

SIXTH MEETING

Wednesday, 23 January 2008, at 14:10

Chairman: Dr B. SADASIVAN (Singapore)

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

Global immunization strategy: Item 4.11 of the Agenda (Documents EB122/14 and EB122/14 Add.1)

The CHAIRMAN drew attention to the draft resolution contained in document EB122/14.

Dr ABDESSELEM (Tunisia), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the overview of Member States' action on immunization coverage and new vaccines. Nevertheless, the report failed to reflect the impact of the Global Immunization Vision and Strategy; an analysis of the situation before and after its adoption in 2005 was needed. The report should have referred to pneumococcal conjugate vaccine, which was mentioned in the third preambular paragraph of the draft resolution; the report should also have mentioned the problem faced by middle-income countries in the introduction of new vaccines with a view to attaining the Millennium Development Goals. In the draft resolution, a new sixth preambular paragraph preceding the present sixth and final preambular paragraph should be added, worded: "Concerned about the failure to make available the necessary resources for the introduction of new vaccines, especially in middle-income countries". In addition, he proposed a new subparagraph in paragraph 2, requesting the Director-General "to approach international partners and donors as well as the vaccine producers in order to mobilize the necessary resources to support low- and middle-income countries and ensure that all Member States have access to sufficient supplies of affordable vaccines of assured quality".

Dr SUGIURA (alternate to Dr Shinozaki, Japan) commended WHO's leadership in promoting immunization and reducing mortality caused by vaccine-preventable diseases. Further reductions could be expected from new vaccines, including that against *Haemophilus influenzae* type b infection. However, the limited funds available should not be shifted to new vaccines, which would cause a shortage of funds for regular programmes such as those against diphtheria-pertussis-tetanus or measles. The flow of funds for vaccinations should therefore be monitored. He suggested using the strong infrastructure of the Expanded Programme on Immunization, in particular the poliomyelitis programme in each type of child health service. He referred to the example of UNICEF's Child Health Days. He supported the draft resolution.

Dr REN Minghui (alternate to Mr Li Baodong, China) commended the report and the contribution to implementing the Global Immunization Vision and Strategy 2006–2015 and resolution WHA58.15. China was increasing immunization coverage. In 2006 it had introduced a plan to eradicate measles, reducing morbidity and halting the indigenous transmission of measles virus. The number of vaccines in its immunization programme had been increased to 15 and included hepatitis A and meningococcal meningitis vaccines. China favoured wider cooperation with WHO on the subject of new vaccines and cost-effectiveness, and was seeking to increase the capacity of developing countries to manufacture vaccines. He proposed an amendment to paragraph 2 of the draft resolution in the form of a new subparagraph 2(3) to read: "to take measures, as appropriate, to help developing

countries establish and strengthen their capacities in vaccine research, development and production, with the aim of ensuring vaccine supplies, reducing vaccine prices and improving access to affordable vaccines”.

Mrs SEBUDANDI (alternate to Dr Ntawukuriryayo, Rwanda), speaking on behalf of the Member States of the African Region, commended the report but noted that access to vaccination in some countries remained a problem owing to weak health systems. Up to July 2007, for example, 38 of the 46 countries in the Region had adopted hepatitis B vaccine and 22 of the 31 countries with a risk of yellow fever had adopted the vaccination of infants in the districts concerned. Promotion of child survival through systematic and supplementary vaccination had been introduced. Partnerships must play an important part. The GAVI Alliance provided financial support for States in the “reaching every district” programme and for the strengthening of health systems in that respect. Urgent challenges remained, such as: extending coverage with three doses of diphtheria-tetanus-pertussis vaccine to all children in all countries, especially the most highly populated and those with weak health systems; providing support to health systems; determining health priorities in the allocation of resources; and meeting targets in the fight against measles, tetanus and yellow fever, and overall the targets of the global immunization strategy. The Board should approve the draft resolution.

Mr TOURÉ (Mali) commended the report. Most unvaccinated children lived in the least developed countries, where the burden of disease was the heaviest, with insufficient access to vaccination services. Vaccines were still not used effectively and the failure to cover all districts remained a concern. In 2006, only 40 countries in the African Region had more than 80% coverage with three doses of diphtheria-tetanus-pertussis vaccine. The vaccination of previously neglected children required innovative practices such as the “reaching every district” strategy and the accelerated Strategy for Child Survival and Development. As a result, vaccination coverage with three doses of diphtheria-tetanus-pertussis vaccine had surged from 74% in 2005 to 94% in 2007; yellow fever vaccine had been introduced in 2002, hepatitis B vaccine in 2003 and the vaccine against *Haemophilus influenzae* type b infection in 2005.

In regard to the global immunization strategy, Mali had developed a plan for the period 2007–2011. The introduction of new vaccines against pneumococcal diseases in 2008, and against meningitis in 2009, was promising results. The problems were to guarantee the availability of such expensive vaccines in the African Region; to extend coverage by 2011 to more than 90% of children in remote districts; and to use existing resources to strengthen health systems and consolidate recent successes. An integrated campaign covering five interventions had been initiated in December 2007 to tackle inadequate resources and competing health priorities.

