

TENTH MEETING

Friday, 25 January 2008, at 14:10

Chairman: Dr B. SADASIVAN (Singapore)

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

Female genital mutilation: Item 4.12 of the Agenda (Documents EB122/15 and EB122/15 Add.1) (continued from the ninth meeting, section 1)

Mr BERLING-RASMUSSEN (adviser to Mr Fisker, Denmark), speaking as a member of the informal drafting group, said that all delegations had shown flexibility in attempting to reach a consensus on the text of the draft resolution. The amendments proposed by Denmark to preambular paragraph 3 and paragraph 1(6) were intended to strengthen the text and bring it into line with resolution 51/2 of the United Nations Commission on the Status of Women, adopted in 2007 and subsequently endorsed by the Economic and Social Council and the United Nations General Assembly. Almost all the delegations at the current session had supported the proposed amendments. Their global resolve to end female genital mutilation made it inappropriate to follow the Chairman's suggestion of deleting the two paragraphs in question in the interests of achieving a consensus. He stressed that lack of agreement on the remaining issues in the draft resolution in no way undermined WHO's existing mandate for combating female genital mutilation; nor did it affect the Director-General's authority to sign the revised WHO/UNFPA/UNICEF joint statement on female genital mutilation in March 2008.

Proposing that the draft resolution should be forwarded to the Health Assembly with the bracketed text, he indicated that the main sticking point in the working group's deliberations had been the use of the word "Reaffirming" at the beginning of the third preambular paragraph – a surprise in view of the long-standing agreement to use that word in discussions within the United Nations on the topic of female genital mutilation.

Mr KIDDLE (alternate to Mr McKernan, New Zealand) endorsed the statement by the previous speaker. Any action taken by WHO against female genital mutilation, a terrible form of violence and an abuse of human rights, must be anchored in the political and legal framework supporting all United Nations agency activity on the rights of women and girls and other gender issues, namely the Beijing Declaration and Platform for Action and the outcome documents of the five- and ten-year reviews. For that reason it was essential to use the word "Reaffirming", as the language used by WHO's governing bodies must chime with that used in other United Nations forums. It was not enough for Member States to "recall" the Declaration or to "affirm" certain parts of the framework; they must affirm it in its entirety. Submitting a draft resolution to the Health Assembly with bracketed text might be regrettable, but it would afford Member States time to reconsider the issues in order to demonstrate within WHO the same approach to the subject as that shown in other United Nations forums; in no way did it detract from the engagement of WHO in interagency action against female genital mutilation; nor should it prevent the Director-General from signing the revised interagency joint statement.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) supported the comments of the previous two speakers and expressed confidence that a consensus would be reached before the draft resolution came before the Health Assembly.

Mr ABDOO (alternate to Dr Wright, United States of America) considered that the documents listed in the third preambular paragraph were not legally binding, since they were not formal conventions or treaties; to “recall” rather than “reaffirm” them was thus appropriate, as had been the case in resolution WHA60.25. The proposed solution of submitting text in square brackets to the Health Assembly was the best in the circumstances, and he expressed the hope that a consensus would soon be reached.

Dr KEAN (Executive Director, Office of the Director-General) suggested changing the word “adoption” in the introductory text of the draft resolution to “consideration”, since the Board could not recommend that the Health Assembly adopt a draft that still had text in square brackets. The third preambular paragraph would be transmitted to the Health Assembly with three alternatives in square brackets, namely: “Reaffirming”, “Reaffirming the goals and commitments contained in” or “Recalling”. In the same paragraph, the phrase “and related reports” would be placed in square brackets. The entire paragraph 1(6) would likewise be placed in square brackets.

The CHAIRMAN said that, if there were no objection, he took it that the Board wished to transmit the draft resolution to the Health Assembly for its consideration, with the changes that had been mentioned.

