



WORLD HEALTH ORGANIZATION

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# **EXECUTIVE BOARD**

**122<sup>ND</sup> SESSION**

**GENEVA, 21–25 JANUARY 2008**

**SUMMARY RECORDS**

GENEVA  
2008

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## ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACHR	– Advisory Committee on Health Research	PAHO	– Pan American Health Organization
ASEAN	– Association of Southeast Asian Nations	UNAIDS	– Joint United Nations Programme on HIV/AIDS
CEB	– United Nations System Chief Executives Board for Coordination (formerly ACC)	UNCTAD	– United Nations Conference on Trade and Development
CIOMS	– Council for International Organizations of Medical Sciences	UNDCP	– United Nations International Drug Control Programme
FAO	– Food and Agriculture Organization of the United Nations	UNDP	– United Nations Development Programme
IAEA	– International Atomic Energy Agency	UNEP	– United Nations Environment Programme
IARC	– International Agency for Research on Cancer	UNESCO	– United Nations Educational, Scientific and Cultural Organization
ICAO	– International Civil Aviation Organization	UNFPA	– United Nations Population Fund
IFAD	– International Fund for Agricultural Development	UNHCR	– Office of the United Nations High Commissioner for Refugees
ILO	– International Labour Organization (Office)	UNICEF	– United Nations Children’s Fund
IMF	– International Monetary Fund	UNIDO	– United Nations Industrial Development Organization
IMO	– International Maritime Organization	UNRWA	– United Nations Relief and Works Agency for Palestine Refugees in the Near East
ITU	– International Telecommunication Union	WFP	– World Food Programme
OECD	– Organisation for Economic Co-operation and Development	WIPO	– World Intellectual Property Organization
OIE	– Office International des Epizooties	WMO	– World Meteorological Organization
		WTO	– World Trade Organization

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The designations employed and the presentation of the material in this volume do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Where the designation “country or area” appears in the headings of tables, it covers countries, territories, cities or areas.

## **PREFACE**

The 122nd session of the Executive Board was held at WHO headquarters, Geneva, from 21 to 25 January 2008. The proceedings are issued in two volumes. The present volume contains the summary records of the Board's discussions, list of participants and officers, and details regarding membership of committees and working groups. The resolutions and decisions and relevant annexes are published in document EB122/2008/REC/1.



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<sup>1</sup> As adopted by the Board at its first meeting (21 January 2008).

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- B. Strengthening nursing and midwifery (resolution WHA59.27)
- C. International trade and health (resolution WHA59.26)
- D. Health promotion in a globalized world (resolution WHA60.24)
- E. Smallpox eradication: destruction of variola virus stocks (resolution WHA60.1)
- F. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)
- G. Infant and young child nutrition: biennial progress report (resolution WHA58.32)
- H. [Transferred to section 6, as item 6.8]

### 9. Closure of the session

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EB122/1 Rev.1	Agenda <sup>1</sup>
EB122/1(annotated)	Provisional agenda (annotated)
EB122/2	Report by the Director-General to the Executive Board at its 122nd session
EB122/3	Report of the Programme, Budget and Administration Committee of the Executive Board
EB122/4	Climate change and health
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<sup>1</sup> See page ix.

<sup>2</sup> See document EB122/2008/REC/1, Annex 3.

EB122/14	Global immunization strategy
EB122/14 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>1</sup>
EB122/15	Female genital mutilation
EB122/15 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>1</sup>
EB122/16 Rev.1	International migration of health personnel: a challenge for health systems in developing countries
EB122/17	Director-General of the World Health Organization
EB122/18	United Nations reform process and WHO's role in harmonization of operational development activities at country level
EB122/19	Partnerships
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EB122/22	Provisional agenda for the Sixty-first World Health Assembly
EB122/23	Appointment of the Regional Director for the Americas
EB122/24	Human resources: annual report
EB122/24 Add.1 and Add.1 Corr.1	Human resources: annual report
EB122/25	Report of the International Civil Service Commission
EB122/26 and EB122/26 Add.1	Reports of advisory bodies. Advisory Committee on Health Research (ACHR)
EB122/27	Reports of advisory bodies. Expert committees and study groups
EB122/28	Reports of advisory bodies. Expert committees and study groups. Expert advisory panels and committees and their membership
EB122/29 EB122/29 Add.1	Progress reports
EB122/30	Confirmation of amendments to the Staff Regulations and Staff Rules <sup>1</sup>

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<sup>1</sup> See document EB122/2008/REC/1, Annex 3.

