SECOND MEETING

Monday, 21 January 2008, at 14:05

Chairman: Dr B. SADASIVAN (Singapore)

1. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 3 of the Agenda (Document EB122/3)

Professor PEREIRA MIGUEL (Portugal), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, highlighted the issues in the Committee's report that were not on the agenda of the Board. The Committee had been updated on the status and cost implications of WHO's global management system and service centre to be established in Kuala Lumpur, and on performance monitoring, financing, staffing, operational support, oversight and accountability, and internal justice. The Committee had welcomed the management reforms and the transparency provided in the Secretariat's report on performance assessment of the Programme budget 2006–2007, based on provisional figures, which had been prepared in response to the Committee's request for an analysis of reasons for low financial implementation. The performance assessment for the full biennium would include the final figures.

Partnerships and the impact of their funding on the Programme budget would be discussed by the Board as a substantive agenda item. The Secretariat should begin drafting policy on WHO's involvement in global health partnerships, and clearly reflect the work of partnerships in the Programme budget.

The Committee had noted the monitoring of the Eleventh General Programme of Work and the importance of timely monitoring for assessing implementation of the Programme budget. Stronger monitoring tools should be devised and the responsibilities for monitoring within the Secretariat should be clarified. The Committee had noted the following with satisfaction: the reports on internal oversight and implementation of external and internal audit recommendations; that risk management would be tackled during the course of the biennium; and the rigorous procedures for implementation of the global management system. In future, the summary tables tracking external and internal audit recommendations should be made available earlier. The Committee had commended the reports of the Joint Inspection Unit.

Professor SALANIPONI (Malawi), speaking on behalf of the Member States of the African Region, commended audit compliance in Africa. The Board should set criteria to decide which of its agenda items should first be discussed by the Programme, Budget and Administration Committee. Items concluded in previous meetings had been included on the agendas of both the Board and the Committee, giving the impression that there was a wish to amend decisions.

He sought assurances that the global management system would meet the needs of clients and Member States, encourage management innovation and ensure effective delegation. Regular assessment and use of information on clients' needs remained essential.

Human resources for health were important for the African Region, which bore the greatest burden for many diseases. The Secretariat needed to provide technical and financial support as Member States expanded health services to underserved, new or post-conflict areas. In 2007 the Committee had expressed concern over the large number of temporary employees in WHO offices in the African Region. Moving personnel from temporary to long-term positions was a necessity if the Organization was to fulfil its mandate. Concerns voiced over the future financial burden represented by retired staff were valid. He emphasized the supervision and monitoring of staff.

Mrs PRADHAN (Assistant Director-General) emphasized that the global management system would respond to the needs of all clients, including the country and regional offices as well as WHO headquarters.

Dr KEAN (Executive Director, Office of the Director-General) explained that the agenda was set in accordance with the terms of reference of the Programme, Budget and Administration Committee as agreed by the Executive Board at its 117th session. The first item of the agenda, "Management reforms: review of progress", had been instituted by the Committee two years previously in order to set the scene for discussion of other management items.

2. TECHNICAL AND HEALTH MATTERS: Item 4 of the Agenda

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 4.2 of the Agenda (Document EB122/5)

The CHAIRMAN drew attention to the report on the Intergovernmental Meeting held in November 2007 contained in document EB122/5 and invited comments thereon.

Mr TOURÉ (Mali), speaking on behalf of the Member States of the African Region, said that the threat of pandemic influenza continued: to date, eight countries in the African Region had reported outbreaks of avian influenza in poultry, with the first confirmed human case in Nigeria in 2007. The situation in Djibouti and Egypt, neighbouring countries of WHO's Eastern Mediterranean Region, highlighted the need for continued vigilance. Although avian influenza had not been found in Mali, the risks were significant given that bordering countries had been affected and that the River Niger delta and the Senegal River basin were home to migratory birds. Mali had put in place a coordination committee in order to combat avian influenza with emergency, contingency, and longer-term plans for prevention and control. Mali had hosted the fourth International Conference on Avian Influenza in December 2006, at which US$ 475 million had been pledged. Despite the progress made, a lack of resources to implement national action plans for detection and containment rendered African Member States more vulnerable. National, regional and subregional surveillance and laboratory networks were needed in order to improve diagnosis and detection. Timely sharing of information resulting from surveillance was essential. The exchange of viruses between the WHO Global Influenza Surveillance Network, WHO collaborating centres on influenza and WHO H5 reference laboratories in order to prepare vaccines against seasonal influenza had proved effective. Strengthening capacities and the transfer of technology from developed to developing countries were equally important in identifying viruses and producing vaccines. The Regional Office for Africa was collaborating with headquarters in collecting baseline data from Member States in order to identify vaccine requirements and sources of funding. Member States sought an equitable distribution of H5N1 vaccines: an international mechanism to protect the interests of developing countries was imperative.

The African Region had been represented in the Interdisciplinary Working Group on Pandemic Influenza preparedness by Cameroon, Ghana, Nigeria and South Africa. The Group had not reached consensus on all points and the documents were due to be revised for the resumed Intergovernmental Meeting. Representatives of African Member States would participate in the resumed Intergovernmental Meeting. An expert would also report to the Intergovernmental Meeting on influenza virus and gene patents.

There was a need for transparent and equal access to diagnosis and treatment, including vaccines at affordable prices, supplied rapidly, especially in developing countries. All members should support the establishment of an international mechanism to protect the interests of developing countries.