The resolution, as amended, was adopted.¹

2. MATTERS FOR INFORMATION: Item 8 of the Agenda (continued)

Progress reports: Item 8.2 of the Agenda (Documents EB122/29 and EB122/29 Add. 1)

A. Control of human African trypanosomiasis (resolution WHA57.2)

Mr TOURÉ (Mali), speaking on behalf of the Member States of the African Region, said that three million people in 36 countries of sub-Saharan Africa were at risk from human African trypanosomiasis. Surveillance activities between 1997 and 2004 had increased the number of people covered by active case detection from 1.3 million to 3.3 million. Nevertheless, the cases reported were only a small fraction of the total, since surveillance coverage was still low and information systems were inadequate. *Trypanosoma brucei gambiense* was the parasite responsible for 97% of reported cases of trypanosomiasis; the disease it caused was endemic in 24 countries. The most seriously affected were Angola, Democratic Republic of the Congo and Sudan. The first two had sound national control programmes, and the third received considerable support from nongovernmental organizations.

Of the 13 countries where disease due to *T. b. rhodesiense* was endemic, only Kenya, Malawi, Uganda and United Republic of Tanzania conducted control activities. In 18 countries in which the disease was endemic, all trypanosomiasis patients had received free treatment in 2006. Following a recent agreement, a pharmaceutical company would donate medicines worth US\$ 5 million. WHO was working with the Pan African Tsetse and Trypanosomiasis Eradication Campaign in order to eradicate the disease itself and its carrier, the tsetse fly.

In view of the significant number of cases involved, trypanosomiasis should remain a public health priority in Africa. Control efforts had been hampered by the lack of financing and qualified health workers. Epidemiological information and surveillance systems must be improved through capacity building in order to ensure the evaluation of control programmes in trypanosomiasis-endemic countries. The disease posed the greatest problems in rural areas, where weak or non-existent health

¹ Resolution EB122.R13.

services rendered surveillance ineffective. Diagnosis required qualified health workers and proper equipment. In addition, more support was required for controlling the human reservoir of the parasite *T.b. rhodesiense*.

Research into new drugs and training must be strengthened. Trypanosomiasis was a neglected disease that did not attract research funding; it should be included on health agencies' agendas alongside HIV/AIDS, malaria and tuberculosis.

Collaboration between all those involved in control of trypanosomiasis and between countries in which the disease was endemic should be strengthened. Control campaigns were needed with targeted interventions and investment. Continuing tsetse fly trapping campaigns in collaboration with local farmers was vital.

Dr NAKATANI (Assistant Director-General) acknowledged that trypanosomiasis remained a major problem in Africa. Monitoring and surveillance had been cited as areas to be improved, and the Secretariat was committed to increasing its surveillance activities for malaria and neglected tropical diseases. Furthermore, cross-cutting activities were being performed in the areas of diagnosis, treatment, training of human resources and research and development. The organizational structure at headquarters had been changed, grouping the technical units combating neglected tropical diseases, HIV/AIDS, malaria and tuberculosis, since those diseases severely impeded economic development in developing countries. Synergies could thus be achieved.

B. Strengthening nursing and midwifery (resolution WHA59.27)

Professor SALANIPONI (Malawi), speaking on behalf of the Member States of the African Region, said that the problems facing nursing and midwifery in the Region included the lack of a qualified health workforce, poor human resources planning and capacity, inappropriate training, loss of staff due to HIV/AIDS, unfavourable terms of employment and poor working conditions. Welcoming the global survey on monitoring strategic directions, he urged WHO to provide support to other Member States in preparing such plans. A strategic plan had been developed in order to strengthen nursing and midwifery in the African Region, and WHO's Global Advisory Group on Nursing and Midwifery had brought support for the planning and implementation of regional capacity building.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that in monitoring nursing worldwide the Council had seen signs of impending disaster in many national health-care systems: hospitals so overcrowded and understaffed that patients' dignity and needs received scant attention; nurses so overworked and underpaid that they hated their jobs despite loving their profession; errors and staff turnover on the increase, patient safety on the decline. In response, a group of member associations were launching a five-year campaign in order to foster a positive practice environment, improve nurse retention and attract new recruits at minimum cost. He welcomed WHO's renewed commitment to dealing with the crisis in nursing and midwifery. But those professions relied also on a long-term commitment on the part of governments and donors to building human resources capacity. The Council was ready to work with WHO at country level in order to optimize the work of nurses in support of the Millennium Development Goals and national priorities. Never had the need for WHO's leadership at the national and regional levels been greater. But never had the representation of nursing and midwifery at WHO been so poor. How was the Organization planning to respond?

