federation, and resolution WHA47.12 on the pharmacist's role, the Federation urged all Member States to recognize the role of pharmacists in developing, promoting and implementing national medicines policies, and particularly their standard treatment guidelines and essential medicine lists; and to use pharmacists' expertise at all levels of their health-care systems. Investment in human resources for health and ongoing training was necessary for the rational and safe use of medicines. Member States should therefore consider continuing professional development for pharmacists and other health-care professionals as a requirement for licensing.

The Federation was committed to facilitating teamwork at national and regional levels in order to improve the rational use of medicines, including better medicines for children.

Dr HOPPU (International Union of Basic and Clinical Pharmacology), speaking at the invitation of the CHAIRMAN, said that his Union's work focused on children's medicines. It welcomed WHO's initiative to promote better essential medicines for children, and would continue to collaborate in order that more children's medicines might be included in the WHO Model List of Essential Medicines. He supported the draft resolution.

The criteria for determining whether a medicine should be included in the Model List reflected the problems that had to be overcome in order to provide better medicines for children. The current use of many paediatric medicines, even in the most developed countries, was not backed by adequate evidence of efficacy and safety from clinical studies; such medicines were not available in age-appropriate formulations of proper quality and were not well established in use. Only when those problems were solved would children's medicines fulfil the selection criteria and provide benefits for children. The unavailability of age-appropriate formulations was illustrated by the need for paediatric fixed-dose combinations (for instance, of antiretroviral and antimalarial medicines). There were clear signs that adult fixed-dose combinations did not have the optimal ratio of components for children of all ages and therefore ran the risk of causing resistance. Work on the Model List alone was not enough to provide children with all, or even most of, the important medicines they needed: effective means were also needed to increase research, development and authorization of medicines in suitable formulations. He looked forward to continued collaboration with WHO.

Dr WAGNER (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, and on behalf of the Ecumenical Pharmaceutical Network and Health Action International, observed that the draft resolution on the rational use of medicines promoted an approach in which all stakeholders had a role and which would affect various WHO programmes, such as tuberculosis, malaria, noncommunicable diseases, and women's and child health. A holistic health systems approach to rational use through national programmes would reduce morbidity, mortality and resistance complications, and curb both government and out-of-pocket expenditure. The resolution's success, and the future sustainability of the programme depended on several essential elements: establishing and funding multidisciplinary bodies in order to monitor and coordinate national rational use programmes; combating inaccurate, misleading and unethical promotion of medicines and

enforcing WHO's ethical criteria and measures in order to halt consumer-directed advertising; developing programmes aimed at improving the use of medicines, such as treatment guidelines; and strengthening the WHO Model List of Essential Medicines.

Ms KEITH (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that paragraph 1 of the draft resolution in document EB120/7 should highlight the need for strong supervision and monitoring systems in order to reduce ineffective use of medicines. The text should also contain a reference to the negative effect of user fees on the rational use of medicines. A request might also be included for a country-by-country analysis of policies that promoted irrational use of medicines, such as user charges, inadequate salaries for health workers and unrealistic resource flows to district health facilities. That would make the resolution consistent with previous resolutions on the subject, and improve social accountability.

With regard to document EB120/37, she welcomed more research into safe formulations for children, bearing in mind that 75% of preventable childhood deaths could be avoided by the use of effective existing interventions and by making them available to the poorest free of charge at the point of access. Paragraph 1(2) of the draft resolution should therefore be amended to read: "to devise measures which ensure essential medicines are available free at the point of access for the world's poorest children". A further subparagraph should be added to paragraph 1 urging Member States to monitor the rational use of medicines and regulate their health delivery systems. Paragraph 2(4) should also request the Director-General to highlight policy alternatives that would overcome the barriers to children's prompt access to essential medicines. She pledged her organization's support for endeavours to attain Millennium Development Goals 4 and 6 by improving the rational use of medicines.

Dr ZUCKER (Assistant Director-General) said that, since 1985, progress had been made in promoting better use of medicines, but a different approach was needed. Local small-scale interventions had been effective, but few countries had scaled up to programmes for reaching larger populations, and no single intervention would be successful by itself. Different types of programmes were needed in different countries and regions, and coordination between the many different stakeholders, albeit difficult, was necessary. Although the appropriateness of the possible interventions listed in document EB120/7 would vary for each country, a package would need to be developed on a country-by-country basis. The Secretariat proposed to support countries in setting up a national, multidisciplinary coordinating body, drawing together all national stakeholders and tailored to meet the needs of each country. Its task would be to develop, implement and evaluate country interventions, identify the problems, find the most appropriate solutions for each country, scale them up into programmes, and monitor progress. It would address the roles of prescribers, dispensers and patients in the appropriate use of medicines, and enforce good pharmacy practice. The approach, therefore, would be flexible.

At its 118th session, the Board had not reached consensus on some of the strategies discussed, but they were relevant to the draft resolution currently before it. The WHO Model List of Essential Medicines was used in some 157 countries throughout the world in order to guide prescribers. Medicinal and therapeutic committees were used extensively in hospitals in many industrialized and some developing countries in order to deal with medication errors and compliance. Where such committees did not exist, who would ensure that medicines were used appropriately? Promotional activities related to pharmaceuticals might, in some countries, need monitoring and control, a point which touched on the issues raised by the member for Sri Lanka. How health providers were paid and how patients paid for medicines affected the way in which medicines were used. Those issues needed to be investigated on a country-by-country basis, as the member for Thailand had highlighted. The Secretariat recognized the key role of patients in their own health care, and public health leaders must encourage that endeavour; by means of the resolution, it would support Member States in developing an approach to appropriate use of medicines and monitoring progress. Such action appeared to fulfil the wish of many delegations.

In reply to a question from the member for the United States on the financial implications of the two resolutions, he said that the total budget for the six years for both resolutions was some US\$ 50 million; about one third was already included in the draft Medium-term strategic plan 2008–2013, leaving a deficit of some US\$ 35 million, which would need to be added to make the initiative feasible. For the period 2008–2009, an additional US\$ 10–12 million would be required, 60% of which would go to the regions. Member States would be approached for financial support.

Referring to document EB120/37, he applauded the European Commission's accomplishments in its work on better essential medicines for children.

The DIRECTOR-GENERAL thanked the members for their valuable contribution to the debate. In response to the comment that she should do battle with the pharmaceutical industry, she said that, unlike the tobacco industry, the pharmaceutical industry, far from being an enemy of public health, made products that provided relief from suffering, cured conditions and saved lives. It was therefore important to work with that industry in order to find solutions to health problems. However, WHO's decisions must be based on scientific evidence and made on public health grounds. The Organization would maintain its independence in the decision-making process and would not be influenced by the pharmaceutical industry.

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

**The meeting rose at 17:45.**

## **NINTH MEETING**

**Friday, 26 January 2007, at 09:05**

**Chairman:** Dr F. ANTEZANA ARANÍBAR (Bolivia)

### **1. ORGANIZATION OF WORK**

After a procedural discussion in which Mr CAMPOS (alternate to Dr Buss, Brazil), Mr HOHMAN (alternate to Dr Agwunobi, United States of America), Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand), Dr NYIKAL (Kenya), Ms HALTON (Australia), Dr TANGI (Tonga) and Dr SHANGULA (Namibia) took part, the CHAIRMAN suggested that in view of the limited time available consideration of item 4.10 (Workers' health: draft global plan of action), which would need substantial discussion, should be deferred. In view of its importance, item 4.14 (Public health, innovation and intellectual property: towards a global strategy and plan of action) should be taken up that morning rather than being left to a later stage.

**It was so agreed.**

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

**eHealth: standardized terminology:** Item 4.11 of the Agenda (Document EB120/9)

Professor PEREIRA MIGUEL (Portugal) spoke in the name of the German Presidency and on behalf of the European Union and its 27 Member States, the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and Ukraine and the Republic of Moldova. He welcomed WHO's engagement in the field of standardized clinical terminologies, which should be continued and broadened, as semantic terminologies would become increasingly important for the full interoperability of health technologies. WHO should therefore insist on openness with regard to the systematized nomenclature,<sup>1</sup> with the long-term goal of an open-source solution available to all countries. Resources should not be invested in proprietary products, products whose use was restricted or products whose internal logic was kept secret. The purpose of the new International Health Terminology Standards Development Organization was to make development of, and access to, the clinical terminology an open process. WHO should also participate in the harmonization board of that Organization, and facilitate equitable access to all artefacts related to the systematized nomenclature, including software, terminology and definitions, which could be established in cooperation with the Organization. Health information standards and rules should draw on established best practices in the development of ontologies, which were a necessary prerequisite for the presentation of health knowledge in an increasingly computerized environment.

The process of defining mappings was expensive, slow and delicate, and should therefore aim first at mapping health terminologies at a high semantic level. If any chance arose of establishing the clinical terminology as a common tool for the European Union in a foreseeable time scale, a strategy

---

<sup>1</sup> Systematized Nomenclature of Medicine-Clinical Terms (SNOMED-CT, registered trade mark).

would be needed in order to ensure its royalty-free use. Modifying and implementing such a tool within existing national documentation systems entailed significant work and costs, as had been the case with the development and distribution of the International Classification of Diseases (tenth revision) in the 1990s. The Secretariat should use its position to promote a political decision by WHO's Member States to use the clinical terminology actively and generally in its work with the Standards Development Organization. WHO should participate in the creation of an infrastructure for the development, application and interoperation of health terminologies and ontologies. Scientific efforts to ensure the robustness of the clinical terminology should be supported and insisted upon.

Dr SADASIVAN (Singapore), noting that the development of eHealth systems was increasing worldwide, said that, when used effectively and appropriately, such systems could be a valuable addition to existing health systems. They were already being used extensively in Singapore. The adoption of standardized terminology was thus of great importance.

WHO's involvement in the development of standardized terminology for eHealth would be beneficial to the global community and should ensure equal access to it for Member States, but duplication of its efforts by different groups was not the most efficient use of resources. He urged the Secretariat, Member States and all stakeholders to work together in developing standardized terminologies. WHO should play an active role in ensuring equal access to developments arising from the standardization of terminology in eHealth systems.

Dr AGWUNOBI (United States of America) said that the Secretariat should encourage stakeholders from both the public and private sectors to use its expertise and resources in order to develop one or more strategies for the interoperability of eHealth applications. One such initiative should be the harmonization of the leading candidate for a standardized global clinical terminology for use within eHealth applications with WHO's family of international classifications.

The Secretariat should not waste scarce resources in creating a new, WHO-controlled clinical terminology or the further development of an alternative to the proposed set of terms. Similarly, the Standards Development Organization should not duplicate decades of work by the Secretariat by developing the robust and clinically up-to-date health classifications that were widely used in health care and for administrative data and statistics. Rather, the two organizations should collaborate on unified standards for classification and terminology, and improve information on individual, national and international health. He supported the option for WHO's involvement in standardization described in paragraph 3(b) of document EB120/9.

The Secretariat should negotiate an agreement with the Standards Development Organization that would: fulfil complementary, rather than competitive, functions; establish a harmonization board, in order to validate mappings between terminology and classifications and bridge them in future versions of the clinical terminology and WHO's family of international classifications; and create a non-voting liaison seat for the Secretariat on the new Organization management board in order to coordinate the two organizations' activities in eHealth.

Ms HALTON (Australia) emphasized that eHealth terminologies should be available to all countries. Noting that Australia was a founder member of the International Health Terminology Standards Development Organization, she endorsed the view expressed by the previous speaker regarding the importance of one sole classification for a common international language in that area. She supported the creation of a harmonization board in order to ensure collaboration and accessibility for all countries. She too preferred the option for WHO's involvement set out in paragraph 3(b) of document EB120/9.

Ms ABDI (alternate to Mr Miguil, Djibouti), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that standardized terminology was a cornerstone of health information systems and should be used in all computer-based health records. WHO had established usable global terminology standards through its family of international classifications, and its terminology management should be strengthened in order to ensure equitable support for different

languages and regions. Improved resource allocation would support terminology development and standardization at regional level.

The new Standards Development Organization presented a challenge to other international agencies already working on standardization, and in particular WHO. It should not deprive WHO of one of its major contributions to global health, but should provide technical input to WHO's global terminology databank, not to one that served only a few countries or one particular linguistic group.

The development of international standards was a multidisciplinary process, and WHO should continue to be active in guiding standard setting, authentication, and approval and mapping of technology. Other stakeholders might participate in networking, and the dissemination, coordination and documentation of international normative tools and standards. New technological developments such as specifically distributed databases, decentralized systems and web-based applications provided opportunities for all organizations to collaborate in using virtual space without compromising their identity or role. WHO's eHealth policies should enhance multilingualism, and the capacities of countries to manage standardized terminology in local languages, along with eHealth applications such as statistical databases, health information systems, geographic information systems and electronic health records. Multilingualism could be supported by machine-readable multilingual dictionaries, classification systems and computer-assisted translation, and WHO should support research in that area.

WHO should ensure equity among languages by providing standards and classifications at national and local levels. An equal share of funds should be allocated to all WHO's official languages, in order to bridge the gap between English, French and Spanish on the one hand, and Arabic, Chinese and Russian on the other.

Dr SHINOZAKI (Japan) said that he was uncertain whether the standardized clinical terminology was to be an international public good which could be shared, free of charge, by all Member States, as was the case with the International Classification of Diseases and WHO's other international classifications. Multilingualism was an important principle because of differences in national interpretations of certain clinical terms, particularly between different language groups. Most countries had established clinical terminology databases in their own languages and rooted in their own cultures.

Dr MOLLAHALIOGLU (alternate to Professor Aydin, Turkey) observed that collaboration among Member States and a minimum consensus on requirements were crucial for the interoperability of standardized terminologies. WHO should have a seat on the board of the international standardization organization, rather than observer status. Harmonizing and achieving consensus would require considerable resources, but, in return, many of the problems countries might otherwise face in adopting the terminologies could be avoided.

Dr QI Qingdong (China) urged WHO to exert its leadership in the development of health information systems and international disease classification. Because developing countries would encounter more difficulties in using a standardized clinical terminology, WHO should be involved in order to represent the interests of all Member States, and cooperate with the relevant international organizations. The members for Djibouti and Japan had emphasized multilingualism, but the report did not explain how that would be achieved. The proposed standardized clinical terminology should benefit as many countries as possible.

Mr CAMPOS (alternate to Dr Buss, Brazil) drew attention to the difficulty of retaining primary care staff in remote areas of Brazil because they often felt unable to deal with the needs of patients. With the support of eHealth applications, for example, in making diagnoses, they would be less likely to leave. Furthermore, patients often required transport over long distances to more sophisticated medical centres, which was costly in comparison with eHealth. Brazil's ministries of health, education, science and technology, and defence and communications had therefore cooperated in the establishment of a national eHealth programme providing primary care facilities. Support, including



diagnostic assistance and training, was made available for primary care in remote areas through university hospitals, resulting in greater retention of health workers. eHealth applications illustrated the need for a standardized terminology, and he therefore supported the draft resolution.

Dr SOPIDA CHAVANICHKUL (adviser to Dr Suwit Wibulpolprasert, Thailand), referring to paragraphs 3(a) and (b) of the report, indicated that health information systems in most developing countries lacked basic infrastructure and human resources. It would therefore be pointless to develop a more sophisticated terminology. Moreover, developing countries were not represented in the new Standards Development Organization. She favoured the option set out in paragraph 3(b), whereby WHO would be involved in the harmonization board and be able to respond to the needs of Member States, for example by ensuring multilingualism. She also favoured strengthening WHO's terminology network and ensuring that all Member States had equal access to it. The network should also focus on public health information systems.

Dr RAHANTANIRINA (Madagascar) said that the entry into force of the International Health Regulations (2005) had increased the need to update, standardize and harmonize relevant technologies and terminologies. Access to reliable information facilitated decision-making, which was important for developing countries that had to deal with major epidemics with few financial, material or human resources at their disposal. WHO should lead in setting health-information standards and rules, and assist developing countries to gain access to new technologies. She supported the option set out in paragraph 3(b), which would strengthen WHO's role in the development of a standardized terminology.

Mr HIWAL (alternate to Dr Al-Eissawi, Iraq), endorsing the comments made by Japan, stressed standardized terminology as a means of harmonizing different perspectives. The focus should be on scientific and managerial terminologies as they were critical for joint activities. The standardization process would require intersectoral collaboration and a bottom-up approach beginning at the country level. WHO should play a central role in coordinating the production of a standardized terminology.

Mr DEL PICÓ (Chile)<sup>1</sup> supported the option contained in paragraph 3(a) as WHO should lead in the setting of international clinical standards. He acknowledged the efforts of the United States of America and the United Kingdom in developing a comprehensive clinical terminology. However, the criteria for access were not clear, in particular the costs. Precise definition of the links between terminologies and classifications was needed.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN, drew the Board's attention to the International Classification for Nursing Practice, which allowed international sharing and comparison of data in order to support clinical decision-making, evaluate nursing care and patient outcomes, develop health policy and generate knowledge through research. There was a continued need for the development and application of standardized health-care terminologies. A WHO terminology network could help to facilitate harmonization of the various terminologies, including the aforementioned classification.

He welcomed the plans to support Member States in the development, implementation and management of standardized terminologies. The report clarified the role of WHO in relation to the Standards Development Organization, which had been set up to administer the clinical terminology. He expressed concern about the latter's accessibility and relevance for developing countries. He asked for more information about the Secretariat's plans to ensure its equitable and balanced dissemination among Member States that did not join the Standards Development Organization for financial or other reasons.

---

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

Dr EVANS (Assistant Director-General) said that there appeared to be a consensus that standardization of terminology was important and that WHO must be involved. WHO would participate as an observer in the harmonization board of the new Standards Development Organization. However, the creation of the new organization would not, in itself, ensure universal access to standardized terminology, nor make it available in many languages. WHO would continue to work on those issues with the new body and its own collaborating centres. Considerable investment would be required in order to solve the many technical challenges, including reliability, validity and interoperability. The Secretariat would help Member States as much as possible, but they should not expect too much.

**The Board noted the report.**

**Oral health: action plan for promotion and integrated disease prevention:** Item 4.6 of the Agenda (Document EB120/10) (continued from the sixth meeting)

The CHAIRMAN invited the Board to consider a revised draft resolution on oral health, incorporating amendments proposed by members, which read:

The Executive Board,

Having considered the report on oral health: action plan for promotion and integrated disease prevention,<sup>1</sup> and the report on prevention and control of noncommunicable diseases: implementation of the global strategy,<sup>2</sup>

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:

The Sixtieth World Health Assembly,

Recalling resolutions WHA22.30, WHA28.64 and WHA31.50 on fluoridation and dental health, WHA36.14 on oral health in the strategy for health for all, WHA42.39 on oral health; WHA56.1 and WHA59.17 on the WHO Framework Convention on Tobacco Control; WHA58.22 on cancer prevention and control; WHA57.14 on scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS; WHA57.16 on health promotion and healthy lifestyles; WHA57.17 on the Global Strategy on Diet, Physical Activity and Health; WHA58.16 on strengthening active and healthy ageing; WHA51.18 and WHA53.17 on prevention and control of noncommunicable diseases, and WHA58.26 on public-health problems caused by harmful use of alcohol;

Recognizing the important role of oral health for health in general and for quality of life;

**Acknowledging the intrinsic link between oral health, general health and quality of life; [Kenya]**

Emphasizing the need to incorporate programmes for promotion of oral health and prevention of oral diseases into national programmes for the integrated prevention and treatment of chronic diseases;

**Aware that the importance of the prevention and control of noncommunicable diseases has been highlighted in the Eleventh General Programme of Work 2006–2015; [Kenya]**

---

<sup>1</sup> Document EB120/10.

<sup>2</sup> Document EB120/22.

**Appreciating the role that WHO collaborating centres, partners and nongovernmental organizations play in improving oral health globally, [Kenya]**

1. URGES Member States:

(1) to adopt measures to ensure that oral health is incorporated **as appropriate [Australia]** into ~~national~~ **[Australia]** policies for the integrated prevention and treatment of chronic noncommunicable diseases;

(2) **to take measures to ensure that evidence-based approaches are used to incorporate oral health into national policies for integrated prevention and control of noncommunicable diseases; [Kenya]**

~~(2)(3)~~ **(3) to consider mechanisms [Australia]** to provide coverage for the population with essential oral-health care, ~~and to incorporate oral health to ensure [USA]~~ within the framework of enhanced primary health care for chronic noncommunicable diseases, **and to promote [USA]** the availability of ~~national~~ **[USA]** oral health ~~systems [USA]~~ that should be directed towards disease prevention and health promotion for poor and disadvantaged populations, in collaboration with integrated programmes for the prevention of chronic noncommunicable diseases;

~~(3)(4)~~ **(4) for those countries without access to optimal levels of fluoride, or which that have [Thailand]** not yet established systematic water-fluoridation programmes, ~~to develop and implement~~ **consider the development and implementation of national [Australia]** fluoridation programmes, giving priority to equitable strategies such as the automatic administration of fluoride, for example, in drinking water, salt or milk, and to the provision of affordable fluoride toothpaste;

~~(4)(5)~~ **(5) to take measures steps [Australia]** to ensure that prevention of oral cancer is an integral part of national cancer-control programmes, ~~and to involve [Australia]~~ ~~encourage the involvement of~~ oral-health professionals ~~or and [Australia]~~ personnel **with relevant training in oral health** ~~with special training in oral health and specialized in detection, early diagnosis and treatment [Australia]~~ in detection, early diagnosis and treatment;

~~(5)(6)~~ **(6) to develop and implement programmes for take steps to ensure [Australia]** the prevention of oral disease associated with HIV/AIDS, **and** the promotion of oral health and quality of life for people living with HIV, ~~that involve~~ **involving [Australia]** oral-health professionals or staff who are specially trained in primary health care, **and** applying primary oral-health care **where possible; [Australia]**

~~(6)(7)~~ **(7) to develop and implement the promotion of oral health and prevention of oral disease for preschool and school [Thailand]** children as ~~an integral [Australia]~~ **part of activities in national healthy schools programmes health-promoting schools; [Thailand]**

**(8) to scale up capacity to produce oral-health personnel, including dental hygienists, nurses and auxiliaries, providing for equitable distribution of these auxiliaries to the primary-care level, and ensuring proper service back-up by dentists through appropriate referral systems; [Thailand]**

~~(7)(9)~~ **(9) to develop and implement, in countries affected by noma, national programmes to control the disease within national programmes for the integrated management of childhood illness and for the reduction of malnutrition and poverty, in line with internationally agreed health-related development goals, including those contained in the Millennium Declaration;**

~~(8)(10)~~ **(10) to incorporate an oral-health information system into health surveillance plans so that oral-health objectives are in keeping with international standards, and to evaluate progress in promoting oral health;**

~~(9)~~(11) to strengthen oral-health research and use evidence-based oral-health promotion and disease prevention to consolidate and adapt ~~national~~ [USA] oral-health programmes and to encourage the intercountry exchange of reliable knowledge and experience of community oral-health programmes;

**(12) to address human resources and workforce planning for oral health as part of every national plan for health; [Kenya]**

**(13) to increase the budgetary provisions that are dedicated to the prevention and control of oral and craniofacial diseases and conditions; [Kenya]**

2. REQUESTS the Director-General:

(1) to raise awareness of the global challenges to improving oral health, the specific needs of low-income countries and of poor and disadvantaged population groups;

(2) to ensure that the Organization, at global and regional levels, provides advice and technical support, on request, to Member States for the development and implementation of oral-health programmes within integrated approaches to monitoring, prevention and management of chronic noncommunicable diseases;

(3) continually to promote international cooperation and interaction with and among all actors concerned with the implementation of the oral-health action plan, including WHO collaborating centres for oral health and nongovernmental organizations;

**(4) to communicate to UNICEF and other organizations of the United Nations system that undertake health-related activities, the need to include oral health as an integral component of their programmes; [Jamaica]**

**(5) to strengthen WHO's technical leadership in oral health by expanding its oral health programme at both headquarters and regional offices. [Kenya]**

Ms HALTON (Australia) suggested that the word “national” should be deleted from the phrase “national programmes” in the fourth preambular paragraph, since it was not appropriate for federal States such as her own. The same problem occurred in paragraph 1(2), where she suggested that the phrase “as appropriate” should be added; it would then read: “... to incorporate oral health into national policies, as appropriate, for integrated prevention ...”. Paragraph 1(13) should be amended to read: “to consider increasing the budgetary provisions ...”.

Dr AGWUNOBI (United States of America) said that paragraph 2(4), as currently worded, might be seen as implying that WHO should tell UNICEF and other organizations of the United Nations system what to do.

Dr CAMPBELL FORRESTER (alternate to Dr Allen-Young, Jamaica) suggested that the wording: “to communicate with UNICEF and other organizations of the United Nations system ...” might be preferable.

Dr SOPIDA CHAVANICHKUL (adviser to Dr Suwit Wibulpolprasert, Thailand) suggested that paragraph 1(4) should be amended to read: “... and which have not yet established systematic water-fluoridation programmes ...”.

The CHAIRMAN suggested that the Board should return to the draft resolution at a later stage.

**It was so agreed.**

(For adoption of the resolution, see p.219 below.)

**Health systems, including emergency-care systems:** Item 4.7 of the Agenda (Documents EB120/27, EB120/27 Add.1, EB120/38 and EB120/38 Add.1) (continued from the fifth meeting)

The CHAIRMAN invited the Board to consider a revised draft resolution on emergency-care systems, reflecting the amendments proposed, and which read:

The Executive Board,  
Having considered the report on health systems: emergency-care systems;<sup>1</sup>

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>2</sup>

The Sixtieth World Health Assembly,

Having considered the report on health systems: emergency-care systems;

Recalling resolutions WHA56.24 on implementing the recommendations of the *World report on violence and health* and WHA57.10 on road safety and health, which respectively noted that violence was a leading worldwide public health problem and that road traffic injuries caused extensive and serious public health problems;

Further recalling that resolution WHA56.24 requested the Director-General to provide technical support for strengthening trauma and care services to survivors or victims of violence, and that resolution WHA57.10 recommended Member States to strengthen emergency and rehabilitation services, and requested the Director-General to provide technical support for strengthening systems of prehospital and trauma care for victims of road-crash injuries;

Recognizing that each year worldwide more than 100 million people sustain injuries, that more than five million people die from violence and injury, and that 90% of the global burden of violence and injury mortality occurs in low- and middle-income countries;

Aware of the need for primary prevention as one of the most important ways to reduce the burden of injuries;

Recognizing that improved organization and planning for **provision of** trauma and emergency-care ~~services~~ [USA] is an essential part of **integrated health-care delivery, plays an important role in**[Jamaica] preparedness for, and response to, mass-casualty incidents, and can lower mortality, reduce disability and prevent other adverse health outcomes arising from the burden of everyday injuries;

Considering that WHO's published guidance and electronic tools offer a means to improve the organization and planning of trauma and emergency care ~~services~~ [USA] that is particularly adapted to meeting the needs of low- and middle-income countries,

1. CONSIDERS that additional efforts should be made globally to strengthen **provision of** trauma and emergency care ~~services~~ [USA] so as to ensure timely and effective delivery to those who need ~~them~~ **it in the context of the overall health-care system, and related health and health-promotion initiatives; [Jamaica, Kenya]**

---

<sup>1</sup> Document EB120/27.

<sup>2</sup> See document EB120/27 Add.1 for the administrative and financial implications for the Secretariat of this resolution.

2. URGES Member States:
  - (1) to assess comprehensively the prehospital and emergency-care context, including, **where necessary, [Australia]** identifying unmet needs;
  - (2) to ensure involvement of ministries of health in, and an intersectoral coordination mechanism for, review and strengthening of trauma and emergency-care ~~services~~ **provision; [USA]**
  - (3) to consider establishing formal prehospital trauma and emergency-care systems in locations where they would be cost-effective, including those where the frequency of injury is high, and to draw on informal systems and community resources in order to establish prehospital-care capacity in areas where formal prehospital emergency medical ~~service~~ **[USA]** systems are impractical;
  - (4) in settings with a formal ~~system of~~ **[USA]** emergency medical-care ~~system~~ **services, [USA]** and where appropriate and feasible, to ensure that a monitoring mechanism exists to promote and assure minimum standards for training, equipment, infrastructure and communication;
  - (5) in locations with a formal ~~system of~~ **[USA]** emergency medical-care ~~system~~ **services, [USA]** or where one is being developed, to establish, and make widely known, a universal-access telephone number;
  - (6) to identify a core set of trauma and emergency-care services, and to develop methods for assuring and documenting that such services are provided appropriately to all who need them;
  - (7) **to determine a realistic timeframe in which emergency care should be provided; [Latvia]**
  - (8) **to create incentives for training and improve working conditions for health-care providers concerned; [Jamaica, Kenya]**
  - ~~(7)~~(9) to ensure that ~~relevant~~ **appropriate** core competencies are part of relevant health curricula and to promote continuing education for providers of trauma and emergency care;
  - ~~(8)~~(10) to ensure that data sources are sufficient to monitor objectively the outcome of efforts to strengthen trauma and emergency-care systems;
  - ~~(9)~~(11) to review and update relevant legislation, **including financial mechanisms and management methods, so as to ensure that a core set of trauma and emergency-care services are accessible to all people who need them; [Thailand]**
3. REQUESTS the Director-General:
  - (1) to devise standardized tools and techniques for assessing need for prehospital and facility-based capacity in trauma and emergency care ~~services; [USA]~~
  - (2) **to develop techniques for reviewing legislation relateding to provision of emergency care services, [USA]** and to compile examples of such legislation;
  - (3) to determine standards, **mechanisms, [Jamaica, Kenya]** and techniques for inspection of facilities, and to **provide support to Member States for [Kenya]** design of quality-improvement programmes and other methods needed for competent and timely provision of essential trauma and emergency care ~~services; [USA]~~
  - (4) to provide guidance for the creation and strengthening of mass-casualty management systems;
  - (5) to provide support to Member States, upon request, for needs assessments, facility inspection, quality-improvement programmes, review of legislation, and other aspects of strengthening **provision of their** trauma and emergency care ~~services; [USA]~~

- (6) to encourage research and collaborate with Member States in establishing science-based policies and programmes for implementation of methods to strengthen trauma and emergency care ~~services~~;[USA]
- (7) to collaborate with Member States, nongovernmental organizations and other stakeholders in order to help ensure that the necessary capacity is in place effectively to plan, organize, administer, finance and monitor **provision of** trauma and emergency care ~~services~~;[USA]
- (8) to raise awareness that low-cost ways exist to reduce mortality through improved organization and planning of **provision of** trauma and emergency care ~~services~~, [USA] and to organize regular expert meetings to further technical exchange and build capacity in this area;
- (9) to report on progress made in implementing this resolution to the World Health Assembly through the Executive Board.

Ms HALTON (Australia) said that paragraph 2(7) was unacceptable. It was impossible to stipulate a timeframe for the provision of emergency care that would be appropriate for all Member States. Paragraph 2(8) should be amended to read: “to consider creating incentives ...”, and paragraph 2(11) should be amended to read: “... including where necessary financial mechanisms ...”.

Dr AGWUNOBI (United States of America) said, with reference to paragraph 2(7), that it was for each Member State to determine the emergency-care delivery times most appropriate to its own situation. He accepted the proposed amendments to paragraphs 2(8) and 2(11).

The CHAIRMAN said that the consensus within the Board appeared to be that paragraph 2(7) should be deleted.

Mr HIWAL (alternate to Dr Al-Eissawi, Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the draft resolution placed too little emphasis on emergency preparedness and response, an area in which many countries, including his own, required more guidance.

Dr TANGI (Tonga) pointed out that the draft resolution was intended to be a general one, dealing with all aspects of emergency care.

The DIRECTOR-GENERAL drew the Board's attention to resolution WHA59.22 on emergency preparedness and response which mandated the Secretariat to provide the support requested by the member for Iraq.