Dr VOLJČ (Slovenia), speaking on behalf of the Member States of the European Union, 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 also Ukraine, the Republic of Moldova and Armenia, aligned themselves with the statement. Unfortunately, the report on pandemic influenza preparedness had not been issued in sufficient time for it to be properly reviewed. The European Union had already expressed concerns about procedural aspects of the Intergovernmental Meeting held in November 2007.

While the European Union acknowledged the interim statement agreed at the Intergovernmental Meeting, additional clarifications as to its role would be welcome. The statement stressed timely and transparent sharing of information and viruses in compliance with the International Health Regulations (2005) – crucial to early response and global public health. Integrated approaches to pandemic preparedness beyond vaccine development were needed, including reliable surveillance, reporting, rapid response, containment, robust health care structures and general infrastructure. The European Union continued to support such enhanced capacity building in developing countries.

Underlining the leading role of WHO in pandemic preparedness, the Global Influenza Surveillance Network and provision of an equitable and transparent supply of vaccines for States in need, the European Union remained committed to the WHO Global pandemic influenza action plan to increase vaccine supply. In order to improve the transparency, efficiency and scope of the Surveillance Network, an independent body of experts should be established to report on its activities. He commended the progress made on a traceability system for all shared H5N1 and other potentially pandemic human viruses. He urged the Director-General to consult with international parties before the system was completed.

In order to find long-term solutions to the key challenges of pandemic influenza preparedness, additional joint efforts by governments, international organizations and industry were necessary. The focus of the proposed open-ended working group should be technical in order to devise a revised system for virus sharing, enabling the resumed Intergovernmental Meeting to agree on the new system.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) recalled the efforts expended by the Secretariat and Member States: in addition to a technical meeting, held in Singapore in August 2007, and the Intergovernmental Meeting on Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and other Benefits, held in Geneva in November 2007, numerous bilateral discussions had taken place between countries and with the Secretariat. The Secretariat had been implementing the global pandemic influenza action plan, a vital element in widening access for vulnerable countries to vaccines and other benefits, and he urged members to support that aspect of WHO's work.

Since the Sixtieth World Health Assembly, Member States had demonstrated commitment to accommodating the differing national positions on transparent virus sharing, involving fair and equitable access to vaccines and other benefits. Several Board members had stressed rapid and free sharing of viruses with WHO in support of global health security. All countries should take individual responsibility in order to prepare the global community's response to a pandemic.

Professor SALANIPONI (Malawi) said that the suspended Intergovernmental Meeting should be resumed before May 2008 in order to allow time for the final report to be submitted to the Sixty-first World Health Assembly. He sought an assurance that the draft negotiation document on sharing influenza viruses and access to vaccines and other benefits, incorporating proposed amendments submitted by Member States of the African Region, Indonesia, Thailand and others, would be made available before the end of the current session of the Board. Would it be legally possible for the Director-General to act on an interim statement by an Intergovernmental Meeting before the Health Assembly had approved it?

Dr WRIGHT (United States of America) endorsed the statements made by Slovenia on behalf of the European Union and by the United Kingdom of Great Britain and Northern Ireland. Preparation for and response to pandemic influenza required the sustained attention of all Member States and the Secretariat. Timely access to epidemiological data and clinical samples was critical to global health security. The WHO Global Influenza Surveillance Network had served the world well for many years and any steps to alter it must be considered carefully. He recognized the concern regarding access to pre-pandemic and pandemic vaccines and the desire of developing nations for more equitable access to benefits derived from the Network. His Government would like to see the following: the establishment of a system for sharing seasonal and pandemic human influenza virus samples; provision by the academic and private sectors of broad access to such samples and sample sequence data; and support for technical assistance and access to multilateral stockpiles of countermeasures for those countries that fostered global health security. He welcomed the Intergovernmental Meeting's interim statement and the establishment of a traceability mechanism.

Dr AL-HASNAWI (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that national preparedness plans needed to be further elaborated in order to deal with a potential human influenza pandemic. That required the collaboration of all countries, international organizations and agencies. A new virulent pandemic strain could emerge in a country with little or no capacity in diagnostic virology. Many countries in the Eastern Mediterranean Region still lacked the epidemiological and laboratory capacity needed for implementation of the International Health Regulations (2005) and isolation of influenza viruses. Although many countries in the Region had developed national preparedness plans, none had yet produced a seasonal influenza vaccine and it was unlikely that they would be able to produce a vaccine for the pandemic strain in the near future. Technical support for infrastructures and international cooperation fostered by WHO were also required in order to accelerate technology transfers and capacity building, particularly for developing countries, if humanity was to be saved from the threat of pandemic influenza.

The sharing of clinical specimens and viruses with collaborating centres through the WHO Global Influenza Surveillance Network was crucial for the assessment of pandemic risk and development of vaccines. Any deviation from that practice would threaten global health security, particularly in case of a new strain of H5N1 emerging. The sharing of benefits arising from the virus samples and a transparent system for tracking the biological specimens provided through WHO were also needed. Without those, the notion of virus sharing and international cooperation, as well as WHO's credibility could be in jeopardy. His Region looked forward to timely and equitable access to influenza vaccines at affordable prices, should human pandemic influenza emerge.

Mr CÓRDOVA-VILLALOBOS (alternate to Dr Hernández Ávila, Mexico), referring to the growing risk of the avian influenza virus being transmitted between people and the resulting effects, stressed the need to strengthen the response capacity of Member States. His country continued to strengthen preparedness and participated in various multilateral mechanisms and agreements. His Government was developing preparedness and response strategies based on inter-institutional cooperation, and working groups had been established in basic services, health, animal health, security, education, border control, foreign affairs and tourism. Mexico was developing capacity to produce its own seasonal and pandemic influenza vaccines and, eventually, to provide support to other countries in the Region.