Dr NORDSTRÖM (Assistant Director-General) said that the Secretariat greatly appreciated working on nursing and midwifery with professional associations. A recent meeting in Addis Ababa had discussed maternal mortality, particularly in relation to HIV/AIDS, and how to expand the role of midwives. The Organization should respond to challenges concerning midwifery and take steps to improve the number and mix of health workers available. WHO's changing agenda entailed changes in

staffing patterns; midwives were increasingly being sought for regional and country offices, in support of skilled attendance at delivery.

C. International trade and health (resolution WHA59.26)

Ms SEBUDANDI (Rwanda), speaking on behalf of the Member States of the African Region, said that 37 of the 46 Member States were Members of WTO and signatories to multilateral agreements on barriers to trade, sanitary and phytosanitary measures, trade-related intellectual property rights and trade in services. The agreements established principles and rules for expanding trade in conditions of transparency and progressive liberalization, presenting both opportunities and risks for public health. Limited awareness of the agreements and their implications for health services in the Region hampered national authorities negotiating at WTO meetings in their efforts to maximize public health benefits while mitigating any negative effects.

Some Member States had received support for preliminary studies on trade in health services. In 2006 the Regional Committee for Africa had adopted a resolution¹ urging Member States to promote dialogue with stakeholders at national level on the relationships between international trade and health, and to adopt policies, laws and regulations in response to issues identified. The Regional Office for Africa had prepared terms of reference for country-level studies on trade in health services. Difficulties remaining included lack of funding for research and capacity building in Member States.

Dr EVANS (Assistant Director-General) assured the Board that the Secretariat would continue to act – particularly on capacity building – in accordance with resolution WHA59.26.

D. Health promotion in a globalized world (resolution WHA60.24)

Professor PEREIRA MIGUEL (Portugal) observed that the report recalled the main basis for action in health promotion, taking into consideration the principles set out in the Ottawa Charter for Health Promotion and the recommendations of the Bangkok Charter for Health Promotion in a Globalized World. Progress towards a healthier world required strong political action, broad participation and sustained advocacy. Governments, international bodies, civil society and the private sector must cooperate closely and make health promotion central to the global development agenda.

Portugal's integrated programme on health determinants focused on tobacco, nutrition and physical activity. A law on tobacco control had entered into force on 1 January 2008 to make enclosed public spaces and workplaces smoke free, and the health service offered smoking cessation services. Also, a partnership initiative against obesity had been launched in August 2007.

In support of essential actions on good practice in the implementation of health promotion programmes, he emphasized the Secretariat's expertise in health promotion for Member States' work. He also supported WHO's role in facilitating intergovernmental cooperation, such as that on the Framework Convention on Tobacco Control. Similar instruments should be developed in other areas. Organizing global multisectoral conferences on health promotion could improve the training and motivation of health professionals.

He asked for more information on the global framework for the promotion of health, especially forthcoming activities and when the global strategy might be submitted to the governing bodies. WHO should increase its involvement in health promotion at global and regional levels.

Dr MATHESON (alternate to Mr McKernan, New Zealand) asked whether WHO viewed health promotion as a framework for organizing health systems or as a specialized discipline. Noting that the Regional Office for Europe had used health promotion to strengthen its health systems strategy, he enquired to what extent health promotion was integrated throughout the Organization's programmes as

¹ Resolution AFR/RC56/R4.

a model for health systems in general. The global framework project should strategically position health promotion within health systems at both national and global levels.

Mr RAKOTONIRINA (alternate to Dr Jean Louis, Madagascar), speaking on behalf of the Member States of the African Region, recalled that the aim of resolution WHA60.24 had been to place the equitable improvement of health at the centre of development efforts at national, regional and global levels. Health promotion was vital to health development and development in general through public information, health education and adoption of healthy lifestyles.

Health promotion with regard to the various provisions of resolution WHA60.24 varied across the African Region. The Regional Office had supported Member States to strengthen national capacities and formulate health promotion policies. High-level training was planned for 2008 and 2009. Several countries had already taken steps in mapping health promotion activities, developing partnerships, elaborating a multisectoral approach and mobilizing resources.

Madagascar's health promotion policy was being finalized, with numerous activities involving actions at community level, adapted to the circumstances of each community. Those had proved effective, to judge by the best practices that had been shared within the Region. The health ministry was conducting a study on harmonizing community approaches, whose results would inform strategic planning.