Dr KEAN (Executive Director, Office of the Director-General) read out the proposed amendments. Paragraph 2(7) would be deleted. Paragraph 2(8) would be amended to read: “to consider creating incentives ...”. Paragraph 2(11) would be amended to read: “... including where necessary financial mechanisms ...”.

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

**Oral health: action plan for promotion and integrated disease prevention:** Item 4.6 of the Agenda (Document EB120/10) (resumed)

The CHAIRMAN invited the Board to resume consideration of the draft resolution.

---

<sup>1</sup> Resolution EB120.R4.

Dr KEAN (Executive Director, Office of the Director-General) read out the amendments proposed to the draft resolution, with the exception of paragraph 2(4), the new wording of which would be proposed subsequently. In the fourth preambular paragraph, the word “national” would be deleted. In paragraph 1(2) the words “as appropriate” would be inserted between “national policies” and “for integrated prevention”. In paragraph 1(4) the phrase “or which” would be replaced by “and which”. Paragraph 1(13) would be amended to read “to consider increasing the budgetary provisions ...”.

Dr AGWUNOBI (United States of America) proposed that in paragraph 2(4) the phrase “the need to include oral health as an integral part of their programmes” should be amended to read “the importance of integrating oral health into their programmes”. Paragraph 2(5) should be amended to read “to strengthen WHO’s technical leadership in oral health” in order to give the Director-General greater flexibility by not specifying how the related programmes should be funded.

Dr NYIKAL (Kenya) favoured retaining the wording of the original amendment to paragraph 2(5), as he failed to see why the specific request made in it should be changed. He would be prepared, however, to accept the addition of “and in any other way” after “and regional offices”.

Dr CAMPBELL FORRESTER (alternate to Dr Allen-Young, Jamaica) proposed that in the first part of paragraph 1(4) “water-fluoridation programmes” should be replaced by “fluoridation programmes”.

Dr AGWUNOBI (United States of America), in reply to the member for Kenya, said that the Director-General should be given more flexibility on the scope, scale and funding of programmes.

The DIRECTOR-GENERAL expressed her preference for the amendment proposed by the member for the United States. She would indeed appreciate more flexibility; country offices were not included in the scope of the current wording, for example. She acknowledged the importance that members attached to the issue of oral health and their suggestion that more needed to be done.

Dr NYIKAL (Kenya) said that he would naturally not refuse the Director-General’s suggestion.

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

**Gender, women and health: draft strategy for integrating gender analysis and actions into the work of WHO:** Item 4.8 of the Agenda (Documents EB120/6 and EB120/6 Add.1) (continued from the sixth meeting)

The CHAIRMAN invited the Board to consider the revised draft resolution on integrating gender analysis and actions into the work of WHO: draft strategy, which after further informal consultations read:

The Executive Board,

Having considered the draft strategy for incorporating a gender perspective into the mainstream of WHO’s work,<sup>2</sup>

---

<sup>1</sup> Resolution EB120.R5.

<sup>2</sup> Document EB120/6.



RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>1</sup>

The Sixtieth World Health Assembly,

Having considered the draft strategy for incorporating a gender perspective into the mainstream of WHO's policies and programmes;

Recalling **the Programme of Action of the International Conference on Population and Development (Cairo, 1994)**, the Beijing Declaration and Platform for Action (Beijing, 1995), the recommendations of Beijing plus 10 Conference (2005) **and their reports**, the Economic and Social Council's agreed conclusions 1997/2, the United Nations Millennium Declaration 2000, the 2005 World Summit Outcome<sup>2</sup> and resolution WHA58.30 on accelerating achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration,

1. **NOTES WITH APPRECIATION** the strategy for incorporating a gender perspective into the mainstream of WHO's work;

2. **URGES** Member States:

(1) to include gender analysis and planning in joint strategic and operational planning, including country cooperation strategies;

(2) to formulate national strategies for addressing gender issues in health policies, programmes and research, **including in the area of reproductive and sexual health;**

(3) **to lay emphasis on training and sensitization on, and promotion of, gender, women and health;**

(4) **to ensure that gender-friendly health care is incorporated in all levels of health-care delivery;**

~~(3)~~(5) to collect and analyse sex-disaggregated data and use the results to inform policies and programmes;

~~(4)~~(6) to make progress towards gender equality in the health sector, in order to ensure that **the contribution of women and men, girls and boys** to health care, is considered in health policy and planning;

3. **REQUESTS** the Director-General:

(1) **to assess and address** gender differences and inequalities in the planning, implementation, monitoring and evaluation of **WHO's** work, and to include this requirement in post descriptions and criterion in performance evaluation;

(2) **to define indicators and** to monitor, and assure accountability for, implementation of the strategy **by WHO's Secretariat at headquarters and in regional and country offices;**

(3) to support and sustain incorporation of a gender perspective into the mainstream of WHO's policies and programmes, **including through recruiting staff with specific responsibility and experience on gender and women's health;**

(4) to provide support to Member States for formulating and sustaining strategies and action plans for integrating gender equality in all health policies, programmes, and research;

<sup>1</sup> See document EB120/6 Add.1 for the administrative and financial implications for the Secretariat of this resolution.

<sup>2</sup> United Nations General Assembly resolution 60/1.

- (5) to give priority to the use of sex-disaggregated data and gender analysis in WHO's publications, and in efforts to strengthen health-information systems, in order to ensure that they reflect awareness of gender equality as a determinant of health;
- (6) to ensure that programmatic and thematic evaluations indicate the extent to which gender issues have been incorporated in the Organization's work;
- (7) to ensure full implementation of the strategy, and **to report every two years** on progress to the Health Assembly **through** the Executive Board.

He said that, in the absence of comments, he took it that the Board wished to adopt the draft resolution.

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

**Public health, innovation and intellectual property: towards a global strategy and plan of action:**  
Item 4.14 of the Agenda (Documents EB120/35, EB120/35 Add.1, EB120/INF.DOC./1 and EB120/INF.DOC./4)

The CHAIRMAN invited the Board to consider the draft resolution on public health, innovation and intellectual property: towards a global strategy and plan of action, proposed by Kenya and Switzerland, which read:

The Executive Board,

Having considered the report on the progress made by the Intergovernmental Working Group on Public Health, Innovation, and Intellectual Property at its first session,<sup>2</sup> and the suggestions made by some Member States of possible areas for early implementation,<sup>3</sup>

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:

The Sixtieth World Health Assembly,

Bearing in mind the report of the Commission on Intellectual Property Rights, Innovation and Public Health and its recommendations;<sup>4</sup>

Recalling resolution WHA59.24, that established an intergovernmental working group open to all interested Member States to draw up a global strategy and plan of action in order to provide a medium-term framework based on the recommendations of the Commission;

Having considered the report on the progress made by the Intergovernmental Working Group on Public Health, Innovation, and Intellectual Property at its first session, and the information document listing possible points for early implementation and related WHO activities;

Bearing in mind that resolution WHA59.24 requests the above-mentioned working group to report to the Sixtieth World Health Assembly through the Executive Board, giving particular attention to areas for early implementation;

---

<sup>1</sup> Resolution EB120.R6.

<sup>2</sup> Document EB120/35, section F.

<sup>3</sup> Document EB120/INF.DOC./1.

<sup>4</sup> Document CIPIH/2006/1.

Aware of the need to act quickly to address effectively the growing burden of diseases and conditions disproportionately affecting developing countries, particularly those affecting women and children, including an upsurge in noncommunicable diseases;

Aware of the need to start immediately basic actions to lay the ground for implementation of the future global strategy and action plan;

Bearing in mind that these preliminary actions for early implementation should not prejudice or limit the content of the future global strategy and plan of action;

Noting that the Secretariat is already undertaking work in certain areas for early implementation identified by the Working Group in accordance with existing World Health Assembly resolutions, and desiring the scaling up of these activities,

1. WELCOMES the progress made by the Intergovernmental Working Group on Public Health, Innovation, and Intellectual Property;

2. URGES Member States:

(1) to contribute actively to the development of a global strategy and plan of action by the Intergovernmental Working Group on Public Health, Innovation, and Intellectual Property;

(2) to report voluntarily to WHO on actions taken on the recommendations of the Commission on Intellectual Property Rights, Innovation and Public Health;

3. REQUESTS the Director-General:

(1) to identify gaps in the current coverage of research and development of medicines and vaccines for diseases that disproportionately affect developing countries, taking into account other work under way in this field;

(2) to bring together academics, small and large companies in pharmaceuticals and biotechnology, aid donors, medical-research councils, foundations, public-private partnerships, international institutions, and patient- and civil-society groups in a standing forum in order to assure a more organized sharing of information and greater coordination between various stakeholders in research and development of medicines and vaccines for diseases that disproportionately affect developing countries;

(3) to promote partnerships in order to make compound libraries more accessible and identify potential compounds for addressing diseases that affect developing countries;

(4) to promote, with other relevant organizations, patent pools of upstream technologies that may be useful to foster innovation which addresses diseases that disproportionately affect developing countries;

(5) to strengthen the clinical trials and regulatory infrastructure in developing countries, in particular in sub-Saharan Africa, including the improvement of ethical-review standards;

(6) to provide support for developing countries to establish, implement or strengthen national programmes for health research;

(7) to provide support to countries so that, through patenting and licensing policies and respecting international obligations, they may maximize the availability of innovations, including research tools and platform technologies, in order to develop products of relevance to public health, particularly to conditions prevalent in developing countries;

(8) to collaborate with relevant stakeholders to enhance the sustainability of public-private partnerships;

(9) to continue to monitor, from a public-health perspective, the impact of intellectual property rights and other factors, on the development of new products and access to medicines and other health-care products in developing countries;

(10) to report, in the context of the adoption of a global strategy and plan of action, to the Sixty-first World Health Assembly, through the Executive Board, on implementation of this resolution.

Mr CAMPOS (alternate to Dr Buss, Brazil) expressed satisfaction at WHO's activities (set out in document EB120/INF.DOC./4) and reaffirmed the importance of resolution WHA59.24 on public health, innovation, essential health research and intellectual property rights. Consensus on that resolution had been reached in a positive and harmonious atmosphere – a “spirit of Geneva”, that had reflected well on the Organization as a whole. Unfortunately, that had not been the case at the first meeting of the Intergovernmental Working Group on Public Health, Innovation, and Intellectual Property, held in December 2006. Without seeking to blame any person, country or the Secretariat, he described the meeting as “ridiculous” and did not intend to comment on the draft resolution. The damage must be repaired and forces joined for a new way forward. A new process was required to lay the ground for the hoped-for results at the Working Group's meeting in October 2007.

Dr NYIKAL (Kenya), speaking on behalf of the Member States of the African Region, recalled the establishment through resolution WHA59.24 of the Intergovernmental Working Group on Public Health, Innovation, and Intellectual Property, which had called for submissions from Member States and had indicated areas of possible early implementation. His country and Switzerland had proposed the current draft resolution. At informal meetings, a consensus had emerged to strengthen the process of the Working Group without engaging in extensive discussions on a resolution, and, since the Working Group had not agreed on areas for possible early implementation, he asked for consideration of the draft resolution to be postponed.

The Board should request the Secretariat to expedite the activities of the Working Group by enabling Member States to make contributions to the content and process of drafting the global strategy and action plan. The process needed to move faster, and the recommendations of the Commission on Intellectual Property Rights, Innovation and Public Health should be considered and included in the aforesaid action plan.

The issue of access to products of innovation such as diagnostics, medicines and vaccines was all-important to health care in Africa. More resources needed to be assigned to research on diseases. He looked forward to the future global plan of action to address those concerns.

Ms SRIPEN TANTIVESS (adviser to Dr Suwit Wibulpolprasert, Thailand) concurred with the comments made by the members for Brazil and Kenya, particularly concerning the importance of the “spirit of Geneva”. The Board should focus on the process of the Working Group. She recalled resolution WHA59.24, in particular paragraphs 3(3) and 3(4). At its first meeting the Working Group had proposed that Member States should provide it with their official submissions by the end of February 2007. However, no specific message had been issued to inform Member States not present at the meeting of the need for, or content of, such submissions. Official submissions should contain recommendations on the future global strategy and action plan, with particular reference to: securing a sustainable basis for research and development related to diseases that disproportionately affected developing countries; proposing clear objectives and priorities; and estimating related funding requirements. Public health and intellectual property were critical issues. The deadline of the end of February 2007 should be extended.

Constructive discussions had taken place that week. In order to maintain their momentum, some Member States wished to speed up implementation of resolution WHA59.24. With the aim of supporting the work of the Working Group, she proposed that the Board should adopt a decision, which would read as follows:

The Executive Board decides to request the Secretariat at all levels to proactively support the implementation of resolution WHA59.24, by providing:

- (a) support to Member States for their contributions to the content and processes in the drafting of the global strategy and action plan, by mid-March;
- (b) a summary, synthesis and elaboration of relevant documentation by the end of June 2007;
- (c) support to Member State contributions in the finalization of the global strategy and action plan as a major input for the second meeting of the Intergovernmental Working Group, through the regional mechanism and intensive consultations.

Professor PEREIRA MIGUEL (Portugal), speaking in the name of the German presidency of the European Union and on behalf of the European Union and its 27 Member States, welcomed the development of a plan of action, but saw a need for additional discussion on strategic issues, in particular the future global strategy. The Intergovernmental Working Group was the proper forum for continued discussions on public health, innovation and intellectual property, and he strongly encouraged Member States to submit written comments in order to further the Group's work. Thorough preparation was needed in order to continue the process. Background documents should be provided by the Secretariat on each of the eight proposed actions of the plan. The documentation should include a matrix showing ongoing activities and current gaps, another showing current proposals and key stakeholders, and information on financial implications.

Turning to the progress report (document EB120/INF.DOC./1), he noted that certain actions had not been included, for example, the progress made by the European Union in implementing the provisions contained in paragraphs 9, 13, 23 and 29. The European Union had also been active in formulating research policy, with funding for neglected diseases, and development, through its support and financing of public-private partnerships, expert exchanges and human resources.

Speaking as the member for Portugal, he said that his country would be taking over the European Union presidency in July 2007 and, in that capacity, his Government would assist Member States, where necessary, in facilitating the Working Group process.

Mr HOHMAN (alternate to Dr Agwunobi, United States of America) said that his country had participated in the Working Group's meeting in December 2006. The outcomes had not met expectations. A thorough preparatory process was needed if the October 2007 meeting of the Working Group were to produce concrete results, but it was unclear from the proposal put forward by Thailand what, exactly, that preparatory process should entail. The proposal should be issued in writing as an official Board document. Resolution WHA59.24 called for the Working Group to report to the Health Assembly through the Executive Board, but he was unsure whether it was for the Board formally to introduce changes in the process instituted by the Health Assembly through that resolution. He asked for clarification on the Board's role.

The CHAIRMAN, speaking as the member for Bolivia, agreed that it was premature for the Board to take any action on the item. There should be further consultation before any resolution was proposed. For example, consultations should determine the feasibility of the actions to be taken.

Dr SHANGULA (Namibia) recalled that the Board had agreed earlier to proceed with consideration of public health, innovation and intellectual property, as long as the discussion would not be prolonged. The only issue at present before the Board should be the request by the member for Kenya to postpone consideration of the draft resolution.

The CHAIRMAN, agreeing that it had not been intended that the Board should engage in an in-depth discussion, said that he understood that it was the consensus of members that no formal action should be taken on the item at present.

Mr SILBERSCHMIDT (Switzerland)<sup>1</sup> said that, as a cosponsor of the proposed draft resolution, he concurred with the earlier statement by the member for Kenya. He also agreed with the member for Brazil on the need to preserve “the spirit of Geneva” as the process moved forward.

Mr BURCI (Legal Counsel), responding to the question from the member for the United States, said that, in accordance with the process established by the Health Assembly, the Intergovernmental Working Group was the forum for discussion of both the substance of the matter and the process to be followed in dealing with it. The Working Group was a subsidiary body of the Health Assembly and reported to it. Because the Working Group was to report to the Health Assembly through the Board, the Board was entitled, in the exercise of its normal functions under WHO’s Constitution, to discuss the item if it saw fit to do so and to present its views and recommendations to the Health Assembly. In his opinion, however, the Board was not authorized to take decisions that went beyond what the Health Assembly or the Working Group had decided. Regarding the proposal by Thailand, once it had been distributed in writing, it would be easier to assess whether it lay within the Board’s authority. A general request to the Secretariat to support the Working Group process would arguably be a matter for the Board, but the Board should avoid any step that would purport to change the process established by the Working Group, as such action might be seen as interference in the work of a subsidiary body of the Health Assembly.

Mr HOHMAN (alternate to Dr Agwunobi, United States of America), thanking the Legal Counsel for his clear explanation, said that procedural issues should not impede progress towards a tangible outcome. He appreciated the concerns expressed by the member for Namibia, but Board members should, at some point, have an opportunity to express their views on the matter to the Director-General. Such guidance was probably the best contribution that the Board could make to the process.

Dr NYIKAL (Kenya) said that it was clear to him that everyone agreed on the need to support the process. That spirit seemed to underlie the Thai proposal. What was unclear was whether the Board would have another chance to discuss the matter further after the proposal had been circulated in writing.

Ms SRIPEN TANTIVESS (adviser to Dr Suwit Wibulpolprasert, Thailand) said that she was prepared to circulate the proposal in writing if the Board so desired.

Dr ZUCKER (Assistant Director-General) outlined the proposed next steps in the Working Group process. The report of its first session had just been released (document A/PHI/IGWG/1/6). A circular letter had been sent to Member States soliciting additional input on the outcome (document A/PHI/IGWG/1/5) and proposals for experts and concerned entities, to be received by the end of February 2007. The input and suggestions from Member States would be incorporated in a revised working document, which would be prepared by in-house task groups, at headquarters and in the regional offices, and made available to Member States in July 2007. The Director-General, in consultation with the officers of the Working Group, would identify a pool of experts and concerned entities, as called for in resolution WHA59.24, with balanced representation in terms of regions, gender, and developed and developing countries. In August and September 2007, through a second round of Internet-based public hearings the Secretariat would solicit additional input on the working document distributed in July, possibly with regional consultations. The regional committees could also discuss the working document and the outcome of the regional consultations.

The Working Group planned to hold its second and final session in October 2007 in order to finalize the draft global strategy and plan of action, with its officers meeting as necessary in the

---

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

interim. The Secretariat would implement the recommendations of the Commission on Intellectual Property Rights, Innovation and Public Health specifically directed to WHO and any additional activities endorsed by Member States. The Secretariat would further set up a specific web site enabling voluntary reporting online by Member States on the implementation of resolution WHA59.24.

In response to a request from Professor PEREIRA MIGUEL (Portugal), Dr ZUCKER (Assistant Director-General) agreed that that information would be circulated in writing.

Mr RAJALA (European Commission), noted that resolution WHA59.24 provided for the participation of regional integration organizations in the work of the Intergovernmental Working Group. Such organizations should be included in the distribution lists for all documentation pertaining to the Working Group.

The CHAIRMAN asked how the Board wished to proceed regarding the proposal by the member for Kenya to postpone consideration of the draft resolution.

Mr CAMPOS (alternate to Dr Buss, Brazil) favoured the decision process outlined by Thailand.

Dr SHANGULA (Namibia) supported the proposal by the member for Kenya.

The CHAIRMAN said that he took it that the Board wished to postpone consideration of the draft resolution, as proposed by Kenya.

**It was so agreed.**

Ms HALTON (Australia), rising to a point of order, said that she had understood that there were two proposals before the Board. One was the proposal to withdraw the draft resolution from consideration, to which the Board had agreed. The other was the proposal by Thailand. Would that proposal be provided in writing as a formal document for later consideration?

The CHAIRMAN said that he expected that the Thai proposal would be distributed as an informal information document not an official document of the Board.

Dr KEAN (Executive Director, Office of the Director-General) proposed that Thailand should circulate its draft decision informally during the day. In order for the Board to make a decision, the document would have to be translated into all six official languages.

The DIRECTOR-GENERAL, taking into consideration the comments of the Legal Counsel, suggested that the process involving the Working Group should accord with the request by the Fifty-ninth World Health Assembly. Suggestions by Member States were nevertheless welcome, such as through the informal document to be circulated by Thailand. All suggestions would be given due consideration and acted on by the Secretariat. Some adjustments might be required to the timeline, in order to take into account regional committee meetings and availability for consultation, but she pledged her full support for the Working Group process, in view of the importance attached to it by the Board.

The CHAIRMAN said that all the recommendations, including those contained in the documents to be circulated by Thailand, would be brought to the attention of the Director-General, who would address their application.

**It was so agreed.**

**Malaria, including a proposal for establishment of World Malaria Day:** Item 4.2 of the Agenda (Documents EB120/5 and EB120/5 Add.1) (continued from the eighth meeting, section 2)

The CHAIRMAN drew attention to the revised draft resolution on malaria, including a proposal for establishment of World Malaria Day, which read:

The Executive Board,

Having considered the report on malaria, including a proposal for establishment of World Malaria Day;<sup>1</sup>

Concerned that few malaria-endemic countries have made substantial progress towards achieving the internationally agreed development goals, including those contained in the Millennium Declaration relating to malaria, and that a number of countries have not yet met the commitments to increase their national budgets that they made when adopting the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases;

Noting that valuable opportunities are being created in the form of new tools and better defined strategies, and that the momentum for expanding malaria-control interventions, and increasing financial resources at country and global levels, is growing,

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>2</sup>

The Sixtieth World Health Assembly,

Having considered the report on malaria, including a proposal for the establishment of World Malaria Day;

Concerned that malaria continues to cause more than one million preventable deaths a year;

Noting the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Bank Global Strategy and Booster Program; the Bill & Melinda Gates Foundation; the President's Malaria Initiative; and other donors have made substantial resources available;

Welcoming the contribution to the mobilization of resources for development of voluntary innovative financing initiatives taken by groups of Member States and, in this regard, noting the activities of the International Drug Purchasing Facility, UNITAID, the International Finance Facility for Immunisation, and the ~~intention~~ **commitment** to launch a pilot project in 2006 within the advance market commitment initiatives;<sup>3</sup>

Recalling that combating HIV/AIDS, malaria and other diseases is included in the United Nations Millennium Development Goals;

Mindful that the global burden of malaria needs to be decreased in order to reach the Millennium Development Goal of reducing child mortality by two thirds by 2015 and to help to achieve the Millennium Development Goals of improving maternal health and eradicating extreme poverty,

1. URGES Member States:

- (1) to apply to their specific contexts the policies, strategies and tools recommended by WHO, and to establish evidence-based national policies, operational plans and performance-based monitoring and evaluation in order to

<sup>1</sup> Document EB120/5.

<sup>2</sup> See document EB120/5 Add.1 for the administrative and financial implications for the Secretariat of the resolution.

<sup>3</sup> This paragraph quotes operative paragraph 5 of United Nations General Assembly draft resolution, 2001–2010: Decade to Roll Back Malaria in Developing Countries, Particularly in Africa.



expand coverage with major preventive and curative interventions in populations at risk, and assess programme performance and the coverage and impact of interventions in an effective and timely manner, particularly with use of the WHO country-profile database;

(2) to assign national and international resources, both human and financial, for the provision of technical support in order to ensure that the most locally and epidemiologically appropriate strategies are effectively implemented and target populations are reached;

(3) **progressively** to [China] ~~to withdraw from the market or withdraw the marketing authorization~~ **prohibit the practice** [Thailand] in both the public and private sectors ~~for of~~ [Thailand] oral artemisinin monotherapies i.e. artemisinins used alone without the accompaniment of a partner medicine, and to promote the use of artemisinin-combination therapies, to implement policies that prohibit the production of counterfeit antimalarial medicines; and assure that financing bodies cease to provide for those monotherapies ~~or other medicines~~; [USA, Namibia]

(4) ~~to identify and implement appropriate means to make effective medicines, long-lasting insecticide-treated nets and other products as indicated by WHO available at low cost or free of charge;~~ **to intensify access to affordable, safe and effective antimalarial combination treatments, intermittent preventive treatment in pregnancies, insecticide-treated mosquito nets, including through the free distribution of such nets where appropriate, and insecticides for indoor residual spraying for malaria control, taking into account relevant international rules, standards and guidelines;**<sup>1</sup> [USA]

[(5) to provide in their legislation for use to the full of the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to increase access to antimalarial medicines, diagnostics and preventive technologies;]

OR

[(5) to encourage trade agreements to take into account the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights and recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health in order to increase access to antimalarial medicines, diagnostics and preventive technologies; [USA]]

(6) to aim at reducing transmission risk-factors through integrated vector management, promoting improvement of local and environmental conditions and healthy settings, and increasing access to health services in order to reduce disease burden; [Mexico]

(7) to implement integrated approaches to malaria prevention and control through multisectoral collaboration and community responsibility and participation; [Mexico]

## 2. REQUESTS international organizations:

(1) to provide support **for the development of capacities in developing countries** ~~to countries~~ [Namibia] ~~in~~ to expanding use of artemisinin-based combination therapies that are appropriate for local drug-resistance conditions, integrated vector-management that includes use of long-lasting insecticide-treated nets, and indoor residual spraying with appropriate and safe insecticides as indicated by WHO and in accordance with the Stockholm Convention on Persistent

---

<sup>1</sup> This paragraph quotes from operative paragraph 9 of United Nations General Assembly draft resolution 2001–2010: Decade to Roll Back Malaria in Developing Countries, Particularly in Africa.

Organic Pollutants, and using monitoring and evaluation systems, including the country database, as developed by WHO;

(2) to increase funding to the various financing mechanisms for malaria control, so that they can continue providing support to countries, and to channel additional resources, for technical support to ensure that they can be absorbed and used effectively in countries;

~~(3) to provide support for the development of capacities in developing countries to produce and distribute appropriate medicines and long-lasting insecticide-treated nets; [Namibia]~~

3. REQUESTS the Director General:

(1) to take steps to identify knowledge gaps for malaria control; to provide support for the development of new tools and strategies; to estimate more accurately the global burden of disease and determine trends; to develop new tools and methods for assessing impact and cost-effectiveness of interventions; to build up WHO's current research on malaria, including that of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases; and to provide technical support to countries for conducting operational and implementation research into ways to ensure adequate coverage with antimalarial interventions;

(2) to strengthen and rationalize human resources for malaria by decentralizing staff to country level, thus improving the capacity of WHO's country offices to provide support to national health programmes for coordinating partners to prevent and control malaria; and to provide technical guidance for the management of malaria control in refugee camps and in complex emergencies;

(3) to bring together WHO's Global Malaria Programme, the Roll Back Malaria Partnership, the Global Fund to Fight AIDS, Tuberculosis and Malaria, academics, small and large pharmaceutical and biotechnology companies, interested Member States, medical-research councils, and foundations in a ~~standing~~ [USA] forum in order to improve coordination between different stakeholders in the fight against malaria;

(4) to report to the Health Assembly through the Executive Board on progress made in implementation of this resolution;

4. RESOLVES that:

(1) Malaria Day shall be commemorated annually on 25 April or on such other day or days as individual Member States may decide, in order to provide education and understanding of malaria as a global scourge that is preventable and a disease that is curable;

(2) Malaria Day shall be the culmination of year-long intensified implementation of national malaria-control strategies, including community-based activities for malaria prevention and treatment in endemic areas, and the occasion to inform the general public on the obstacles encountered and progress achieved in controlling malaria.

The CHAIRMAN said that the administrative and financial implications of the draft resolution remained unchanged, except for the deletion in paragraph 3(b) of the word "standing".

Dr QI Qingdong (China) suggested that in paragraph 1(3) the word "prohibit" should be replaced by "cease".

Dr AGWUNOBI (United States of America) said that if "prohibit" was to be replaced by "cease", he suggested also replacing "the practice" by "the provision". Referring to the preambular

paragraph beginning “Welcoming the contribution to the mobilization of resources”, he reiterated his concern that the quote contained in that paragraph, adequately referenced in footnote 1, did not end after the acronym “UNITAID”, since the International Finance Facility for Immunisation did not support work on malaria. Turning to the second option suggested for paragraph 1(5), proposed by the United States, he requested that the words “in order to increase access to antimalarial medicines, diagnostics and preventive technologies” be removed since they were not in his Government’s original proposal. He nevertheless recognized the value of that portion of the text, and proposed that it be shifted to subparagraph 6, so that the final clause should be amended to read: “and increasing access to health services, antimalarial medicines, diagnostics and preventive technology in order to reduce disease burden”.

Dr SHANGULA (Namibia) expressed regret at the lack of response to his request at the eighth meeting for clarification of “the President’s Malaria Initiative” referred to in the third preambular paragraph.

Dr NYIKAL (Kenya) considered that replacing the word “prohibit” with “cease” in paragraph 1(3) was inappropriate, since it did not give States any direction, while “prohibit” required States to take active steps in order to prevent the practices concerned. The first option suggested for paragraph 1(5), through its opening words “to provide in their legislation”, presented States with a specific request, as opposed to the undesirable second option. Moreover, he disapproved of the suggestion to shift the final words of paragraph 1(5), which constituted the objective of the subparagraph, to subparagraph 6, which related to disease prevention. States were not being compelled, but urged, to make appropriate provisions in their legislation. Thus, no expectations would be placed on Member States not affected by malaria, but the initial subparagraph would enable the introduction of relevant provisions into the national legislation of malaria-affected areas, where children continued to die.

Dr AGWUNOBI (United States of America) concurred that controlling malaria was extremely important. The language he had proposed in paragraph 1(5) reflected aspects that had been generally agreed upon but, given the strong views expressed by Kenya, he requested the establishment of a formal drafting group.

Professor PEREIRA MIGUEL (Portugal) responded to two proposals by the member for the United States since they referred to positions he had voiced on behalf of the European Union. He had no objection to the deletion of the end of the fourth preambular paragraph. With respect to paragraph 1(5), he favoured the first alternative, which was more consistent with existing binding legislation in the European Union.

Dr SOMSAK AKKSILP (adviser to Dr Suwit Wibulpolprasert, Thailand) said that both “cease” and “prohibit” in paragraph 1(3) were acceptable. He associated himself with the comments of the members for Kenya and Portugal regarding paragraph 1(5).

Dr SHANGULA (Namibia) shared the concerns expressed by the member for Kenya, which applied to his own country. The first, and initial, option for paragraph 1(5) was clearer and more action-oriented than the alternative paragraph proposed, which did not fit the context of the current draft resolution. He therefore urged the member for the United States to reconsider his position on the issue.

Mr CAMPOS (alternate to Dr Buss, Brazil) suggested that UNITAID, one of the key players in the fight against malaria, should be added to the list of stakeholders contained in paragraph 3(3).

Dr QI Qingdong (China) believed that “cease” and “prohibit” produced the same result, but “prohibit” was too negative and a more neutral word acceptable to all parties would be preferable.

The CHAIRMAN said that a drafting group would be set up immediately.

Dr NYIKAL (Kenya) recalled that four members agreed on the wording of paragraph 1(5), with only one differing. On what grounds, therefore, should a drafting group be established? He failed to understand how a country not concerned by the issue would be affected by such a measure. Valuable time could be saved by not referring the matter unnecessarily to a drafting group.

Ms IMAI (alternate to Dr Shinozaki, Japan) said that her country aligned itself with the United States in respect of paragraph 1(5).

Dr SADASIVAN (Singapore) said that sovereign countries had the right to deal with the issue as they wished, through legislation or trade agreements. Their decision should not be dictated by other parties. A drafting group could accommodate both views.

Dr AGWUNOBI (United States of America), in response to the concerns voiced by the member for Kenya, proposed another alternative to paragraph 1(5), to read, under paragraph 1(2): “to consider, whenever necessary, adapting national legislation in order to use to the full the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)”. That contained language already discussed and agreed upon in different settings and jurisdictions within governments. He agreed on the need to save time and try to resolve the matter.

Professor PEREIRA MIGUEL (Portugal) noted that, although he had expressed his preference for paragraph 1(5), the European Union maintained a flexible approach to the issue.