Dr SUPARI (Indonesia) said that, in finding solutions to the problem of virus sharing, a great deal still remained to be done. She endorsed the comments made by the members for Malawi, Mali, Slovenia, the United Kingdom of Great Britain and Northern Ireland, and the United States of America, and noted that the Intergovernmental Meeting on Pandemic Influenza Preparedness would continue the discussion through an open-ended working group. The Board should support the continued work of the Intergovernmental Meeting in establishing a new mechanism for sharing of viruses and other benefits.

Mr LI Baodong (China) said that China advocated the equitable sharing of public-health and economic benefits derived from the distribution of virus strains, and support by governments, nongovernmental organizations and enterprises to developing countries in increasing their capacity to respond to avian and pandemic influenza. He put forward several proposals. First, research results emanating from WHO collaborating centres and H5 reference laboratories should be communicated to the countries providing virus strains in a timely manner. Secondly, the appropriate technology for production of vaccines should be provided as a priority to countries supplying virus strains. Thirdly, skilled personnel from those countries should participate in research on virus strains carried out in WHO collaborating centres, in order to improve their technical capacity. Fourthly, WHO should oversee the formulation of standard operating procedures for sharing virus strains with Member States, and specify the use of those strains. Fifthly, WHO and regional organizations should support the establishment of stocks of medicines and vaccines, and distribution systems for responding to an influenza pandemic. His Government was ready to control a national pandemic and would donate vaccines to international stocks, should its own supply so permit. Individual laboratories should not use virus strains to carry out research other than that for which they were intended.

Mr VALLEJOS (Peru) said that since 2006 the Peruvian Ministry of Health had been drawing up a national preparedness response plan in order to mitigate the impact of a possible influenza pandemic. The national plan focused on improving epidemiological surveillance, strengthening public-health laboratories, raising awareness and the technical capacity of health personnel, and improving biosecurity within the health system. The plan included distribution of clinical guidelines on the treatment of H5N1 virus infection in humans; the creation of stockpiles of medicines and equipment needed to combat a pandemic; the training of health personnel in managing a human influenza pandemic; strengthening the health infrastructures to meet present and future demand; and testing health services through simulated emergency procedures. With regard to vaccinating the public against influenza, it was planned to provide cover in 2008, with priority given to vulnerable groups.

Dr DULLAK PEÑA (Paraguay) supported WHO's efforts to step up international preparedness. His Government's contingency plan included epidemiological surveillance and improving the response capacity of the health service. Government departments were involved, including the agriculture and livestock ministry, since it was likely that the H5N1 virus would be linked to an avian influenza outbreak and early identification would depend on a high level of surveillance. Detection and response depended heavily on the effectiveness of diagnostic mechanisms, which tended to be concentrated in urban centres. Rural areas lacked health personnel and access to information and laboratories. Preparedness exercises had highlighted the gaps in his country's response capability. Paraguay was unable to produce enough vaccines on its own. He therefore favoured a regional solution whereby the more developed countries would join with the smaller countries in order to manufacture their own vaccines. Paraguay was currently working with other countries within the MERCOSUR framework, including Brazil, which already had vaccine production capacity. Brazil should be given sufficient resources to supply vaccines to other countries in the Region. Paraguay's regular vaccination programme against seasonal influenza had doubled its stocks of vaccine during the past year and was extending cover to higher risk groups.

Dr MAZA BRIZUELA (El Salvador) said that El Salvador had been developing plans for pandemic influenza preparedness since 2005 with other Central American countries and the Dominican Republic, with support from PAHO, the United States Centers for Disease Control and Prevention and other countries. His country had a national council to deal with a possible avian influenza pandemic and had organized preparedness exercises, tested policies and human resources and trained staff. There were five places in the country where the virus could be isolated and sent to the Centers for Disease Control and Prevention for identification. There had also been five vaccination campaigns since 2003, when WHO had asked countries to vaccinate against seasonal influenza. The vaccination programme had begun in 2004 and covered more than 90% of adults over 60 years old and 75% of children aged between six and 23 months. El Salvador was concerned about its financial

resources and insufficient capacity to treat patients; it needed to be well prepared logistically but might lack vaccines. That was a serious problem in Central America and the Dominican Republic, where the population of 47 million comprised many children and adults over 60 years of age. El Salvador would need help from countries with greater capacity for action. In the event of a pandemic, united and coordinated action would be necessary: any weak link in a small country or area could ruin the work of all the others. Countries had to work with WHO in assuming responsibility in the event of a global emergency.

Mr DE SILVA (Sri Lanka) commended the Secretariat's work on a traceability mechanism for shared H5N1 viruses, an interim system to provide for disclosure of information on the movement of viruses and an advisory mechanism for the Director-General. He regretted the lack of agreement on some of those sensitive issues, which could have serious implications for risk assessment management. He supported the proposal by the member for Indonesia regarding the work of the Intergovernmental Meeting.

Ms HUNT (Belize)[1] said that it was the right of every part of the world to be included in the disease control system and that all must collaborate whether or not they were WHO Member States. Certain entities, not Members of the Organization but with a competent health authority, had been debarred from the Intergovernmental Meeting on Pandemic Influenza Preparedness (Geneva, 20–23 November 2007). Fighting pandemics required universal efforts and pragmatism. The exclusion of stakeholders would deprive them of up-to-date information, block their participation in global mechanisms and prevent them from following up highly technical measures, which would eventually affect the rest of the world.