Dr DAHL-REGIS (Bahamas) welcomed the global impact of the child immunization programme, which could serve as a template for work towards Millennium Development Goal 4 and on other health initiatives and indices. Significant funding had been attracted, but without political will and increased contributions from governments, the reduction of under-five childhood mortality could not be sustained. She congratulated those responsible for implementing the “reaching every district” strategy – whose relevance emerged from data concerning countries, towns and villages – and asked about data from South-East Asia. Following the statement by the member for Tunisia, she asked whether the success of immunization coverage and the reduction in childhood mortality were evenly shared among all lower-income countries. How did countries with just over US\$ 1000 per year in per capita gross domestic product, which thus did not qualify for resources, compare with those with just under US\$ 1000 in respect of immunization coverage? In the African Region, but also in Central America, some low-income countries did not receive funds because their immunization coverage was so good. Their health infrastructures still needed support. A situation analysis was therefore required and she asked whether there existed synergies with the poliomyelitis eradication programme, such as maintaining the infrastructure to sustain immunization practices. According to the report, the uptake of *Haemophilus influenzae* type b vaccine was comparable with that of hepatitis B vaccine; did that mean that supplies were in line with demand for increased uptake? Given the reference in the report to

human papillomavirus and dengue vaccines, she asked whether adult immunization was covered in the strategic plan or placed under family health.

Dr WRIGHT (United States of America) said that in many countries poor and marginalized children remained unvaccinated and the United States had fully supported the Global Immunization Vision and Strategy. Success depended on the delineation of goals for immunization coverage and disease-specific reduction of mortality. Failure to do so would limit the credibility of any global strategy and dampen the support of international donors that was vital to implementation at the national level. Member States and the Secretariat needed to strengthen the monitoring of vaccination coverage, disease surveillance and laboratory networks. WHO should address the issue of data quality; vaccine programmes should provide accurate data concerning routine coverage and estimates of disease mortality, essential for accurate monitoring. Many new vaccines and delivery technologies could save thousands of lives. Countries needed strong immunization infrastructures in order to benefit from such advances. However, financing for the long-term sustainability of new vaccines and technologies was uncertain. Of immediate concern was the ability of middle-income countries to afford new vaccines. The United States of America supported the strategy of using immunization contacts to provide other public health and medical interventions where appropriate, cost-efficient, and effective. He supported the draft resolution as it stood and would like to see the suggested amendments in writing.

Mr VALLEJOS (Peru) said that immunization coverage in Peru, after falling to 84% in 2006, had risen to 96% by the end of 2007 thanks largely to the assistance of PAHO, which had helped eradicate congenital rubella syndrome in the country after a five-week vaccination campaign covering more than 20 million Peruvians aged from 0 to 39 years. Hepatitis B, on the other hand, remained endemic, and a campaign to vaccinate 11 million Peruvians aged from 0 to 19 years was planned. Since 50% of the Peruvian population lived in poverty with high infant mortality due to respiratory infections and acute diarrhoea, the Government had increased funding for vaccines and the intention was to provide rotavirus vaccination for infants from birth to six months in areas without water or sanitation. Furthermore, vaccination against pneumonia and influenza was planned.

Professor SALANIPONI (Malawi) said that Malawi was fully committed to achieving the goal of a 90% reduction in global measles mortality by 2010 as set out in the Global Immunization Vision and Strategy (2006–2015). Malawi had itself achieved elimination of both measles and neonatal tetanus with fewer than one in 1000 newborn babies dying of tetanus each year. Malawi had been declared poliomyelitis-free in 2005. Overall, immunization coverage was in excess of 80%. Target attainment was attributable to the “reaching every district” strategy, currently covering 70% of the country, and to the support of WHO, UNICEF, the GAVI Alliance and other partners. The Secretariat should continue providing support to the implementation of African Member States’ immunization strategies.

Mr MCKERNAN (New Zealand) said that his country prioritized immunization, one of its 10 national health targets. Further progress was essential to achieving Millennium Development Goal 4. Furthermore, it prioritized funding for new vaccines over funding for other potential new interventions. He supported the draft resolution and proposed inserting, between commas, the words “in accordance with national priorities” after “vaccines of assured quality” in paragraph 1(3).

Dr MENESES GONZÁLEZ (alternate to Dr Hernández Ávila, Mexico) affirmed his country’s commitment to WHO’s global immunization strategy and to achieving Millennium Development Goal 4. In 2006, delivery of rotavirus and heptavalent pneumococcal vaccines in Mexico had been extended to municipalities inhabited mainly by indigenous populations. In 2007, the immunization services ensured universal application of the former and increased deliveries of the latter. Also in 2007, hepatitis B vaccination had been introduced for newborn babies and adolescents. A campaign

to eradicate rubella and congenital rubella syndrome had begun; the financial and technical feasibility of introducing vaccines against human papillomavirus infection was being assessed.