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

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

## **TENTH MEETING**

**Friday, 26 January 2007, at 14:20**

**Chairman:** Dr J. NYIKAL (Kenya)  
**later:** Dr F. ANTEZANA ARANÍBAR (Bolivia)

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

**Contribution of traditional medicine to public health: coca leaf:** Item 4.13 of the Agenda (Document EB120/36)

Ms NAVARRO LLANOS (alternate to Dr Antezana Aranibar, Bolivia) said that her Government would be carrying out a study on traditional medicine, with technical support from WHO and in line with resolution WHA56.31, in order to identify methods for monitoring and ensuring the quality, efficacy and safety of products, and to define indications for the treatment of diseases and conditions by means of traditional medicine. Although Bolivia had proposed the inclusion of the agenda item, the discussion might usefully be postponed until the results and scientific data from the study became available.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that traditional medicine was an important global issue; it was based on age-old cultural and spiritual traditions, and could complement commercial modern medicine. The benefits of *Artemisia annua*, for example, had first been identified hundreds of years ago in China; the knowledge had not been patented but had been made available to the public in the traditional way. Modern medicine was in danger of moving too far in the other direction. Artemisinin-based combination therapies had been patented in recent years and promoted as being the best against malaria. In that connection, he was pleased that the Board had not deleted the reference to monotherapies from the draft resolution on malaria. Both traditional and modern medicine were needed, but just as traditional medicine needed commercial investment, modern medicine needed the spiritual and cultural values of traditional medicine.

He supported Bolivia's preference to defer further consideration of the item.

Dr BUSS (Brazil) said that the Board must remain open to new forms of therapy based on natural products, and to the value of combining traditional and modern medicine. He welcomed the study to be carried out by Bolivia. Further discussion should be deferred.

Dr AGWUNOBI (United States of America) supported the proposal to defer the discussion and emphasized that research on substances like the coca leaf should be conducted by bodies with the appropriate scientific background, such as the United Nations Office on Drugs and Crime.

The CHAIRMAN said that he took it that the Board agreed that further discussion of the item would best be deferred, and that it wished, in the meantime, to note the report.

**It was so agreed.**

**Commission on Social Determinants of Health:** Item 4.15 of the Agenda (Documents EB120/35 and EB120/35 Add.1)

Dr AGWUNOBI (United States of America), referring to the statement in paragraph 17 of document EB120/35 that the Sixty-second World Health Assembly was expected to consider a global strategy and resolution for addressing the social determinants of health and health equity, said that the progress reports should not prejudge either the Commission's outcomes or the agendas of future Health Assemblies. Member States must be able to review the Commission's conclusions fully before deciding whether any action, including the preparation of a global strategy, should be taken by the Secretariat or the Health Assembly.

Dr RAHANTANIRINA (Madagascar) said that in developing countries, and particularly in Africa, women and children were facing health problems associated with extreme poverty, unhealthy environment and accommodation, lack of access to education, poor diet, and other social determinants, exacerbated by civil unrest and armed conflicts. Action focusing exclusively on health services would not remedy the situation. An intersectoral approach to the elements at the heart of the Declaration of Alma-Ata was needed. Social determinants and community participation in the health system must be part of the public health vision. She commended public-private partnerships linking WHO with national and regional civil society organizations at all levels, including in sub-Saharan Africa.

The Commission's work should be given priority within WHO.

Dr BUSS (Brazil) endorsed the views of the member for Madagascar. Making the social determinants of health one of the five priorities of the Eleventh General Programme of Work and one of the 15 strategic objectives of the draft Medium-term strategic plan 2008–2013 would contribute towards a better understanding of social and health conditions. The influence on health of social determinants, especially in the developing and least developed countries, could not be overemphasized. His Government had established a national commission on social determinants and was raising awareness among scientists, nongovernmental organizations, and medical and nursing students of the way people lived, in order to provide more effective treatment. It was working throughout Latin America and with lusophone African countries in order to establish national commissions and involve services that were important for health, as well as health services themselves.

Ms TOR-DE TARLÉ (France)<sup>1</sup> said that there could be no sustainable improvement in health without strengthening the foundations of health. The question of social determinants of health involved many international players, such as United Nations agencies and international financial institutions, which must be made more aware of promoting an environment conducive to health for all. France commended the work performed by the Commission in 2006 with international institutions, including the G8, as outlined in the report. As part of the follow-up to the G8 Summit 2006 in St Petersburg, Russian Federation, France would be hosting a high-level international conference in Paris from 15 to 16 March 2007 on social health protection in developing countries, and breaking the vicious circle of disease and poverty. The lack of social health protection systems in developing countries was a powerful obstacle to poverty reduction and achievement of the Millennium Development Goals. The conference would build on the work of both the 2005 Conference on Social Insurance in Developing Countries and the German Agency for Technical Cooperation–ILO–WHO consortium on social health protection in developing countries. The aim would be to compare the most effective public, private or community-based mechanisms in developing countries and suggest new partnerships for social health protection systems. The environment should be considered among the

---

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

social determinants of health: the promotion of good air and water quality and waste management on a global scale would be addressed at the conference.

Dr EVANS (Assistant Director-General) said that the Commission had recently held its seventh meeting in Geneva and, after 18 months, key messages were emerging relating to how the Secretariat and Member States engaged with the Commission, and the reaction of WHO's key partners to the Commission's recommendations. The question of services that were important to health raised by the member for Brazil was relevant in that connection. Paragraph 17 of the report, queried by the member for the United States, might not be sufficiently clear: the Sixty-second World Health Assembly would take place in 2009 and the Commission's report would be issued in 2008, giving Member States ample time to consider it. With regard to the remarks made by the representative of France, the Commission had a knowledge network specifically focused on the urban environment, and had received a presentation from WHO on the intersection with social determinants. The Secretariat looked forward to the preparatory meeting to the G8 Summit on social health protection as it related to a critical dimension of social determinants.

#### **The Board took note of the report.**

**Workers' health: draft global plan of action:** Item 4.10 of the Agenda (Documents EB120/28 Rev.1 and EB120/28 Add.1)

Dr GWENIGALE (Liberia), speaking on behalf of the Member States of the African Region, supported the draft resolution contained in the document in view of the increasing hazards in the workplace for people in the Region. Many leaders in the Region were seeking to increase employment and were bringing in foreign companies in order to set up manufacturing plants, but without the local expertise to monitor the use of imported chemicals. Harmful chemicals could not be disposed of safely. They affected the health of workers and polluted the air and water. In order to improve crop yields, farmers were given chemicals, either unlabelled or labelled in languages which local people could not understand. Crops harvested shortly after spraying were often contaminated, affecting local communities. In some countries, leaders who were not working in the interest of their people brought in materials for their own benefit. Dangerous waste chemicals, exported by a European country, had recently been dumped in one west African city. Such exports must be prevented and the chemicals disposed of at source. Hospitals and clinics in the Region had become aware that fear of diseases, such as HIV/AIDS, and contamination was reducing the number of training applications from nurses and laboratory technicians. Expert support from WHO was needed for monitoring imported industrial chemicals and protecting agricultural crops.

Dr KHALFAN (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that since 1996, when the Health Assembly had endorsed the global strategy for occupational health for all, Member States, with the support of the Regional Office, had been improving programmes for workers' health, a good basis for a global plan of action on workers' health. The Region had been incorporating workers' health into primary health care, as reflected in the draft global plan of action. However, problems persisted, because of a lack of coordination among the sectors concerned, a lack of financial, technical and human resources, the low coverage of occupational health services, and a lack of awareness of workers' health as a priority for public health programmes – all challenges for the global plan of action.

He proposed three amendments to the draft resolution: the addition, at the end of paragraph 2(4), of the words "and health systems development"; the addition of a new subparagraph in paragraph (2) that would read: "to encourage the development of effective mechanisms of collaboration and cooperation between developed and developing countries (north-south and south-south) at regional, subregional and country levels in implementing the global plan of action on workers' health"; and the addition of the words "and country" after "regional" in paragraph 3(2).

Ms HALTON (Australia) endorsed the remarks of the previous speakers about the importance of workers' health. However, the annex to the report by the Secretariat, containing the draft global plan of action on workers' health 2008–2017, had not been received in advance of the Board's session, and no consultation had been possible. She was therefore looking for a way that would permit consideration of the global plan of action, particularly bearing in mind the desire of a number of Board members to forward the draft to the Sixtieth World Health Assembly.

The CHAIRMAN said that efforts would be made to resolve that procedural question during the meeting.

Dr INAOKA (adviser to Dr Shinozaki, Japan), welcoming the draft resolution, drew attention to paragraph 2(4), and the importance of promoting occupational health in a manner consistent with public health policy. She emphasized primary prevention of occupational health hazards, and building institutional capacity for dealing with the needs of different occupational groups. WHO's support in the form of policy instruments and monitoring measures would be much appreciated. The increasing numbers of informal-sector and migrant workers were straining occupational health services. Health care for those groups must be improved. Many workers in Japan were covered by an HIV prevention programme in a large-scale infrastructure project financed by her Government.

Mr CAMPOS (alternate to Dr Buss, Brazil) welcomed the choice of health workers as the topic for World Health Day 2006. A robust national health system could not be built unless health workers had proper working conditions. Of the 2.5 million health workers in Brazil, many had insecure jobs. With a view to protecting them, his Government had been working with WHO and ILO on appropriate indicators for improving working conditions.

Dr CAMPBELL FORRESTER (alternate to Dr Allen-Young, Jamaica), speaking on behalf of the member countries of the Caribbean Community, said that they were committed to the draft global plan of action. Many were devising and implementing policy instruments in order to protect and promote health in the workplace. In Jamaica, an occupational safety and health bill was being drafted to cover the obligations of owners, employers and workers in the workplace, and a linked approach had been adopted on asbestos management and air quality regulations. Much work had also been done, in collaboration with the private sector, on HIV/AIDS and workplace policy. Improved occupational health services were being integrated into the environmental health programme. She endorsed the concerns expressed by the member for Australia.

Dr SUPAKIT SIRILAK (adviser to Dr Suwit Wibulpolprasert, Thailand) said that most of the principles in the draft global plan had been adopted by his Government. Since 1998, a labour protection act had been in force encompassing safety at work and occupational health. Employees received a free annual physical check-up and risk-specific laboratory examinations. Pregnant workers were well protected. A workers' compensation fund provided compensation for work-related injuries and deaths. Private-sector employees were covered by both workers' compensation and social security schemes. Informal workers were covered by the universal scheme, funded from tax receipts. The Ministry of Public Health also provided health services for migrant workers from three neighbouring countries. A global plan of action would help to close the gap between workers in the formal and informal sectors of the economy. He supported the draft resolution, but proposed that in paragraph 2(2), the words "migrant workers and" should be inserted after "all workers, including".

Mr DE SILVA (Sri Lanka), supporting the draft resolution, said that all occupations bore a potential risk or health hazard. Precautionary measures must be taken in order to mitigate those risks. Public awareness, legislation and regulation were vital. With funding from WHO, Sri Lanka's Ministry of Healthcare and Nutrition was currently exploring the possibility of integrating existing primary health-care services with the occupational health services of the Ministry of Labour. More than 1.5 million Sri Lankan workers were currently working overseas, and a considerable effort was



being made to educate them about the dangers of HIV/AIDS. The draft resolution called for strengthened collaboration with ILO, and joint regional efforts on workers' health. Some 75% of the economic wealth of Western countries was produced by migrant workers, who were often exploited and living in inadequate conditions.

Dr AGWUNOBI (United States of America) said that agencies in his country were highly active in protecting workers' health, and provided guidance and technical assistance to other countries. He faced the same procedural difficulties with the draft resolution as the member for Australia, and asked what opportunities existed for consultation.

Professor PEREIRA MIGUEL (Portugal) said that the draft global plan of action provided a framework for concerted action in health and other sectors. In view of the comments by other members, further consultations on the plan might be helpful. However, the issue should not be deferred until the Sixty-first World Health Assembly. WHO's commitment to reinforcing cooperation with ILO would promote policy implementation in the field. During Portugal's Presidency of the European Union in the second half of 2007, it would address the concerns about workers' health. A European conference on health and migration, to be held in September 2007, would focus on migrants' working conditions as a health determinant, and on providing them with better access to health care. Health of migrants would be on the agenda of the 122nd session of the Board, and he proposed that the item should also include workers' health.

Dr SHANGULA (Namibia) said that the health of workers was a fundamental right articulated in Namibia's Constitution. The Government was setting up a welfare programme in order to assist employees in all its institutions in the physical and social aspects of their work. He supported the spirit of the draft resolution, but, in view of the procedural concerns expressed, suggested that the Board approve it in principle pending further consultations. Referring to paragraph 3(4), he queried the significance of the dates cited for reporting to the Board, namely 2013 and 2018.

Ms HALTON (Australia) said that she could not approve the document in principle. No consultation had yet been undertaken with the Australian authorities on the draft global plan of action contained in the annex to the report. Perhaps consultations could be carried out by electronic means.

Dr SUPAKIT SIRILAK (adviser to Dr Suwit Wibulpolprasert, Thailand) said that deferral or delay of the adoption of the draft resolution would be a blow to the cause of workers' health. He supported the proposal by the members for Portugal and Namibia for the Board to move forward on the draft resolution.

Professor PEREIRA MIGUEL (Portugal) said that he could agree to electronic consultations.

The CHAIRMAN, responding to a remark by Dr GWENIGALE (Liberia), suggested that a time limit of 1 March 2007 should be set for those consultations.

Dr AGWUNOBI (United States of America) agreed that a time limit was necessary. Since the consultations on the plan of action would affect the positions to be taken on the draft resolution, the former should be completed before the latter were adopted.

The DIRECTOR-GENERAL agreed that the fact that the draft resolution indicated that the Board had considered the draft global plan of action could create problems for members that had not had time to carry out domestic consultations. She accordingly proposed that the Board should note the progress made as described in the report. The Secretariat would then carry out consultations with Member States by electronic means on the plan of action, which would then be submitted to the Sixtieth World Health Assembly. A deadline would be set for the consultations.

Following a procedural discussion in which Dr GWENIGALE (Liberia), the DEPUTY DIRECTOR-GENERAL, Dr KHALFAN (Bahrain) and Dr SHANGULA (Namibia) participated, the CHAIRMAN suggested that the Board take note of the draft resolution on the draft global plan of action on workers' health on the understanding that, following further consultations by electronic means, it would be submitted in a revised form to the Sixtieth World Health Assembly.

**It was so agreed.**

Ms KAZRAGIENE (Lithuania)<sup>1</sup> said that addressing workers' health was part of the broader strengthening of health systems. She supported the draft resolution and draft global plan of action, including the emphasis on diagnosis of occupational diseases, labour inspections and primary prevention of occupational risks. Early diagnosis and standardized statistics on occupational and work-related diseases and injuries provided evidence for strengthening health systems.

In elaborating its prevention policies, Lithuania had to deal with inadequate and under-reported statistics. Data needed to be more comparable and more comprehensive. Harmonizing occupational health statistics, normative guidance, and information on good practice in assessing workplace hazards, chemical safety, radiation protection and other threats to health at work would all be useful.

She advocated the regional networking of stakeholders, including the exchange of evidence for making policy and setting standards, including agreed definitions, classification systems and indicators. WHO should work on occupational safety and health in partnership with other intergovernmental and international organizations, primarily ILO. Close cooperation and enhanced synergies would avoid duplication and facilitate effectiveness at the national, regional and international levels. Through the Northern Dimension Partnership in Public Health and Social Well-being, which Lithuania chaired, occupational health would be further discussed.

**Dr Antezana Aranibar took the Chair.**

Ms BELLO DE KEMPER (Dominican Republic)<sup>1</sup> asked whether the electronic consultations would be open to all Member States, given the indication in paragraph 2 of the report that the draft global plan of action on workers' health had been based on a survey in which only 104 countries had taken part.

Mr RAJALA (European Commission) said that the Commission was content to inform the Board in written or electronic form. The diagnosis of occupational diseases and labour inspection were areas in which collaboration between ILO and WHO was of the utmost importance. The Commission was interested in being an active partner at the conception and implementation stages of the draft global plan of action on workers' health.

Dr FEDOTOV (International Labour Organization) said that ILO and WHO were the two United Nations specialized agencies that were directly concerned with the promotion and protection of workers' health and occupational health as a whole. They shared a common definition of occupational health and efficiently coordinated their activities, particularly in the context of the Joint ILO/WHO Committee on Occupational Health, set up in 1950. The draft global plan of action on workers' health was intended to give effect to the recommendations adopted by that Committee.

Cooperation between ILO and WHO was important for developing a multidisciplinary and intersectoral approach to occupational health. The new ILO Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187) provided for reinvigorated action to strengthen national occupational safety and health infrastructures on the basis of the systems approach. WHO used a primary health-care approach to reach working populations and had developed the *Global strategy for*

---

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

*occupational health for all: the way to health at work.* Both organizations applied the same principles in promoting sound occupational health practice and could reach the key stakeholders at the national level: their policies and programmes complemented one another. Both organizations were committed to improving the working environment and providing occupational health for all.

The draft global plan of action was a powerful tool in the implementation of the global strategy. In the face of globalization, ILO and WHO should enhance their cooperation on the protection of workers' health. He supported the adoption of the draft global plan of action and cooperation with WHO for its successful implementation.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN and on behalf of FDI World Dental Federation, the International Confederation of Midwives, the International Pharmaceutical Federation, the World Confederation for Physical Therapy and the World Medical Association, Inc., outlined the associations' cooperation with WHO at headquarters and regionally. Given the problems of recruiting and retaining health personnel, he supported all measures that protected, promoted and improved the health, safety and well-being of health workers, as well as patient safety. Workforce deployment needed to accommodate manageable workloads and stress levels. Such efforts transcended the mandates of any one organization or country and were the responsibility of all health-sector stakeholders. WHO should join health professionals in an annual campaign to promote safe and healthy workplaces for all health workers, to be launched in 2007.

Professor RANTANEN (International Commission on Occupational Health) welcomed the draft global plan of action on workers' health. The global coverage of occupational health services was still low, although the needs were enormous. As many as 160 million cases of occupational diseases and 270 million occupational accidents were estimated to occur annually. Access to preventive and protective services, particularly in developing countries, was lowest where the needs were greatest and the current trend was not towards improvement. The needs of agricultural workers, small-scale enterprises, the self-employed and workers in the informal sector, who together numbered over 2000 million workers with virtually no access to occupational health services, should be particularly emphasized. International guidance and technical support from WHO were needed. He noted the inclusion of basic occupational health services in the action plan. Developed countries needed the action plan in order to deal with emerging occupational epidemics, such as stress, musculoskeletal disorders and occupational allergies. Globally and regionally WHO played an important role in identifying new risks and disseminating information in a usable form.

Ms WEBER-MOSDORF (Assistant-Director-General), welcoming the commitment to workers' health, fully respected the request by Member States for further consultations; all Member States would be invited to participate in electronic consultations. She looked forward to receiving further input from Member States and to the discussion of the subject at the Sixtieth World Health Assembly.

Replying to the question from the member for Namibia regarding paragraph 3(4), she said that the global plan was a 10-year exercise with the year 2013 as the midpoint; that therefore seemed an appropriate date to review the progress made in implementation.

**It was so noted.**

**Malaria, including proposal for establishment of World Malaria Day:** Item 4.2 of the Agenda (Documents EB120/5 and EB120/5 Add.1) (continued from the ninth meeting, section 2)

Dr NYIKAL (Kenya) said that, after informal discussions with the member for the United States of America, he conceded that there was little difference in meaning between urging Member States to "prohibit" a practice and urging them to "cease" that practice and could accept the wording proposed for paragraph 1(3). In that member's last proposal for paragraph 1(5) the word "consider" was too weak and should be deleted, so that the text would simply urge Member States to "whenever necessary

adapt national legislation". He also proposed the retention of the words "in order to increase access to antimalarial medicines, diagnostics and preventive technologies".

Dr AGWUNOBI (United States of America) said that it had never been his intention to delete that wording. He was reluctant to alter the wording of paragraph 1(5), as it quoted language from another document on which consensus had been reached previously. His proposal was to move the phrase from the end of paragraph 1(5) to the end of paragraph 1(6).

Dr NYIKAL (Kenya) argued that retaining the phrase in paragraph 1(5) made more sense.

Dr AGWUNOBI (United States of America) said that, although he recognized the importance attached to the issue by the member for Kenya, he wished to keep the language of the paragraph true to its source, namely resolution WHA56.27 on intellectual property rights, innovation and public health, which should be referenced.

Dr SHANGULA (Namibia) suggested that, as the difficulty seemed to lie in the reluctance of the last speaker to append new language to a direct quotation, the paragraph should be reformulated in such a way as to replace the direct quotation with a reference to its source.

Dr KHALFAN (Bahrain) proposed that, as it was proving difficult to reach consensus, consideration of the draft resolution should be deferred.

Dr NYIKAL (Kenya) proposed that, if the Board were unable to reach agreement, his original wording should be strengthened and the text submitted to the Health Assembly in square brackets.

In response to a proposal by Ms HALTON (Australia) that the members for Kenya and the United States should consult informally in order to agree wording, the CHAIRMAN suggested that the Board should defer further consideration of the item to allow time for informal consultations between the members concerned.

**It was so agreed.**

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

**Avian and pandemic influenza: developments, response and follow-up, and application of the International Health Regulations (2005):** Item 4.4 of the Agenda (Documents EB120/15, EB120/15 Add.1, EB120/INF.DOC./3 and EB120/16) (continued from the fourth meeting)

The CHAIRMAN drew attention to an amended version of the draft resolution, which read:

**Avian and pandemic influenza: developments, response and follow-up,  
~~and application of the International Health Regulations (2005)~~<sup>†</sup>  
and best practice for sharing influenza viruses and sequence data**

The Executive Board,

Having considered the reports on avian and pandemic influenza: developments, response and follow-up, ~~and application of the International Health Regulations (2005)~~, **and best practice for sharing influenza viruses and sequence data,**<sup>21</sup>

---

<sup>†</sup>See document EB120/16 for information on application of the International Health Regulations (2005).

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>1</sup>

The Sixtieth World Health Assembly,

Having considered the report on avian and pandemic influenza: developments, response and follow-up;

Recalling resolutions WHA58.5 and WHA59.2, which expressed concern about the potential of the H5N1 avian influenza virus to cause a pandemic and urged Member States to disseminate to WHO collaborating centres information and relevant biological materials, including clinical specimens and viruses;

Recognizing, in particular, the importance of international sharing, with WHO collaborating centres, of clinical specimens and viruses as a contribution to assessment of the pandemic risk, the development of pandemic vaccines, the updating of diagnostic reagents and test kits, and surveillance for resistance to antiviral medicines,

1. URGES Member States:

(1) to continue to support the WHO Global Influenza Surveillance Network and its procedures for the routine collection, exchange and characterization of circulating strains of seasonal influenza viruses;

(2) to establish mechanisms, **in accordance with the Member States' domestic laws and regulations, such as those for biosafety and transportation, [China]** that ensure the routine and timely sharing of biological materials related to novel influenza viruses posing a pandemic threat, including H5N1 virus isolates from both humans and animals, and the **routine and timely [China]** placement of data on the genetic sequences of these viruses in the public domain;

(3) to support implementation of the WHO global pandemic influenza action plan to increase vaccine supply<sup>2</sup> as a means of increasing availability and access to pandemic influenza vaccines;

(4) to continue to conduct rapid clinical and epidemiological investigation of human infections, and to share findings in a timely manner with WHO and the international community;

2. REQUESTS the Director-General:

(1) to continue to coordinate international surveillance of seasonal influenza viruses and viruses with pandemic potential;

(2) **to set up a mechanism so that national influenza centres are routinely notified in a timely manner about the summary results of important virologic analyses conducted by WHO collaborating centres and H5 reference laboratories; [China]**

~~(2)~~(3) to ensure that the results of research on influenza viruses, including the H5N1 virus, lead to the broadest possible access to practical products, including pandemic influenza vaccines;

(4) **to take appropriate action if WHO is notified by a Member State that believes that the viruses provided by that Member State were misused by a WHO collaborating centre or an H5 reference laboratory for research or profit-making in a manner that violates best practice; [China]**

---

<sup>1</sup> Documents EB120/15, ~~and~~ EB120/16, and EB120/INF.DOC/3, respectively.

<sup>31</sup> See document EB120/15 Add.1 for the administrative and financial implications for the Secretariat of this resolution.

<sup>2</sup> Document WHO/IVB/06.13 – WHO/CDS/EPR/GIP/2006.1.

~~(3)~~(5) to ensure broader **and more equitable** [Bahrain] regional distribution of production capacity for influenza vaccine and increasing production capacity for pandemic vaccines by leading implementation of the WHO global pandemic-influenza action plan to increase vaccine supply, emphasizing those activities that help to increase access to pandemic vaccines in developing countries and other countries that lack domestic manufacturing capacity;

~~(4)~~(6) to continue to assess the evolving threat of an influenza pandemic and keep the international community informed **in a timely manner**; [Singapore]

(7) **to provide support to developing countries, including those sharing their viruses, for building capacity for surveillance, case-detection and reporting, by inviting scientists from countries sharing viruses to participate in relevant research and analysis conducted by the collaborating centres of the WHO Global Influenza Surveillance Network**; [China]

(8) **to work with Member States to identify and establish feasible and sustainable incentives, including encouragement and public acknowledgement of their contributions, for sharing their viruses and genetic sequence information**; [China]

(9) **to mobilize additional support for Members States with vulnerable health systems in order to strengthen these systems and improve their state of preparedness**; [Kenya]

(10) **to identify and recommend possible options aimed at promoting the accessibility of pandemic-influenza vaccine and antiviral medicines to all, for example by mobilizing adequate funding in order to compensate for the cost of research on, and development of, the pandemic-influenza vaccine and antiviral medicines**; [Thailand]

(11) **to report annually to the Health Assembly through the Executive Board on the situation of pandemic influenza and global preparedness**. [Thailand]

Ms HALTON (Australia) said that, in paragraph 2(4), she proposed moving the words “by a WHO collaborating centre or an H5 reference laboratory” to the end of the sentence and replacing the words “profit-making” with “for commercial purpose”. The source of the wording of the subparagraph, namely document EB120/INF.DOC./3, should be identified in a footnote. Paragraph 2(10) should be amended so as to begin with the words “to identify, recommend and support as appropriate the implementation of possible options ...”. The words “in order to compensate” and “the cost of” should be deleted and the entire subparagraph relocated so as to follow paragraph 2(5).

Dr AGWUNOBI (United States of America), referring to paragraph 1(2), proposed replacing the words “the Member States” by “their”. He also suggested inserting “and international regulations” after the word “regulations” and replacing the words “public domain” by “publicly available database”. With regard to paragraph 2(2), he requested that the words “set up a” should be replaced by “strengthen the communications” and the words “are routinely notified” be replaced by “receive routine notifications”. For clarity, the first and last lines of paragraph 2(3) should be transposed, so that the paragraph would read: “to promote the broadest possible access to practical products, including pandemic influenza vaccines, resulting from research on influenza viruses, including the H5N1 virus”. In paragraph 2(5), “ensure” should be replaced by “facilitate”. In paragraph 2(7), he proposed replacing “inviting” by “facilitating the participation of” and in paragraph 2(8), “work” should become “cooperate”; the words “identify and” should be deleted.

Dr NYIKAL (Kenya), referring to the amendment just proposed to paragraph 2(3), took issue with the word “promote”, which was too vague: the paragraph should spell out what specific actions should be taken to ensure access to products.

The DIRECTOR-GENERAL, referring to the previous speaker's comments, recalled that the paragraph in question was a request to the Director-General, not to national authorities, and that the wording was therefore appropriate.

The CHAIRMAN said that he took it that the Board wished to adopt the draft resolution as amended.

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

**Prevention and control of noncommunicable diseases: implementation of the global strategy:** Item 4.5 of the Agenda (Documents EB120/22 and EB120/22 Add.1) (continued from the eighth meeting, section 2.)

The CHAIRMAN invited the Board to consider the amended draft resolution on prevention and control of noncommunicable diseases: implementation of the global strategy, which read:

The Executive Board,

Having considered the report on prevention and control of noncommunicable diseases: implementation of the global strategy,<sup>2</sup>

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>3</sup>

The Sixtieth World Health Assembly,

Having considered the report on prevention and control of noncommunicable diseases: implementation of the global strategy;

Recalling resolutions WHA53.17 on Prevention and control of noncommunicable diseases, WHA56.1 on the WHO Framework Convention on Tobacco Control, WHA57.17 on Global strategy on diet, physical activity and health, WHA57.16 on Health promotion and healthy lifestyles, WHA58.22 on Cancer prevention and control, and WHA58.26 on Public-health problems caused by harmful use of alcohol, and the many related regional committee resolutions, including on mental health;

Deeply concerned that in 2005 ~~chronic~~ noncommunicable diseases caused an estimated 35 million deaths (60% of all deaths globally), that 80% of these deaths occurred in low- and middle-income countries, and that about 16 million deaths occurred among people under 70 years of age;

Noting that the mortality due to ~~chronic~~ noncommunicable diseases is expected to rise by a further 17% by 2015, with serious socioeconomic consequences for Member States, communities and families;

Noting the links between ~~chronic~~ noncommunicable diseases, development, the environment, and human security, and their contribution to health inequalities;

Noting that multisectoral responses continue to be limited by lack of awareness about, and appropriate action to reverse, the pandemic of ~~chronic~~ noncommunicable diseases;

Noting that the importance of the prevention and control of ~~chronic~~ **noncommunicable** diseases has been highlighted in the Eleventh General Programme of

---

<sup>1</sup> Resolution EB120.R7.

<sup>2</sup> Document EB120/22.

<sup>3</sup> See document EB120/22 Add.1 for the financial and administrative implications for the Secretariat of this resolution.