Mr BURCI (Legal Counsel), responding to a question regarding the request made to the Director-General in the interim statement of the Intergovernmental Meeting on Pandemic Influenza Preparedness, and more particularly concerning the status of that statement and its implications for the Director-General, agreed that it was unusual for a sitting intergovernmental body to issue an interim statement. However, the request to the Director-General, as reflected in the final paragraph of the interim statement, concerned action that fell within the Director-General's existing mandates and the relevant resolution of the Health Assembly. It was in that spirit that the Director-General had accepted. Regarding the nature of the measures, they were, in WHO's view, temporary urgent measures agreed by broad consensus within the Intergovernmental Meeting. The Director-General had considered it appropriate to support the process in order to facilitate a solution. Of course, as suggested by its title, the interim statement was a temporary decision, without prejudice to the final authority of the Health Assembly to confirm such actions or take different decisions when the Intergovernmental Meeting reported to it.

Dr KEAN (Executive Director, Office of the Director-General), responding to the first procedural question raised by the member for Malawi concerning papers presented by Indonesia, Thailand and the African group during the Intergovernmental Meeting, said that they had formed the basis for Annex 6 of document EB122/5. The papers would be available on the web site of the Intergovernmental Meeting as working papers after the Executive Board session, though not all of them had been translated. Regarding the second question, concerning the operationalization of resolution WHA60.28 and more particularly the involvement of African group members in activities mentioned in paragraphs 2(2) and 2(3), he said that the two elements concerned formed part of the agenda of the Intergovernmental Meeting covered in paragraph 2(7) requesting the Director-General to convene that Meeting. He assured members of the African group that they would be included with all other Member States of WHO in taking the matter forward. The issue of the meeting of the Working

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

Group and the resumed Intergovernmental Meeting had been raised by several members. He was unable to reassure the member for Malawi that the process would be completed for the Sixty-first World Health Assembly in May. Venues for such a big meeting needed to be reserved at least a year ahead and other meetings, the availability of the Chairman, public holidays and WHO's other intergovernmental meetings had to be taken into account. In short, every slot before the Health Assembly had been taken. The Secretariat therefore proposed that the Working Group should meet in August at the Geneva International Conference Centre and that the Intergovernmental Meeting should resume its session in November, at the same venue. The necessary bookings had been made. Attendance at the resumed Intergovernmental Meeting followed the Rules of Procedure of the World Health Assembly, with invitations issued as for a governing body meeting.

Dr HEYMANN (Assistant Director-General) thanked members for their descriptions of country preparedness activities and for stressing international solidarity. WHO was continuing its work under the International Health Regulations (2005). Regarding work that included technology transfer capacity from industrialized to developing countries, WHO was grateful for the contributions by Canada, Japan, the United Kingdom of Great Britain and Northern Ireland, the United States of America and the Asian Development Bank. Such transfers were vital to ensuring the capacity to produce vaccines. WHO's collaborating centre network was being broadened and it was working with Brazil, China, India, Indonesia, Russian Federation and South Africa in order to establish collaborating centres necessary for achieving a geographical balance. The Strategic Advisory Group of Experts had reviewed the need for H5N1 vaccine and had recommended a stockpile of 50 million doses for use against an early phase 4 event. The Group of Experts had also recommended an additional 100 million doses of H5N1 vaccine for use in the event of a pandemic caused by the H5 virus with priority for health workers in developing countries. Broader access to pandemic vaccines was also being developed with consideration for future action. Stockpiles of oseltamivir were being constituted and decentralized in order to facilitate access, especially for countries at risk, and discussion was continuing on potentially useful strains. The Global Immunization Programme had established a transparent interim tracking mechanism with information on viruses shared with WHO. The system was available on the Internet. A mechanism to examine the Global Influenza Surveillance Programme and a definitive tracking system were being established by the Secretariat.

The DIRECTOR-GENERAL thanked members for their comments and assured them of her commitment to carry out their instructions and guidance. Since the Intergovernmental Meeting, the Secretariat had established a tracking system to enhance transparency in the movement of viruses and was working on setting up the advisory mechanisms required by the interim statement, in consultation with Member States and with equitable representation of all regions, particularly affected countries.

The Board noted the report.

Poliomyelitis: mechanism for management of potential risks to eradication: Item 4.3 of the Agenda (Documents EB122/6 and EB122/6 Add.1)

The CHAIRMAN drew attention to the draft resolution contained in paragraph 11 of document EB122/6.

Dr HEYMANN (Assistant Director-General) said that the report covered both the intensified eradication effort launched in February 2007, and strategies for managing long-term risks. The introduction of monovalent oral poliomyelitis vaccines, especially through the increased and intensive use of monovalent oral poliomyelitis vaccine type 1, had led to an 82% decline in poliomyelitis due to type 1 poliovirus. Such vaccines had also interrupted wild poliovirus transmission in 25 of the 27 countries where it had been reintroduced over the previous three years. Development of a major strategy for risk assessment and long-term risk management after eradication was progressing. The report and the draft resolution before the Board provided the Health Assembly with some possibilities

for the coordination of risk management strategies, namely, a convention, a resolution or an annex to the International Health Regulations (2005). WHO was examining the potential role of inactivated poliovirus vaccines in a post-eradication era, seeking to determine whether immunization with such vaccines could be achieved at a cost equal to that with oral poliovirus vaccine and whether the need to use wild poliovirus in the production of inactivated poliovirus vaccines could be obviated. Research to inform policies on the use of such vaccines was continuing.