Countries of the Region were updating their monitoring and evaluation mechanisms for health promotion activities, with best practices disseminated in preparation for the 7th Global Conference on Health Promotion, to be held in Kenya in 2009. Various countries were reorienting their public health systems towards the adoption of healthier lifestyles; Botswana and South Africa had established programmes that encouraged physical activity in the workplace. In Madagascar, a department to combat noncommunicable diseases had been established within the Ministry of Health and a policy had been drawn up on reducing lifestyle-related risk factors.

Following the strengthening of capacities at subregional level, databases would be set up in each country in order to develop health promotion activities within the African Region. The impact of WHO's priority programmes had been enhanced through the incorporation of health promotion elements.

The Regional Office was encouraging the exchange of experience and best practice with the International Union for Health Promotion and Education. A similar facility was available through an online forum for health promoters within the Southern African Development Community.

The principal challenges for Africa were to identify the resources needed for health promotion and to recycle or recruit the necessary staff. Madagascar faced the challenges of adopting a national policy on health promotion and in raising awareness that the concept was a key element for all participants in health development.

Dr SUGIURA (alternate to Dr Shinozaki, Japan) welcomed the health promotion activities and meetings organized worldwide. Health promotion for both developed and developing countries must move from theory to practice. He supported primary health care and school health as entry points for health promotion. In Japan, schools promoted child and adolescent health, and the National Institute of Public Health provided training on health promotion in collaboration with WHO. Health promotion should not be treated as an independent programme; at county level, staff should integrate health promotion into disease-control programmes.

Dr DAHL-REGIS (Bahamas), highlighting the cross-cutting nature of health promotion and its importance for building systems, said that, despite much effort, including the adoption of health promotion charters, many countries struggled to institutionalize health promotion as integral to system performance. She echoed other speakers' requests for information on how health promotion was integrated into WHO's programmes, and a review of evidence supporting changes at country level.

Mr AITKEN (Assistant Director-General, ad interim), responding to questions asked, said that the draft global framework, which was primarily the Secretariat's initiative, would be circulated to

Member States for their comments. No decision had been taken on whether it would be necessary to submit the document to the governing bodies for their approval. The Secretariat was engaged in interdepartmental collaboration in order to ensure that health promotion was integrated into all other programmes. Countries and regions provided the main sources of skills for making health promotion a priority within WHO programmes. The 7th Global Conference on Health Promotion would provide a prominent occasion to highlight the importance of health promotion throughout WHO's work.

E. Smallpox eradication: destruction of variola virus stocks (resolution WHA60.1)

Dr HEYMANN (Assistant Director-General) said that the annual meeting of the WHO Advisory Committee on Variola Virus Research had been delayed until the last week of November 2007 because of conflicting meetings. The report had been prepared, sent out and reviewed against tight deadlines so that it could be provided to the Executive Board. Additional comments from participants had been received subsequently and would be incorporated in the final meeting report to be submitted to the Sixty-first World Health Assembly.

Professor SALANIPONI (Malawi), speaking on behalf of the Member States of the African Region, expressed appreciation for the research and work of the Advisory Committee outlined in the report. The global eradication of smallpox had been declared in resolution WHA33.3. Subsequent Health Assembly resolutions had referred to the temporary retention of variola virus stocks and their eventual destruction, culminating in resolution WHA60.1.

Member States of the African Region requested the Director-General to continue to tighten control and oversight, including through a major review of the research that had been completed, was in progress or planned, and to conduct an annual assessment of the need for retention of virus stocks. The Member States further requested the Director-General to ensure balanced regional representation in the Advisory Committee, to continue the inspections for biosafety and biosecurity of the two authorized repositories and to submit a detailed annual report to the Health Assembly. He also requested the Director-General to ensure that the time frames set out in resolution WHA60.1 were met and to provide, in the report to the Sixty-first World Health Assembly, an update on the major review process. He confirmed the Member States' commitment to reaching a date for the destruction of the variola virus in line with the decisions of the Health Assembly.

Dr SUGIURA (alternate to Dr Shinozaki, Japan) welcomed the progress of research activities described in the report, including those on antiviral agents and vaccines. Consensus at the Sixty-fourth World Health Assembly on the timing of the destruction of existing variola virus stocks was highly likely. He supported WHO's work in promoting wide and equitable access to research, which should be extended to other diseases and fields.