Work 2006–2015, which includes the target of reducing death rates from all ~~chronic~~ **noncommunicable** diseases by 2% annually during the next 10 years;

Noting the increasing evidence on the cost-effectiveness of several simple interventions for prevention and control of ~~chronic~~ noncommunicable diseases;

Noting the importance of motivating, educating and supporting individuals and families to make healthy choices in their daily lives, **and the important role played by governments in providing healthy public policy and environments;** [Thailand]

Confirming the importance of tackling the major underlying risk factors for ~~chronic~~ noncommunicable diseases in an integrated, comprehensive, multisectoral and step-by-step manner;

Bearing in mind that the response to the triple burden of infectious diseases, ~~chronic~~ noncommunicable diseases, and injuries faced by many countries and their severe resource constraints requires a strong primary health-care system within an integrated health system;

Recognizing that the implementation of the WHO Framework Convention on Tobacco Control is an essential measure for the prevention and control of ~~chronic~~ noncommunicable diseases;

Recognizing that greater efforts are required globally to promote physical activity, and to improve the quality of food and drink products, including information available to consumers and the way in which [**new and healthy** [USA]] or [~~new and healthy~~ [Denmark]] products are marketed, especially to children;

Recognizing that more information is required on the socioeconomic and developmental impact of ~~chronic~~ noncommunicable diseases and on the outcome of available interventions;

Aware that Member States spend only a small proportion of their health-care budget on prevention of ~~chronic~~ noncommunicable diseases and on public health, and that even a minor increase in that percentage would yield tremendous health and socioeconomic benefits;

1. URGES Member States:

(1) to strengthen national and local political will to prevent and control ~~chronic~~ noncommunicable diseases as part of a commitment to achieving the target of reducing death rates from all ~~chronic~~ noncommunicable diseases by 2% annually for the next 10 years, as contained in the Eleventh General Programme of Work 2006–2015;

(2) to establish **where appropriate** [Australia] or to strengthen a national coordinating mechanism for prevention of ~~chronic~~ noncommunicable diseases, ~~where appropriate to national circumstances,~~ [Kenya] **where appropriate to national circumstances** [USA] with a broad multisectoral mandate, including mobilization of political will and financial resources, and involving all relevant stakeholders;

(3) to develop and implement a national multisectoral evidence-based action plan for prevention and control of ~~chronic~~ noncommunicable diseases that sets out priorities, a time frame and performance indicators, and that provides the basis for coordinating the work of all stakeholders, and actively engage civil society;

**(3bis) to consider increasing** ~~increase~~ [Australia] budgetary provisions that are dedicated to the prevention and control of ~~chronic~~ noncommunicable diseases, [Kenya] and to implement a line item **where appropriate** [Australia] for prevention and control of ~~chronic~~ noncommunicable diseases in the annual health budget as an essential step in policy implementation; [Jamaica]

**OR**

**(3bis) to increase, as appropriate, resources for programmes for the prevention and control of noncommunicable diseases;** [USA]



(3ter) to consider implementing **existing** [Australia] international agreements and increasing support for global initiatives that will contribute to achieving the target of reducing death rates from ~~chronic~~ noncommunicable diseases by 2% annually for the next 10 years; [Kenya]

**OR**

~~(3ter) to consider implementing existing [Australia] international agreements and increasing support for global initiatives that will contribute to achieving the target of reducing death rates from chronic noncommunicable diseases by 2% annually for the next 10 years; [USA]~~

(4) to make prevention and control of ~~chronic~~ noncommunicable diseases an integral part of programmes aimed at strengthening primary health-care systems, and to strengthen primary health care ~~systems~~ **institutions** [USA] so that they respond to the challenges raised by ~~chronic~~ noncommunicable diseases; [Jamaica]

(5) to strengthen monitoring and evaluation systems, including country-level epidemiological surveillance mechanisms, in order to compile evidence to inform policy decisions;

(6) to ensure that ~~national~~ [USA] health ~~systems~~ **institutions** [USA] are adequately organized, in order to ~~tackle~~ **address** the serious challenges raised by noncommunicable diseases, which implies a particular focus on primary health care; [Portugal]

~~(7) to consider possibilities to use national legislative or regulatory mechanisms with the aim of preventing and controlling noncommunicable diseases; [Portugal]~~  
**to emphasize the key role of governmental functions, including regulatory functions, when combating noncommunicable diseases; [USA]**

2. REQUESTS the Director-General:

(1) on the basis of an outline contained in the report<sup>1</sup> on prevention and control of noncommunicable diseases: **implementation of the global strategy**, [Australia] to prepare an action plan to be submitted to the Sixty-first World Health Assembly **through the Executive Board** [USA] that sets out priorities, actions, a time frame and performance indicators for prevention and control of noncommunicable diseases between 2008 and 2013 at global and regional levels, and to provide support where needed for elaboration, intensified implementation and monitoring of national plans for prevention and control of ~~chronic~~ noncommunicable diseases, including the further development of an intervention to manage the conditions of people at high risk of such diseases;

(2) to raise further awareness among Member States of the importance of drawing up, promoting and funding supportive national multisectoral coordination and surveillance mechanisms, and plans for prevention and control of ~~chronic~~ noncommunicable diseases;

(3) to provide support to Member States, on request, and to foster partnership, collaboration, cooperation and sharing of best practices among Member States, for incorporating comprehensive ~~chronic~~ noncommunicable disease interventions into national policies and programmes, including health systems policies and programmes, and for expanding interventions, including strategies to educate and support individuals and families;

(4) to disseminate to Member States, in a timely and consistent manner, information on cost-effective, core interventions aimed at preventing and controlling ~~chronic~~ noncommunicable diseases;

<sup>1</sup> Document EB120/22.

(4bis) to encourage dialogue with international, regional and national nongovernmental organizations, donors and technical-agency partners **and the private sector** [Denmark and Jamaica] in order to increase support, resources and partnerships for prevention and control of noncommunicable diseases, **including health and wellness programmes at the workplace**; [Denmark and Jamaica]

~~(5) to encourage dialogue with the private sector in particular [Australia and Portugal] in order to increase the relative demand for, and availability of, healthy foods, promote healthy diets, and the marketing and promotion of unhealthy products, [USA] and increase access to medicines for high-risk populations in low- and middle-income countries, and include **where appropriate** [Australia] health and wellness programmes at the workplace; [Brazil and Denmark]~~

**(5) to promote initiatives aimed at implementing the global strategy with the purpose of increasing availability of healthy foods, promoting healthy diets, and reducing marketing and promotion of unhealthy products, in dialogue with all relevant stakeholders, including private-sector parties, which are committed to reducing the risks of noncommunicable diseases, and increasing access to medicines for high-risk populations in low- and middle-income countries; [Brazil and Denmark]**

(6) to build and sustain contact with the mass media in order to ensure continued prominence in the media of issues related to the prevention and control of ~~chronic~~ noncommunicable diseases;

(7) to improve understanding of the socioeconomic impact of ~~chronic~~ noncommunicable diseases at national and household levels, especially in low- and middle-income countries;

(7bis) to ensure that the work on prevention and control of noncommunicable diseases is given suitably high priority, and support **where appropriate**; [Australia and USA]

(8) to report to the Sixty-third World Health Assembly, and subsequently every two years to the Health Assembly through the Executive Board, on progress in implementing the global strategy on prevention and control of noncommunicable diseases, including progress on the action plan.

Dr SMITH (Denmark), referring to the thirteenth preambular paragraph, reiterated her suggestion that the words “new and healthy” should not be inserted as that insertion considerably weakened the thrust of the paragraph. She much preferred the second alternative for paragraph 1(3bis), proposed by the United States, as it reflected more clearly the desire to allocate adequate national resources to noncommunicable diseases. Paragraph 1(3ter) should be retained, but amended to read: “to consider implementing existing international agreements and increasing support for global initiatives that will contribute to reducing death rates significantly”.

Dr AGWUNOBI (United States of America) expressed support for Denmark’s request and welcomed the endorsement of paragraph 1(3bis). As he was unsure of the meaning of the expression “healthy public policy”, in the ninth preambular paragraph, he suggested replacing “healthy public policy and environments” by “public policy for health and environments”. He was prepared to withdraw the proposal to insert the words “new and healthy” in the thirteenth preambular paragraph.

He also proposed amending paragraph 1(3ter) to read “to implement the Framework Convention on Tobacco Control and increase support for other global initiatives that could contribute to achieving the target of reducing death rates from noncommunicable diseases by 2% annually for the next 10 years”. He further proposed deleting from new paragraph 2(5) the wording: “with the purpose of increasing availability of healthy foods, promoting healthy diets, and reducing marketing and promotion of unhealthy products”. The words “and increasing access to medicines for high-risk populations in low- and middle-income countries” should be deleted from that paragraph and

transferred to a new paragraph 1(8), which would read: “to increase access to relevant medicines for high-risk populations in low- and middle-income countries”.

Dr SUWIT WIBULPOLPRASERT (Thailand), referring to the proposal to amend “healthy public policy” to “public policy for health” in the ninth preambular paragraph, observed that there was a precedent for the use of the phrase “healthy public policy”, which meant public policy that was conducive to health; the expression originated in the 1986 Ottawa Charter for Health Promotion. The existing wording should therefore be retained.

Dr NYIKAL (Kenya) suggested inserting the text “, avoiding potential conflict of interest,” after “all stakeholders” in paragraph 1(3).

Ms HALTON (Australia) said that the scope of the thirteenth preambular paragraph should not be limited to children, because the information and marketing issues relating to food and drink concerned all consumers. She therefore suggested that the phrase “especially to children” should be deleted. In paragraph 2(4bis), she proposed adding “as appropriate” after “at the workplace”.

Dr KEAN (Executive Director, Office of the Director-General) read out the suggested amendments. The thirteenth preambular paragraph, as amended, would read: “Recognizing that greater efforts are required globally to promote physical activity, and to improve the quality of food and drink products, including information available to consumers and the way in which products are marketed”. Paragraph 1(3), as amended, would read: “to develop and implement a national multisectoral evidence-based action plan for prevention and control of noncommunicable diseases that sets out priorities, a time frame and performance indicators, and that provides the basis for coordinating the work of all stakeholders, avoiding potential conflict of interest, and actively engage civil society”. Paragraph 1(3bis) would read: “to increase, as appropriate, resources for programmes for the prevention and control of noncommunicable diseases”. Paragraph 1(3ter), as amended, would read: “to consider implementing existing international agreements and increasing support for other global initiatives that will contribute to significantly reducing death rates”. The end of paragraph 2(4bis) would be amended by the addition of “as appropriate”.

Responding to requests for clarification, Dr AGWUNOBI (United States of America) said that his proposal was that paragraph 2(5) should read: “to promote initiatives aimed at implementing the global strategy in dialogue with all relevant stakeholders, including private-sector parties, which are committed to reducing the risks of noncommunicable diseases”. A new subparagraph 1(8) would read: “to increase access to relevant medicines for high-risk populations in low- and middle-income countries”.

Dr CAMPBELL FORRESTER (alternate to Dr Allen-Young, Jamaica) proposed that the words “especially to children” in the thirteenth preambular paragraph should be retained, and followed by the addition of “and young people”.

Dr SMITH (Denmark) supported most of the proposed amendments. However, paragraph 2(5) had been carefully drafted by a number of interested Board members, and, although she could accept the proposal made by the member for the United States that the last phrase should be transferred to a new paragraph 1(8), she could not accept the deletion of the words “with the purpose of increasing availability of healthy foods, promoting healthy diets, and reducing marketing and promotion of unhealthy products”.

Dr AGWUNOBI (United States of America) said that he had strong concerns regarding that particular wording.

Dr SMITH (Denmark), supported by Mr CAMPOS (alternate to Dr Buss, Brazil), said that the members concerned also had strong feelings about that wording, which, furthermore, had been included in the text originally proposed by the Secretariat.

Dr GWENIGALE (Liberia) said that, in view of the rising levels of obesity around the world, he would not wish to see such important wording deleted.

Dr NYIKAL (Kenya) supported the views of the members for Denmark and Liberia; diet was an important factor in the promotion of health.

Dr AGWUNOBI (United States of America) proposed that, in the interests of achieving consensus, only the wording “with the purpose of increasing availability of healthy foods and promoting healthy diets” should be retained.

Dr KEAN (Executive Director, Office of the Director-General) said that paragraph 2(5) would then read “to promote initiatives aimed at implementing the global strategy with the purpose of increasing availability of healthy foods and promoting healthy diets, in dialogue with all relevant stakeholders, including private-sector parties, which are committed to reducing the risks of noncommunicable diseases”. There would also be a new paragraph 1(8), to read: “to increase access to medicines for high-risk populations in low- and middle-income countries”.

Dr AGWUNOBI (United States of America) asked whether Board members might accept the replacement of the contentious wording “and reducing marketing and promotion of unhealthy products” by “and increasing the marketing and promotion of healthy products”.

Dr SUWIT WIBULPOLPRASERT (Thailand) proposed the replacement of “reducing” by “restricting”.

Dr SHANGULA (Namibia) expressed a preference for retention of the original text: the last proposal made by the member for the United States would do nothing to reduce the availability of unhealthy foods, and it was important to send a strong message in that regard. Moreover, it would be difficult for the Director-General, to whom the paragraph was addressed, to “restrict” marketing. Referring to the amendments proposed to the thirteenth preambular paragraph, he would prefer to replace “, especially to children” with “to the public”.

Dr CAMPBELL FORRESTER (alternate to Dr Allen-Young, Jamaica) stressed that the thirteenth preambular paragraph should reflect the particular risk posed to children and adolescents.

Dr AGWUNOBI (United States of America) suggested the establishment of a working group to consider the draft resolution further, and notably paragraph 2(5).

Mr CAMPOS (alternate to Dr Buss, Brazil) reiterated his support for the position taken by the member for Denmark. It was important to retain a reference to the need to reduce the marketing of unhealthy products.

Ms HALTON (Australia) proposed that, in the thirteenth preambular paragraph, it would be preferable to replace “especially to children” with “especially to vulnerable populations”, thereby encompassing other vulnerable groups such as indigenous peoples. It was important to distinguish between products that were harmful to health in any quantity, such as tobacco, and those that were harmful only in excessive quantities, such as “unhealthy” foods. She supported the establishment of a drafting group, to consider in particular, the wording of paragraph 2(5).

Professor PEREIRA MIGUEL (Portugal), supporting the position taken by the member for Denmark, proposed the replacement of “reducing” by “limiting”.

Dr SUWIT WIBULPOLPRASERT (Thailand), referring to his earlier proposal to substitute the word “restricting” for “reducing”, pointed out that the provision requested the Director-General to promote initiatives with the purpose of restricting marketing, not actually to restrict marketing. As a compromise, the Board might find it acceptable to replace “reducing marketing” with “reducing aggressive marketing”.

Dr AGWUNOBI (United States of America) supported the view expressed by the member for Australia regarding “unhealthy products”; too much, or in some cases too little, of any product could prove unhealthy.

Dr SHANGULA (Namibia) reiterated his view that the Director-General could not be requested to reduce marketing.

The CHAIRMAN took it that a working group should be established.

**It was so agreed.**

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

**Draft resolutions deferred from the Fifty-ninth World Health Assembly and the 118th session of the Executive Board:** Item 4.12 of the Agenda

- **Essential health technologies** (Documents EB120/13 and EB120/13 Add.1)

The CHAIRMAN recalled that the Board had discussed the topic at its 118th session and had requested the Executive Board to consider it further at its present session.<sup>1</sup> He drew attention to the draft resolution set out in paragraph 16 of document EB120/13.

Mrs VELÁZQUEZ (alternate to Mr Bailón, Mexico), recalling that the draft resolution was the first on the subject to be considered by the Board, said that essential health technologies enabled the dispensing of safe and effective good-quality health care. Her health ministry had therefore established a health technology centre in 2004 in order to inform and guide health ministries in the Region of the Americas in promoting and evaluating the rational use of health technologies. Consideration of the draft resolution should be postponed pending a wide-ranging consultation process, involving experts, nongovernmental organizations and Member States. That would enable the Secretariat to define more clearly the scope and implications of the draft resolution.

Dr SUWIT WIBULPOLPRASERT (Thailand) supported that proposal.

Dr JAKSONS (Latvia) said that it would be important to define the terminology precisely in order to avoid confusion, for example, whether treatment procedures and protocols should be regarded as health technologies.

The CHAIRMAN said that it was his understanding that Mexico was proposing consultations to clarify such matters.

---

<sup>1</sup> Document EBSS–EB118/2006/REC/1, summary record of the fourth meeting, section 2.

Dr ZUCKER (Assistant Director-General) explained that the aim was to determine which basic health technologies should be available in all countries. A consultation process would define the scope and terminology of the health technologies concerned, including equipment, treatment procedures or laboratory tests.

Mrs VELÁZQUEZ (alternate to Mr Bailón, Mexico) confirmed that she was proposing further consultations on which health technologies were to be included.

Ms HALTON (Australia) requested further information on the suggested process, including who would be involved and consulted, the proposed timetable, expected end result, and timescale for resubmission to a governing body.

Dr ZUCKER (Assistant Director-General) said that the aim was to complete the consultation process with Member States and experts in the field in time for the draft resolution to be revised and submitted to the Sixtieth World Health Assembly in May 2007. The purpose would be to suggest what general health technologies were needed in order to provide basic health care for all, rather than to draw up a specific list: for example, defining a need for the evaluation of cardiac rhythm instead of specifying a piece of equipment for that purpose.

Dr SUWIT WIBULPOLPRASERT (Thailand) pointed out that there would be scant time for consultation given the deadline for submission of draft resolutions for the May Health Assembly. He proposed that the Secretariat should be requested to provide further clarification of the proposed process later in the Board's present session.

The DIRECTOR-GENERAL endorsed that proposal.

Mr ALLAGE (alternate to Dr Saheli, Libyan Arab Jamahiriya), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that a resolution along the lines proposed would reaffirm previous decisions, including resolution WHA55.18 on quality of care: patient safety, and the Secretariat's subsequent report on the same subject (document EB113/37), which urged countries to develop appropriate national regulations, quality assurance systems and procedures for procurement and risk assessment. Those activities could provide a useful basis for policy formulation in that area.

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

**Progress in the rational use of medicines, including better medicines for children:** Item 4.9 of the Agenda (Documents EB120/7, EB120/7 Add.1, EB120/37 and EB120/37 Add.1) (continued from the eighth meeting, section 2)

The CHAIRMAN proposed that a drafting group should be established to consider the two draft resolutions on the item.

**It was so agreed.**

(For adoption of the resolutions, see summary record of the twelfth meeting, section 3.)

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

## **ELEVENTH MEETING**

**Saturday, 27 January 2007, at 09:05**

**Chairman:** Dr F. ANTEZANA ARANÍBAR (Bolivia)

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

**Draft resolutions deferred from the Fifty-ninth World Health Assembly and the 118th session of the Executive Board:** Item 4.12 of the Agenda

- **Essential health technologies:** (Documents EB120/13 and EB120/13 Add.1) (continued from the tenth meeting)

In response to Mrs VELÁZQUEZ (alternate to Mr Bailón, Mexico), who reiterated her call for a working group so as to benefit from the presence of members and hear their ideas, the CHAIRMAN suggested that discussions could take place on an informal basis.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) concurred with the member for Mexico. Observing that discussion had already been deferred from the 118th session of the Board, he regretted that the Secretariat had not explored the matter further. Most members were ready to progress with the draft resolution. The Secretariat's proposal would unnecessarily delay the work of the Board. The draft resolution would enable the Secretariat and Member States to act at once on the matter.

The DIRECTOR-GENERAL said that she had understood that Mexico wanted to postpone the discussion, but, in view of the foregoing comments, arrangements would be made for a meeting of a drafting group as proposed.

**It was so agreed.**

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

- **Smallpox eradication: destruction of variola virus stocks** (Documents EB120/11, EB120/11 Add.1 and EB120/39) (continued from the second meeting, section 3)

Professor PEREIRA MIGUEL (Portugal), speaking as chairman of the drafting group, introduced the proposed amendments to the draft resolution on smallpox eradication: destruction of variola virus stocks, which read:

The Executive Board,  
Having considered the reports on smallpox eradication: destruction of variola virus stocks,<sup>1</sup>

---

<sup>1</sup> Documents EB120/11 and EB120/39.

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>1</sup>

The Sixtieth World Health Assembly,

Recalling resolution WHA49.10, which recommended a date for the destruction of the remaining stocks of variola virus, subject to a decision by the Health Assembly, and resolution WHA52.10, which authorized temporary retention of the virus stocks to a later date, subject to annual review by the Health Assembly;

Noting that the Health Assembly decided in resolution WHA55.15 to authorize further, temporary, retention subject to all approved research being outcome-oriented, time-limited and periodically reviewed, and to a proposed new date for destruction being set when research accomplishments and outcomes allowed consensus to be reached on the timing of destruction of variola virus stocks;

Noting that authorization was granted to permit essential research for global public health purposes, including further international research into antiviral agents and improved and safer vaccines, and for high priority investigations of the genetic structure of the virus and the pathogenesis of smallpox;

Noting that resolution WHA52.10 requested the Director-General to appoint a group of experts that will establish what research, if any, must be carried out in order to reach global consensus on the timing for destruction of existing variola virus stocks;

Recalling the decisions of previous Health Assemblies that the remaining stocks of the variola virus should be destroyed;

Recognizing that the destruction of all variola virus stocks is an irrevocable event and that the decision of when to do so must be made with great care;

Recalling resolution WHA55.16, which called for a global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health;

Further recognizing that unknown stocks of live variola virus might exist, and that the deliberate or accidental release of any smallpox viruses would be a catastrophic event for the global community;

Having considered the report on smallpox eradication: destruction of variola virus stocks and the report of the eighth meeting of the WHO Advisory Committee on Variola Virus Research;<sup>2</sup>

Noting with satisfaction the considerable progress achieved in the development of antiviral agents, improved and safer vaccines, and sensitive and specific diagnostic tests, and in sequencing of entire genomes of viruses from numerous different strains;

Aware that no antiviral agents for smallpox have been licensed, that live variola virus will be needed to ensure efficacy testing in vitro, and that further refinement of the animal model might be needed to make it more suitable for efficacy testing of these agents;

Further noting that the WHO-led inspections in 2005 of the two authorized repositories reaffirmed that the safety and security of the virus stocks are satisfactory;

Noting that the WHO Advisory Committee on Variola Virus Research at its seventh meeting perceived an urgent need to review all proposals for further research using live variola virus against the considerable progress made to date;<sup>3</sup>

---

<sup>1</sup> See document EB120/11 Add.1 for the administrative and financial implications for the Secretariat of this resolution.

<sup>2</sup> Document EB120/39.

<sup>3</sup> See document A59/10.



Further noting that the Secretariat, as requested by the WHO Advisory Committee, has identified a format for research proposals and has established a protocol and time frame for their submission to the Committee for its consideration, and that approved research is reported to WHO according to an established protocol;

1. STRONGLY REAFFIRMS the decisions of previous Health Assemblies that the remaining stocks of variola virus should be destroyed;

2. FURTHER REAFFIRMS:

(1) the need to reach consensus on a proposed new date for the destruction of variola virus stocks, when research outcomes crucial to an improved public-health response to an outbreak so permit;

(2) the decision in resolution WHA55.15 (to continue the work of the Advisory Committee on Variola Virus Research with respect to the research involving variola virus stocks and to ensure that the research programme is conducted in an open and transparent manner) that the research programme shall be conducted in an open and transparent manner only with the agreement and under the control of WHO;

3. DECIDES to include a substantive item: “Smallpox eradication: destruction of variola virus stocks” on the provisional agenda of the **[Sixty-third/Sixty-fourth]** World Health Assembly;

4. REQUESTS the Director-General:

(1) to undertake a major review **[in 2009/2010]** of the results of the research undertaken, currently under way and the plans and requirements for further essential research for global public health purposes, taking into account the recommendations of the WHO Advisory Committee on Variola Virus Research, so that the **[Sixty-third/Sixty-fourth]** World Health Assembly may reach global consensus on the timing of the destruction of existing variola virus stocks;

(2) to continue the work of the WHO Advisory Committee on Variola Virus Research, and to disseminate its recommendations more widely to the scientific community;

(3) to review the membership of the WHO Advisory Committee, and the representation of advisers and observers at meetings of this Committee, in order to ensure balanced geographical representation, with the inclusion of experts from developing countries, and substantial representation of public health experts, and the independence of the members of this Committee from any conflict of interest;

(4) to ensure that approved research proposals, research outcomes and the benefits of this research are made available to all Member States;

(5) to maintain biannual inspections of the two authorized repositories in order to ensure that conditions of storage of the virus and of research conducted in the laboratories meet the highest requirements for biosafety and biosecurity;

(6) to develop continually the operational framework for WHO's smallpox vaccine reserve;

(7) to continue to report annually on progress in the research programme, biosafety, biosecurity and related issues to the Health Assembly, through the Executive Board, and on implementation of the recommendations of the WHO Advisory Committee on Variola Virus Research accepted by the Director-General;

(8) to ensure that any research undertaken does not involve genetic engineering of the variola virus;

**(9) [to ensure that the two authorized repositories, and any other institution that has fragments of variola virus DNA, only distribute such DNA in accordance with recommendations of the WHO Advisory Committee on Variola Virus Research]**

(or)

**[to ensure that the two authorized repositories do not distribute variola virus DNA for non-diagnostic purposes];**

(10) to submit an annual detailed report to the Health Assembly, through the Executive Board, of the research that has been completed, the results of such research, research being undertaken, and research being planned at the two authorized repositories;

(11) to submit a report to the Sixty-first World Health Assembly on the legal status of the variola virus strains held at the two repositories with respect to their ownership;

(12) to submit a report to the Sixty-first World Health Assembly, through the Executive Board, on measures that promote in Member States the widest and most equitable access possible to the outcomes of the research, including antiviral agents, vaccines and diagnostic tools, that arise out of the research.

The group had failed to reach consensus on the wording of paragraphs 3, 4(1) and 4(9), and considered that no further progress was possible. The draft resolution in its current form should be submitted to the Sixtieth World Health Assembly. Work would continue in a bid for consensus.

Dr SHANGULA (Namibia), speaking on behalf of the Member States of the African Region, expressed confidence that consensus could be reached on the destruction of variola virus stocks. Nevertheless, the temporary retention of the variola virus for research purposes at the Centers for Disease Control and Prevention in the United States of America and at the Russian State Research Centre of Virology and Biotechnology were a security concern. He remained opposed to genetic engineering of the variola virus because of the risk of laboratory accidents, deliberate release, bioterrorism or the potential emergence of more dangerous forms of the virus. Contrary to the Health Assembly's decision that the WHO Advisory Committee on Variola Virus Research would include a group of experts from Member States of each WHO Region, that Committee lacked broader representation, especially from developing countries, and its composition should be reviewed in accordance with paragraph 4(3) of the revised draft resolution. That had been drafted in order to keep the Committee independent of the two repositories and avoid bias.

The issue was destruction of the remaining variola virus stocks and not the expansion of research in that area. The temporary retention of those stocks had been agreed, provided that approved research remained outcome-oriented, time-limited and periodically reviewed. The Secretariat's report to the Fifty-sixth World Health Assembly<sup>1</sup> indicated that most of the essential research requiring the use of live variola virus had been concluded. It was time to reach global consensus on the timing of the destruction of existing stocks in keeping with resolutions WHA49.10 and WHA52.10; he regretted that the revised draft resolution contained no mention of that. The need to set a date for that action had been the subject of numerous Health Assembly resolutions, but each time the task had been postponed.

The draft resolution appeared to address the most salient issues. The Board had been unable to set a date for a major review of the current research results: that should be decided by the Health Assembly. He proposed the following amendment to paragraph 4(9): "... only distributed such DNA **for diagnostic purposes** and in accordance with recommendations ...".

---

<sup>1</sup> Document A56/14.

Dr VOLJČ (Slovenia), speaking in the name of the German Presidency of the European Union, and on behalf of the European Union and its 27 Member States, said that the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and the potential candidates Bosnia and Herzegovina and Montenegro, as well as the Republic of Moldova, aligned themselves with the statement. He acknowledged the efforts of the Advisory Committee in the period since the eradication of smallpox. Remarkable advances had been made in new diagnostic procedures and treatments for orthopoxvirus infections. He reaffirmed the decision to destroy all variola virus stocks at a precise date to be fixed. At present, live variola virus was required for research that could not be done with other materials. All approved research should remain outcome-oriented, time-limited and transparent. The existing stocks should be retained at their current locations for international research, and a new date proposed for their destruction when the research results allowed a consensus to be reached.

He expressed concern about incomplete reporting on health-related research on humans using DNA fragments from variola virus and urged the Secretariat to request reports from the laboratories concerned.

Dr TANGI (Tonga) noted the reference to “any other institution that has fragments of variola virus DNA” in paragraph 4(9) of the draft resolution. Which institutions were involved, and what control did WHO have over them? Could WHO enforce a decision to destroy all stocks of variola virus throughout the world? Would the Governments of the two repository countries destroy the virus if WHO so requested them? It was unclear to him who legally owned the virus stocks.

Dr KHALFAN (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the progress made in variola virus research. All essential research requiring live variola virus in the areas of genome sequencing and development of diagnostics and vaccines had been completed. Future research should not require the use of live variola virus. A definite date should be set for the destruction of all virus stocks in order to remove, finally, the threat of a catastrophic re-emergence of smallpox arising from either an accidental or malicious release.

Dr AGWUNOBI (United States of America), recalling that research on the variola virus had been authorized in order to develop better diagnostics, vaccines and treatments for smallpox, said that the Advisory Committee, in the report of its sixth meeting in November 2004,<sup>1</sup> had laid down strict rules about the areas of research in which fragments of variola virus DNA could be used by laboratories other than the two official repositories, besides specifying areas of research in which variola virus was not to be used in any circumstances. For instance, it had stated explicitly that any attempt to synthesize full-length variola virus genomes or infectious variola viruses from smaller DNA fragments was strictly forbidden. Moreover, no laboratory, with the exception of the two repository laboratories, was allowed to hold DNA comprising more than 20% of the total genome. He asked for the Secretariat’s views on that issue. DNA fragments had been legitimately distributed to laboratories all over the world, but only the two repository laboratories held the entire virus.

The compromise wording proposed by the member for Namibia for paragraph 4(9) would, however, if adopted, mean that laboratories other than the two repository laboratories would be confined to diagnostic research and unable to conduct research into treatment or vaccines against smallpox. Everyone looked forward to the day when diagnostics, vaccines and treatment were so advanced that there was no further need for the live variola virus, but that day had not yet come.

Dr NYIKAL (Kenya) reiterated his concern about the possible manipulation of variola virus DNA and placed great responsibility upon the Advisory Committee in that regard. Review of the membership of that committee, as requested in paragraph 4(3), was urgently needed. WHO recognized

---

<sup>1</sup> Document WHO/CDS/CSR/ARO/2005.4.

that unknown stocks of live variola virus might exist, but had not attempted to verify that statement. Indeed, those in favour of retaining the official stocks used the possible existence of such stocks as justification to prepare for deliberate or accidental release of a smallpox virus. WHO should investigate the issue of unofficial variola virus stocks. The future destruction of the virus stocks was being discussed and so was the distribution of the same virus – or parts of it – to various laboratories, compounding further the difficulty of keeping track of the stocks. He supported the draft resolution, with the amendment proposed by the member for Namibia. WHO should focus more on two issues: the existence of unofficial virus stocks and the distribution of stocks to laboratories.

Dr KHALFAN (Bahrain) said that the destruction of variola virus stocks did not require a resolution, as one already existed. A resolution was needed, however, to urge the two laboratories to destroy stocks as soon as possible and to abide by the decision taken in 1999.

Ms MAFUBELU (South Africa)<sup>1</sup> supported the remarks of the member for Bahrain on behalf of the Eastern Mediterranean Region, and pointed out that the full report of the eighth meeting of the Advisory Committee, which had examined the need for further sequencing of variola virus DNA, had stated that “a balance was needed between sequences that might be scientifically interesting and those that were essential for public health purposes”.<sup>2</sup> Further temporary retention of live variola virus had been granted to permit essential research for global public health purposes, and not research work that was simply “scientifically interesting”. She therefore welcomed the Committee’s vigilance.

She sought clarification of the implementation process of the Advisory Committee’s recommendations. She had noted with surprise from the report that neutralizing antibodies induced against variola virus were being studied, despite the Advisory Committee’s statement at its seventh meeting that it did not see the need for the use of live variola virus for vaccine research. Similarly, she had been surprised that the Committee had revisited the further sequencing of variola virus DNA, despite having recommended at its seventh meeting that no further full-length DNA sequences were needed. She opposed genetic engineering of the smallpox virus because of the risks: accidental or deliberate release, bioterrorism, and emergence of more dangerous forms of variola virus. She welcomed the Committee’s decision to reject the proposal of introducing individual variola virus genes into other orthopoxviruses.

Mr MACPHEE (Canada)<sup>1</sup> endorsed the comments made by the member for Slovenia and welcomed the clarifications provided by the member for the United States of America. With regard to the report of the eighth meeting of the Advisory Committee, he commented that science was ongoing. The report indicated that decisions were pending on seven research projects (paragraph 12), and that the Advisory Committee had decided to maintain the policy of excluding staff from the collaborating centres from participating in the scientific subcommittee, whose membership should be reviewed, with up to one third of its members replaced on an annual basis (paragraph 14).

Mr RASOLONJATOVO (alternate to Dr Rahantanirina, Madagascar) also requested clarification of the process being followed in the work of the WHO Advisory Committee on Variola Virus Research.

The CHAIRMAN noted that certain elements of the text still needed decisions at the highest level. It had been suggested that the resolution should be submitted to the Health Assembly as it stood, without a decision on the points that were still pending. He asked the chairman of the drafting group for his views.

---

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

<sup>2</sup> Document WHO/CDS/CSR/EPR/2007.1.

Professor PEREIRA MIGUEL (Portugal), speaking as chairman of the drafting group, suggested that in order to meet the concerns of the members for Namibia and the United States of America the words “for the purpose of research on diagnostic treatment and vaccines” should be added after “only distribute such DNA” in paragraph 4(9) of the draft resolution.