Dr SUPARI (Indonesia) said that Indonesia had been free of poliomyelitis from 1995 to 2005, when an outbreak had occurred following the importation of wild poliovirus into a poorly immunized or non-immunized population living in a high-density area with poor hygiene in a tropical climate. To change to injectable vaccine against poliomyelitis had implications for developing countries, which would have to buy such vaccines from developed countries at affordable prices. Indonesia and its region proposed, first, that the timing for ending of routine immunization with oral poliovirus vaccine should take full account of the situation of developing countries; secondly, that the shift from oral to injectable vaccine against poliomyelitis and the reduction in the number of poliovirus facilities should be discussed step by step; and, that access by developing countries to technology for ensuring sufficient vaccine supply should be facilitated.

Dr DE CARVALHO (Sao Tome and Principe), speaking on behalf of the Member States of the African Region, said that wild poliovirus transmission in the northern states of Nigeria remained the most serious risk to poliomyelitis eradication in his Region. Increased immunization had helped improve access for children in those states, but coverage of exposed populations in some areas remained insufficient. The country still accounted for 81% of the Region's confirmed cases. Other countries faced a high risk of reintroduction of poliovirus or re-emergence of poliomyelitis for want of routine, high-quality vaccination. Action must be taken to produce vaccines and to replace oral poliovirus vaccine with inactivated poliovirus vaccine. African countries also faced challenges relating to the political will to prioritize poliomyelitis eradication; of allocating resources for the levels of surveillance required for certification of the interruption of wild poliovirus transmission, as in Kenya and Namibia; and in reaching a consensus on the long-term use of poliovirus vaccine and the biocontainment of infected and potentially infectious materials. He endorsed the proposed strategy and the draft resolution.

Dr SUGIURA (alternate to Dr Shinozaki, Japan) acknowledged the importance of managing the long-term risk of poliovirus, but said that poliomyelitis-endemic countries were not yet ready to meet the goal of eradication. Wild poliovirus transmission occurred in geographical areas marked by high population density, poor sanitation and hygiene, and malnutrition, and by a refusal of oral poliovirus vaccine. It was important to support affordable strategies for use of inactivated poliovirus vaccine.

Japan would complete phase I of the WHO global action plan for laboratory containment of wild polioviruses in the course of 2008.

Dr AHMADZAI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, despite conflict, political instability and wild poliovirus importation, poliomyelitis eradication had made progress. Epidemics in three countries since 2004 had been curtailed after giving rise to more than 1000 cases and costing US$ 10 million. No further cases had been reported in Somalia since 2007. However, the risk of importation remained, as seen in Sudan where early detection of poliovirus imported from Chad in September 2007 had stopped an outbreak. Transmission continued in southern Afghanistan and on the border with Pakistan, where access for children was undermined by insecurity and a refusal of immunization on traditional cultural grounds. Poliovirus transmission in every other country in the Region had been interrupted for many years, as accepted by the Regional Certification Commission. Advocacy, surveillance and high-quality immunization in the remaining areas had been stepped up. Population immunity had been secured and surveillance maintained in order to protect poliomyelitis-free areas.

Phase I of the WHO global action plan for laboratory containment of wild polioviruses had been completed in all but the two endemic countries. Of the 20 000 laboratories surveyed only eight were storing wild poliovirus materials.

In accordance with the Regional Technical Advisory Group for poliomyelitis eradication, every country in the Region had agreed to synchronize their cessation of immunization in the oral poliovirus vaccine. Three countries had introduced immunization with inactivated poliovirus vaccine as part of a routine immunization programme combining both vaccines, and several were researching better, affordable tools. A clinical trial in Egypt had proved the superiority of monovalent oral poliomyelitis vaccine type 1 and a trial in Oman was assessing functional dosing of inactivated poliovirus vaccine and cost implications.

The Eastern Mediterranean Region supported the draft resolution. It endorsed the establishment, by amending international regulations, of a mechanism to guard against the long-term risk of reintroduction of poliovirus or re-emergence of poliomyelitis after the interruption of wild poliovirus transmission.

Dr DAHL-REGIS (Bahamas) said that document EB122/6 lacked information on several issues. She asked the Secretariat to provide information on the funding shortfall and on surveillance in relation to the poliomyelitis endemic countries; a timetable outlining the steps for the cessation of oral poliovirus vaccine and the implementation of immunization with inactivated poliovirus vaccine associated costs; and the various regional positions on the timetable.

Professor SALANIPONI (Malawi) said that Nigeria remained the greatest risk to poliomyelitis eradication in the African Region, and, even though the Immunization Plus Days had improved access to children, some northern states capable of sustaining transmission had remained inadequately immunized. Low immunity in other countries had facilitated wild poliovirus importation into previously poliomyelitis-free areas, with confirmed cases reported in Angola, Chad, Democratic Republic of the Congo and Niger as recently as September 2007. There were long-term risks of reintroduction of poliovirus or re-emergence of poliomyelitis associated with the use of oral poliovirus vaccine in the post-eradication period. Political commitment, community involvement, the declaration of Immunization Plus Days and the use of monovalent oral poliovirus vaccine had contributed to reduced wild poliovirus transmission in Nigeria. The number of cases had decreased from 810 to 188 in the year from September 2006 to September 2007. Transmission of imported wild poliovirus in Kenya and Namibia had been interrupted less than two months after confirmation of an outbreak. Ethiopia had confirmed no new cases since 7 November 2006. However, Angola, Democratic Republic of the Congo and Nigeria needed to curtail the current circulation of wild poliovirus. In order to address those and other relevant issues, he proposed that a new paragraph 3(4) should be added to the draft resolution, reading "to develop a new strategy for a renewed fight to eradicate poliomyelitis from the remaining countries, drawing on experience from regions where it has been eradicated and operations to determine the most efficient and cost-effective means of intervention". The existing paragraph 3(4) would then be renumbered 3(5).