The DIRECTOR-GENERAL thanked the members for Malawi and Japan for their advice; she would follow the actions outlined in resolution WHA60.1 and report to Member States accordingly.

F. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)

Mr RAKOTONIRINA (alternate to Dr Jean Louis, Madagascar), speaking on behalf of the Member States of the African Region, recalled their commitment to achieving the Millennium Development Goals. As they reached the halfway mark, it was important to assess how far Goals 4, 5 and 6 had been reached in order to determine future strategies, actions and initiatives.

The Member States of the Region were confronted with problems of access to quality services. In rural areas, more than half the population lived over an hour's walk from medical centres. Obstacles to understanding and facilitating the use of reproductive health services included customs, values, illiteracy, and low levels of education. Women lacked economic power, had low social status and poor access to information on reproductive rights and health.

Available data showed positive, though slow, progress in maternal health care. Contraceptive coverage stood at 13%. In sub-Saharan Africa, 70% of pregnant women were able to receive at least one prenatal consultation. Teenage pregnancy and abortion rates were high, with unsafe abortions causing 13% of maternal deaths. Maternal mortality rates had fallen as countries strengthened primary health care and emergency obstetric services; however, one in 16 women in sub-Saharan Africa died as a result of complications in pregnancy and childbirth, whereas in developed countries the proportion was one in 2800. Early diagnosis could prevent 80% of deaths due to cervical cancer; however, 50% of cases were diagnosed late due to lack of access to diagnostic services. Between 20% and 30% of pregnant women were estimated to be HIV-positive and rates of mother-to-child transmission of HIV were between 25% and 40%. Efforts had been focused on: evaluating three reproductive health research centres in Burkina Faso, Ghana and Senegal; using advocacy tools for family planning; improving access to and availability of family planning services, emergency obstetric care and centres for voluntary counselling and testing and prevention of mother-to-child transmission of HIV; integrating reproductive health services; and strengthening logistics in order to secure the supply of reproductive health products, including contraceptives.

Ten African countries had benefited from support to integrate action against HIV/AIDS into maternal and neonatal services, and 11 countries had updated their family planning guidelines and strengthened the links between reproductive health, sexually-transmitted diseases and HIV/AIDS.

In order to achieve the health-related Goals, it was essential to make access to care in childbirth and caesarean sections free of charge so that women could be assisted by qualified personnel; improve the drafting of comprehensive policies for reproductive health; increase the number of qualified personnel; integrate sexual education into the school curriculum in order to make young people aware of the dangers of early marriages and unsafe abortions; ensure the availability of contraceptives and reproductive health medicines; improve coverage of reproductive health services; develop community health networks; and promote initiatives to enhance the status of women. Efforts to improve reproductive health should be redoubled and more resources mobilized.

Professor PEREIRA MIGUEL (Portugal) said that the complex, multicultural nature of contemporary societies should be considered when developing reproductive health interventions. For as long as inequality of opportunity existed, women's reproductive health, gender equality and female empowerment would continue to be global priorities. At the same time, interventions to promote the reproductive health of cultural and ethnic minorities should be broadened to involve men in the use of contraceptives and the prevention of sexually-transmitted diseases. Men could thus be made responsible for the sexual and reproductive health of both partners.

Professor SALANIPONI (Malawi) noted that Africa was facing major obstacles in achieving the Millennium Development Goal related to maternal mortality. It was a scandal that so many African women died while giving life. Little progress had been made in reducing maternal mortality, which in Malawi stood at 984 per 100 000 live births; 80% of maternal deaths in Malawi occurred at the community level and only 30% of deliveries were attended by qualified personnel. Although 93% of pregnant women presented themselves at health facilities for antenatal care, many were unable to reach the health facility to give birth owing to lack of transport. Even more disturbingly, of those women who were able to deliver their babies, many succumbed to postpartum infection within a fortnight. In order to overcome the obstacles Malawi's actions included district health management through working at grassroots level with village chiefs in order to develop transport links to the nearest health centres and hospitals, and enhancing basic obstetric care in health facilities. Such pragmatic interventions contributed significantly to reducing maternal and neonatal mortality in Malawi.