Dr AGWUNOBI (United States of America) said that if the recommendations on DNA fragments issued by the Advisory Committee were covered by the proposed text, he could accept that wording.

Dr HEYMANN (acting Assistant Director-General) indicated that action had already been taken on the recommendation in paragraph 4(2) of the draft resolution to review the membership of the WHO Advisory Committee on Variola Virus Research with a view to establishing a more balanced geographical representation and ensuring the participation of experts in virology and public health from developing countries. At the Committee’s most recent meeting, for example, the number of members from Africa had risen from four to six out of a total of 25, including three virologists and three public health experts. During that meeting, safety concerns had been raised about the maintenance of live virus at the two repositories. WHO would continue its biannual inspections of biosecurity at the two repositories, with the next inspection later in the year.

Regarding the question concerning paragraph 4(9) of the draft resolution, the Secretariat’s view was that the proposal for ensuring that variola virus DNA was distributed only for purposes of research on diagnostics, treatment and vaccines was consistent with the research report presented at the most recent meeting of the Advisory Committee. Such advisory groups were continuously reviewing available information and knowledge in order to make the best decisions for completing their research agendas. As new research developed, new understanding emerged, which might lead to an even more rapid completion of the research agenda.

In response to the CHAIRMAN, Dr AGWUNOBI (United States of America) said that he would accept the proposed amendment to paragraph 4(9) if the member for Namibia concurred.

Dr SHANGULA (Namibia) affirmed that he was in agreement with the amendment.

Dr KEAN (Executive Director, Office of the Director-General) said that paragraph 4(9) would thus read: “to ensure that the two authorized repositories, and any other institution that has fragments of variola virus DNA, only distribute such DNA for purposes of research on diagnostics, treatment and vaccines, in accordance with the recommendation of the WHO Advisory Committee on Variola Virus Research”.

Dr KHALFAN (Bahrain) proposed that the brackets around the dates in paragraphs 3 and 4(1) should be removed. Otherwise, it would appear that the actions called for were being deferred indefinitely.

Dr AGWUNOBI (United States of America) recalled that the drafting group had not been able to reach consensus on the dates. It had therefore been agreed that the brackets would remain and that the text would be sent on to the Health Assembly as it stood for further discussion.

Dr RAHANTANIRINA (Madagascar) considered that the Secretariat had not fully responded to the question posed by the representative of South Africa on the work of the Advisory Committee.

Dr HEYMANN (acting Assistant Director-General) said that his explanations with regard to the research agendas of advisory committees had been intended to respond to that question. Each year, the Advisory Committee on Variola Virus Research, like all such advisory committees, reviewed all the

available data and made new recommendations on what needed to be done in order to complete its research agenda as mandated by the Health Assembly.

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

• **Health promotion in a globalized world** (Documents EB120/12 and EB120/12 Add.1)

Dr RUIZ MATUS (alternate to Mr Bailón, Mexico) recalled the importance accorded to health promotion in the Declaration of Alma-Ata, the Ottawa Charter for Health Promotion and subsequent international conferences. It had become essential for sustainable health reforms and health systems. Since the Ottawa Conference, WHO had neither established an effective follow-up mechanism, nor provided specific support for countries, and its response capacity had been diluted. He therefore supported the draft resolution contained in document EB120/12.

Dr SMITH (Denmark), supporting the draft resolution, said that Board members evidently shared a mutual understanding of health promotion as the key to diminishing the global problems caused by noncommunicable diseases. Health promotion and the prevention and control of those diseases should receive higher priority in terms of resources.

Mr HOHMAN (alternate to Dr Agwunobi, United States of America) recalled that several resolutions on the subject of health promotion had already been adopted. Another resolution was not necessary. If, however, the Board wished to proceed with the adoption of the draft resolution, he had several amendments to propose.

In the first preambular paragraph, “five international conferences” should be amended to “six international conferences” and a reference to the 6th Global Conference on Health Promotion (Bangkok, 7–11 August 2005) should be added. The last preambular paragraph should be deleted because the wider determinants of health were already mentioned in the fifth preambular paragraph.

He could accept references to the Bangkok Charter in the preambular paragraphs, but, as it had no standing in an intergovernmental context, it should not be referred to in the operative paragraphs, particularly as a basis for action by the Director-General. Accordingly, in paragraph 2(6), the reference to the Bangkok Charter should be deleted, leaving that paragraph to read: “to facilitate exchange of information with international non-health forums on key aspects related to health promotion”.

Dr QI Qingdong (China) emphasized health promotion, its important role in reducing the disease burden and impact on economic and social development. He proposed two amendments to the draft resolution: in paragraph 1(1), the words “and develop sound policies” should be inserted after “investments”, and paragraphs 1(4) and 1(6) should be merged to read: “to monitor and evaluate systematically health promotion policies, programmes, infrastructure and investment on a regular basis through development and implementation of health impact assessment approaches”.

Dr NYIKAL (Kenya), speaking on behalf of the Member States of the African Region, said that health promotion was central to reducing the burden of disease and underpinned public health. His Government would host the 7th Global Conference on Health Promotion, in Nairobi, in 2009. Implementation of the Ottawa Charter for Health Promotion and the Bangkok Charter for Health Promotion in a Globalized World should significantly improve the health of men, women and children everywhere. He urged all stakeholders to draw inspiration from both Charters.

He proposed that paragraph 1(1) of the draft resolution should be amended to read: “to increase, as appropriate, investments in health promotion as an essential component of equitable social and economic development”. Paragraph 1(2) should read: “to establish effective mechanisms for a

---

<sup>1</sup> Resolution EB120.R8.

multisectoral approach in order to address effectively the social, economic, political and environmental determinants of health". The words "while avoiding any possible conflict of interest" should be inserted after "private sector" in paragraph 1(3) and after "and other bodies" in paragraph 2(3).

He noted that more than US\$ 1 million would be required for the 7th Global Conference on Health Promotion, and that only US\$ 100 000 of the estimated cost for the biennium 2006–2007 (US\$ 790 000) could be subsumed under existing programmed activities.<sup>1</sup> The large funding gap exposed the programme to the risk of poor performance.

The CHAIRMAN suggested that, in view of the number of proposals for amendments to the draft resolution, they should be submitted to the Secretariat in writing so that a revised version of the document could be issued to the Board at the next meeting.

**It was so agreed.**

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

- **WHO's role and responsibilities in health research** (Documents EB120/14 and EB/120/14 Add.1)

Dr SMITH (Denmark) recalled that, at the Fifty-ninth World Health Assembly, the Nordic countries had proposed the submission to the Sixty-first World Health Assembly of a strategy on the management and organization of research within WHO.<sup>2</sup> Denmark supported the development of such a strategy by the Sixty-second World Health Assembly, with an emphasis on governance and prioritization mechanisms, and drawing on WHO research strategies from 1986 and 1993. Consultations should be held with partners such as governments, donors and nongovernmental organizations.

She proposed the following amendments to the draft resolution contained in document EB120/14: the insertion in paragraph 3 of a new subparagraph before subparagraph (1), to read: "to promote and advocate research in neglected research areas of importance for better health, in particular for poor and disadvantaged groups"; a new subparagraph before subparagraph (5), to read: "to establish transparent mechanisms for the prioritization of research activities and projects within WHO, including independent peer-review mechanisms, and selection criteria such as relevance and scientific quality"; the words "to build up capacity in order" at the beginning of paragraph 3(13); and a new subparagraph before subparagraph (6), to read: "to advise Member States, when required, on how best to organize comprehensive systems for research for better health". In addition, the words "and on support provided to countries in organizing health research when required" should be deleted from the second part of paragraph 3(14).

Dr QI Qingdong (China) supported increased responsibilities for WHO in health research, a key to sound evidence in policy making and health improvement, especially with the significant gap between developed and developing countries. The Eleventh Global Forum for Health Research (Beijing, 29 October–2 November 2007) would focus on equitable access to health research, and through the broad participation of experts it would enhance the research capacities and achievements of developing countries. He proposed that an additional paragraph should be inserted in the preambular part of the draft resolution, to read: "Realizing the existing wide gap between developed and developing countries in the capacity of health research which may hamper the effort to achieve better health results".

---

<sup>1</sup> Document EB120/12 Add.1.

<sup>2</sup> Document WHA59/2006/REC/3, summary record of the fourth meeting of Committee B, section 3.

Professor PEREIRA MIGUEL (Portugal) said that WHO should play a more operational role, define health research priorities, create or promote means of funding, and be directly involved in the research process itself. He emphasized the reference in the third preambular paragraph of the draft resolution to “acknowledging the critical role of the entire spectrum of health and medical research”, since every health problem lacked information which needed specific research. Those needs could be identified within the framework of formal priorities. At least 2% of national health expenditures should be invested in research and building capacity, as set out in paragraph 1(1).

Expressing support for the draft resolution and the amendments proposed by the member for Denmark, he said that he would submit some further amendments in writing.

Although health research in Portugal accounted for some 30% of Portuguese publications in peer-reviewed journals despite receiving only about 10% of total funding, it had had only a modest impact on the health and quality of life of the population. A national health research agenda would identify the main research areas for public funding under the national health plan.

WHO should continue to support efforts to bridge the “10/90 gap” in health research by collaborating with the Global Forum for Health Research. It should also allocate more funds, set research priorities, support open access, promote health technology assessment, and evaluate the validity of health interventions, while taking account of ethical, legal and social issues.

Dr AGWUNOBI (United States of America) said that health research required transparency, independent peer review, sustainable investment and a strategic vision of how that knowledge could be translated into practical action in order to guide policy, minimize disparities and improve quality of life. Medical and public health research relied on the ideas and initiative of individuals. Increased investment by public and private research institutions was accelerating progress across the entire spectrum of biomedical and behavioural sciences. In the United States, research was built on public-private partnerships, with the private sector acting as a driving force. Partnerships with all stakeholders were vital if the scientific infrastructure and research were to be expanded.

A global agenda, however, could stifle research: the generation of ideas for research was best left to the scientific community and research institutions. Countries should work together on proactive strategies appropriate to national or regional circumstances; the Secretariat could facilitate convergence of ideas, support innovative research, incubate ideas and stimulate strategies that could benefit the community. He supported the draft resolution contained in document EB120/14 as originally drafted.

The CHAIRMAN reminded the Board that it had already examined and amended the draft resolution at a previous session and forwarded it to the Health Assembly, which had returned it to the Board for refinement.

Dr SALEHI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that huge disparities remained in health-care and delivery systems, with populations in developing countries particularly at risk. Health research should be fully integrated into public health, with investment in health-care delivery worldwide.

Research had always been integral to WHO’s collaborative programmes, in accordance with Article 2(n) of its Constitution: the Secretariat had assisted Member States with their research capacities, through advisory panels and committees, and investment, which had benefited all countries. Although responsibility for developing and using research ultimately rested with Member States, the role of WHO in promoting health research and the technical support it could offer in building national health systems according to their needs was essential. Health systems research was vital for their effective and efficient functioning. WHO’s responsibilities were to ensure that research was conducted properly and on an equitable, fair and ethical basis. WHO should also support collaboration with research institutes, provide policy advice for strengthening health research, and encourage the use of research results.



Dr DIALLO (alternate to Dr Youba, Mali), speaking on behalf of the Member States of the African Region, supported the draft resolution; he would submit his statement to the Secretariat in writing. His country would be hosting the Global Ministerial Forum on Research for Health (Bamako, 17–20 November 2008).

Dr CAMPBELL FORRESTER (alternate to Dr Allen-Young, Jamaica) agreed with the member for China regarding the research gap between developed and developing countries. She suggested inserting the phrase “so that research does not contribute to the challenge of the already grave brain drain” in the amendment he had proposed to the preambular section.

Ms HALTON (Australia), referring to the Chairman’s comment, said that the fact that the Health Assembly had returned the draft resolution to the Board without approving it legitimated further amendment. Noting the long list of actions requested of the Director-General, she recalled previous discussions concerning the level of prescription in draft resolutions and the need for budgetary discipline, since both time and financial resources were finite. She agreed with the spirit of the draft resolution, but had some amendments which she would submit to the Secretariat in writing.

Mr RAJALA (European Commission) said that the draft resolution should more clearly reflect WHO’s policy towards other stakeholders, how it determined which bodies should receive advice, how collaboration was carried out, and how WHO could demonstrate internal coordination in the area of research. The role of industry in health research might also be considered: early industry involvement in the debate would facilitate actions later on.

Mr MACPHEE (Canada)<sup>1</sup> echoed the views of the member for Australia regarding the significant shortfall between available time and funds and the number of actions requested of the Director-General. They would be entirely theoretical if funds were not available.

Professor WHITWORTH, speaking as the Chairman of ACHR, said that the Advisory Committee would continue contributing to WHO’s research strategy. Its Subcommittee on the Use of Research Evidence had published articles on the methods used by WHO and other organizations in order to formulate health recommendations. Best use of evidence in the formulation of policy, guidelines and recommendations was an essential part of WHO’s normative role. The Subcommittee had proposed the establishment within WHO of a guidelines review committee, which would definite standardized procedures relating to guideline development, and an expert advisory group would be convened under the auspices of ACHR to provide guidance to that committee.

The Advisory Committee would establish standard procedures and mechanisms for the conduct of research and the use of findings by the Organization, including registration, peer review, dissemination of findings and monitoring expenditure on health research. It supported the international clinical trials registry platform, a practical example of WHO’s stewardship and best use of evidence. The need to register clinical trials in advance attracted public attention, and some high-profile trials had underscored the need for full early disclosure of the WHO registration data set. The issue of adequate reporting of trial results had prompted the introduction of legislation in the United States of America to enforce minimum reporting standards. Ways had been explored of using trial registers in order to facilitate building capacity for research infrastructure, including support for ethical review. The WHO network of collaborating clinical trial registers, and the search portal, would be formally launched in April 2007.

---

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

Concerning the technical support requested in paragraph 3(8) of the draft resolution for reviewing complex research protocols, ACHR was considering what steps could be taken to rectify inequities in research contracts with developing countries.

**The meeting rose at 11:45.**

## **TWELFTH MEETING**

**Monday, 29 January 2007, at 09:05**

**Chairman:** Dr F. ANTEZANA ARANÍBAR (Bolivia)

### **1. FINANCIAL MATTERS:** Item 6 of the Agenda

**Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution:** Item 6.1 of the Agenda (Document EB120/19)

Ms HALTON (Australia), speaking as Chairman of the Programme, Budget and Administration Committee, said that the Committee's conclusions on the item were set out in paragraphs 32-33 of its report (document EB120/3). The status of collection of assessed contributions at 31 December 2006 had been about the same as in previous years. The Committee had noted the efforts of the Secretariat to resolve the long-term arrears, and would be making a further report to the Sixtieth World Health Assembly in May 2007 which would consider whether any Member State would be affected by Article 7 of the Constitution.

The CHAIRMAN said that the Secretariat would be approaching Member States in arrears to see whether they could accelerate payment with a view to avoiding the application of Article 7. He took it that the Board wished to note the report.

**The Board noted the report.**

**Scale of assessments 2008–2009:** Item 6.2 of the Agenda (Document EB120/20)

Ms HALTON (Australia), speaking as Chairman of the Programme, Budget and Administration Committee, said that the Committee's conclusions were set out in paragraph 34 of its report (document EB120/3). It had noted the contents of the report by the Director-General (document EB120/20) and, in particular, that the proposed scale of assessments was derived from the latest scale adopted by the United Nations in December 2006. It was therefore recommending that the Board propose to the Health Assembly adoption of the scale set out in paragraph 3 of the Director-General's report.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) asked when the General Assembly of the United Nations had last updated the scale of assessments.

Mr JEFFREYS (Comptroller) said that the United Nations scale had last been updated in December 2003 for the biennium 2004–2005.

The CHAIRMAN said that, in the absence of further comments, he would take it that the Board wished to recommend to the Health Assembly the adoption of the scale of assessments as set out in document EB120/20.

**It was so decided.<sup>1</sup>**

---

<sup>1</sup> Resolution EB120.R18.

**Amendments to the Financial Regulations and Financial Rules:** Item 6.3 of the Agenda (Documents EB120/21 and EB120/21 Corr.1)

The CHAIRMAN said that the Programme, Budget and Administration Committee had considered certain amendments to the Financial Regulations and Financial Rules. It had also discussed the proposed introduction of the International Public Sector Accounting Standards. He invited the Board to consider the draft resolution on the amendments, and on the introduction of those Standards contained in document EB120/21 Corr.1.

Ms HALTON (Australia), speaking as Chairman of the above-mentioned Committee, said that it was recommending to the Board adoption of that draft resolution. She was grateful to the Secretariat for its assistance in explaining the International Public Sector Accounting Standards and the proposed changes to the Financial Regulations and Financial Rules, which would involve making the transition from a cash-based approach to accounting to an accrual-based one.

**The resolution was adopted.<sup>1</sup>**

**2. STAFFING MATTERS:** Item 7 of the Agenda (continued)

**Human resources: annual report:** Item 7.2 of the Agenda (Documents EB120/24, EB120/24 Add.1 and EB120/24 Add.1 Corr.1)

Ms HALTON (Australia), speaking as Chairman of the Programme, Budget and Administration Committee, said that the Committee had extensively discussed the Secretariat's targets and achievements with regard to gender and geographical diversity, a matter to which it attached considerable importance (document EB120/3, paragraphs 39–40). The Committee had underscored the need to increase the number of applicants from unrepresented and underrepresented countries. Another matter of concern was the apparent high number of temporary staff in the Regional Office for Africa (paragraph 41). The Committee had been told that the position of those staff members would be regularized by creating new fixed-term posts. It had discussed the introduction of the global management system and the issue of management competence (paragraphs 43–44). The Committee recommended that the Board should take note of the report contained in documents EB120/24, EB120/24 Add.1 and EB120/24 Add.1 Corr.1.

Dr SHINOZAKI (Japan) welcomed the increased percentage of women in the professional and higher categories, and the outreach workshops for recruiting from a wider base. Although recruitment should be based on merit, the staff of the Secretariat should reflect the membership of the Organization. Equitable geographical representation and gender balance should continue to be emphasized at all levels of the Secretariat.

Dr SALEHI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that he would submit his comments to the Secretariat in writing.

**The Board took note of the report.**

---

<sup>1</sup> Resolution EB120.R9.

**Report of the International Civil Service Commission:** Item 7.3 of the Agenda (Document EB120/25)

Ms HALTON (Australia), speaking as Chairman of the Programme, Budget and Administration Committee, said that the Committee had been informed that the United Nations General Assembly had approved the recommendations of the International Civil Service Commission to adopt the revised mobility and hardship scheme and assignment grant from 1 January 2007. It had also been informed that the Commission had reported to the General Assembly that the current scale of common staff assessment should continue to apply, and had recommended that the General Assembly urge organizations to establish policies and strategies in order to improve gender balance in their recruitment. The Board was asked to note the report contained in document EB120/25.

**The Board took note of the report.****Confirmation of approval by the United Nations General Assembly of the International Civil Service Commission's general framework, including implementation and cost of amendments to the Staff Rules:** Item 7.4 of the Agenda (Documents EB120/26 and EB120/26 Add. 1)

Ms HALTON (Australia), speaking as Chairman of the Programme, Budget and Administration Committee, referred to item 3.10 of the Committee's report (document EB120/3). The Committee had been informed that the United Nations General Assembly had noted the decision of the International Civil Service Commission to adopt the general framework of contractual arrangements. The Committee was recommending that the Board approve the draft decision contained in paragraph 16 of document EB120/26, amended by the deletion of the words "of approval" after "confirmation" in the first line.

**The decision, as amended, was adopted.<sup>1</sup>****Confirmation of amendments to the Staff Rules:** Item 7.5 of the Agenda (Documents EB120/29 and EB120/29 Add.1)

Ms HALTON (Australia), speaking as Chairman of the Programme, Budget and Administration Committee, said that the Committee had been informed that the United Nations General Assembly had approved the recommendations of the International Civil Service Commission relating to the increase in the net base salary of staff members in the professional and higher categories on a "no loss no gain" basis from 1 January 2007; changes in maximum admissible expenses and maximum education grant with effect from the school year in progress on 1 January 2007; and changes to the period of eligibility for the education grant with effect from the same date.

Ms BLACKWOOD (alternate to Dr Agwunobi, United States of America) welcomed the clarification of impending changes set out in document EB120/26 and the improved human resource planning and contractual reform. She supported contract reform, but it was premature for WHO to implement that reform in advance of a decision by the United Nations General Assembly on the recommendations of the International Civil Service Commission. At its sixty-first session the United Nations General Assembly had considered and noted the new contractual framework, but had not approved it, nor had it decided to implement it. The General Assembly had merely noted the work of the Commission primarily because of concerns about the implementation costs. It would be premature to make a decision before the issuance of two forthcoming reports, on benefits for field staff and on review of the conditions of service of staff in non-family duty stations, which would bear directly on

---

<sup>1</sup> Decision EB120(1).

the General Assembly's discussion. She emphasized consistency in the common system, and the need to avoid any changes pending a final decision by the General Assembly.

She was concerned about the amendment to Staff Rule 760.2, referred to in paragraph 28 of the report contained in document EB120/29, whereby maternity leave would be extended in the case of multiple births. That would create disparities in entitlements between different organizations of the United Nations common system.

Mr HENNING (Human Resources Management) recalled that the Programme, Budget and Administration Committee had discussed the mandate and authority of the International Civil Service Commission and the issues for which it required the approval of the United Nations General Assembly. On matters relating to the salaries and entitlements of staff, the Commission had to request the General Assembly to make a decision. It could, however, make its own decisions on human resources management in a general sense, contract reform and performance management. It informed the General Assembly of the decisions and proposals it had put forward to the common system agencies and the funds and programmes of the United Nations Secretariat. In its resolution on the contract reform framework, the General Assembly had taken note of the recommendation of the Commission to all the common system agencies, funds and programmes. The Commission was empowered to reach its own decisions and make its own recommendations within that framework. Any objection raised by a Member State or the General Assembly to a decision of the Commission would be recorded in a General Assembly resolution. The Commission would then normally be requested, in such a resolution, to report to the General Assembly at its next regular session, or within a year, on the manner in which the issue had been resolved. General Assembly resolution 61/239 raised no such issue; it merely took note of the decision of the Commission. Accordingly, there was no contradiction in WHO implementing the proposal on contract reform, since no issue had been raised by the General Assembly on that matter.

The CHAIRMAN invited the Board to consider the first draft resolution on confirmation of amendments to the Staff Rules contained in paragraph 40 of document EB120/29.

**The resolution was adopted.<sup>1</sup>**

The CHAIRMAN invited the Board to consider the second draft resolution on confirmation of amendments to the Staff Rules, as amended by the Programme, Budget and Administration Committee, which read:

The Executive Board,

**Having considered the report on confirmation of amendments to the Staff Rules,<sup>2</sup>**

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>3</sup>

The Sixtieth World Health Assembly,

Noting the recommendations of the Executive Board with regard to remuneration of staff in ungraded posts and of the Director-General,

---

<sup>1</sup> Resolution EB120.R10.

<sup>2</sup> Document EB120/29.

<sup>3</sup> See document EB120/29 Add.1 for the administrative and financial implications for the Secretariat of this resolution.

1. ESTABLISHES the salaries of Assistant Directors-General and Regional Directors as from 1 January 2007 at US\$ 168 826 per annum before staff assessment, resulting in a modified net salary of US\$ 122 737 (dependency rate) or US\$ 111 142 (single rate);
2. ESTABLISHES the salary of the Deputy Director-General as from 1 January 2006 at US\$ 181 778 per annum before staff assessment, resulting in a net salary of US\$ 131 156 (dependency rate) or US\$ 118 034 (single rate); and, as from 1 January 2007, at US\$ 185 874 per annum before staff assessment, resulting in a net salary of US\$ 133 818 (dependency rate) or US\$ 120 429 (single rate);
3. ESTABLISHES the salary of the Director-General as from 1 January 2007 at US\$ 228 818 per annum before staff assessment, resulting in a modified net salary of US\$ 161 732 (dependency rate) or US\$ 143 829 (single rate).

**The resolution was adopted.<sup>1</sup>**

**Statement by the representative of the WHO staff associations:** Item 7.6 of the Agenda (Document EB120/INF.DOC./2)

Mr MATSIONA (representative of the WHO staff associations) congratulated Dr Margaret Chan on her election as Director-General. The staff pledged its support and commitment to working together.

Important steps had been taken to ensure institutional integrity, but a comprehensive legal framework was needed in order to define the domains, roles and interaction between the various participants. In general, the staff associations supported the process but consultations would be needed on channels for presenting confidential complaints, and protecting staff against retaliation. The integrity system must also have a training programme, a code of ethics, a communication plan for all staff, and equal access to new mechanisms, services and legal resources. The streamlined framework would help to end the use of “second class” contracts and ensure that staff received equal pay for equal work. All fixed-term posts, namely all functions expected to continue for at least 12 months, would be included in the Organization’s human resource plan.

Regarding rotation and mobility, staff welcomed career development through rotation, but such moves should add value for the Organization, not just for staff. Staff needed more information about the advantages and the drawbacks of the new policy, with advocacy for rotation and mobility as career development rather than a punishment. The planned mobility pilot scheme should provide valuable experience. Work remained to be done on improving the new global framework for career development, both within WHO and within the United Nations common system, in order to increase interagency mobility.

Staff associations in the regions should be able formally to address their respective regional governing bodies, such as the regional committees. The decisions reached during the eighth Global Staff/Management Council must be put into practice.

**The Board noted the statement by the representative of the WHO staff associations.**

---

<sup>1</sup> Resolution EB120.R11.

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

**Progress in the rational use of medicines, including better medicines for children:** Item 4.9 of the Agenda (Documents EB120/7, EB120/7 Add.1, EB120/37 and EB120/37 Add.1) (continued from the tenth meeting)

Dr CAMPBELL FORRESTER (alternate to Dr Allen-Young, Jamaica) introduced amended versions of the draft resolutions on rational use of medicines and better medicines for children, which read:

#### **Rational use of medicines**

The Executive Board,

Having considered the report on progress in the rational use of medicines, including better medicines for children,<sup>1</sup>

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>2</sup>

The Sixtieth World Health Assembly,

Having considered the report on rational use of medicines: progress in implementing the WHO medicines strategy;

Recalling the report by the Secretariat on rational use of medicines by prescribers and patients, discussed at the Fifty-eighth World Health Assembly;

Recalling resolutions WHA39.27, WHA41.16 and WHA47.13 on the rational use of drugs, WHA41.17, WHA45.30 and WHA47.16 on ethical criteria for medicinal drug promotion, WHA43.20 and WHA45.27 on the WHO Action Programme on Essential Drugs, WHA47.12 on the role of the pharmacist, WHA49.14 and WHA52.19 on the revised drug strategy, WHA51.9 on cross-border advertising, promotion and sale of medical products using the Internet, WHA54.11 on the WHO medicines strategy, and WHA58.27 on antimicrobial resistance;

Recognizing the efforts of WHO in collaboration with governments, universities, the private sector, and nongovernmental organizations, in areas related to health care delivery systems and health insurance programmes to improve the use of medicines by prescribers, dispensers and patients;

Aware of the core components of WHO's strategy for promoting the rational use of medicines;<sup>3</sup>

Wishing to promote evidence-based rational use of medicines by providers and consumers and better access to essential medicines;

Aware that irrational use of medicines continues to be an urgent and widespread problem in the public and private health sector in developed and developing countries with serious consequences in terms of poor patient outcome, adverse drug reactions, increasing antimicrobial resistance and wasted resources;

Acknowledging that successful implementation of previous resolutions on antimicrobial resistance cannot be achieved without addressing the global problem of irrational use of medicines;

---

<sup>1</sup> Document EB120/7.

<sup>2</sup> See document EB120/7 Add.1 for the administrative and financial implications for the Secretariat of this resolution.

<sup>3</sup> Document WHO/EDM/2004.5.



Recognizing that many countries do not have a stringent drug regulatory authority nor a full national programme/body to promote rational use of medicines;

Emphasizing that global initiatives to increase access to essential medicines should adhere to the principle of rational use of medicines, and especially patient adherence;

Concerned that insufficient attention and resources are being directed towards tackling the problem of irrational use of medicines by prescribers, dispensers and consumers;

Emphasizing the need for a comprehensive, sustainable, national and sector-wide approach to promote the rational use of medicines;

Recognizing that financing of medicines and methods of arrangements for provider payments can have a major impact on rational use, and that appropriate policies on financing health care are required;

Recognizing there may be incentives for the irrational use of medicines throughout the health system, for example in some circumstances which give rise to conflict of interest;

Concerned that direct-to-consumer or internet sales may give rise to irrational use of medicines;

Convinced that it is time for governments, the health professions, civil society, the private sector and the international community to pledge their commitment, including adequate resources, to promoting the rational use of medicines,

1. URGES Member States:<sup>1</sup>

- (1) to invest sufficiently in human resources and provide adequate financing in order to strengthen institutional capacity to ensure more appropriate use of medicines in both the public and the private sector;
- (2) to consider establishing and/or strengthening, as appropriate, a national drug regulatory authority and a full national programme and/or multidisciplinary body, involving civil society and professional bodies, to monitor and promote the rational use of medicine;
- (3) to consider developing, strengthening and implementing, where appropriate, the application of an essential drug list into the benefit package of the existing or new insurance funds;
- (4) to develop and strengthen existing training programmes on rational use of medicines and ensure that they are taken into account in the curricula for all health professionals and medical students, including their continuing education, where appropriate, and to promote programmes of public education in rational use of medicines;
- (5) to enact new, or enforce existing, legislation to ban inaccurate, misleading or unethical promotion of medicines, to monitor drug promotion, and to develop and implement programmes that will provide independent, nonpromotional information about medicines;
- (6) to develop and implement national policies and programmes to improve medicine use, including clinical guidelines and essential medicines lists, as appropriate, with an emphasis on multifaceted interventions targeting both the public and private health systems, and involving providers and consumers;
- (7) to consider developing, and strengthening where appropriate, the capacity of hospital drug and therapeutic committees to promote the rational use of medicines;
- (8) to expand to national level, sustainable interventions successfully implemented at local level;

---

<sup>1</sup> And regional economic integration organizations, where appropriate.

2. REQUESTS the Director-General:
- (1) to strengthen the leadership and evidence-based advocacy role of WHO in promoting rational use of medicines;
  - (2) in collaboration with governments and civil society, to strengthen WHO's technical support to Member States in their efforts to establish or strengthen, where appropriate, multidisciplinary national bodies for monitoring medicine use, and implementing national programmes for the rational use of medicines;
  - (3) to strengthen the coordination of international financial and technical support, in terms of rational use of medicines;
  - (4) to promote research, particularly on development of sustainable interventions for rational medicine use at all levels of the health sector, both public and private;
  - (5) to promote discussion among health authorities, professionals and patients on the rational use of medicines;
  - (6) to report to the Sixty-second World Health Assembly, and subsequently biennially, on progress achieved, problems encountered and further actions proposed in the implementation of WHO's programmes to promote rational use of medicines.

and

### **Better medicines for children**

The Executive Board,  
Having considered the report on progress in the rational use of medicines, including better medicines for children,<sup>1</sup>

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>2</sup>

The Sixtieth World Health Assembly,

Having considered the report on progress in the rational use of medicines, including better medicines for children;

Recalling resolutions WHA39.27, WHA41.16 and WHA47.13 on the rational use of drugs, WHA41.17 on ethical criteria for medicinal drug promotion, WHA43.20 and WHA45.27 on the WHO Action Programme on Essential Drugs, WHA47.12 on the role of the pharmacist in support of the WHO revised drug strategy, WHA49.14 and WHA52.19 on the revised drug strategy, WHA54.11 on the WHO medicines strategy, and WHA58.27 on improving the containment of antimicrobial resistance;

Recognizing the efforts of WHO in collaboration with governments, other organizations in the United Nations system, universities, the private sector, nongovernmental organizations and funding agencies in areas related to improving access to better medicines for children;

Aware of the core components of WHO's global framework for expanding access to essential medicines;

---

<sup>1</sup> Document EB120/37.