Mexico's reorganized immunization programme relied on continuous disease surveillance, highly qualified biologists, operational research, and supply of quality products. A survey had been conducted in order to determine cold-chain needs, and equipment was being modernized. Immunization coverage stood at between 95% and 98%, depending on the type of vaccine. The aim was to see 100% of the population enjoy equitable coverage and to eradicate vaccine-preventable diseases. He endorsed the draft resolution.

Dr SINGAY (Bhutan), speaking on behalf of the Member States of the South-East Asia Region, said that the Expanded Programme on Immunization had been widely successful, thanks to the support of the Government of Japan, WHO, UNICEF and the GAVI Alliance. Countries in his Region would increase coverage and introduce a pentavalent vaccine, including the *Haemophilus influenzae* type b antigen, and other new vaccines. However, those vaccines were much more expensive, raising concerns about the Programme's sustainability. He urged WHO to support expanded manufacturing capacity in order to enable developing countries to produce the newer vaccines; to continue research for better, more affordable vaccines; and to mobilize resources for sustaining the related technology. The Organization should continue discussing the issue with partners and prevent any "donor fatigue".

He supported the draft resolution.

Dr MAZA BRIZUELA (El Salvador) said that, in spite of the many shortcomings affecting his country's poorly managed health system, its disparate sectors had always prioritized immunization; even during the civil war of the 1980s health workers had carried out vaccination campaigns in rural areas. Current coverage for most vaccines stood at more than 95%. However, in the case of influenza, immunization services had vaccinated only 70% to 75% of children, but over 90% of adults; and between 2003 and 2007 the number of people treated for pneumonia had halved, with considerably lower mortality among those aged over 60 years.

In the case of rotavirus diseases, even though every infant aged between two and five months had been vaccinated when the vaccine was introduced in October 2006, routine coverage, once again, was no higher than 70%. For acute rotavirus diarrhoea, 30% fewer hospital consultations had been recorded in 2007. Gradual reduction in gastroenteritis, which was common in the region, would depend not just on immunization but also on improvements in socioeconomic circumstances, education and training. El Salvador enjoyed financial and other support from WHO. It had obtained vaccines on credit from PAHO. In 2008, partners had donated a further 300 000 doses of influenza vaccine. International and domestic teamwork was the key to sustainable success in vaccination campaigns.

Mr KWON Jun-Wook (alternate to Professor Sohn Myongsei, Republic of Korea) said that measles had been eliminated in his country by 2006, thanks to measures such as compulsory measles, mumps and rubella immunization for children on school entry and a catch-up immunization campaign for schoolchildren aged from seven to 16 years. The current immunization rate was 99%.

Minimizing adverse reactions following vaccination was essential to overall immunization strategy; why had that issue not been mentioned in the report or the draft resolution? He proposed the following amendments to the draft resolution: paragraph 1 should call upon Member States to develop, strengthen and/or maintain surveillance systems for adverse reactions to vaccines; paragraph 2 should request the Director-General to provide guidelines and technical support to Member States for the minimization of such adverse reactions.

Ms WISEMAN (Canada)¹ welcomed the progress made in the area of immunization. Canada's national immunization strategy had increased access to new and underused vaccines, including the human papillomavirus vaccine. The Canadian international immunization initiative provided support to the GAVI Alliance, and Canada would continue to work with WHO and other partners in implementing the Global Immunization Vision and Strategy 2006–2015.

Ms NICOLA (Netherlands)¹ noted that the cost–benefit aspects of immunization had not been addressed in the draft resolution and proposed that the words “and cost-beneficial” should be added after “available” in paragraph 1(3). In paragraph 2(1), the phrase “that have proven to have a positive cost–benefit balance for a particular (sub)population” should be added after “vaccines”. Her proposal was seconded by Mr FISKE (Denmark) and Mrs PARRA (alternate to Professor Pereira, Portugal).

Dr VILLENEUVE (UNICEF) noted that the report emphasized the potential of community outreach services to increase access to immunization and other child survival interventions. UNICEF greatly valued its collaboration with WHO on the Global Immunization Vision and Strategy 2006–2015, which should guide immunization practices at both global and national levels. He supported the draft resolution on the implementation of the strategy, which was intended to achieve equitable and universal immunization coverage and expand access to new vaccines to all target populations. UNICEF would collaborate with WHO and other partners to mobilize the necessary political commitment and financial resources.

UNICEF recognized the progress made in 2007 towards the eradication of poliomyelitis and supported WHO's call to the remaining states in which the disease was endemic to ensure that all children were immunized and that wild poliovirus transmission was rapidly interrupted. He called upon all Member States to make available the resources necessary for intensified eradication. He commended the new international support for national efforts to strengthen health systems, including child immunization services.