Ms MAFUBELU (Assistant Director-General), thanking speakers for their comments, said that the members for Madagascar and Malawi had comprehensively highlighted the issues in Africa. She agreed with the emphasis placed on integration of sexual and reproductive health in health systems and the focus on interventions against loss of life in childbirth, including access to skilled birth attendants, transport and postpartum care. She expressed appreciation of the comments from the

member for Portugal concerning the sexual and reproductive health of minorities and the importance of involving men. She would work with WHO's partners to do everything possible to reduce the figure of 536 000 mothers who died each year.

G. Infant and young child nutrition: biennial progress report (resolution WHA58.32)

Mr TOURÉ (Mali), speaking on behalf of the Member States of the African Region, recalled that exclusive breastfeeding for the first six months of life significantly reduced under-five mortality and represented the easiest, cheapest and most effective means of improving survival prospects and favouring the healthy development of children. Promoting exclusive breastfeeding was therefore essential in Africa, where 30% of infants under six months of age were currently breastfed, with 67% receiving complementary foods between the ages of six and nine months and 55% were still being breastfed at 20 months. Widespread malnutrition was responsible for over 60% of deaths among children under five years of age. (In Mali, for example, a significant proportion of infants aged between 6 and 59 months remained exposed to life-threatening malnutrition and many were stunted and underweight.) Furthermore, without preventive action, the risk of mother-to-child transmission of HIV from seropositive mothers who breastfed remained high. Benin, Burundi, Niger, Togo and Zambia were receiving support for the development of national strategies and action plans on infant and young child feeding, bringing to 28 the number of countries with such activities. In Mali, implementation of the national strategy was continuing. The Baby-Friendly Hospital Initiative was being revitalized to strengthen the fight against HIV/AIDS. Lesotho, Madagascar, Malawi, Namibia, South Africa and Swaziland among others had received training in new WHO/UNICEF evaluation tools. Mali had 32 baby-friendly hospitals. In Eritrea, Kenya, Mali, Mozambique, Namibia and Nigeria, technical guidelines and policies on HIV infection and infant feeding had been revised and disseminated to health-care workers. Mali had also benefited from national and regional training for trainers.

Resolution WHA58.32 and the International Code of Marketing of Breast-milk Substitutes offered a means of protecting breastfeeding against adverse commercial influences. Nigeria had revised its legislation on the marketing of foods for infants and young children. Gambia, Mali and Zambia had incorporated the Code into their national legislation. Mozambique and South Africa were doing likewise, and the Code was under review in Ghana, Madagascar, Nigeria, United Republic of Tanzania, Zambia and Zimbabwe.

National courses to train trainers in integrated counselling on infant and young child feeding had been organized in a dozen countries, including Mali, bringing the total to 29. In Mali additional activities included health-worker training, vitamin A supplementation, deworming programmes, distribution of insecticide-treated bednets, immunization and implementation of a nationwide salt-iodization strategy.

Remaining challenges included: extending feeding interventions, within limited financial resources, to reach every child; accelerating expansion of the Baby-Friendly Hospital Initiative; introducing infant and young child feeding into pre-service training programmes; introducing legislation to regulate the marketing of breast-milk substitutes; and mobilizing funding for the management of severe malnutrition.

He requested that a report on the implementation of resolution WHA58.32 should be submitted to the Sixty-first World Health Assembly in response to the two reporting requirements contained in that resolution.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that in resolution WHA58.32 the Director-General was requested to report to the Health Assembly each even year, and to report on the International Code of Marketing of Breast-milk Substitutes. Since there had been no report in 2006, it was imperative that in 2008 a full report should be submitted. He recognized that the current agenda had been full; nevertheless, that important issue should receive greater attention on the agendas of future sessions of the Executive Board and the Health Assembly.

Professor PEREIRA MIGUEL (Portugal) observed that a powerful reason for encouraging breastfeeding was the possible contamination of formulas by *Enterobacter sakazakii* and salmonella. Exclusive breastfeeding during the first six months of life should also be promoted because it benefited both mother and child. Commending the report, he suggested that the Board might wish to consider the following: the adoption of a code for manufacturers of infant and young child food that would provide a level of health protection; the framing of international legislation to prevent the use of misleading information to market infant and transition formulas, including on packaging; the definition of measures for expanding the number of baby-friendly hospitals; and strengthened measures to protect breastfeeding mothers in paid employment.