<sup>2</sup> See document EB120/37 Add.1 for the administrative and financial implications for the Secretariat of this resolution.

Wishing to promote evidence-based selection and use of medicines for children by health providers and carers;

Aware that there are regional initiatives to address inadequate access to essential medicines for children;

Wishing to ensure better access to essential medicines for children as a prerequisite for achieving health outcomes as set out in the internationally agreed health-related development goals, including those contained in the Millennium Declaration;

Aware that the lack of access to essential medicines of assured quality continues to pose significant risks of high morbidity and mortality in children, especially those under five years of age;

Concerned that children can be further disadvantaged by lack of physical and economic access to essential medicines, especially in vulnerable communities;

Recognizing that many countries do not have the requisite capacity to regulate and control medicines for children;

Aware that many manufacturers of essential medicines have neither developed nor produced appropriate dosage forms and strengths of medicines for children;

Concerned that there is insufficient investment in the clinical trials, development and manufacture of medicines for children;

1. URGES Member States:

- (1) to take steps to identify appropriate dosage forms and strengths of medicines for children, and to encourage their manufacture and licensing;
- (2) to investigate whether currently available medicines could be formulated to make them suitable for use in children;
- (3) to encourage research and development of appropriate medicines for diseases that affect children, and to ensure that high-quality clinical trials for these medicines are conducted in an ethical manner;
- (4) to enable timely licensing of appropriate, high-quality and affordable medicines for children with innovative methods for monitoring the safety of such medicines, and to encourage the marketing of adequate paediatric formulations together with newly developed medicines;
- (5) to promote access to essential medicines for children through inclusion, as appropriate, of those medicines in national medicine lists, procurement and reimbursement schemes, and to devise measures to monitor prices;
- (6) to collaborate in order to facilitate the innovative research and development, formulation, regulatory approval, provision of adequate prompt information on, and rational use of, paediatric medicines and medicines authorized for adults but not approved for use in children;
- (7) to use mechanisms including, where appropriate, existing international trade agreements that might impact health, to ensure children's access to essential medicines, where applicable;

2. REQUESTS the Director-General:

- (1) to promote the development, harmonization and use of standards for clinical trials of medicines for children, to revise and regularly update the Model List of Essential Medicines in order to include missing essential medicines for children, using evidence-based clinical guidelines, and to promote application of such guidelines by Member States and international financing bodies, with initial focus on treatments for HIV/AIDS, tuberculosis, malaria and chronic diseases;
- (2) to ensure that all relevant WHO programmes, including but not limited to that on essential medicines, contribute to making safe and effective medicines as widely available for children as for adults;

- (3) to promote the development of international norms and standards for quality and safety of formulations for children, and the regulatory capacity to apply them;
- (4) to make available evidence-based treatment guidelines and independent information on dosage and safety aspects of essential medicines for children, and progressively to cover all medicines for children, and to work with Member States in order to implement such guidelines;
- (5) to collaborate with governments, other organizations of the United Nations system, donor agencies and nongovernmental organizations in order to encourage fair trade in safe and effective medicines for children and adequate financing for securing better access to medicines for children;
- (6) to report to the Sixty-second World Health Assembly, and subsequently as appropriate, through the Executive Board, on progress achieved, problems encountered and specific actions needed to further promote better access to medicines for children.

Dr KHALFAN (Bahrain) suggested that the matter should be considered by the Health Assembly as two items.

The CHAIRMAN agreed. In the absence of further comment, he took it that the Board wished to adopt the draft resolutions.

**The resolutions were adopted.<sup>1</sup>**

**Draft resolutions deferred from the Fifty-ninth World Health Assembly and the 118th session of the Executive Board:** Item 4.12 of the Agenda (continued)

- **Health promotion in a globalized world** (Documents EB120/12 and EB120/12 Add.1) (continued from the eleventh meeting)

The CHAIRMAN invited the Board to consider the amended draft resolution on health promotion in a globalized world, which read:

The Executive Board,  
Having considered the report on health promotion in a globalized world,<sup>2</sup>

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>3</sup>

The Sixtieth World Health Assembly,  
Recalling resolutions WHA42.44 on health promotion, public information and education for health, WHA51.12 on health promotion, WHA57.16 on health promotion and healthy lifestyles, and the outcomes of the ~~five~~ **six** [USA] international conferences on health promotion (Ottawa, 1986; Adelaide, Australia, 1988; Sundsvall, Sweden, 1991; Jakarta, 1997; Mexico City, 2000; **Bangkok, 2005**); [USA]

<sup>1</sup> Resolutions EB120.R12 and EB120.R13, respectively.

<sup>2</sup> Document EB120/12.

<sup>3</sup> See document EB120/12 Add.1 for the administrative and financial implications for the Secretariat of this resolution.

Having considered the report on follow-up to the 6th Global Conference on Health Promotion, held in Bangkok in 2005, which confirms the need to focus on health promotion actions to address the determinants of health;

Drawing on the Declaration of Alma-Ata, the Ottawa Charter for Health Promotion, and the Bangkok Charter for Health Promotion in a Globalized World which sets out strategic directions for equitable health improvement in the first decades of the twenty-first century;

Considering the actions and recommendations set out in the Bangkok Charter for Health Promotion in a Globalized World to make the promotion of health central to the global development agenda, a core responsibility for all governments, **and [Australia]** a key focus of communities, ~~and [Australia]~~ civil society, and **the private sector** a requirement for good corporate practice; **[Australia]**

Noting that health promotion is essential for meeting the targets of the Millennium Development Goals, is intimately related to the work of WHO's Commission on Social Determinants of Health, and makes an important contribution to realizing the objectives of the Eleventh General Programme of Work;

Recognizing that the dramatic changes of the global burden of disease require greater attention, and call for adjustments in society at large and in resource allocation in order to tackle the immediate and underlying determinants of health;

~~Confirming the importance of addressing also the wider determinants of health, and of implementing recommendations on, and undertaking action for, health for all, as set out in the Bangkok Charter for Health Promotion in a Globalized World;~~ **[USA]**

**[OR]**

Confirming the importance of addressing also the wider determinants of health, and of implementing recommendations on, and undertaking action for, health for all, ~~as set out in the Bangkok Charter for Health Promotion in a Globalized World;~~

1. URGES all Member States:

[(1) to ~~consider the need to increase~~ **increase, as appropriate**, investments in health promotion as an essential component of equitable social and economic development; **[Kenya]**

**[OR]**

[(1) to consider the need to increase investments **and frame sound policies** in health promotion as an essential component of equitable social and economic development; **[China]**

[(2) to establish, **as appropriate**, mechanisms for involving government as a whole in order to address effectively the social, economical and environmental determinants of health throughout the life course; **[Australia]**

**[OR]**

[(2) to establish **effective** mechanisms for **a multisectoral approach** ~~involving government as a whole~~ in order to address effectively the social, economical, **political** and environmental determinants of health ~~throughout the life course~~; **[Kenya]**

(3) to support and foster the active engagement **in health promotion** of communities, civil society, the private sector, **while avoiding any possible conflict of interest**, **[Kenya]** and nongovernmental organizations, including associations of public health, ~~in health promotion~~;

(4) to monitor and evaluate systematically health promotion policies, programmes, infrastructure and investments, on a regular basis, **including consideration [Australia] of the use of health-impact assessments**; **[China]**

(5) to close the gap between current practices and those functions based on the evidence of effective health promotion by the full use of evidence-based health promotion;

~~(6) to develop and implement systematically health impact assessments of policies, programmes and projects, in order to contribute to better decision-making across all sectors of society; [China]~~

2. REQUESTS the Director-General:

- (1) to strengthen the capacity for health promotion across the Organization in order to provide better support to Member States by advancing knowledge and the active engagement of other appropriate United Nations and international organizations;
- (2) to provide support to Member States in their continuous efforts to strengthen national health systems with a special focus on the primary health sector, with the purpose to enhance the ability to tackle the serious threats to health, **including those [Australia]** caused by noncommunicable diseases;
- (3) to optimize use of existing forums of Member States for multisectoral stakeholders, interested organizations and other bodies, **while avoiding any possible conflict of interest, [Kenya]** in order to support the development and implementation of health promotion, ~~and to report on the need for new forums or bodies to encourage health promotion; [Australia]~~
- (4) to encourage the convening of national, subregional, **regional [Australia]** and global conferences on health promotion ~~on a regular basis; [Australia]~~
- (5) to monitor and evaluate progress and identify major shortcomings in health promotion globally and report through a regular system;
- (6) to facilitate exchange of information with international nonhealth forums on key aspects ~~related to~~ **health promotion** ~~the Bangkok Charter and develop mechanisms of feedback to the Health Assembly; [USA]~~
- (7) to report to the Sixty-first World Health Assembly, through the Executive Board, on progress in implementing this resolution.

Mr ABDOO (alternate to Dr Agwunobi, United States of America) proposed replacing the words “private sector” with “public and private sectors” in paragraph 1(3) and moving the phrase “while avoiding any possible conflict of interest” to the end of the paragraph.

Dr SMITH (Denmark), referring to the second alternative for paragraph 1(1), said that the word “in”, before “health”, should be replaced by “for”. In the second alternative for paragraph 1(2), the phrase “throughout the life course” should be retained, as that was an important concept. In paragraph 2(4), she would prefer to retain the final words “on a regular basis”.

Dr NYIKAL (Kenya) said that if “life course” meant the same thing as “life cycle”, he could agree to retaining the phrase in the draft resolution.

Ms HALTON (Australia) explained, in response to the member for Denmark, that deleting the words “on a regular basis” had been proposed because paragraph 2 was a request to the Director-General, and “regular” implied a lack of flexibility for her. The draft made the importance of health promotion very clear.

Dr SMITH (Denmark) said that health promotion had to be given prominence and that holding global conferences was one way of doing so.

The DIRECTOR-GENERAL said that, whether or not the phrase “on a regular basis” was retained, she would be guided by Member States in addressing important issues, and in any case enjoyed flexibility in deciding “how regular”. The Board’s discussion had made it clear how important health promotion was.

Dr GWENIGALE (Liberia) favoured retaining the phrase “on a regular basis”.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) urged the Board to send a clear signal to the Health Assembly on the need for health promotion, about which everyone agreed, by removing all square brackets and selecting one of the alternatives put forward for certain paragraphs. He proposed that the second alternative for the seventh preambular paragraph should be adopted. The two alternatives for paragraph 1(1) could be combined into one paragraph, to read: “to increase, as appropriate, investment and frame sound policies for health promotion as an essential component of social and economic development”. He appealed to the members for Australia and Kenya to reach a consensus on paragraph 1(2).

Dr QI Qingdong (China) endorsed the combined text for paragraph 1(1).

Ms HALTON (Australia) said that the second alternative for paragraph 1(2) would be acceptable as long as the words “as appropriate” were inserted after “establish”, since some countries already had a multisectoral approach.

The CHAIRMAN said that, in the absence of further comment, he took it that the Board was ready to adopt the resolution.

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

- **WHO’s role and responsibilities in health research** (Documents EB120/14 and EB120/14 Add.1) (continued from the eleventh meeting)

The CHAIRMAN drew attention to a new, amended version of the draft resolution, which read:

The Executive Board,  
Having considered the report on WHO’s role and responsibilities in health research,<sup>2</sup>

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>3</sup>

The Sixtieth World Health Assembly,  
Recalling resolution WHA58.34 on the Ministerial Summit on Health Research;  
Having considered the report on WHO’s role and responsibilities in health research;

Acknowledging the critical role of the entire spectrum of health and medical research in improving human health;

Recognizing that research into poverty and inequity in health is limited, and that the ensuing evidence is important to guide policy in order to minimize gaps;

Reaffirming that research to strengthen health systems is fundamental for achieving internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration;

**Recognizing that a wide gap exists between developed and developing countries in the capacity for health research, that it may hamper efforts to achieve**

---

<sup>1</sup> Resolution EB120.R14.

<sup>2</sup> Document EB120/14.

<sup>3</sup> See document EB120/14 Add.1 for the administrative and financial implications for the Secretariat of this resolution.

**better health results, [China] and that it may contribute to worsening the brain drain; [Jamaica]**

Noting in particular the work of IARC, the WHO Centre for Health Development, the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, and the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction;

Convinced that research findings and data derived from effective health-information systems should be used to inform decisions about the delivery of interventions to those who need them most;

Mindful that the Organization should lead by example in the use of research findings to inform decisions about health;

Reaffirming the role of WHO's cosponsored research programmes in support of neglected areas of research relevant to poor and disadvantaged populations, **particularly poverty-related diseases, tuberculosis, malaria and AIDS**, [Portugal] and recognizing the contributions of WHO to strengthening research capacity;

Committed to ensuring ethical standards in the conduct of health research supported by the Organization,

1. URGES Member States: ~~to mobilize the necessary scientific, social, political and economic resources in order;~~ [Australia]

(1) to consider implementing the recommendation made by the Commission on Health Research for Development in 1990 that "developing countries should invest at least 2% of national health expenditures in research and research capacity strengthening, and at least 5% of project and programme aid for the health sector from development aid agencies should be earmarked for research and research capacity strengthening";<sup>1</sup>

(2) to **consider the development** and strengthening of [Australia] resource-tracking tools in order to monitor the expenditure on health research from government and donor sources, and to disseminate **relevant** [Australia] research findings to policy-makers, civil-society entities and the general public;

(3) to integrate research in the mainstream of national programme activities and plans, and to promote wider access to research findings;

(4) to strengthen the capacity of national and institutional ethics committees that review health-research proposals, **as appropriate**; [Australia]

(5) to draw up or strengthen health-research policies and health-research legislative documents, **as appropriate**; [Australia]

(6) to create a sustained training programme for research managers and to facilitate a cadre of trained professionals to manage health research, **where necessary**; [Australia]

(7) to improve the career management of researchers who do not necessarily come under the authority of the ministry responsible for research, **as appropriate**; [Australia]

(8) to **consider** strengthening [Australia] national research capacities in the following complementary areas: generation of new knowledge, human and financial resources, research institutes, and use of research findings in policy decisions, and to foster national and international networks for research collaboration;

<sup>1</sup> In *Commission on Health Research for Development. Health research: essential link to equity in development*. New York, Oxford University Press, 1990.



(9) to develop and strengthen a participatory mechanism, **as appropriate**, [Australia] for all stakeholders in order to prioritize the health-research agenda based on the basis of dynamic changes in health systems, disease burden, and emerging health-related issues.

2. CALLS UPON the health-research community, other international organizations, the private sector, civil society and other concerned stakeholders to provide strong, sustained support to research activities across the entire spectrum of health, medical and behavioural research, especially research into communicable diseases and poverty and inequity in health, with the participation of communities and in keeping with the national priorities, and to maintain support of activities that promote the use of research findings to inform policy, practice and public opinion;

3. REQUESTS the Director-General:

**(1) to promote and advocate research in neglected areas of importance for better health, in particular for poor and disadvantaged groups;** [Denmark]

~~(1)~~(2) to strengthen the culture of research for evidence-based decision making in the Organization and to ensure that research informs its technical activities;

~~(2)~~(3) to develop a reporting system on WHO's activities in health research;

~~(3)~~(4) to improve coordination of **relevant** [Australia] research activities, including integration of research into disease control and prevention;

~~(4)~~(5) to review the use of research evidence for major policy decisions and recommendations within WHO;

**(6) to establish transparent mechanisms for prioritization of research activities and projects within WHO, including independent peer-review mechanisms, and selection criteria such as relevance and scientific quality;** [Denmark]

~~(5)~~(7) to establish standard procedures and mechanisms for the conduct of research and use of findings by the Organization, including registration of research proposals in a publicly accessible database, peer review of proposals, and dissemination of findings;

**(8) to advise Member States, when required, on the best ways to organize comprehensive systems for research for better health;** [Denmark]

~~(6)~~(9) to promote better access to **relevant** research findings; [Australia]]

**[OR]**

~~(6)~~(9) to promote better access to research findings, **including by supporting the movement towards open access to scientific journals;** [Portugal]]

~~(7)~~(10) to provide support to Member States to develop capacities for health-systems and health-policy research, **where necessary;** [Australia]

~~(8)~~(11) to provide technical support to Member States for strengthening the capacity of national and institutional health-research ethics committees; reviewing complex research protocols; and drafting national health policies and health-research legislative documents;

~~(9)~~(12) ~~to continue to decentralize competencies and resources to countries and regions in order~~ [Australia] **to identify and implement mechanisms** to provide better support **to countries and regions** [Australia] in recognizing and maximizing health research as a key factor in the development of health systems, in particular in developing countries;

~~(10)~~(13) to formulate simple priority-setting strategies for health research for use by national governments, **where appropriate;** [Australia]

~~(11)~~(14) to institute appropriate systems and mechanisms for greater interaction and convergence among researchers and users of **relevant** [Australia] research in order to improve use of research findings and to enhance framing of health policy;  
~~(12)~~(15) to provide capacity-building opportunities in health economics, economic impact of disease, ~~and~~ costing of various interventions, **and assessment of health technology** in order to help identify the most suitable **interventions** ~~ones~~ for a country to optimize its health-system delivery; [Portugal]  
~~(13)~~(16) **to build up capacity in order** [Denmark] to monitor and report to Member States the total expenditure on health research by country and region, by public and donor sources, and by type of expenditure;  
~~(14)~~(17) to submit to the Sixty-second World Health Assembly a strategy for the management and organization of research activities within WHO; ~~and on support provided to countries in organizing health research when required.~~ [Australia, Denmark]

The CHAIRMAN suggested merging the two options proposed in respect of paragraph 3(9) by inserting the word “relevant” before “research findings” in the second of the two proposed options.

Mr ABDOO (alternate to Dr Agwunobi, United States of America) proposed in paragraph 3(1) deleting the words “in neglected areas of importance”. In paragraph 3(8) he proposed replacing the word “required” with “requested” and deleting the words “best” and “comprehensive”. Paragraph 3(15) should be amended to read: “to provide capacity-building opportunities in health economics, health technology assessment, economic impact of disease, costing of various interventions, in order for a country to optimize its health-system delivery”.

Professor PEREIRA MIGUEL (Portugal) proposed adding the word “significantly” before “improve” in paragraph 3(4) and adding, at the end of the same paragraph, the words “and to designate one focal point within the organization who has the overview of all WHO’s research activities”. The new wording proposed for paragraph 3(15) was fully acceptable to Portugal.

Dr SHANGULA (Namibia) said that the words “in neglected areas of importance” in paragraph 3(1) must be retained. The lack of research in such areas was a problem recognized by WHO that affected the developing world.

Dr SMITH (Denmark) endorsed the comments of the previous speaker; research was needed in neglected areas such as tropical diseases. She also supported the amendment proposed by the member for Portugal.

Dr NYIKAL (Kenya) and Dr VOLJČ (Slovenia) echoed the views expressed by the previous speaker. The words “in neglected areas of importance” were the very essence of paragraph 3(1).

Mr ABDOO (alternate to Dr Agwunobi, United States of America), referring to paragraph 3(1), proposed that, in a spirit of consensus, the words “in neglected areas of importance” should be replaced by “for diseases that disproportionately affect developing countries”.

The CHAIRMAN, speaking as the member for Bolivia, said that the alternative wording proposed by the United States did not convey the same meaning.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) proposed that the words “in neglected areas of importance” should be retained, and the words “especially for diseases that disproportionately affect developing countries” should be added after “importance”.

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

**Malaria, including proposal for establishment of World Malaria Day:** Item 4.2 of the Agenda (Documents EB120/5 and EB120/5 Add. 1) (continued from the tenth meeting)

The CHAIRMAN drew attention to a new, further amended version of the draft resolution, which read:

The Executive Board,

Having considered the report on malaria, including a proposal for establishment of World Malaria Day;<sup>2</sup>

Concerned that few malaria-endemic countries have made substantial progress towards achieving the internationally agreed development goals, including those contained in the Millennium Declaration relating to malaria, and that a number of countries have not yet met the commitments to increase their national budgets that they made when adopting the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases;

Noting that valuable opportunities are being created in the form of new tools and better defined strategies, and that the momentum for expanding malaria-control interventions, and increasing financial resources at country and global levels, is growing,

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>3</sup>

The Sixtieth World Health Assembly,

Having considered the report on malaria, including a proposal for the establishment of World Malaria Day;

Concerned that malaria continues to cause more than one million preventable deaths a year;

Noting that the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Bank Global Strategy and Booster Program; the Bill & Melinda Gates Foundation; the Malaria Initiative of the President of the United States of America; and other donors have made substantial resources available;

Welcoming the contribution to the mobilization of resources for development of voluntary innovative financing initiatives taken by groups of Members States and, in this regard, noting the activities of the International Drug Purchasing Facility (UNITAID);<sup>4</sup>

Recalling that combating HIV/AIDS, malaria and other diseases is included in internationally agreed health-related development goals including those contained in the Millennium Declaration;

Mindful that the global burden of malaria needs to be decreased in order to reach the Millennium Development Goal of reducing the mortality rate among children under five by two thirds by 2015 and to help to achieve the Millennium Development Goals of improving maternal health and eradicating extreme poverty,

---

<sup>1</sup> Resolution EB120.R15.

<sup>2</sup> Document EB120/5.

<sup>3</sup> See document EB120/5 Add.1 for the administrative and financial implications for the Secretariat of the resolution.

<sup>4</sup> This paragraph quotes operative paragraph 5 of United Nations General Assembly draft resolution A/61/L.50: 2001–2010: Decade to Roll Back Malaria in Developing Countries, Particularly in Africa.

## 1. URGES Member States:

(1) to apply to their specific contexts the policies, strategies and tools recommended by WHO, and to establish evidence-based national policies, operational plans and performance-based monitoring and evaluation in order to expand coverage with major preventive and curative interventions in populations at risk, and assess programme performance and the coverage and impact of interventions in an effective and timely manner, particularly with use of the WHO country-profile database;

(2) to assign national and international resources, both human and financial, for the provision of technical support in order to ensure that the most locally and epidemiologically appropriate strategies are effectively implemented and target populations are reached;

(3) progressively to cease the provision in both the public and private sectors of oral artemisinin monotherapies, i.e. artemisinins used alone without the accompaniment of a partner medicine, and to promote the use of artemisinin-combination therapies, to implement policies that prohibit the production of counterfeit antimalarial medicines, and to assure that financing bodies cease to provide for those monotherapies;

(4) to intensify access to affordable, safe and effective antimalarial combination treatments, intermittent preventive treatment in pregnancies,<sup>1</sup> insecticide-treated mosquito nets, including through the free distribution of such nets where appropriate, and insecticides for indoor residual spraying for malaria control, taking into account relevant international rules, standards and guidelines;<sup>2</sup>

**(5) to provide in their legislation for use to the full of the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to increase access to antimalarial medicines, diagnostics and preventive technologies;**

OR

**(5) to encourage trade agreements to take into account the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights and recognized by the Doha Declaration on the TRIPS Agreement and Public Health in order to increase access to antimalarial medicines, diagnostics and preventive technologies;**

OR

**(5) to consider, whenever necessary, adapting national legislation in order to use to the full the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to increase access to antimalarial medicines, diagnostics and preventive technologies;**

(6) to aim at reducing transmission risk-factors through integrated vector management, promoting improvement of local and environmental conditions and healthy settings, and increasing access to health services in order to reduce disease burden;

(7) to implement integrated approaches to malaria prevention and control through multisectoral collaboration and community responsibility and participation;

<sup>1</sup> With special precautions in HIV-infected pregnant women who are receiving co-trimoxazole chemotherapy (WHO guidelines for the treatment of malaria. Geneva, World Health Organization, 2006, p. 39). (Footnote not contained in draft resolution A/61/L.50.)

<sup>2</sup> This paragraph quotes from operative paragraph 9 of United Nations General Assembly draft resolution A/61/L.50: 2001–2010: Decade to Roll Back Malaria in Developing Countries, Particularly in Africa.

2. REQUESTS international organizations:
  - (1) to provide support for the development of capacities in developing countries to expand use of artemisinin-based combination therapies that are appropriate for local drug-resistance conditions, integrated vector management that includes use of long-lasting insecticide-treated nets, and indoor residual spraying with appropriate and safe insecticides as indicated by WHO and in accordance with the Stockholm Convention on Persistent Organic Pollutants, and using monitoring and evaluation systems, including the country database, as developed by WHO;
  - (2) to increase funding to the various financing mechanisms for malaria control, so that they can continue providing support to countries, and to channel additional resources for technical support in order to ensure that they can be absorbed and used effectively in countries;
3. REQUESTS the Director-General:
  - (1) to take steps to identify knowledge gaps for malaria control; to provide support for the development of new tools and strategies; to estimate more accurately the global burden of disease and determine trends; to develop new tools and methods for assessing impact and cost-effectiveness of interventions; to build up WHO's current research on malaria, including that of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases; and to provide technical support to countries for conducting operational and implementation research into ways to ensure adequate coverage with antimalarial interventions;
  - (2) to strengthen and rationalize human resources for malaria by decentralizing staff to country level, thus improving the capacity of WHO's country offices to provide support to national health programmes for coordinating partners to prevent and control malaria; and to provide technical guidance for the management of malaria control in refugee camps and in complex emergencies;
  - (3) to bring together WHO's Global Malaria Programme, the Roll Back Malaria Partnership, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the International Drug Purchase Facility (UNITAID), academics, small and large pharmaceutical and biotechnology companies, interested Member States, medical-research councils, and foundations in a forum in order to improve coordination between different stakeholders in the fight against malaria;
  - (4) to report to the Health Assembly through the Executive Board on progress made in implementation of this resolution;
4. RESOLVES that:
  - (1) Malaria Day shall be commemorated annually on 25 April or on such other day or days as individual Member States may decide, in order to provide education and understanding of malaria as a global scourge that is preventable and a disease that is curable;
  - (2) Malaria Day shall be the culmination of year-long intensified implementation of national malaria-control strategies, including community-based activities for malaria prevention and treatment in endemic areas, and the occasion to inform the general public on the obstacles encountered and progress achieved in controlling malaria.

In paragraph 3(b) of the report on the financial and administrative implications of the amended draft resolution, the words "standing forum" should read "forum".

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) requested an explanation of the reasons for the inclusion in parentheses of the words “Footnote not contained in draft resolution A/61/L.50” in the second footnote to the draft resolution.

Dr KEAN (Executive Director, Office of the Director-General) explained that the footnote had been included in the interests of clarity because the text of paragraph 1(4) corresponded to text contained in General Assembly draft resolution A/61/L.50, in which the footnote did not appear.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) said that, that being the case, he would prefer the content of the footnote to be incorporated into the text of paragraph 1(4). The amendment was strictly technical in nature, and related to the proper use of medication. Failure to take special precautions in the case of HIV-infected pregnant women receiving co-trimoxazole would have serious consequences for their health.

Mr ABDOO (alternate to Dr Agwunobi, United States of America) said that he could not accept the amendment proposed, as it would constitute a modification of language agreed by the United Nations General Assembly. He had no objection to the information being included in footnote form.

The CHAIRMAN requested clarification from the Secretariat as to whether the relegation of text to a footnote affected the degree of importance that was attached to it.

Mr BURCI (Legal Counsel) explained that footnotes were not considered to constitute an integral part of the text. Although it was unusual for footnotes to be used in resolutions, the Health Assembly had used them occasionally in order to facilitate reaching consensus. Text contained in footnotes did not have the same legal force as the text of the resolution, but allowed for the possibility of cross-references that might clarify the meaning of the resolution.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) said that, particularly in the light of the resolution adopted on rational use of medicines, the Board must do its utmost to prevent incidents resulting from medication errors. He again called for the footnote to be incorporated in the main body of the text.

Mr ABDOO (alternate to Dr Agwunobi, United States of America) said that it was not usual for Health Assembly resolutions to serve as clinical guidelines for treatment. However, he would be willing to accept the proposal by Thailand provided that the cross-reference to United Nations General Assembly draft resolution A/61/L.50 was deleted.

Dr NYIKAL (Kenya) said that the second of the three proposed options for paragraph 1(5) could be eliminated. The Health Assembly would therefore be presented with two alternatives in respect of paragraph 1(5), corresponding to the first and third options shown in the latest amended text of the draft resolution.

Mr ABDOO (alternate to Dr Agwunobi, United States of America) explained that the proposal had simply been to use agreed language. In the second of the two options that would be submitted to the Health Assembly, paragraph 1(5) should end after the word “Rights”. The words “antimalarial medicines, diagnostics and preventive technologies” should be inserted into paragraph 1(6) after the word “services”.

Dr NYIKAL (Kenya) said that in that case the words “antimalarial medicines, diagnostics and preventive technologies” would need to be placed in square brackets.

Dr KEAN (Executive Director, Office of the Director-General) read out the suggested amendments to paragraphs 1(5) and 1(6). Two alternatives were to be proposed in respect of

paragraph 1(5): the first would correspond to the first of the three options in the most recent text of the draft resolution, beginning with the words “to provide in their legislation ...”. The second option would read: “to consider, whenever necessary, adapting national legislation in order to use to the full the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights”. The words “antimalarial medicines, diagnostics and preventive technologies” would then be inserted in square brackets after the word “services” in paragraph 1(6).

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

**Draft resolutions deferred from the Fifty-ninth World Health Assembly and the 118th session of the Executive Board:** Item 4.12 of the Agenda (resumed)

- **Essential health technologies** (Documents EB120/13 and EB120/13 Add.1) (continued from the eleventh meeting)

The DIRECTOR-GENERAL recognized Member States’ three main concerns with the draft resolution: the excessively broad scope; the lack of any definition of the term “essential” or of any criteria that would determine which health technologies were essential; and the question of a list. She therefore proposed that all references to those concerns should be deleted and that the Secretariat, after consulting with relevant experts, should then revise its report and submit a revised draft resolution to the Sixtieth World Health Assembly.

Mrs VELÁZQUEZ (alternate to Mr Bailón, Mexico) endorsed that proposal. She would be able to support the draft resolution with such amendments and would like to participate in the proposed group of experts.

Ms HALTON (Australia), supporting the Director-General’s proposal, asked whether a revised text of the draft resolution would be made available and who the experts might be: some Member States were particularly keen to participate in the group.

Dr GWENIGALE (Liberia) asked whether and how the Secretariat intended to communicate the results of its consultations to the Board in advance of the Health Assembly.

The CHAIRMAN said that, in accordance with its Rules of Procedure, the Board should consider the draft resolution before it was forwarded to the Health Assembly; the Secretariat should be able to communicate to members the outcome of its consultations electronically.

Dr KEAN (Executive Director, Office of the Director-General) reading out the proposed amendments, said that the word “essential” should be deleted from the first preambular paragraph, and the title of the draft resolution should be changed before it was submitted to the Health Assembly. The preambular paragraph starting “Understanding essential health technologies ...” should be deleted. Paragraph 1(1) would read: “to collect, verify, update and exchange information on health technologies as an aid to Member States in their prioritization of needs and allocation of resources”. In paragraph 1(4), “centres of excellence” should be replaced by “institutes”. In paragraph 2(1), “a WHO list of essential” should be replaced by “WHO’s norms and standards in”. The word “essential” should be deleted from paragraphs 2(2), 2(3), 2(4) and 2(5), and “centres of excellence as” should also be deleted from paragraph 2(4).

---

<sup>1</sup> Resolution EB120.R16 and EB120.R16 Corr.1.

Ms HALTON (Australia), observing that some countries, including her own, had systems for assessing, procuring and managing health technologies, and had established regional and national institutes in health technology, proposed adding “as appropriate” at the end of paragraph 1(2) and “where necessary” at the end of paragraph 1(4).

Mr ABDOO (alternate to Dr Agwunobi, United States of America), referring to paragraph 2(1), asked for clarification: the amended wording seemed to imply that it was WHO’s responsibility to set norms and standards in health technologies.