Ms ARENDT LEHNERS (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, highlighted the immunoactive properties of breast milk, noting that recent estimates indicated that many more than one million infant deaths a year could be prevented by breastfeeding. The Global Immunization Vision and Strategy should stress the importance of breastfeeding as a child's first, freely available form of immunization.

Ms MAFUBELU (Assistant Director-General) thanked all speakers for their valuable comments. Progress in immunization had certainly been made, but child mortality was still unacceptably high. The measles immunization campaign in Africa had been very successful, but it was important to maintain routine immunization so that all children born in the future would also be covered. Speakers' comments had emphasized four main points: (1) sufficient funding must be made available to ensure the long-term sustainability of immunization programmes, especially in middle-income countries that were not eligible for funding from the GAVI Alliance; (2) further resources must be mobilized outside the GAVI Alliance; (3) manufacturing capacity must be further expanded, especially in developing countries; and (4) research into better and cheaper vaccines must continue.

The Secretariat would take the comments by the member for Tunisia into account in its report to the Sixty-first World Health Assembly. The member for the Bahamas had noted the potential for synergy with the poliomyelitis eradication programme. The Secretariat had learned many lessons from that programme, which were being applied to immunization activities and in other areas of work. At least three suppliers of *Haemophilus influenzae* type b and hepatitis B vaccines had been identified, and UNICEF was able to meet the demand for vaccines.

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

The Secretariat had begun discussions in the Region of the Americas and in the Eastern Mediterranean and Western Pacific regions with a view to raising additional funding for immunization in countries that did not qualify for funding from the GAVI Alliance. Mechanisms such as the Revolving Fund for Vaccine Procurement in the Region of the Americas had proved very useful, although they required more capital.

The member for the United States of America had rightly stressed the importance of data quality. That issue was being addressed by the new global framework for immunization monitoring and surveillance, launched in 2007. The global framework also monitored adverse reactions to vaccines. In addition, the Secretariat was working with 10 selected countries to improve surveillance of adverse reactions.

She thanked all donors for their generous support for global immunization activities and expressed her appreciation of the close collaboration between WHO and UNICEF.

Dr KEAN (Executive Director, Office of the Director-General) read out the proposed amendments to the draft resolution. A new preambular paragraph should be added after the paragraph beginning “Alarmed that ...”, to read: “Concerned about the failure in availing necessary resources for introduction of new vaccines, especially in the middle-income countries”. Paragraph 1(3) should be amended to read: “... available and cost-beneficial new life-saving vaccines of assured quality, in accordance with national priorities, for all target populations ...”. A new paragraph 1(4) would read: “to develop, strengthen and/or maintain surveillance systems for vaccine adverse events”.

Paragraph 2(1) should be amended to read: “... all available vaccines that have proven to have a positive cost–benefit balance for a particular (sub)population”. Three new subparagraphs should be added after the current subparagraph 2(2), the first reading: “to approach the international partners and donors, as well as the vaccine producers, to mobilize necessary resources in order to support low- and middle-income countries and to ensure that all Member States have access to sufficient supplies of affordable vaccines of assured quality”. New subparagraph 2(4) would read: “to take measures as appropriate to help developing countries establish and strengthen the capacity of vaccine research, development and production with an aim of ensuring vaccine supplies, reducing vaccine prices and improving access to affordable vaccines”. New subparagraph 2(5) would read: “to provide guidelines and technical support to Member States for the minimization of vaccine adverse events”.

The DIRECTOR-GENERAL suggested that a new draft should be prepared, incorporating all the proposed amendments, for consideration at a later meeting.

It was so agreed.

(For continuation of the discussion, see summary record of the seventh meeting, section 1.)

Female genital mutilation: Item 4.12 of the Agenda (Documents EB122/15 and EB122/15 Add.1)

The CHAIRMAN drew attention to the draft resolution contained in document EB 122/15.

Mr MIGUIL (Djibouti), speaking on behalf of the Member States of the Eastern Mediterranean Region, acknowledged that, despite decades of work to prevent female genital mutilation, progress to reduce the practice in Member States had been slow. Work to eliminate the practice should be stepped up, addressing in particular its increasing medicalization.

Legislation was critical to elimination, and he therefore supported paragraph 1(2) of the draft resolution. Nevertheless, he cautioned against relying too heavily on legislation, since adopting laws would not necessarily stop the practice. The paragraph should include reference to the need to strengthen mechanisms for enforcing legislation that prohibited the practice and ensuring that future legislation included strong enforcement mechanisms.

The countries of the Region had long been committed to community initiatives, and he endorsed paragraph 1(3) of the draft resolution. He emphasized cost-effective and easily replicable community efforts that ensured participation and respect for cultural sensitivities.

Although it was important to protect the value system of communities, especially the institution of the family, there must be action by all sectors to address conditions that did not favour positive health outcomes for all. Female genital mutilation was a needless and harmful practice that violated the human rights of girls and women and prevented them from attaining optimal health. He supported the draft resolution.