Dr WRIGHT (United States of America) agreed with the member for the Bahamas. The goal of the Global Polio Eradication Initiative was still feasible, but, in the light of the challenges faced by the remaining four poliomyelitis-endemic countries, it would not be achieved until well beyond 2008. Member States must remain focused on garnering the human and financial resources needed to eradicate poliomyelitis at a global level. Since June 2007, poliomyelitis had been officially listed as a disease requiring immediate notification under the International Health Regulations (2005). He urged all nations to adhere to that and remain vigilant against imported wild poliovirus. The Secretariat was proposing a comprehensive approach to cessation of the use of oral poliovirus vaccine and management of the residual risk. All Member States should support that. Amending the International Health Regulations (2005) was not appropriate as it could be a difficult process, and many Member States lacked the capacity to implement the Regulations fully. He therefore requested that the last part of paragraph 3(4) of the draft resolution – from "and to submit with that report" through to "and

re-emergence of poliomyelitis" – should be deleted. The Secretariat should prepare one or more proposals for a mechanism to mitigate the risk of the reintroduction of poliovirus for review by the Executive Board at a future session; it should not involve amending the International Health Regulations (2005) or developing another binding instrument.

Dr DULLAK PEÑA (Paraguay) said that his country had interrupted poliovirus transmission and been free of wild poliovirus since 1985, as a result of the Expanded Programme on Immunization. However, Paraguay had experienced outbreaks of dengue fever, including a major epidemic in 2007. Resources had been diverted from other immunization programmes, thereby reducing coverage and risking a reintroduction of poliovirus. He concluded that concentrating resources on the poliomyelitis-endemic countries might make those that had achieved eradication less capable of maintaining immunization at an adequate level to protect their populations.

Mr MIGUIL (Djibouti) drew attention to the population suffering as a result of the blockade in the Gaza Strip, not least the deplorable situation in its hospitals, and raised the question of the responsibilities of the Organization and the international community in the matter. He called on the Executive Board and the Health Assembly to take action on the criminal injustices by immediately working on a declaration.

Dr MENESES GONZÁLEZ (alternate to Dr Hernández Ávila, Mexico) outlined his country's epidemiological surveillance and immunization coverage. Its last recorded case of poliomyelitis dated back to October 1990. Coverage rates were higher than 90%. However, outbreaks on other continents where the disease was endemic meant that there was always a risk of reintroduction of wild poliovirus. Vigilance was crucial. In 2006, for example, 461 cases of acute flaccid paralysis had been screened in order to ensure that they were not related to poliovirus. The total eradication of poliomyelitis depended on the financial input and the political will of the entire international community, and Mexico would support whatever the Executive Board decided would best achieve that objective.

Dr VOLJČ (Slovenia), speaking on behalf of the Member States of the European Union, emphasized the mechanism for management of potential threats to the eradication of poliomyelitis and said that the European Union was taking action. He asked why the draft resolution proposed the adoption of a new annex to the International Health Regulations (2005) for long-term management of the risk of re-emergence of poliomyelitis, rather than a simpler mechanism such as a standing recommendation. There was no need to reopen negotiations on the Regulations.

Dr BIN SHAKAR (United Arab Emirates) said that his country had been free of poliomyelitis for the past seven years, and was awaiting certification. He supported the remarks made by the member for Djibouti about the situation in the Gaza Strip.

Ms LANTERI (Monaco)[1] said that her country supported the Global Polio Eradication Initiative. She agreed with the members for Slovenia and the United States of America regarding a mechanism to manage the long-term risk of re-emergence of poliomyelitis. A standing recommendation would be appropriate.

Mr LACY (Rotary International), speaking at the invitation of the CHAIRMAN, noted that his organization's first fundraising campaign, over two decades before, had acted as a catalyst for the eradication initiative. Now, in partnership with the Bill & Melinda Gates Foundation, Rotary International aimed to raise at least US$ 200 million over the next four years. Lack of financial support threatened progress. His organization's fundraising would not provide all the money for

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

achieving the goals of interrupting transmission of wild poliovirus before the end of 2008, and he appealed to all donor countries.

Rotary International would continue recruiting new partners and providing support required to achieve eradication. The leadership of WHO was essential in the campaign for a world free of poliomyelitis.

Dr HEYMANN (Representative of the Director-General for Polio Eradication) expressed gratitude to the partners in the Global Polio Eradication Initiative, including UNICEF, Rotary International and the United States Centers for Disease Control and Prevention. The Advisory Committee on Poliomyelitis Eradication had concluded that eradication was feasible but continued funding was essential: US$ 525 million of the US$ 1300 million required for the biennium 2008–2009 had still to be obtained. It had recommended that WHO should continue its research in two areas: assessing the long-term risks of re-emergence of poliomyelitis and affordable use of inactivated poliovirus vaccine. It had also recommended that WHO should set up an advisory group in order to identify further research and should organize consultations among Member States on means of managing the long-term risks to poliomyelitis eradication, including measures such as all countries ceasing use of oral poliovirus vaccine at the same moment. He welcomed members' suggestions for amendments to the draft resolution.

Dr KEAN (Executive Director, Office of the Director-General) read out the proposed amendments to the draft resolution. A new subparagraph 3(4) would read: "to develop a new strategy for renewed fight to eradicate poliomyelitis from the remaining countries, drawing on experience from regions where poliomyelitis is eradicated and on operations research in order to determine the most efficient and cost-effective interventions".