Dr KEAN (Executive Director, Office of the Director-General) said that paragraph 2(1) in its entirety would read: “to establish a committee of experts on health technologies to assist in the development and maintenance of WHO norms and standards in health technologies”.

The CHAIRMAN said that the wording did not imply that WHO set standards in health technology, but that it provided countries with guidelines for setting their own standards appropriate to their needs. A single world standard was not intended.

Mr ABDOO (alternate to Dr Agwunobi, United States of America) said that he had some difficulty with that explanation and suggested that, in the interests of reaching a consensus, the whole of paragraph 2(1) should be deleted.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) pointed out that WHO was required to fulfil a normative function by providing guidelines, norms and standards to countries that needed them. Paragraph 2(1) should therefore be retained as currently drafted, with the possible addition of “as appropriate”, as suggested by Australia.

The DIRECTOR-GENERAL suggested that paragraph 2(1) should be amended to read: “to establish a committee of experts to advise WHO on its work on health technologies”.

The CHAIRMAN, speaking as the member for Bolivia, said that the Board should be careful not to introduce any elements in the draft resolution that required Member States to comply with health technology standards. It should wait to receive advice from the committee of experts on that complex subject.

Dr SHANGULA (Namibia) supported the Director-General’s proposed wording.

Dr NYIKAL (Kenya) pointed out that Member States were not obliged to comply with the health technology standards set by WHO; standards provided formal guidance where needed. He therefore supported Thailand’s view. The addition of the phrase “as appropriate”, would absolve those Member States that did not wish to adopt those standards.

Mr ABDOO (alternate to Dr Agwunobi, United States of America) said that the Director-General’s proposal, which he accepted, appeared to make paragraph 2(4) redundant; the two paragraphs could be combined. He agreed with the member for Australia that interested Member States should be able to participate in the work of the expert group.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) agreed with the suggestion to combine paragraphs 2(1) and 2(4), and proposed that the Secretariat should draft an appropriate text. The words “development and maintenance” were too specific at the present stage.

Mrs VELÁZQUEZ (alternate to Mr Bailón, Mexico) proposed, for consideration by the group of experts, that paragraph 2(1) might read: “to establish a committee of experts on health technologies



to assist in the development and maintenance or coordination of information banks for knowledge management on health technologies (clearing houses) and further development of tools and guidelines”.

The CHAIRMAN said that, because of the complexity of the subject, it would serve no purpose to propose further drafting changes. He therefore suggested that the Secretariat should prepare a revised text for the Board to consider later in the day.

The DIRECTOR-GENERAL said that the Secretariat would prepare an amended version of the draft resolution that would reflect the essence of the Board’s discussions.

**It was so agreed.**

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

**Prevention and control of noncommunicable diseases: implementation of the global strategy:** Item 4.5 of the Agenda (Documents EB120/22 and EB120/22 Add.1) (continued from the tenth meeting)

The CHAIRMAN drew the Board’s attention to a revised draft resolution on the prevention and control of noncommunicable diseases, which read:

The Executive Board,

Having considered the report on prevention and control of noncommunicable diseases: implementation of the global strategy,<sup>1</sup>

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>2</sup>

The Sixtieth World Health Assembly,

Having considered the report on prevention and control of noncommunicable diseases: implementation of the global strategy;

Recalling resolutions WHA53.17 on Prevention and control of noncommunicable diseases, WHA56.1 on the WHO Framework Convention on Tobacco Control, WHA57.17 on Global strategy on diet, physical activity and health, WHA57.16 on Health promotion and healthy lifestyles, WHA58.22 on Cancer prevention and control, and WHA58.26 on Public-health problems caused by harmful use of alcohol, and the many related regional committee resolutions, including on mental health;

Deeply concerned that in 2005 noncommunicable diseases caused an estimated 35 million deaths (60 percent of all deaths globally), that 80 percent of these deaths occurred in low- and middle-income countries, and that about 16 million deaths occurred among people under 70 years of age;

Noting that the mortality due to noncommunicable diseases is expected to rise by a further 17 percent by 2015, with serious socioeconomic consequences for Member States, communities and families;

Noting the links between noncommunicable diseases, development, the environment, and human security, and their contribution to health inequalities;

---

<sup>1</sup> Document EB120/22.

<sup>2</sup> See document EB120/22 Add.1 for the financial and administrative implications for the Secretariat of this resolution.

Noting that multisectoral responses continue to be limited by lack of awareness about, and appropriate action to reverse, the pandemic of noncommunicable diseases;

Noting that the importance of the prevention and control of noncommunicable diseases has been highlighted in the Eleventh General Programme of Work 2006–2015, which includes the target of reducing death rates from all noncommunicable diseases by two percent annually during the next 10 years;

Noting the increasing evidence on the cost-effectiveness of several simple interventions for prevention and control of noncommunicable diseases;

Noting the importance of motivating, educating and supporting individuals and families to make healthy choices in their daily lives, and the important role played by governments in providing healthy public policy and environments;

Confirming the importance of tackling the major underlying risk factors for noncommunicable diseases in an integrated, comprehensive, multisectoral and step-by-step manner;

Bearing in mind that the response to the triple burden of infectious diseases, noncommunicable diseases, and injuries faced by many countries and their severe resource constraints requires a strong primary health-care system within an integrated health system;

Recognizing that the implementation of the WHO Framework Convention on Tobacco Control is an essential measure for the prevention and control of noncommunicable diseases;

Recognizing that greater efforts are required globally to promote physical activity **and healthy lifestyles [USA]**, and to improve the quality of food and drink products, including **the way in which they are marketed and the [USA]** information available to consumers, **their families and children;** ~~and the way in which products are marketed~~

[OR]

Recognizing that greater efforts are required globally to promote physical activity, and to improve the quality of food and drink products, including information available to consumers, and the way in which products are marketed **to vulnerable populations, especially children and young people; [Tonga]**

Recognizing that more information is required on the socioeconomic and developmental impact of noncommunicable diseases and on the outcome of available interventions;

Aware that Member States spend only a small proportion of their health-care budget on prevention of noncommunicable diseases and on public health, and that even a minor increase in that percentage would yield tremendous health and socioeconomic benefits;

1. URGES Member States:

(1) to strengthen national and local political will to prevent and control noncommunicable diseases as part of a commitment to achieving the target of reducing death rates from noncommunicable diseases by two percent annually for the next 10 years, as contained in the Eleventh General Programme of Work, 2006–2015;<sup>1</sup>

(2) to establish where appropriate or to strengthen a national coordinating mechanism for prevention of noncommunicable diseases, where appropriate to national circumstances with a broad multisectoral mandate, including mobilization of political will and financial resources, and involving all relevant stakeholders;

<sup>1</sup> Document A59/25, Appendix 6.

- (3) to develop and implement a national multisectoral evidence-based action plan for prevention and control of noncommunicable diseases that sets out priorities, a time frame and performance indicators, and that provides the basis for coordinating the work of all stakeholders, **while ensuring avoidance of potential conflict of interest**, and actively engage civil society;
- (4) to increase, as appropriate, resources for programmes for the prevention and control of noncommunicable diseases;
- (5) to implement and increase support for existing global initiatives and the Framework Convention on Tobacco Control, which contribute to achieving the target of reducing death rates from noncommunicable diseases by two percent annually for the next ten years;
- (6) to make prevention and control of noncommunicable diseases an integral part of programmes aimed at strengthening primary health-care systems, and to strengthen primary health care institutions so that they respond to the challenges raised by noncommunicable diseases;
- (7) to strengthen monitoring and evaluation systems, including country-level epidemiological surveillance mechanisms, in order to compile evidence to inform policy decisions;
- (8) to ensure that health institutions are adequately organized, in order to address the serious challenges raised by noncommunicable diseases, which implies a particular focus on primary health care;
- (9) to emphasize the key role of governmental functions, including regulatory functions, when combating noncommunicable diseases;
- (10) to increase access to medicines for high-risk populations in low- and middle-income countries;**

2. REQUESTS the Director-General:

- (1) on the basis of an outline contained in the report<sup>1</sup> on prevention and control of noncommunicable diseases: implementation of the global strategy, to prepare an action plan to be submitted to the Sixty-first World Health Assembly through the Executive Board that sets out priorities, actions, a time frame and performance indicators for prevention and control of noncommunicable diseases between 2008 and 2013 at global and regional levels, and to provide support where needed for elaboration, intensified implementation and monitoring of national plans for prevention and control of noncommunicable diseases, including the further development of an intervention to manage the conditions of people at high risk of such diseases;
- (2) to raise further awareness among Member States of the importance of drawing up, promoting and funding supportive national multisectoral coordination and surveillance mechanisms, and plans for prevention and control of noncommunicable diseases;
- (3) to provide support to Member States, on request, and to foster partnership, collaboration, cooperation and sharing of best practices among Member States, for incorporating comprehensive noncommunicable disease interventions into national policies and programmes, including health systems policies and programmes, and for expanding interventions, including strategies to educate and support individuals and families;

---

<sup>1</sup> Document EB120/22.

(4) to disseminate to Member States, in a timely and consistent manner, information on cost-effective, core interventions aimed at preventing and controlling noncommunicable diseases;

(5) to encourage dialogue with international, regional and national nongovernmental organizations, donors and technical-agency partners and the private sector, while ensuring the avoidance of potential conflict of interest, in order to increase support, resources and partnerships for prevention and control of noncommunicable diseases, including health and wellness programmes at the workplace as appropriate;

(6) to promote initiatives aimed at implementing the global strategy with the purpose of increasing availability of healthy foods, promoting healthy diets, **[and reducing OR limiting [Portugal]] OR [restricting aggressive [Thailand]]** marketing and promotion of unhealthy products, in dialogue with all relevant stakeholders, including private-sector parties, which are committed to reducing the risks of noncommunicable diseases;

**[OR]**

(6) to promote initiatives aimed at implementing the global strategy with the purpose of increasing availability of healthy foods, promoting healthy diets, ~~and reducing marketing and promotion of unhealthy products~~ in dialogue with all relevant stakeholders, including private-sector parties, that are committed to reducing the risks of noncommunicable diseases; **[USA]**

**[OR]**

(6) to promote initiatives aimed at implementing the global strategy with the purpose of **promoting healthy diets and healthy lifestyles, and to promote the practice of responsible marketing particularly with regard to foods high in saturated fats, trans-fatty acids, free sugars, or salt, [Australia]** in dialogue with all relevant stakeholders, including private-sector parties, that are committed to reducing the risks of noncommunicable diseases;

**[OR]**

(6) to promote initiatives aimed at implementing the global strategy with the purpose of increasing availability of healthy foods, promoting healthy diets, **and reducing marketing and promotion of products such as foods high in saturated fats, trans-fatty acids, free sugars, or salt, [EU and Finland]** in dialogue with all relevant stakeholders, including private-sector parties, that are committed to reducing the risks of noncommunicable diseases;

**[OR]**

(6) to promote initiatives aimed at implementing the global strategy with the purpose of increasing availability of healthy foods, promoting healthy diets, **and to improve marketing in order to reduce the impact of foods high in saturated fats, trans-fatty acids, free sugars, or salt, [EU and Germany]** in dialogue with all relevant stakeholders, including private-sector parties, that are committed to reducing the risks of noncommunicable diseases;

**[OR]**

(6) to promote initiatives aimed at implementing the global strategy with the purpose of increasing availability of healthy foods, promoting healthy diets, **and to improve marketing, including voluntary changes in promotional practices, particularly with regard to foods high in saturated fats, trans-fatty acids, free sugars, or salt, [USA]** in dialogue with all relevant stakeholders, including private-sector parties, that are committed to reducing the risks of noncommunicable diseases;

(7) to build and sustain contact with the mass media in order to ensure continued prominence in the media of issues related to the prevention and control of noncommunicable diseases;

- (8) to improve understanding of the socioeconomic impact of noncommunicable diseases at national and household levels, especially in low- and middle-income countries;
- (9) to ensure that the work on prevention and control of noncommunicable diseases is given suitably high priority, and support where appropriate;
- (10) to report to the Sixty-third World Health Assembly, and subsequently every two years to the Health Assembly through the Executive Board, on progress in implementing the global strategy on prevention and control of noncommunicable diseases, including progress on the action plan.

Dr SHANGULA (Namibia), speaking as chairman of the drafting group, said that a common position had been reached on the two outstanding issues, namely, the thirteenth paragraph of the preambular section and paragraph 2(6). The two versions of the thirteenth paragraph in the preambular section would be replaced by a paragraph reading: “Recognizing that greater efforts are required globally to promote physical activity and healthy lifestyles, and to improve the nutritional quality of food and drink products, including the way in which they are marketed and the quality and availability of information to the consumers, in particular children, young people and their families and other population groups in vulnerable circumstances”.

The six alternative versions of paragraph 2(6) would be combined into a single paragraph, which would read: “to promote initiatives aimed at implementing the global strategy with the purpose of increasing availability of healthy foods, promoting healthy diets, and to promote responsible marketing in order to reduce the impact of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt, in dialogue with all relevant stakeholders, including private-sector parties, that are committed to reducing the risks of noncommunicable diseases”.

Dr NYIKAL (Kenya) concurred with the last version of the thirteenth preambular paragraph. He suggested adding “while avoiding conflict of interest” at the end of paragraph 2(6).

Mr ABDOO (alternate to Dr Agwunobi, United States of America) supported Kenya’s proposal. For the sake of uniformity, the words “while ensuring avoidance of potential conflict of interest” should be moved to the end of paragraph 1(3), after “civil society”.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) said that paragraph 2(6) made it difficult at the operational level to distinguish between parties that were committed to reducing the risks of noncommunicable diseases and those that were not.

Dr SHANGULA (Namibia) said that the proposed wording for paragraph 2(6) had been the result of informal consultations held after the drafting group’s meeting. The phrase “relevant stakeholders” covered all those concerned. The last phrase, “including private-sector parties, that are committed to reducing the risks of noncommunicable diseases” was redundant and could be deleted.

Dr NYIKAL (Kenya) supported that proposal, since the inclusion of “while ensuring the avoidance of potential conflict of interest” should be sufficient to cover any concerns.

Ms HALTON (Australia) underlined retention of the reference to the private sector and she therefore proposed that only the words “that are committed to reducing the risks of noncommunicable diseases” should be deleted.

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

---

<sup>1</sup> Resolution EB120.R17.

#### 4. MANAGEMENT MATTERS: Item 8 of the Agenda

**Director-General and Deputy Director-General of the World Health Organization: review of matters arising from the special and 118th sessions of the Executive Board:** Item 8.1 of the Agenda (Document EB120/30)

The CHAIRMAN recalled that the report had been considered by the Programme, Budget and Administration Committee, which had proposed amendments to the draft resolution set out in paragraph 27 of document EB120/30. The amended text read as follows:

The Executive Board,

Having considered the proposals contained in the report on the Director-General and Deputy Director-General of the World Health Organization: review of matters arising from the special and 118th sessions of the Executive Board,<sup>1</sup>

1. AGREES with the procedure developed by the Secretariat as to the manner in which the Executive Board assesses whether the candidate nominated by it for the post of Director-General has the good physical condition required of all staff members of the Organization;
2. DECIDES that the curriculum vitae and supporting information of each candidate proposed under Rule 52 of the Rules of Procedure of the Executive Board shall be limited to 2000 words and shall also be submitted in electronic format to enable the Chairman of the Board to verify that this limit is not exceeded;
3. CONFIRMS its previous decision that the curriculum vitae should address the criteria established by the Executive Board, and include a statement on the vision of the candidate on priorities and strategies;<sup>2</sup>
4. DECIDES that **the Chairman of the Executive Board may authorize** the Director-General ~~may~~, in addition to the names of the candidates, **to** post on WHO's web site the curricula vitae and other supporting information as dispatched to Member States, and contact information for each candidate, unless the candidate concerned or the Member State that proposed him or her stipulates otherwise.

Ms HALTON (Australia), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, recalled that the item was a consequence of the untimely death of the previous Director-General. The Committee's discussion on the item and its recommendation was reflected in paragraph 54 of its report (document EB120/3). The Committee's proposed amendments to paragraph 1(4) aimed at ensuring that any decision to post the curricula vitae and supporting information for candidates for the post of Director-General on the WHO web site would be taken by the Chairman of the Board. Such a procedure would be consistent with the Chairman's existing responsibilities in that area as set out in Rule 52 of the Rules of Procedure of the Executive Board. She thanked the Legal Counsel for the guidance provided to the Committee on what was a complex constitutional matter.

Dr GWENIGALE (Liberia), speaking on behalf of the Member States of the African Region, recalled that, during the discussions leading to the election of the current Director-General, Board

---

<sup>1</sup> Document EB120/30.

<sup>2</sup> Decision EB100(7).

members had agreed that a Deputy Director-General should be appointed and that the appointment should be made known publicly. He welcomed the prompt appointment of a new Deputy Director-General and was particularly pleased that that person was from his Region.

The Board's discussions had also concerned geographical rotation of the post of Director-General. As indicated in paragraph 24 of the report, WHO had elected seven Directors-General from three of the Organization's six Regions. No candidate from the African, South-East Asian or Eastern Mediterranean Regions had as yet been successful, despite there being qualified health professionals in those Regions who were capable of managing WHO and would meet the paramount criterion of the highest standard of efficiency and integrity, as called for in Article 35 of WHO's Constitution. Geographical rotation had operated in the selection of Secretary-General of the United Nations. He therefore favoured geographical rotation of the post of Director-General of WHO and any necessary change in the Rules of Procedure to achieve that.

Miss ABDI (alternate to Mr Miguil, Djibouti), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed support for the position taken by the previous speaker. At the Board's 118th session, Djibouti had called for geographical rotation for the post of Director-General, which would ensure fairness and balance between the regions. The selection criteria should include competence and gender balance. The proposal for geographical rotation was not unreasonable, given the procedures involved in the selection of the Secretary-General of the United Nations, and conformed to good governance, the equitable distribution of human resources, and gender equality. The proposal should be submitted to the Sixtieth World Health Assembly in May 2007 for consideration.

Dr KHALFAN (Bahrain) supported geographical rotation. If the Rules stipulated that the Deputy Director-General should take over in the event of the death or incapacitation of the incumbent Director-General, then the appointment of a Deputy Director-General should be mandatory. He proposed that Rule 113 of the Rules of Procedure of the World Health Assembly, which stated that the person to take over should such an event occur should be "the senior officer of the Secretariat", should be changed in order to specify the senior appointed officer, as distinct from elected officer. He further proposed that a standard format for the curricula vitae of candidates for the post of Director-General and a procedure for verifying their state of health should be developed.

Mr HIWAL (alternate to Dr Al-Essawi, Iraq) said that he recognized the need for standardized selection procedures and for equitable opportunities for candidates from all the WHO regions. He supported the views expressed by the member for Liberia.

Dr WANGCHUK (Bhutan) said that no candidate from the South-East Asia Region had ever succeeded to the post of Director-General. He therefore supported the call for geographical rotation. He requested further information regarding the duties of the Deputy Director-General as described in paragraphs 20 and 21 of the report.

Mr DE SILVA (Sri Lanka), speaking on behalf of the Member States of the South-East Asia Region, joined previous speakers in supporting the proposal for geographical rotation of the post of Director-General. A procedure of giving preference to candidates from the three regions that had not yet had a successful candidate might be considered.

Dr NYIKAL (Kenya) supported the call for geographical rotation and for further clarification of the procedures to be followed in the event of incapacitation of the Director-General.

Dr SHANGULA (Namibia), supported by Dr SALEHI (Afghanistan), proposed that the draft resolution should be amended in order to make the appointment of a Deputy Director-General mandatory, and to reflect the call for geographical rotation made by Board members. He requested the Secretariat to suggest appropriate wording.

Dr TANGI (Tonga) did not favour geographical rotation. It was essential to select the best possible candidate for the post without any geographical limitation. Moreover, a Director-General could be in the post for 10 years, so that geographical rotation might give each region a successful candidate only every 60 years. All Member States should have an interest in every selection process.

Dr VOLJČ (Slovenia) said that it was not clear how geographical rotation would work in practice. For example, would candidates be graded according to the region they came from? He requested guidance from the Legal Counsel.

Mr SHIRALIYEV (Azerbaijan) supported the principle of geographical rotation, but said that, in practice, it might restrict the list of potential candidates for the post of Director-General and, therefore, the current selection procedures should be maintained.

Dr INOUE (alternate to Dr Shinozaki, Japan) endorsed the principle laid down in Article 35 of the WHO Constitution that, in the employment of staff, the criterion of geographical representation was secondary to the paramount criterion of the highest standard of efficiency and integrity. That criterion should be applied most strictly in the selection of the Director-General. The geographical element should be secondary, together with other considerations, such as gender balance, mother tongue, ethnic group and religious background. Regional representation was already reflected in the selection of the Regional Directors.

Dr CAMPBELL FORRESTER (alternate to Dr Allen-Young, Jamaica) said that, although geographical rotation would be ideal, it was essential to find the candidate most fit for the post. She preferred the current selection criteria, with each Region submitting its own candidates.

Mr BURCI (Legal Counsel), responding to the requests for clarification, said that the Constitution was rather general since it stated in Article 31 that the Director-General should be appointed by the Health Assembly on the nomination of the Board on such terms as the Health Assembly might determine. More details of the procedure, and in particular the nomination process, were contained in the Rules of Procedure of the World Health Assembly and the Rules of Procedure of the Executive Board. The former focused on the main terms of appointment, whereas the latter, in Rule 52, stated that any Member State might propose for the post of Director-General one or more persons. It was therefore clear that the right to nominate or present a candidate or candidates for the post of Director-General under the current Rules rested with each Member State.

Professor PEREIRA MIGUEL (Portugal) said that no geographical restriction should be imposed; any Member State should be entitled to put forward a candidate in order that the best person was elected to the post.

Dr SHANGULA (Namibia) said that the regions from which a Director-General had not yet been elected did not lack qualified candidates, but the playing field was not level. Unless that was addressed, the only alternative was to look at possible rotation.

Mr ABOUBAKER (alternate to Mr Miguil, Djibouti) said that rotation would lend meaning to the word equity. The provisions of the Constitution and Rules of Procedure could be amended if necessary.

Dr CHEW SUOK KAI (alternate to Dr Sadasivan, Singapore) agreed that the concept of rotation would promote equity. However, WHO should employ the best person for the job. Before taking any decision on geographical rotation, the Secretariat should conduct a review in order to ascertain why candidates from some regions had not been selected.



Dr RAHANTANIRINA (Madagascar) supported the views expressed by the member for Djibouti and agreed that the Constitution and Rules of Procedure might be amended in order to accommodate the principle of geographical rotation.

Mr RAMOTSOARI (Lesotho) expressed support for the concept of equity. In the past, some regions might not have had candidates with the competence to fill the position of Director-General. Quality and expertise must not be compromised and those elements would still be respected with regional rotation. In the recent elections for the position of Director-General, all the candidates had been put forward because of their competence and expertise; however, lobbying and negotiation had also played an important role. He questioned the criteria used in selecting one from a number of competent candidates. The principle of rotation could reflect the changing times.

Dr JAKSONS (Latvia) welcomed the statement by the member for Tonga. Technically, rotation was based on the principle of absolute equity, not always desirable in competitions.

Ms BLACKWOOD (alternate to Dr Agwunobi, United States of America) said that there was nothing prescriptive regarding geographical rotation in the basic texts of any other organization in the United Nations system. She acknowledged an informal recognition of the concept at United Nations headquarters in the light of various political factors. Every effort should be made to ensure that the best person occupied the post.

Ms HALTON (Australia) associated herself with the views expressed by the members for the United States, Tonga and Japan. The paramount consideration in the employment of staff, including the Director-General, was capability. WHO was a technical organization, and it had to command the highest capability. Although she looked forward to the day when a member of the African Region or other regions mentioned was elected, she supported the fundamental position set out in Article 35 of the Constitution.

Dr GWENIGALE (Liberia) agreed with the member for Namibia regarding the lack of a level playing field. Some candidates did not have the means available to others; it was not that the regions did not have candidates with the required competence or integrity. A policy of rotation would mean that a number of candidates from a particular region would be put forward, their competence and integrity assessed, and the person most suited to the job elected according to specified criteria. The matter should be discussed further at the forthcoming Health Assembly.

Dr HANSEN-KOENIG (Luxembourg) said that the person at the helm of WHO had to be strong, competent and charismatic. She would be reluctant to limit the field of candidates through geographical rotation; however, the views of the members for Liberia and Namibia implied that further consideration should be given to the procedure for the submission of candidatures and equal opportunities.

Mr BAILÓN (Mexico) questioned the concept of rotation and its implications. Would candidates be put forward from certain regions only? Would candidates from some regions be at a disadvantage? Would the proposal be implemented for the next or subsequent election? How would rotation affect the Organization's priorities, as established by Member States, and ensure WHO's accountability? WHO had to be able to select the best person for the job, and, if the principle of rotation were introduced, its implications must be clarified.

Dr NYIKAL (Kenya) said that such a complex matter should be referred to the Health Assembly for further discussion, while noting that the Board had not reached a consensus. In the meantime, the Secretariat should study the issues raised, particularly by the member for Mexico. He also requested clarification regarding the position of Deputy Director-General. Was the post

mandatory, or to be filled at the discretion of the Director-General, and what was the process for a handover of powers should the Director-General become incapacitated?

Dr SHANGULA (Namibia) said that it should be made clear that the discussions on rotation had not arisen as a result of the recent elections and in no way reflected on their outcome. The discussions looked to the future within the context of the United Nations reform process.

Dr KHALFAN (Bahrain) said that, although the letter of succession had been accepted in good faith, the process to be followed in the future had to be defined clearly. In order to clarify the interpretation of Rule 113 of the Rules of Procedure of the World Health Assembly, ambiguities regarding the definition of “senior officer” should be resolved. Was the senior officer an elected officer or an officer appointed by the Director-General? Was seniority defined in terms of age, or of length of time in office? If the Deputy Director-General was not to take over, the Assistant Directors-General must be ranked in order of seniority.

The CHAIRMAN, speaking as the member for Bolivia, supported the proposal by the member for Kenya. In electing a Director-General a political element was inevitably added to considerations of quality, capacity and region. If regional rotation were introduced, the election would, to a large extent, take place at the regional level. Candidates from less favoured regions should receive more exposure to meetings and conferences, as talent in candidates from those regions often went unacknowledged. More effective participation by all regions would obviate the need for rotation.

Mr BURCI (Legal Counsel), responding to the question about whether the position of Deputy Director-General was mandatory, said that according to the current Staff Regulations, there was no mandatory requirement for the appointment of a Deputy-Director General. Citing paragraph 20 of document EB120/30, he said that the Deputy-Director General would perform the functions of Director-General should the latter be unable to perform the functions of the office or in case of a vacancy in the office, subject to any relevant decision by the Executive Board.

The DIRECTOR-GENERAL said that, although there was no mandatory requirement for her to appoint a Deputy Director-General, she had made that appointment as soon as possible after she had taken office, knowing that it was what Board members wanted.

Explaining the intention behind the text in paragraph 21, she recalled that, in her address to the First special session of the World Health Assembly, she had promised to work “tirelessly”. Thanks to modern technology she could always be contacted by senior staff, should the need arise, and she would therefore continue to manage the Organization even when absent on duty travel or leave.

The CHAIRMAN noted that, if the draft resolution was to be submitted to the Sixtieth World Health Assembly, the text should be amended in order to reflect the points made during the discussion.

Ms BLACKWOOD (alternate to Dr Agwunobi, United States of America) said that there was no urgency to put the matter before the Health Assembly. Differences of opinion were significant, and the next election for the post of Director-General would not take place for five years. The Secretariat should undertake further work on the item, and the Board could then reconsider it at a future session.

Dr KHALFAN (Bahrain) said that the question of succession following an emergency should be resolved as quickly as possible. He supported the proposal set out in paragraph 20 of the report, namely that the Deputy Director-General should perform the functions of the Director-General in the case of incapacitation or of vacancy in the office, until the Executive Board had taken a decision on the matter.

Dr GWENIGALE (Liberia) said that, whether or not the item was submitted for consideration at the Sixtieth World Health Assembly, the comments made by Board members about geographical

rotation should be recorded, preferably in the draft resolution, and the subject should be put before the Health Assembly at some point.

Dr NYIKAL (Kenya) said that he was not convinced by the reasoning for not considering the item at the Sixtieth World Health Assembly. The draft resolution should be submitted together with a statement that the Board had considered the matter at length but had not reached a conclusion, and that further work was needed. He therefore proposed that, in line with the comments made by the member for Liberia, paragraph 3 of the draft resolution should be amended by inserting the words “as well as the issue of regional rotation” after “priorities and strategies”.

The DIRECTOR-GENERAL pointed out that the draft resolution under consideration was a resolution of the Board and not one that would automatically go before the Health Assembly. However, it was the Board’s prerogative to raise the matter as an additional item at the Health Assembly. She suggested that members adopt the resolution at the current session and request the Secretariat to undertake further work on the item. The item could be reconsidered by the Board at a future session, at which time it could decide whether the item and a draft resolution should be submitted to the Health Assembly.

Dr NYIKAL (Kenya), noting the Director-General’s advice, proposed that the draft resolution should be amended by the addition of a new paragraph in order to indicate that the question of regional rotation should be pursued and that the Board should be provided with further information for discussion at a future session.

Dr SHANGULA (Namibia) asked for an assurance that the amendments he had proposed earlier would appear in the draft resolution.

In reply, Mr BURCI (Legal Counsel) asked the member for Namibia to propose some text. The Secretariat had understood that a consensus had been reached on the question of geographical rotation: the Board would keep the matter under review and the Secretariat would provide further information on the implications for future consideration. He suggested that the new paragraph proposed by the member for Kenya might read:

“5. REQUESTS the Director-General to prepare a report on the geographical rotation of the post of Director-General, taking into account the views expressed by members of the Executive Board, and to report back to the 121st session of the Executive Board”.

Referring to the call by the member for Namibia for the mandatory appointment of a Deputy Director-General, he indicated that, if there was consensus among Member States, the appropriate amendments could be made to the Staff Regulations. However, as only the Health Assembly was competent to make such changes, he was not sure of the significance of including a decision on the matter in an Executive Board resolution.

Dr SHANGULA (Namibia) proposed that the text for the new paragraph suggested by the Legal Counsel should be included in the draft resolution. The Board’s view on the need for clarity in the future appointment and duties of the Deputy Director-General should be forwarded to the Health Assembly, whether or not that view was included in the draft resolution.

**The meeting rose at 13:20.**

## **THIRTEENTH MEETING**

**Monday, 29 January 2007, at 14:50**

**Chairman:** Dr F. ANTEZANA ARANÍBAR (Bolivia)

### **1. MANAGEMENT MATTERS:** Item 8 of the Agenda (continued)

**Director-General and Deputy Director-General of the World Health Organization: review of matters arising from the special and 118th sessions of the Executive Board:** Item 8.1 of the Agenda (Document EB120/30) (continued)

Dr KEAN (Executive Director, Office of the Director-General) recalled that, during the discussion at the previous meeting on the amended version of the draft resolution contained in paragraph 27 of document EB120/30, a new paragraph 5 had been proposed. That new paragraph 5, which had been drafted following informal consultations with members, would read: “REQUESTS the Director-General to prepare a report on the geographical rotation of the post of Director-General and on the requirement to appoint a Deputy Director-General, taking into account the views expressed by members of the Executive Board, and to report to the 121st session of the Executive Board”.

The CHAIRMAN said that, in the absence of objections, he would take it that the Board wished to adopt the draft resolution as amended.