Dr SUGIURA (alternate to Dr Shinozaki, Japan) suggested that health education in schools could change cultural attitudes and traditions that contributed to the persistence of female genital mutilation. It might take three or four generations, but constant effort would eliminate that practice. He supported the draft resolution and called on WHO to provide strong leadership on the issue.

Mr TOURÉ (Mali), speaking on behalf of the Member States of the African Region, said that female genital mutilation was a common practice in various African societies. According to demographic and health surveys carried out between 1989 and 2002, prevalence within the African Region ranged from 5% of women aged from 15 to 49 in Niger to 99% in Guinea. Data revealed that in Mali up to 85% of women had been subjected to the practice.

Despite global mobilization against female genital mutilation, only 15 countries in the Region had made progress in reducing it. A regional action plan to accelerate elimination had been drawn up in 1997 with the aim of formulating and implementing policies at national and regional levels. Fifteen countries in the African Region had national policies and strategies based on WHO's prevention strategy. With WHO's support, 13 countries had included the fight against female genital mutilation in their policies on reproductive health and on protection of women and children, recognizing it as both a health problem and a human rights issue. Three countries had specific laws against female genital mutilation and nine had legal instruments that could be used to protect women and girls from the practice.

The Government of Mali had established a national programme with prohibition of the practice in health-care institutions, provision of training to health professionals on dealing with complications resulting from female genital mutilation, and involvement of religious groups in combating the practice. Training materials for doctors, nurses, midwives and traditional birth attendants would raise awareness of the issue in communities and discourage the practice by health workers. Various nongovernmental organizations and other partners were involved in the fight.

Challenges to the elimination of female genital mutilation in the Region included: harnessing political will to support target groups; changing behaviour, which took time and resources; enlisting the support of political, religious and community leaders and nongovernmental organizations; and involving partners. The African Region was concerned about the health consequences of female genital mutilation and supported the draft resolution. He stressed the need to strengthen national monitoring and evaluation of programmes and enhance care for those who had undergone female genital mutilation.

Mr FISKE (Denmark), speaking on behalf of the Nordic countries and associating himself with the statement made by the member for Mali, said that the practice of female genital mutilation was an obstacle to the full enjoyment of human rights by girls and women and constituted a form of violence, causing severe pain, risk of infection and reproductive complications, in addition to harsh psychological and sexual consequences. He urged the Director-General to increase the Organization's efforts dramatically with a view to ending the practice within one generation. WHO should address that challenge more systematically and develop coherent action plans. Combating the practice was vital to achieving WHO's goals of strengthening both women's health and overall health in Africa. Interventions should include supporting education and information in countries where it was still practised, and providing opportunities for practitioners of female genital mutilation to obtain income from other sources.

Real results required changed behaviour among men and women alike. WHO and the international development community could help but the change must come from within the countries where the practice persisted. Laws prohibiting female genital mutilation must be introduced and enforced. In countries where the practice was illegal, all groups, including migrants, should be informed of its dangers and illegality. Medical, psychological and social support was needed for women and girls who had undergone the procedure. He expressed alarm at the participation of health personnel in female genital mutilation.

He suggested the following amendments to the draft resolution: the words “the goals and commitments contained in” should be deleted from the third preambular paragraph; “particularly ensuring men’s and local leaders’ participation in the process to eliminate the practice” should be inserted at the end of paragraph 1(3); a new paragraph 1(6) should be added, to read: “to develop social and psychological support services and care and to take measures to improve health, including sexual and reproductive health, in order to assist women and girls who are subjected to this violence”; “to continue to provide” should be replaced by “to step up” in paragraph 2(1), “to continue to support research” should be replaced by “to increase support for research” in paragraph 2(2) and “to report regularly, at least every four years” should be replaced by “to report every three years” in paragraph 2(4).

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), expressing support for the statement made by the member for Djibouti and the amendments proposed by the member for Denmark, pointed out that female genital mutilation was not only a problem for developing countries. The practice had been illegal in the United Kingdom since 1985, and the relevant legislation had been revised and extended in 2003, but medical professionals continued to treat people who had undergone the procedure. Trained and culturally sensitive staff provided services, including reversal surgery.

The roots of the problem, such as pressure from family members and resistance to change by practitioners of female genital mutilation, needed to be addressed; education would be a key factor, but advocacy against the practice by community, political and religious leaders – especially males – was also needed. Deploring the involvement of health-care professionals in the practice, he suggested that professional and regulatory bodies might be persuaded to define it as unethical, which could result in disciplinary action against members of such bodies found to be engaging in the practice. He urged the Board to adopt the draft resolution.

Dr BLOOMFIELD (alternate to Mr McKernan, New Zealand) emphasized the need for more rapid progress to eliminate female genital mutilation, a violation of the human rights of women and girls and an unacceptable expression of violence against them. He supported the amendments proposed by the member for Denmark, and suggested that the word “appropriate” should be deleted from paragraph 1(2), as it weakened the text.