Existing subparagraph 3(4) would become subparagraph 3(5) and would be amended to read: "… interrupted globally, and to submit with that report a proposal or proposals for review by the Executive Board for a mechanism to mitigate the risk of the reintroduction of poliovirus that does not involve amending the International Health Regulations (2005) or developing another binding instrument".

The draft resolution, as amended, was adopted.[1]

Eradication of dracunculiasis: Item 4.4 of the Agenda (Document EB122/7)

Mr TOURÉ (Mali), speaking on behalf of the Member States of the African Region, said that the number of reported cases of dracunculiasis had fallen by 99.5% between 1989 and 2006, to just 4636 cases. The disease remained endemic in eight countries: Burkina Faso, Côte d'Ivoire, Ethiopia, Ghana, Mali, Niger, Nigeria and Togo. Migration was a major factor in the persistence of transmission in Burkina Faso, Mali and Niger. Local transmission had been interrupted in Benin, Cameroon, Central African Republic, Chad, Kenya, Mauritania, Senegal and Uganda. Those countries were currently at the pre-certification stage and would be certified free of dracunculiasis when they had successfully interrupted transmission of the disease for a full three years.

The eradication of dracunculiasis would require political will, sustained coordination and support from national authorities and international partners. Progress reports of eradication efforts should be submitted to the Health Assembly.

Dr WRIGHT (United States of America) expressed support for the goal of eradicating dracunculiasis by 2009 and congratulated those States that had achieved pre-certification status. Strategies such as the provision of safe drinking-water, the recruitment of donors from the private

[1] Resolution EB122.R1.

sector and the establishment of good reporting standards had proved successful. It was not necessary to report annually on the progress of the initiative.

Dr SUGIURA (alternate to Dr Shinozaki, Japan) welcomed the progress towards halting the transmission of dracunculiasis. WHO should organize strategy meetings of the countries concerned, the Carter Center and UNICEF. He asked for information about such meetings and opportunities for new partners to become involved in planning and funding.

Primary health care and school health programmes should promote the importance of clean water supply. An integrated rather than a vertical approach to eradication should be taken at the community level. He supported the goal of eradicating dracunculiasis by 2009.

Professor SALANIPONI (Malawi) noted that, when properly implemented, eradication measures had been effective. The countries where the disease was still endemic had many poor farming communities, which were adversely affected by sufferers' inability to work. A primary health care approach was essential in order to tackle determinants of the disease such as drinking contaminated water.

Dr KOKKINAKIS (Austria)[1] affirmed that dracunculiasis could be eradicated easily. Behavioural changes in poor communities were needed. Marked progress had been made towards eradicating the disease, which reduced productivity and made poor people even poorer. One last effort could result in dracunculiasis being the second disease to be eradicated worldwide.

Mr MIGUIL (Djibouti), speaking on behalf of the Member States of the Eastern Mediterranean Region, congratulated the Secretariat and the Carter Center's Guinea Worm Eradication Programme for progress towards eradicating dracunculiasis. He also emphasized that eradication depended, inter alia, on community participation in implementation of eradication measures; strengthened surveillance capacity of health systems; cross-border control activities; and effective pre- and post-certification surveillance.

The current global eradication strategy had been effective and the remaining countries in which the disease was endemic had developed strategies for addressing the main challenges. Dracunculiasis affected poor rural populations in developing countries, but interventions to halt transmission were inexpensive and technically straightforward. Eradication would contribute greatly to achievement of the Millennium Development Goals, and could be realized. He called upon the Director-General to redouble her efforts to mobilize adequate resources.

Dr NAKATANI (Assistant Director-General), responding to comments made, said that the International Commission for the Certification of Dracunculiasis Eradication met as often as required. The last meeting had been in 2007, and a further meeting was planned for late 2008. A conference on dracunculiasis eradication would be held in Abuja, in April 2008. With regard to support available at community level, he cited the example of Sudan, where around 20 000 community workers had been trained in surveillance and health education. The Secretariat was working with development partners in order to fund dracunculiasis eradication activities.

The DIRECTOR-GENERAL observed that opportunities to take public health actions which would have a permanent effect on the health of future generations were limited, but eradicating diseases such as poliomyelitis and dracunculiasis would produce such lasting results. She would indeed redouble her efforts to mobilize resources and would report to the Board soon.

The Board noted the report.

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

Implementation of the International Health Regulations (2005): Item 4.5 of the Agenda (Documents EB122/8, EB122/8 Add.1 and EB122/INF.DOC./2)

The CHAIRMAN drew attention to documents EB122/8 and EB122/8 Add.1, and to a draft resolution on implementation of the International Health Regulations (2005) proposed by Sao Tome and Principe, Paraguay and El Salvador, which read:

> The Executive Board,
>
> Having considered the report on the implementation of the International Health Regulations (2005),[1]
>
> RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:
>
> > The Sixty-first World Health Assembly,
> >
> > Considering that the International Health Regulations (2005), having entered into force since 15 June 2007, are the key global instrument for protection against the international spread of disease;
> >
> > Recalling that the resolution WHA58.3 calls upon Member States and the Director-General to implement these Regulations fully in accordance with the purpose and scope set out in Article 2 and the principles embodied in Article 3, of which the goal of the Regulations' universal application is proclaimed;
> >
> > Aware of fighting pandemic and epidemic needs universal efforts and affirming the importance of the Director-General's policy that "the global surveillance system must have no gaps or weak spots";
> >
> > Noting the fact that as of 8 August 2007, 192 Member States that became States Parties to the Regulations were listed on the official web site of the Organization;
> >
> > > REQUESTS the Director-General:
> > >
> > > (1) to encourage states, areas or territories which are not on the above-mentioned list, to join, for all practical purposes and in operational sense, the global disease control system by, among other things, urging them to designate or establish their respective IHR Focal Point, as guided by the goal of the universal application for the implementation of the Regulations;
> > >
> > > (2) to take necessary actions to facilitate the communication and collaboration between such states, areas or territories and the Organization, including its Member States, so as to ensure the full global implementation of the Regulations with no gaps or weak spots;
> > >
> > > (3) to take into consideration, when implementing the aforesaid, that the resolution shall supersede the relevant previous memorandum of understanding made without the consent of the health authorities of such states, areas or territories.