Ms KRISTENSEN (adviser to Mr Fisker, Denmark) stressed the importance of focusing on nutrition and breastfeeding and drew attention to the link between them and Millennium Development Goal 4 of reducing child mortality. Supporting the comments of the member for the United Kingdom of Great Britain and Northern Ireland, she added that the inclusion of a full discussion on infant and young child nutrition on the Health Assembly agenda would bolster the commitment of the world health community to end a continuing global tragedy. She also highlighted the link between infant and young child nutrition and the overall approach to noncommunicable diseases, and advocated dealing with all issues related to noncommunicable diseases under one umbrella.

Dr AHMADZAI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that nutrition was at the core of child health and should be given priority in the interests of achieving Millennium Development Goal 4. Interventions to improve feeding practices existed, but coverage remained very low both regionally and globally. Expanding coverage of cost-effective interventions throughout his Region was vital. National policies should also ensure universal and equitable access to services and should be adapted in response to new or unresolved issues. Regulatory measures to support activities such as breastfeeding and to counteract negative market-led practices should be developed and enforced. Partners from within and beyond the health sector were needed with strong coordination. He emphasized advocacy initiatives to encourage policy development and implementation monitoring; the creation of an enabling environment; and the securing of adequate resources.

Mr RAKOTONIRINA (alternate to Dr Jean Louis, Madagascar) said that Madagascar had conducted numerous media campaigns to raise awareness of the benefits of breastfeeding. In factories and other enterprises, employers were required to allow mothers the time to breastfeed their babies while at work, and legislation had been passed in order to prevent the Government's efforts to promote breastfeeding being undermined by the advertising of breast-milk substitutes. He urged Member States to intensify their actions in support of breastfeeding, and expressed appreciation of the work of the nongovernmental organizations in that regard.

Dr SINGAY (Bhutan), speaking on behalf of the Member States of the South-East Asia Region, said that initiation of breastfeeding within one hour of birth and exclusive breastfeeding for the first six months of life were essential for reducing neonatal and infant mortality. In his Region, malnutrition was widespread and mortality rates for infants and children under five were unacceptably high. Member States should implement both the International Code of Marketing of Breast-milk Substitutes and WHO's Global Strategy for Infant and Young Child Feeding. National breastfeeding committees needed to coordinate and review policies and programmes on a regular basis. Member States should also guarantee maternity entitlements, integrate infant and young child feeding into national health and nutrition programmes and identify best practices; and government agencies should incorporate into HIV prevention the consensus statement by WHO's technical consultation on HIV and infant feeding. National legislation should be strengthened in order to stop all commercial promotion of breast-milk substitutes and ensure that manufacturers adhered to the Codex Alimentarius or food standard regulations. Training on infant and young child feeding should be given to all health-care personnel and the Baby-Friendly Health Initiative should include baby-friendly hospitals.

Adequate funding was needed to protect, promote and support breastfeeding and infant and young child feeding.

Dr MENESES GONZÁLEZ (alternate to Dr Hernández Ávila, Mexico) said that the report had raised certain points that required clarification. One was the role of breast-milk substitutes and their potential to cause illness in infants and children under five and chronic health problems in later life, an issue that was being discussed in scientific literature. WHO and FAO had produced a joint set of guidelines on safe preparation of powdered infant formula, which also recommended that Member States should report every two years on progress made in implementing the guidelines. That requirement should have been included in the report. If all Member States were to promote breastfeeding as a public health initiative, the number of deaths among children of under five years old could be significantly reduced.

Ms ARENDT LEHNERS (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN and on behalf of the International Confederation of Midwives and La Leche League International, observed that the report had omitted several issues relating to the role of breastfeeding in combating malnutrition. The updated WHO Global Data Bank on Infant and Young Child Feeding enabled assessment but no mention was made of food safety work performed by the Secretariat in relation to resolution WHA58.32, including the expert meetings on *Enterobacter sakazakii* and the contamination of infant formula; nor was there a reference to the new WHO/FAO guidelines for the safe preparation, storage and handling of powdered infant formula, which was also referenced in the recent draft Codex Alimentarius document under the heading “Proposed draft code of Hygienic Practice for Powdered Infant Formula for Infants and Young Children”.