Professor SALANIPONI (Malawi) said that female genital mutilation was a common cultural practice in Africa. The secrecy surrounding it made the practice difficult to monitor and stop. Culturally sensitive strategies should target families, schools, politicians, and local and religious leaders. Female genital mutilation was mainly performed by people with no medical training, generally without anaesthesia, sterilization or proper medical instruments. The practice contributed to the transmission of HIV and could cause death from shock or excessive bleeding.

Malawi was making progress in overcoming the taboos surrounding harmful cultural practices, and open discussions were being held in villages in order to empower women and families by raising awareness of their rights. Malawi had taken steps to enact and enforce legislation aimed at improving management of the problem of HIV/AIDS and protecting girls and women from violence, particularly cultural practices that harmed their reproductive health. He urged WHO to provide support emphasizing concerted action in education and health. In his view, solving the problem would take several generations.

Dr VOLJČ (Slovenia) endorsed the statements of the members for Denmark, Malawi and Mali and supported the amendments proposed by the member for Denmark.

Dr KANDUN (alternate to Dr Supari, Indonesia) expressed deep concern at the serious health consequences of female genital mutilation for women and for their babies. Indonesia prohibited medical personnel from performing female genital mutilation. The tradition continued because it was supported by men and women and usually went unquestioned, and because anyone departing from the norm could face condemnation, harassment and ostracism. It was difficult for families to abandon the practice without support from the wider community: it was a social convention that could be changed only through coordinated collective action. A multisectoral approach and a revised interagency statement were needed: they would empower community projects on gender perspective and human rights.

Dr WRIGHT (United States of America) said that his Government was deeply committed to empowering women and educating girls in health issues that were critical to achieving healthy and sustainable populations. The eradication of female genital cutting would contribute significantly to the reduction of female morbidity, maternal mortality and child morbidity and mortality in countries where it was practised. The United States favoured a culturally sensitive approach, implemented mainly by local groups, to stop the practice. Under no circumstances should the medical community and health-care providers participate in or support the practice of female genital cutting. WHO had an important awareness-raising role to play.

He sought clarification on the funding available for research and programmes as it appeared that, although some US\$ 8.4 million had been budgeted in the current biennium to combat female genital cutting, as much as US\$ 6.9 million of that total remained unfunded. Was it realistic to assume that the funds outstanding could be raised from bilateral and private donors and, if not, what programme had been envisaged? WHO's strengths were in standard setting, building national capacity and enabling an evidence-based approach. An essential first step would be to determine the scope and range of the problem.

He proposed the following amendments to the draft resolution: in the third preambular paragraph, to add the words "and related reports" after "five- and ten-year reviews"; in the fourth preambular paragraph, to replace the word "affirming" with "recognizing", to delete the references to the African Charter and the Solemn Declaration (regional documents that were unfamiliar), and to delete the final phrase "including their right to the highest attainable standard of health"; to delete the fifth preambular paragraph, which referred to a regional document; and to delete the words in parentheses at the end of the eleventh preambular paragraph.

Mrs PARRA (alternate to Professor Pereira Miguel, Portugal) supported the position expressed by the member for Mali and the amendments proposed by Denmark and New Zealand.

Dr MENESES GONZÁLEZ (alternate to Dr Hernández Ávila, Mexico) said that gender-based violence was particularly unacceptable. According to the *World report on violence and health*,¹ female genital mutilation was gender-based violence. The draft resolution represented a great step forward and he supported the amendments put forward by the members for Denmark and New Zealand. The amended resolution should be adopted by the Health Assembly and implemented in all countries in order to secure the rapid eradication of the practice.

Dr FORSTER (Namibia) said that Namibia had actively contributed to the drafting of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa and strongly supported the total abandonment of female genital mutilation. The practice was unacceptable

¹ *World report on violence and health*. Geneva, World Health Organization, 2002.

on the grounds of human rights. The continued high levels of infant and maternal mortality in Africa also made it unacceptable that practices should continue that directly contributed to further morbidity and mortality of women, girls and infants. Namibia was particularly concerned that, in certain settings, female genital mutilation was carried out by practitioners without any censure from licensing bodies. He fully supported the draft resolution.

Dr DAHL-REGIS (Bahamas) was grateful to the Director-General for having brought the subject before the Board. The Bahamas supported the amendments put forward by the members for Denmark and New Zealand and drew attention to the matter of funding, raised by the member for the United States of America, and, given the paucity of baseline data, the need to set indicators.

Ms VRIELINK (Netherlands)¹ said that the practice of female genital mutilation was a serious violation of the human rights of girls and women. She was concerned at the slow progress in halting the practice and supported the goal of eliminating it within one generation. She presented a list of countries that wished to align themselves with the statement by the member for Denmark: Austria, Belgium, Brazil, Canada, Estonia, France, Germany, Greece, Ireland, Israel, Italy, Libyan Arab Jamahiriya, Luxembourg, Monaco, Netherlands, Russian Federation, Spain and Switzerland.