The CHAIRMAN also drew attention to document EB122/INF.DOC./2, which contained a letter from the Ambassador of the People's Republic of China to the United Nations Office at Geneva and other International Organizations in Switzerland.

Before proceeding with discussion of the agenda item, the CHAIRMAN requested the Legal Counsel to comment on the draft resolution.

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[1] Document EB122/8.

Mr BURCI (Legal Counsel) highlighted the request made of the Director-General in paragraph 1 of the draft resolution, in particular, to encourage areas or territories to designate or establish focal points for the International Health Regulations (2005). The request went beyond the provisions of the Regulations, Article 4 of which stated only that States Parties to the instrument should establish focal points. The requested action therefore fell outside the Director-General's authority, and could be interpreted as trying indirectly to amend the Regulations.

Mr LI Baodong (China) said that the Chinese Government strongly opposed the draft resolution, a political resolution aiming to split China. The Taiwanese authorities were behind the draft resolution. For more than 10 years, they had repeatedly asked a small number of countries to submit proposals to the Health Assembly seeking to enable Taiwan to participate in the Health Assembly as an observer or as a Member. Under the current agenda item, they were seeking to establish direct contact with the Secretariat and Member States and to supersede the Memorandum of Understanding between China and the Secretariat concerning the participation by medical and public health experts from Taiwan province of China in WHO's technical activities.

The Chinese Government attached great importance to implementation of the International Health Regulations (2005) throughout China, including Taiwan province. Regarding their application in Taiwan province, the Government had concluded an agreement with the Secretariat in April 2007, whereby the Taiwanese health authorities might communicate directly with the Secretariat as Taiwan's contact point for technical aspects of implementing the Regulations. China was implementing the Regulations within the present Memorandum of Understanding. China's national focal point was responsible for routine communications between the Secretariat and Taiwan province. In emergencies, WHO was able to contact the Taiwanese health authorities directly or to send experts to Taiwan to investigate health situations. In December 2007, the national focal point had submitted a list of ports within China's borders that conformed to the Regulations, including a list of certified ports in Taiwan province.

Through implementation of the Regulations Taiwanese health experts were able to obtain epidemic information and technical cooperation from WHO. Owing to its size and population, China faced specific challenges in implementing the Regulations. Some oversights had occurred, such as the delayed transmission of information from WHO to Taiwan province on contaminated baby corn. His Government had taken great steps to avoid similar occurrences. Offices were on stand-by 24 hours a day all year round in order to communicate WHO's health information to all health authorities, including those in Taiwan province. His Government was willing to further improve implementation of the Regulations. The fact that the Taiwanese authorities would not let go of the incident exposed their political motives.

The mainland and Taiwan belonged to one and the same China and shared a common destiny. The Chinese Government served the interests of its Taiwan compatriots. The Memorandum of Understanding in 2005 facilitated technical exchanges between the Taiwan region and WHO. In the past two years, 26 health experts from Taiwan had taken part in 14 WHO technical meetings. Cross-Strait exchanges in various areas, including health, were expanding. The Memorandum of Understanding was welcomed by the people of Taiwan and the international community. The Taiwan authorities' insistence that the Memorandum of Understanding should be superseded undermined the efforts of the international community and showed an attempt to politicize health.

The Taiwan authorities should not create obstacles to cross-Strait health exchanges; neither block the participation of Taiwanese health experts in WHO activities organized on the basis of the Memorandum of Understanding nor refuse the arrangements made by the Chinese Government for the application of the International Health Regulations (2005) in Taiwan, nor use WHO as a forum for political games. The Health Assembly had rejected proposals related to Taiwan for 11 consecutive years. A very few countries with so-called diplomatic relations with the Taiwan authorities were violating international law and the Charter of the United Nations and were interfering in China's internal affairs. They had tabled a draft resolution related to Taiwan at the current session of the Board, arousing dissatisfaction among Member States. China condemned such behaviour. The Board

should concentrate on health issues of common concern. Political topics wasted time and resources. The Chairman should reject the draft resolution.

The CHAIRMAN, recalling the view expressed by the Legal Counsel that discussing the draft resolution would reopen issues on which decisions had already been reached by the Health Assembly, asked whether the Board would agree to proceed with discussion of the matter of implementation of the International Health Regulations (2005) but decline to consider the draft resolution.

Mr GAUTO (alternate to Dr Dullak Peña, Paraguay) said that a draft resolution proposed by two members of the Board deserved proper consideration.

Dr GWENIGALE (Liberia) pointed out that the Legal Counsel had said that the request made of the Director-General in the draft resolution was illegal. It would therefore be impossible for the Board to adopt the draft resolution.

Mr DE SILVA (Sri Lanka) supported the statement by the member for Liberia and urged the Chairman to declare the draft resolution inadmissible.

The CHAIRMAN ruled that the draft resolution was inadmissible and would not be discussed further.

It was so decided.

The meeting rose at 17:45.