Lactation consultants, midwives and breastfeeding counsellors worldwide would confirm the findings of scientific studies on the success of counselling in enabling mothers to breastfeed for between six months and two years and to introduce adequate complementary food.

Dr BRONNER (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, said that industry-sponsored research had contributed much knowledge about nutritional needs of infants and young children and formula for special medical purposes which had improved the survival rates for children with certain disorders. Infant formula manufactured according to Codex standards was nutritionally complete, replacing dangerous breast-milk substitutes – a major cause of malnutrition and mortality. WHO recognized the value of formula for infants unable to be breastfed. Stressing the need for multisectoral cooperation to optimize infant and young child feeding practices, she said that the International Association of Infant Food Manufacturers had sponsored a PAHO research initiative. She reaffirmed the infant food industry’s commitment to the primary aims of the International Code of Marketing of Breast-milk Substitutes: provision of safe and adequate nutrition through the promotion of breastfeeding and the proper use of breast-milk substitutes.

Ms STERKEN (Consumers International), speaking at the invitation of the CHAIRMAN, said that Consumers International represented over 220 organizations in 115 countries and was a founding member of the International Baby Food Action Network. Scientific evidence confirmed the importance of breastfeeding in the short- and long-term, not only in preventing noncommunicable diseases but also in protecting children against undernutrition and overnutrition, reducing morbidity and mortality and contributing to attainment of Millennium Development Goal 4. The health risks of artificial feeding were compounded by the contamination of powdered infant formula which particularly affected premature, low-birth-weight infants, and babies with impaired immune functions. The Codex Alimentarius Commission was addressing the problem and FAO and WHO had reported on the impossibility of manufacturing sterile products. All users of such products, therefore, required correct information, including product labelling to inform parents of the lack of sterility. The provision in resolution WHA58.32 concerning the need for an explicit warning on packaging about the risk of microbiological contamination should be implemented urgently. However, the marketing and misleading promotion of such products continued. In 2007, “Breaking the Rules”, the International

Baby Food Action Network's report on the International Code of Marketing of Breast-milk Substitutes, exposed strategies to undermine breastfeeding, including unsubstantiated health claims and lack of informative labelling. Resolution WHA58.32 requested the Director-General to report to the Health Assembly each even year on the status of implementation of the International Code. Would that be submitted to the Sixty-first World Health Assembly?

Mr AITKEN (Assistant Director-General) observed that members' comments revealed links with several other areas such as Millennium Development Goal 4, noncommunicable diseases and communicable diseases if the Code was not followed. Work on the Code and on infant and young child nutrition was a key priority. Several members had noted that the report was not comprehensive with respect to food safety; substantive paragraphs would therefore be added to the report to be submitted to the Health Assembly, in particular concerning work in response to resolution WHA58.32. Replying to the member for Portugal, he confirmed that WHO, in cooperation with FAO, was working on new international standards for powdered infant formula through the Codex Alimentarius Commission. The standards would supplement the existing guidelines on the preparation and storage of powdered infant formula.

The Board took note of the reports.

3. CLOSURE OF THE SESSION: Item 9 of the Agenda.

The DIRECTOR-GENERAL said that the present session had been very stimulating and constructive, giving her a stronger sense of Member States' expectations regarding WHO's technical work, strategic policies, such as the issue of partnerships, and administrative matters. The many suggestions for improving efficiency and cost-effectiveness would be carefully heeded. She had also noted that members wanted resolutions that could be implemented and felt uncomfortable with calls for more financing, especially given the well-defined procedures for agreeing on a results-based budget in advance. In addition, members from developing countries had indicated that they needed support for health that was geared to sustainable results and to national priorities, plans and capacities. They had stressed fairness, including fair access to interventions such as vaccination. Countries that invested heavily in training health personnel wanted to see results.

She had been particularly impressed by the number of cosponsors of the resolution on climate change and health; she too was deeply concerned. She had observed the importance of issuing documents in time for the Board's deliberations and had admitted her personal responsibility in that regard. The Secretariat had received many assignments and was fully conscious that a number of documents, especially the draft action plan on noncommunicable diseases, needed revision. Many issues would be revisited in May and she looked forward to continued discussions, collaboration and progress in the effort to make the world a healthier place.

After the customary exchange of courtesies, the CHAIRMAN declared the 122nd session closed.

The meeting rose at 16:50.