Mrs HAMID (UNFPA) said that UNFPA joined with partners around the world in calling for an end to female genital mutilation. She welcomed the report and looked forward to the adoption of the draft resolution. The revision, coordinated by WHO, of the WHO/UNFPA/UNICEF joint statement on female genital mutilation, issued in 1997, was intended to reinforce international commitment to eliminating the practice. Female genital mutilation violated the basic rights of women and girls and compromised their health, posing risks during childbirth and leaving lasting physical and psychological scars. In more than a dozen countries where the practice was widespread, laws had been passed to make it illegal and increasing numbers of women and men disapproved of it, with reduced prevalence in several of those countries.

Her organization called for stronger governmental commitment to funding and implementing programmes to prevent the practice. Laws needed to be enforced, people educated and communities engaged. Social change could not be imposed from the outside but needed support from within the community. Through interventions that fostered dialogue, an increasing number of communities had fully or partially abandoned the practice in favour of alternative initiation ceremonies.

Nevertheless, new concerns were emerging as more parents turned to health-care providers in order to minimize the health hazards of cutting. There was also a tendency to subject girls to the practice at a younger age in order to ensure their compliance. Some communities were also performing less drastic cuts instead of abandoning the practice altogether. UNFPA pledged support for intensified efforts to stop the practice in all its forms and to advance gender equality and the human rights of women. Resolution 51/2 of the United Nations Commission on the Status of Women, adopted in March 2007, was the first-ever United Nations resolution on ending female genital mutilation. It called on States to develop policies, protocols and rules to ensure effective implementation of legislation to eliminate and prevent female genital mutilation, including the training of social workers, medical personnel and other professionals, as well as programmes of alternative professional training for practitioners.

UNFPA looked forward to implementation of the draft resolution currently before the Board and would continue to work with its partners to end the practice.

Ms DELORME (The World Medical Association, Inc.) speaking at the invitation of the CHAIRMAN and also on behalf of FDI World Dental Federation, the International Council of Nurses, and the International Pharmaceutical Federation, which together formed the World Health Professions

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

Alliance, welcomed the report, noting the slow rate of decline of the practice. She commended the draft resolution. Female genital mutilation was seriously detrimental to the physical and mental health of women and girls and constituted a violation of basic human rights. The Alliance strongly condemned the practice and urged medical and nursing associations to develop educational programmes on the acute dangers of female genital mutilation; raise awareness that it violated women's human rights and that physicians and health professionals should never practise it. The Alliance pledged to work to eliminate the practice by health professionals in any setting.

Mrs MAFUBELU (Assistant Director-General) thanked speakers for their comments and guidance, and for their support for the draft resolution. In response to the question from the member for the United States of America, she confirmed that funding existed but was inadequate. Some welcome funding for research had been provided by the European Union and also by the United States Agency for International Development, although more would be required if the practice were to be eliminated within one generation. Some additional funds might be received from charitable foundations. She hoped that the commitment expressed by speakers would encourage more donors. She assured the member for the Bahamas that indicators had been put in place to measure progress towards elimination of the practice.

In response to the remark by the member for Japan on the need to include the subject in school health programmes, she expressed concern that, as the practice was becoming more prevalent among children of pre-school age, that might be too late for many young children. The efforts made in countries of the African Region, such as Mali, were encouraging and she pledged the Secretariat's continued support in working with them to eliminate the practice. She invited all Member States to observe the International Day of Zero Tolerance of Female Genital Mutilation on 6 February 2008.

She concurred that there had been some progress, but the rate of decline in the practice was slow. Increasingly, the practice was being carried out by health professionals. Legislation was essential but so was enforcement. Female genital mutilation was an unacceptable violation of the human rights of women and girls and constituted violence against them. There was a need for behavioural change, requiring support from the wider community and from trained, culturally sensitive health personnel. Empowerment of women and girls was essential to elimination of the practice and the subject could indeed be included as part of school health programmes. The calls to eliminate the practice within one generation emphasized the need for a multisectoral approach. WHO was one of 10 United Nations agencies seeking to combat female genital mutilation; she expressed appreciation for the collaboration with UNFPA on that and other sexual and reproductive health issues. The revised interagency statement on female genital mutilation would be officially launched at the meeting of the United Nations Commission on the Status of Women in February and March 2008 and would be made available on the WHO web site.

The DIRECTOR-GENERAL thanked Member States, partner United Nations agencies and nongovernmental organizations for their strong support for the report and for the draft resolution. Resources were always limited, but, given the strong feelings on that matter, WHO would make every effort to fill the current funding gap. On taking office, she had committed the Organization to be judged on two indicators: improvement in the health of women and in the health of the people of Africa; the current issue encompassed both. She looked forward to financial contributions to WHO's activities in that field from those who had expressed support for the report.