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

**WHO and reform of the United Nations system:** Item 8.2 of the Agenda (Documents EB120/31 and EB120/31 Corr.1)

The CHAIRMAN drew the Board’s attention to the report on the reform of the United Nations system. A Note by the Secretary-General of the United Nations on the follow-up to the outcome of the Millennium Summit, containing the report of the High-level Panel on United Nations System-wide Coherence, entitled “Delivering as One”, was available in the meeting room.<sup>2</sup>

Ms HALTON (Australia), speaking as Chairman of the Programme, Budget and Administration Committee, said that the Committee, as indicated in paragraphs 55 and 56 of its report (document EB120/3), had discussed the reform of the United Nations system, and had stressed the need for WHO to be involved in that process. The Committee had discussed the “One United Nations” pilot projects, stressing the need to avoid duplication and ensure coordination of activities.

Dr SHANGULA (Namibia), speaking on behalf of the Member States of the African Region, emphasized the overdue need for reform of the United Nations. Its structures and operations were at variance with democracy, transparency and good governance. WHO would be affected by the proposed reforms, and should adopt a strategic position from the start.

The 2005 World Summit and the High-level Panel had made recommendations in order to ensure coherence and consolidation of activities, an appropriate funding mechanism and outcome-

---

<sup>1</sup> Resolution EB120.R19 and EB120.R19 Corr.1.

<sup>2</sup> Document A/61/583.

oriented business practices. The proposal to create “One United Nations” at country level, with one leader, one programme, one budget and, where appropriate, one office, was a radical departure from current practices. In future, WHO might have to operate in a completely different environment. The Organization must become aware of such developments.

It appeared that some of the recommendations were already being piloted in some Member States. The Secretariat should follow developments and keep the Health Assembly informed. He welcomed the Director-General’s commitment to WHO’s active part in the reform process.

Professor PEREIRA MIGUEL (Portugal), speaking in the name of the German Presidency and on behalf of the European Union and its 27 Member States, Bosnia and Herzegovina, Norway, Ukraine and the Republic of Moldova, welcomed the discussion. He had noted that the Director-General had assured members that WHO would participate actively in the reform of the United Nations system. He also welcomed WHO’s favourable attitude to the proposed pilot exercises in selected countries.

WHO’s engagement in United Nations reform, especially at country level, was crucial for development and health activities in particular. Its involvement in the coordination of the United Nations system, its commitment to the triennial comprehensive policy review and its implementation of resolution WHA58.25 on the United Nations reform process and WHO’s role in harmonization of operational development activities at country level were all encouraging. The “one-country” approach provided opportunities for United Nations agencies engaged at country level, and he appreciated progress towards “One United Nations” pilot projects. The principle of ownership by countries lay at the heart of the recommendations of the High-level Panel. The first pilot programmes would provide lessons for both WHO and the United Nations system. WHO should participate in those pilot activities and future initiatives. He looked forward to regular reports on progress and lessons learnt.

Ms BLACKWOOD (alternate to Dr Agwunobi, United States of America) said that reform of the United Nations was one of her country’s key priorities. Reform was crucial if the United Nations was to live up to its ideals and be relevant to real challenges and problems. The report of the High-level Panel contained creative recommendations for restructuring operations and improving services to developing countries.

WHO must engage with partners, including other bodies in the United Nations system and civil society, in order to eliminate duplication, strengthen coherence and improve service delivery. Its participation in those efforts was important for its own operations and the system as a whole.

Dr QI Qingdong (China) welcomed the report and efforts to reform the United Nations, which should increase resources for economic and social development and strengthen institutions. Four factors should be considered. First, reform must be gradual with many agencies involved; no benefit was to be gained from arbitrary deadlines. Secondly, there must be a consensus among all parties, especially developing countries. Thirdly, the reforms should increase the available financing and enhance the system’s efficiency, but they should not interfere with the mandate of special agencies such as WHO; it would be necessary to define WHO’s new relationship with other international organizations, its autonomy in project operation, and the use of funds. Fourthly, the reforms must respect the different country situations.

He welcomed the pilot projects currently under way. Effective reforms must be carried out if WHO was to adapt to the changing health situation.

Mr RABGYE (alternate to Dr Wangchuk, Bhutan) expressed his support for United Nations reform and concurred with the conclusions of the Secretariat’s report. It was essential to retain and build on best practices of successful cooperation at national level.

The report of the High-level Panel had not yet been given any formal consideration at an intergovernmental level, and the pilot projects and reform efforts should not be prejudged. All the parties aimed to create a more efficient system and to provide more effective services.

The role of Resident Coordinators was not always well understood by government agencies and other partners not necessarily familiar with the complexities of international management. WHO Representatives might promote a better understanding of how their work related to that of the United Nations country teams.

Mr BAILÓN (Mexico) supported WHO's involvement in the reform of the United Nations system. Improved coordination among international bodies at country level through an integrated approach should result in more efficient use of contributions and easier assessment. He endorsed the views expressed by the member for Portugal, including the request for regular information on the pilot projects involving WHO.

Ms HALTON (Australia) emphasized her Government's commitment to United Nations reform and commended WHO's involvement in the proposed pilot projects. Internal reforms and new ways of doing business would improve the Organization's delivery of assistance.

The CHAIRMAN, speaking as the member for Bolivia and endorsing the views of the members for Australia and Mexico, said that the pilot projects could provide an opportunity for WHO to assume leadership in health matters.

Mr MARTIN (Switzerland)<sup>1</sup> commended the Organization's commitment to the reform process and participation in the pilot projects. That approach, together with WHO's involvement in some preliminary activities in Mozambique, was in line with other commitments, such as the triennial comprehensive policy review of operational activities for development of the United Nations system incorporated in resolution WHA58.25. The Secretariat should keep Member States informed of progress in the pilot projects and the lessons learnt.

The DIRECTOR-GENERAL reaffirmed that WHO would be an active partner in the United Nations reform process in order to ensure that Member States derived the maximum benefit from the collective delivery of results. She would report back to the Board on a regular basis on the progress made in the pilot projects and lessons learnt. Providing that the Board approved the provisional agenda contained in document EB120/32, the first report could be submitted to the Sixtieth World Health Assembly.

**The Board took note of the report.**

**Reports of committees of the Executive Board: Item 8.3 of the Agenda**

- **Standing Committee on Nongovernmental Organizations** (Documents EB120/41 and EB120/41 Add.1)

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand), speaking on behalf of the Chairman of the Standing Committee on Nongovernmental Organizations, said that the Committee had considered applications from seven nongovernmental organizations for admission into official relations with WHO and the reports concerning 80 nongovernmental organizations already in official relations. It had expressed its appreciation of the work of the applicant organizations and those whose activities had been reviewed. The Committee had also considered the participation of nongovernmental organizations in the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property. Section IV of the report contained the Committee's recommendations, set out as a draft resolution and two draft decisions.

---

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

Mr HOHMAN (alternate to Dr Agwunobi, United States of America) noted that, when the participation of nongovernmental organizations in the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property had been discussed in the Intergovernmental Working Group, the intention had not been solely to increase their participation but also to encourage the Director-General to consider the participation of experts who could make a contribution to the work of the Intergovernmental Working Group.

The CHAIRMAN said that he took it that the Board wished to adopt the draft resolution and two draft decisions contained in document EB120/41.

**The resolution and the two decisions were adopted.<sup>1</sup>**

**• Foundations and awards**

**Dr A.T. Shousha Foundation Prize**

**Decision:** The Executive Board, having considered the report of the Dr A.T. Shousha Foundation Committee, awarded the Dr A.T. Shousha Foundation Prize for 2007 to Dr Nabil Kronfol (Lebanon) for his significant contribution to public health in the Eastern Mediterranean Region. The laureate will receive the equivalent of 2500 Swiss francs in United States dollars.<sup>2</sup>

**Léon Bernard Foundation Prize**

**Decision:** The Executive Board, having considered the report of the Léon Bernard Foundation Committee, awarded the Léon Bernard Foundation Prize for 2007 to Dr Than Tun Sein (Myanmar) for his outstanding service in the field of social medicine. The laureate will receive a bronze medal and the sum of 2500 Swiss francs.<sup>3</sup>

**Ihsan Dogramaci Family Health Foundation Prize**

**Decision:** The Executive Board, having considered the report of the Ihsan Dogramaci Family Health Foundation Selection Panel, awarded the Ihsan Dogramaci Family Health Foundation Prize for 2007 jointly to Mrs Mehriban Aliyeva (Azerbaijan) and Maestra Guillermina Natera Rey (Mexico) for their service in the field of family health. The laureates will each receive US\$ 10 000.<sup>4</sup>

In addition, **the Board took note of the Panel's decision to revise Article 5 of the Statutes** of the Ihsan Dogramaci Family Health Foundation.

---

<sup>1</sup> Resolution EB120.R20 and decisions EB120(2) and EB120(3).

<sup>2</sup> Decision EB120(4).

<sup>3</sup> Decision EB120(5).

<sup>4</sup> Decision EB120(6).

**Sasakawa Health Prize**

**Decision:** The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel, awarded the Sasakawa Health Prize for 2007 to Dr Jose Antonio Socrates (Philippines) for his outstanding innovative work in health development. The laureate will receive US\$ 30 000.<sup>1</sup>

**United Arab Emirates Health Foundation Prize**

**Decision:** The Executive Board, having considered the report of the United Arab Emirates Health Foundation Selection Panel, awarded the United Arab Emirates Health Foundation Prize for 2007 to the Bill & Melinda Gates Foundation (United States of America) for its outstanding contribution to health development. The laureate will receive US\$ 40 000.<sup>2</sup>

**State of Kuwait Prize for Research in Health Promotion**

**Decision:** The Executive Board, having considered the report of the State of Kuwait Health Promotion Foundation Selection Panel, decided not to award the State of Kuwait Prize for Research in Health Promotion in 2007.<sup>3</sup>

**Provisional agenda of the Sixtieth World Health Assembly and date and place of the 121st session of the Executive Board:** Item 8.4 of the Agenda (Document EB120/32)

Dr KEAN (Executive Director, Office of the Director-General) said that the proposed provisional agenda set out in Annex 1 to the report had been prepared before the Board's current session. On the basis of the Board's discussions so far, the item "Oral health" should be added under item 12, Technical and health matters. He proposed to include it between existing items 12.8 and 12.9. The subitem "Public health, innovation and intellectual property: progress made by the Intergovernmental Working Group (resolution WHA59.24)" should be moved from existing item 12.19 "Progress reports on technical and health matters" and included as a separate item, which he proposed to add after existing item 12.18. Existing item 12.18 "Contribution of traditional medicine to public health: coca leaf" should be deleted.

Two titles would change: item 12.11 would read "Integrating gender analysis and actions in the work of WHO: draft strategy" and item 12.17 would read "Health technologies". At the request of a Board member that morning, existing item 12.16 would be divided into two parts: "Progress in the rational use of medicines" followed by "Better medicines for children". The exact timing of item 3 "Invited speaker", would be confirmed before the start of the Health Assembly, but was expected to take place on the morning of Tuesday 15 May rather than Monday 14 May.

Mr HOHMAN (alternate to Dr Agwunobi, United States of America) sought clarification as to whether item 12.7 "Evidence-based strategies and interventions to reduce alcohol-related harm" and item 12.9 "Working towards universal coverage of maternal, newborn and child health interventions: biennial report", should not be included instead under item 12.19 "Progress reports on technical health matters". That would be more consistent with the requirements of the relevant Health Assembly resolutions.

---

<sup>1</sup> Decision EB120(7).

<sup>2</sup> Decision EB120(8).

<sup>3</sup> Decision EB120(9).



Dr KEAN (Executive Director, Office of the Director-General) said that item 12.7 had been included as a separate item under Technical and health matters in order to meet the request contained in paragraph 2(4) of resolution WHA58.26: “to report to the Sixtieth World Health Assembly on evidence-based strategies and interventions to reduce alcohol-related harm, including a comprehensive assessment of public-health problems caused by harmful use of alcohol”. The reason it had not been presented to the Board was the convening of an expert group, whose report had yet to be submitted to the Director-General but which would go beyond a progress report. He agreed that item 12.9 could in theory be included with the progress reports, but, in the past, biennial reports had resulted in a resolution or decision, with action taken. For that reason it had been included as an action point.

Mr HOHMAN (alternate to Dr Agwunobi, United States of America) welcomed the clarification, but considered that the Secretariat was anticipating what the Member States might choose to do. Regarding item 12.9, paragraph 2(8) of resolution WHA58.31 called for a progress report, and the item should be listed accordingly, at least in the provisional agenda.

Dr NYIKAL (Kenya) asked whether the item on “Public health, innovation and intellectual property: progress made by the Intergovernmental Working Group (resolution WHA59.24)”, currently proposed as the new agenda item 12.18, could be brought forward in the agenda. He expected a long debate, and it would be better to consider that subject as early as possible.

Dr KEAN (Executive Director, Office of the Director-General) said that the items were currently grouped in logical order. The order in which they were considered could be adjusted at the request of Member States: the General Committee, at its first meeting on Monday 14 May, would decide on the order of work, which would subsequently be confirmed by Committee A.

Dr NYIKAL (Kenya) asked why there was no mention in the provisional agenda of the report on the geographical rotation of the post of Director-General and on the requirement to appoint a Deputy Director-General.

Dr KEAN (Executive Director, Office of the Director-General) recalled that the resolution that had just been adopted by the Board on that subject had indicated that the report would be made to the Executive Board at its 121st session, which immediately followed the Health Assembly.

Dr NYIKAL (Kenya) recalled that the Director-General had said that, if Member States wished to do so, they could raise that issue during the Health Assembly. He sought clarification of the way in which that could happen.

Dr KEAN (Executive Director, Office of the Director-General) said that, if Member States chose to do so, that matter could be included in the agenda of the Health Assembly.

Mr BURCI (Legal Counsel) said that the Board had just decided that the appointment of the Deputy Director-General and geographical rotation of the post of Director-General would be discussed at its 121st session. If the idea currently being proposed was that one or both of those issues should instead be discussed by the Health Assembly, the Board must decide whether it wished to reconsider its earlier decision.

Mr ABOUBAKER (alternate to Mr Miguil, Djibouti) expressed his support for including the issue of the rotation of the post of Director-General on the agenda for the Health Assembly. Surely the Board could still decide to do that, if it chose?

Dr VOLJČ (Slovenia) asked for item 12.7 “Evidence-based strategies and interventions to reduce alcohol-related harm” to remain where it was in the agenda. It was necessary to discuss the issue fully at the Health Assembly, with the possibility of adopting a resolution, and to stress the impact of the harmful use of alcohol on public health and highlight WHO’s recent activities in that field.

Dr SMITH (Denmark) endorsed the comments made by the member for Slovenia. Discussion of the issue was mandatory, in accordance with resolution WHA58.26. Similarly, item 12.9 should remain as a separate item under Technical and health matters, in accordance with standard practice.

Dr VIROJ TANGCHAROENSATHIEN (alternate to Dr Suwit Wibulpolprasert, Thailand) concurred with the previous two speakers about item 12.7: account had to be taken of the expert group meeting on the issue; a draft resolution might be submitted to the Health Assembly.

No alteration should be made to item 12.9, given the importance of maternal, newborn and child health to the targets of the health-related Millennium Development Goals.

Mr HOHMAN (alternate to Dr Agwunobi, United States of America) said that, in asking for clarification of item 12.7, he had not intended to suggest that the matter should be moved to item 12.19 “Progress reports” nor that it should be deleted. He understood the consensus to be that no alteration should be made to the provisional agenda in that regard.

He had also asked for clarification on item 12.9, since his understanding of resolution WHA58.31 was that it requested the Director-General to report on progress to the Sixtieth World Health Assembly, and he had accepted the explanation given by the Secretariat.

Dr SHANGULA (Namibia) observed that the Health Assembly’s deliberations, particularly those of Committee A, often took longer than expected, and he asked whether the efficiency of the Health Assembly could be improved, while still giving proper consideration to the lengthy agenda.

The CHAIRMAN replied that the problem could partly be attributed to delegates making long statements about the situation in their countries under items such as progress reports which did not call for such information. If countries wished to provide detailed information on their activities, they could perhaps do so in writing instead of in their statements to the Health Assembly.

Dr KEAN (Executive Director, Office of the Director-General) confirmed that there had been no request to move item 12.7 and it would therefore remain in its original place on the provisional agenda. The general feeling of the meeting seemed to be that item 12.9, too, should remain under Technical and health matters.

Replying to the member for Namibia, he said that, as could be seen from the preliminary daily timetable set out in annex 2 to document EB120/32, provision had been made for item 12 to be discussed by Committee B as well as Committee A towards the end of the Health Assembly, and the General Committee, during its review of progress, would decide accordingly.

Dr SHANGULA (Namibia) reiterated his concerns regarding the efficiency of the Health Assembly, in particular Committee A, and suggested that guidelines for statements in the committees should be drawn up for the benefit of Member States in order to ensure that time was not wasted.

Dr GWENIGALE (Liberia), endorsing that comment, requested that Member States should be given such guidelines in advance of the Health Assembly in order to assist them in preparing their written statements.

The CHAIRMAN said that, in the absence of further comments, he took it that the Board wished to adopt the draft decision contained in paragraph 3 of document EB120/32, with the agreed amendments to the provisional agenda, which would be circulated to Member States in accordance with Rule 4 of the Rules of Procedure of the World Health Assembly.

**The decision was adopted.<sup>1</sup>**

The CHAIRMAN said that he took it that the Board wished its 121st session to be convened from 24 May to 26 May 2007 at WHO headquarters, Geneva.

**Decision:** The Executive Board decided that its 121st session should be convened on Thursday, 24 May 2007, at WHO headquarters, Geneva, and should close no later than Saturday, 26 May 2007.<sup>2</sup>

**2. MATTERS FOR INFORMATION: Item 9 of the Agenda**

**Expert committees and study groups:** Item 9.1 of the Agenda (Documents EB120/33 and EB120/34)

The CHAIRMAN drew attention to document EB120/34, noting that there had been no change in the membership of expert advisory panels since 2006.

Dr CAMPBELL FORRESTER (alternate to Dr Allen-Young, Jamaica) expressed concern about the gender disparity in the membership of the advisory panels.

Mr HOHMAN (alternate to Dr Agwunobi, United States of America), referring to the report of the WHO Expert Committee on Drug Dependence, said that, although improving access to and promoting the rational use of controlled drugs were laudable goals, those expanded roles for the Committee might not be appropriate, especially if they diverted resources from its primary mission of reviewing information on psychoactive substances and assessing the need for their international control. He also noted that the Committee had met in March 2006, but its Thirty-fourth report (WHO Technical Report Series, No. 942) had only been released a few days earlier. Such a long delay in issuing the report of an expert committee was unacceptable.

The Committee had decided against recommending any change in the present scheduling of buprenorphine, and he commended that decision. However, he could not support the reclassification of dronabinol from Schedule II to Schedule III of the United Nations Convention on Psychotropic Substances.

The CHAIRMAN, agreeing that reports of expert committees should be issued promptly, said that, in the absence of further comments, he took it that the Board wished to thank the experts who had participated in the meetings and to take note of the report contained in document EB120/33.

**It was so agreed.**

---

<sup>1</sup> Decision EB120(10).

<sup>2</sup> Decision EB120(11).

**Progress reports:** Item 9.2 of the Agenda (Documents EB120/35, EB120/35 Add.1 and EB120/35 Add.1 Corr.1)

**A. Strengthening active and healthy ageing (resolution WHA58.16)**

Mr FRANCO BERBERT (alternate to Dr Buss, Brazil) said that population ageing was an important issue for Brazil and reaffirmed support for implementation of resolution WHA58.16.

Dr CAMPBELL FORRESTER (alternate to Dr Allen-Young, Jamaica), noting that Jamaica too was experiencing population ageing, also reaffirmed support for implementation of resolution WHA58.16.

Mr HOHMAN (alternate to Dr Agwunobi, United States of America) welcomed the progress report. Regrettably, the Ageing and life course programme consisted of only two people, one of whom had retired and the other was due to retire later in 2007. He therefore urged the Director-General to ensure adequate staffing of the Programme.

Professor PEREIRA MIGUEL (Portugal) agreed on the need for adequate human and financial resources for the area of healthy ageing, which had received one of the smallest allocations in the draft Proposed programme budget 2008–2009.

Mr HIWAL (alternate to Dr Al-Eissawi, Iraq) emphasized community participation in healthy ageing.

Dr VOLJČ (Slovenia), endorsing the statements by the members for Portugal and the United States, said that preventing and controlling noncommunicable diseases needed more resources if the problems associated with an ageing population were to be addressed.

The CHAIRMAN, speaking as the member for Bolivia, expressed similar concerns. The benefits of rising life expectancy were inevitably accompanied by increased problems related to ageing, including both physical and mental health ones. Whereas older people in some societies had in the past been respected for their wisdom, they tended to be considered a burden. In order to avoid a worsening of mental health problems among older persons, they had to retain a clear role in society.

**The Board took note of the progress report.**

**C. Public-health problems caused by harmful use of alcohol (resolution WHA58.26)**

The CHAIRMAN said that, in the absence of any comment, he took it that the Board wished to take note of the report on progress in implementing resolution WHA58.26.

**It was so agreed.**

**D. Emergency preparedness and response (resolution WHA59.22)**

The CHAIRMAN said that, hearing no comment, he took it that the Board wished to take note of the report on progress in implementing resolution WHA59.22.

**It was so agreed.**

**E. Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (resolution WHA59.12)**

The CHAIRMAN said that, in the absence of any comment, he took it that the Board wished to take note of the report on progress in implementing resolution WHA59.12.

**It was so agreed.**

**G. *World report on violence and health: implementation of recommendations***

**The Board took note of the progress report.**

**H. Health Metrics Network**

Mr ABOUBAKER (alternate to Mr Miguil, Djibouti), commending the Organization for its efforts to strengthen health information systems through the Health Metrics Network, expressed surprise that no country of the Eastern Mediterranean Region was represented on the Board of the Network. That situation should be rectified.

The CHAIRMAN said that, in the absence of any further comment, he took it that the Board wished to take note of the progress report on the Health Metrics Network.

**It was so agreed.**

**I. Cancer prevention and control (resolution WHA58.22): cervical cancer**

The CHAIRMAN said that, hearing no comment, he took it that the Board wished to take note of the report on progress in implementing resolution WHA58.22.

**It was so agreed.**

**J. Reducing global measles mortality**

The CHAIRMAN said that, in the absence of any comment, he took it that the Board wished to take note of the report on progress in implementing resolution WHA56.20.

**It was so agreed.**

Mr HIWAL (alternate to Dr Al-Eissawi, Iraq), noting that a resolution on blindness prevention had been adopted in 2006 (resolution WHA59.25), asked whether the Board might hear a progress report on that topic.

Dr KEAN (Executive Director, Office of the Director-General) said that resolution WHA59.25 had not included any specific reporting requirement. In response to a further question from Mr HIWAL (alternate to Dr Al-Eissawi, Iraq), he said that no additional progress reports could be added to the Board's agenda for the current session because the agenda had already been adopted.

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

#### Draft resolutions deferred from the Fifty-ninth World Health Assembly and the 118th session of the Executive Board: Item 4.12 of the Agenda (continued)

- **Essential health technologies** (Documents EB120/13 and EB120/13 Add.1) (continued from the twelfth meeting, section 3)

The CHAIRMAN invited the Board to consider the revised draft resolution on “health technologies”, which read:

The Executive Board,  
Having considered the report on ~~essential~~ health technologies,<sup>1</sup>

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:<sup>2</sup>

The Sixtieth World Health Assembly,  
Having considered the report on ~~essential~~ health technologies;

~~Understanding that essential health technologies are devices (physical, biological or chemical), procedures or services that have been developed to solve health problems and are considered essential if they are evidence-based, cost-effective and meet priority public health needs;~~

Recognizing that health technologies equip health-care providers with tools that are indispensable to effective and efficient prevention, diagnosis, treatment and rehabilitation and attainment of internationally agreed health-related development goals, including those contained in the Millennium Declaration;

Understanding that health technologies represent an economic as well as a technical challenge to the health systems of many Member States, and concerned about the waste of resources resulting from inappropriate investments in health technologies that do not meet high-priority needs, are incompatible with existing infrastructures, are irrationally or incorrectly used, or do not function efficiently;

Acknowledging the need for Member States and donors to contain burgeoning costs by establishing priorities in the selection and acquisition of health technologies on the basis of their impact on the burden of disease, and to ensure the effective use of resources through proper planning, assessment, acquisition and management,

#### 1. URGES Member States:

- (1) to collect, verify, update and exchange information on health technologies ~~that will contribute to drawing up an evidence-based list of essential health technologies~~ as an aid to **their** prioritization of needs and allocation of resources;
- (2) to formulate **as appropriate** national strategies and plans for the establishment of systems for the assessment, procurement and management of health technologies;
- (3) to draw up national guidelines for good manufacturing and regulatory practices, to establish surveillance systems and other measures to ensure the

<sup>1</sup> Document EB120/13.

<sup>2</sup> See document EB120/13 Add.1 for the administrative and financial implications for the Secretariat of this resolution.

quality, safety and efficacy of procured and donated medical devices, and to contribute to the fight against counterfeit devices;

(4) to establish **where necessary** regional and national ~~centres of excellence institutes~~ **in** of health technology, and to collaborate and build partnerships with health-care providers, industry, patients' associations and professional, scientific and technical organizations;

2. REQUESTS the Director-General:

(1) to ~~establish a committee of experts~~ **engage with Member States and WHO collaborating centres in health technologies** to assist in the development of **guidelines and tools relating to** ~~and maintenance of a WHO list of essential health technologies;~~

(2) to provide support to Member States **where necessary** in establishing mechanisms to assess national needs for ~~essential~~ health technologies and to assure their availability and use;

(3) to provide technical guidance and support to Member States **where necessary** in implementing ~~national~~ policies on ~~essential~~ health technologies;

~~(4) to designate centres of excellence as WHO collaborating centres to advise on norms, standards and guidelines on essential health technologies;~~

~~(5)~~(4) to work jointly with other organizations of the United Nations system, international organizations, academic institutions and professional bodies in order to provide support to Member States in the prioritization, selection and use of ~~essential~~ health technologies;

~~(6)~~(5) to report on implementation of this resolution to the Sixty-second World Health Assembly.

Mr BAILÓN (Mexico) drew attention to a discrepancy between the English and Spanish versions at the beginning of paragraph 2(5).

Mr HOHMAN (alternate to Dr Agwunobi, United States of America) asked whether the "donated medical devices" mentioned in paragraph 1(3) would, or should, include new devices that needed to go through regulatory processes. In paragraph 2(1), he proposed specifying that the development of guidelines and tools relating to health technologies should be achieved "in a transparent, evidence-based way".

Ms PRANGTIP KANCHANAHATTAKIJ (adviser to Dr Suwit Wibulpolprasert, Thailand) welcomed the merging of paragraphs 2(1) and 2(4), but suggested inserting in paragraph 2(1) the word "interested" before "Member States" and the words ", including norms and standards," before "relating to health technologies".

Mr HIWAL (alternate to Dr Al-Eissawi, Iraq) considered that the phrase "and to contribute to the fight against counterfeit devices" in paragraph 1(3) remained ambiguous and that the verb "contribute" was not forceful enough. An amendment or clarification was thus required in order to reflect the idea that effective standards and efforts must be implemented in that regard.

Dr KEAN (Executive Director, Office of the Director-General) read out the proposed amendments to paragraph 2(1), which would read: "to engage with interested Member States and WHO collaborating centres in the development, in a transparent and evidence-based way, of guidelines and tools, including norms and standards, relating to health technologies".

Dr ZUCKER (Assistant Director-General) said that "procured and donated medical devices" did not refer to new devices provided by a manufacturing plant, but to all devices that were in the public domain.

Mr HOHMAN (alternate to Dr Agwunobi, United States of America) asked whether it would be better to delete “procured and donated”.

Dr CAMPBELL FORRESTER (alternate to Dr Allen-Young, Jamaica) proposed retaining “donated” and replacing “counterfeit” by “obsolete”.

Dr GWENIGALE (Liberia) said that the word “counterfeit” needed to be reinforced by “obsolete”; obsolete devices were often offloaded on unsuspecting recipients.

Dr KHALFAN (Bahrain) asked why the reference to “counterfeit” devices – a concept relating to patents and copyright – had initially been inserted in the paragraph. Moreover, he did not see why countries wishing to make use of “obsolete” devices should be prohibited from doing so, provided they were reconditioned.

Mr BAILÓN (Mexico) proposed ending the paragraph after “medical devices”, thus deleting “and to contribute to the fight against counterfeit devices”. That would not undermine the spirit of the resolution, and specific details could be addressed later in technical meetings.

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

Mr HOHMAN (alternate to Dr Agwunobi, United States of America) recalled that, in addressing the same issue at the previous meeting, the Director-General had referred to three areas of concern that had been reflected in earlier versions of the draft resolution, on which the Secretariat would undertake further work. He requested confirmation that a report on that work would be submitted to the Board at its session in May 2007.

The DIRECTOR-GENERAL said that the discussion on item 14.12 of the Agenda had revealed three areas of concern with regard to the draft resolution, one of which had been met by deletion of the word “essential” from the title of the resolution. Further work remained in order to resolve the other two matters, namely, the scope of health technologies and the drawing up of a list thereof. A group of experts and interested Member States would be established for that purpose, with the aim of preparing a report to be submitted to the Health Assembly along with the resolution just adopted.

Mr HOHMAN (alternate to Dr Agwunobi, United States of America) stressed that the results of any further work should be considered by the Board before the report was submitted to the Health Assembly.

The DIRECTOR-GENERAL confirmed that, in accordance with procedure, a revised report would have to be considered by the Board before being submitted to the Health Assembly. The Secretariat would hold consultations with members of the Board by electronic means in order to finalize matters in time for submission to the Sixtieth World Health Assembly in May 2007. Failing that, the matter would be placed on the agenda of the 121st session of the Board. However, given that the Board had just approved the provisional agenda for the Sixtieth World Health Assembly, including an item on health technologies, the report contained in document EB120/13 could perhaps be appropriately amended in order to remove any references to the outstanding areas of concern and submitted to the Sixtieth World Health Assembly along with the resolution just adopted.

---

<sup>1</sup> Resolution EB120.R21.



**4. CLOSURE OF THE SESSION:** Item 10 of the Agenda

Dr SADASIVAN (Singapore), supported by Mr HIWAL (alternate to Dr Al-Eissawi, Iraq), invited the Board to reflect on the possibility of increasing its productivity through more efficient use of information technology. The provision of individual monitors in the Board room would allow drafting changes in resolutions to be displayed on screen as soon as they were proposed, which would eliminate the delays involved in preparing revised paper versions. The availability of broadband communications would allow prepared statements to be circulated digitally to all members.

The DIRECTOR-GENERAL said that her first session of the Board as Director-General had been instructive and stimulating. Members may have differed in their views, on the issues at hand, but they were united in recognizing the common responsibility to the Organization.

A high point had been the offer of support from the three Regional Directors whose regions were free from poliomyelitis to the regions where the disease was still endemic. It exemplified WHO acting as one. The iron will displayed in the fight against poliomyelitis should also be applied to other unresolved public health problems. She had noted, in particular, the concerns at the lack of progress in improving access to essential care, and had adapted her thinking accordingly.

Documentation for the Sixtieth World Health Assembly would be revised in the light of members' comments, in particular the recommendations on both the content and format of the draft Medium-term strategic plan 2008–2013 and streamlining its strategic objectives. Documentation would be dispatched by 29 March 2007. Budgetary discipline would be applied to the Proposed programme budget 2008–2009.

Work on public health, innovation and intellectual property would continue, as outlined in document EB120/INF.DOC./5. Steps would be taken in order to ensure balanced representation in terms of geography and expert views. An electronic consultation on workers' health would be held, and, within the following two weeks, a circular letter would be sent to Member States outlining the procedure. The report on health technologies would be revised and submitted for consideration to the Sixtieth World Health Assembly, together with resolution EB120.R21, which recommended a resolution to the Health Assembly for adoption.

After the customary exchange of courtesies, the CHAIRMAN declared the 120th session closed.

**The meeting rose at 17:15.**

---