Dr KEAN (Executive Director, Office of the Director-General) read out the amendments that had been proposed to the draft resolution. In the third preambular paragraph, the words "the goals and commitments contained in" should be deleted and the words "and related reports" inserted after "five- and ten-year reviews". Three amendments to the fourth preambular paragraph had been proposed: "Affirming" should be replaced by "Recognizing". In the middle of the paragraph the references to "the African Charter on the Rights and Welfare of the Child (1990), and the Solemn Declaration on Gender Equality in Africa (2004)" should be deleted, as should the phrase "including their right to the highest attainable standard of health". The paragraph would then read: "Recognizing that the

International Covenant on Civil and Political Rights (1976), the Convention on the Elimination of All Forms of Discrimination against Women (1979) and the Convention on the Rights of the Child (1989) constitute an important contribution to the legal framework for the protection and promotion of the human rights of girls and women;”. The fifth preambular paragraph, beginning “Recognizing the entry into force...”, should be deleted. At the end of the last preambular paragraph, the phrase “(the last group including bodies representing health professionals and those concerned with human rights.)” should be deleted.

In paragraph 1(2) the word “appropriate” should be deleted. The wording of paragraph 1(3) should be amended to read: “to support and enhance community-based efforts to eliminate the practice, particularly ensuring men’s and local leaders’ participation in the process to eliminate the practice”. A new paragraph 1(6) should be added, to read: “to develop social and psychological support services and care, and to take measures to improve health, including sexual and reproductive health, in order to assist women and girls who are subjected to this violence”. At the beginning of paragraph 2(1) the words “to continue to provide” should be replaced by “to step up”. The words “continue to support”, at the beginning of paragraph 2(3), should be replaced by “increase support for”. In paragraph 2(4) the words “regularly, at the least, every four years,” should be replaced by “every three years”.

Mr TOURÉ (Mali) said that, in view of the large number of amendments proposed, some of which might weaken the text, consultations to secure consensus might be advisable.

Dr GWENIGALE (Liberia) said that the proposed amendments if anything strengthened the text, and the resolution should therefore be adopted with the amendments proposed.

Dr BLOOMFIELD (alternate to Mr McKernan, New Zealand) supported the member for Mali. He too had reservations about some of the proposed amendments and would welcome consultations with other interested parties in order to find consensus.

Dr WRIGHT (United States of America) supported the comments by the members for Mali and New Zealand; a working group would be the proper forum for discussing the proposed amendments.

The CHAIRMAN asked whether informal consultations would be sufficient, since there appeared to be general support for the proposed amendments and only minor concerns over nuances.

Dr FORSTER (Namibia) said that it would be helpful if the Secretariat could advise the Board on the procedures that should be followed when amending preambular paragraphs and, specifically, regarding references to regional agreements.

Mr BURCI (Legal Counsel) said that WHO’s governing bodies tended to avoid references to regional instruments. Although that did not preclude mention being made of instruments of particular significance in the context of a given item, the general practice was to limit references to instruments of universal scope.

Mr FISKE (Denmark) said that his delegation would be happy to work in either an informal or a formal context to finalize an agreed text.

The CHAIRMAN suggested that further consideration of the item should be deferred pending the outcome of informal consultations.

It was so agreed.

(For continuation of the discussion, see summary record of the ninth meeting, section 1.)

International migration of health personnel: a challenge for health systems in developing countries: Item 4.13 of the Agenda (Document EB122/16 Rev.1)

Professor SALANIPONI (Malawi), speaking on behalf of the Member States of the African Region, said that African countries, particularly those in sub-Saharan Africa, were the main losers from international migration of health personnel. He welcomed WHO's comprehensive "four-pillar" approach outlined in the report and asked whether a draft of the code of practice on the international recruitment of health personnel requested in resolution WHA57.19 could be made available to the Board as part of the progress report. Patterns of migration had become complex and more widespread, weakening health services in developing countries. Without action, the Millennium Development Goals and equitable access to health-care services would not be achieved. WHO must ensure that the code of practice provided an international framework for managing the migration of health personnel between receiving and sending countries, and work with African countries to devise a mechanism that would ensure that the receiving countries supported developing countries creating incentives to retain health workers.

Dr AL-HASNAWI (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that migration was a serious obstacle to improving health services in the Region. Many countries coping with complex and unstable situations were losing well-trained health personnel through migration. Country-specific and interregional considerations, as well as the global dynamics of migration, must be emphasized. He stressed resolution WHA57.19, which urged Member States, inter alia, to develop strategies to mitigate the adverse effects of the migration of health personnel and implement policies for effective retention of health personnel. To that end, the Secretariat should work with partner organizations and Member States at all levels. Developing countries needed additional support to implement national policies on migration and enforce retention measures. He stressed the global policy responses and the support needed from receiving countries to enable health professionals working in those countries to pay working visits to their countries of origin, for example the successful arrangement established between the United Kingdom of Great Britain and Northern Ireland, and South Africa. The Secretariat should include those suggestions in the document it was preparing for submission to the forthcoming Health Assembly.

(For continuation of the discussion, see summary record of the seventh meeting, section 1.)

The meeting rose at 17:35.