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EB122/30 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>2</sup>
EB122/31	Foundations and awards. Awards, including the proposal from the Republic of Korea to establish the Dr LEE Jong-wook Memorial Prize for Public Health
EB122/32	Foundations and awards. Administration and award of the Darling Foundation Prize: proposed dissolution
EB122/33	Monitoring of health-related Millennium Development Goals
EB122/34	Reports of committees of the Executive Board. Standing Committee on Nongovernmental Organizations <sup>3</sup>
EB122/34 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>2</sup>
EB122/35	Awards

### **Information documents**

EB122/INF.DOC./1	Statement by the representative of the WHO staff associations
EB122/INF.DOC./2	Implementation of the International Health Regulations (2005)

### **Diverse**

EB122/DIV/1 Rev.1	List of members and other participants
EB122/DIV/2	Preliminary daily timetable
EB122/DIV/3	Decisions and list of resolutions
EB122/DIV/4	List of documents

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<sup>1</sup> See document EB122/2008/REC/1, Annex. 1.

<sup>2</sup> See document EB122/2008//REC/1, Annex 3.

<sup>3</sup> See document EB122/2008//REC/1, Annex 2.





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 Mr I. BALD, Information Management  
 Officer, Pandemic Influenza Contingency,  
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 Inspection Unit

Mr P.L. FALL, Inspector, Joint Inspection  
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Professor C. IJSSELMUIDEN

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**International Pharmaceutical Federation**

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**International Special Dietary Foods Industries**

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**International Union against Cancer**

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Mrs S. PEREL

**International Union of Nutritional Sciences**

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**La Leche League International**

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Dr GUO Zhenyu  
Dr C. BRETSCHER  
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**World Vision International**

Mr T. GETMAN

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**Seventh meeting, 17-18 January 2008:** Professor J. Pereira Miguel (Portugal, Chairman), Dr H. Ahmadzai (Afghanistan, successor to Dr A.S. Salehi), Ms M. Kristensen (Denmark, alternate to Mr J. Fisker), Dr J.G. Maza Brizuela (El Salvador, member ex officio), Dr I. Nyoman Kandun (Indonesia, alternate to Dr S.F. Supari), Dr H. Shinozaki (Japan), Dr W.T. Gwenigale (Liberia, Vice-Chairman), Mr O.I. Touré (Mali, successor to Dr Z.M. Youba), Mrs H. Arrington Avina (Mexico, alternate to Dr M. Hernández Ávila, successor to Mr M. Bailón), Dr D. Matheson (New Zealand, alternate to Mr D. Cunliffe, successor to Mr P. Hodgson), Dr B. Sadasivan (Singapore, member ex officio), Mr N.S. de Silva (Sri Lanka), Dr H. Abdesselem (Tunisia), Ms A. Blackwood (United States of America, alternate to Dr D. Wright, successor to Dr J. Agwunobi)

### 2. Standing Committee on Nongovernmental Organizations

Mr O.K. Shiraliyev (Azerbaijan), Dr Jigmi Singay (Bhutan), Dr Ren Minghui (China), Dr R.R. Jean Louis (Madagascar), Dr J. Calderón Yberico (Peru)

**Meeting of 22 January 2008:** Dr Jigmi Singay (Bhutan, Chairman), Mr O.K. Shiraliyev (Azerbaijan), Dr Ren Minghui (China), Dr R.R. Jean Louis (Madagascar), Mr C. Vallejos (Peru, successor to Dr J. Calderón Yberico)

### 3. Sasakawa Health Prize Selection Panel

The Chairman of the Executive Board, a representative of the founder, and a member of the Executive Board

**Meeting of 23 January 2008:** Dr B. Sadasivan (Singapore, Chairman), Professor K. Kiikuni (representative of the founder), Professor Sohn Myongsei (Republic of Korea)

### 4. United Arab Emirates Health Foundation Selection Panel

The Chairman of the Executive Board, a representative of the founder, and a member of the Executive Board from a Member State of the WHO Eastern Mediterranean Region

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<sup>1</sup> Showing their current membership and listing the names of those committee members who attended meetings held since the previous session of the Executive Board.

**Meeting of 24 January 2008**

Dr B. Sadasivan (Singapore, Chairman), Mr N.K. Al Budoor and Mr A.H. Al Humood (representatives of the founder), Dr H. Abdesselem (Tunisia)

**5. State of Kuwait Health Promotion Foundation Selection Panel**

The Chairman of the Executive Board, a representative of the founder, and a member of the Executive Board from a Member State of the WHO Eastern Mediterranean Region

**Meeting of 23 January 2008**

Dr B. Sadasivan (Singapore, Chairman), Mr T.F.Y.M.A. Al-Doaij (representative of the founder), Dr A.A. Bin Shakar (United Arab Emirates)

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## **SUMMARY RECORDS**

### **FIRST MEETING**

**Monday, 21 January 2008, at 09:40**

**Chairman:** Dr B. SADASIVAN (Singapore)

**1. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA:** Item 1 of the Provisional agenda (Documents EB122/1 and EB122/1(annotated))

The CHAIRMAN declared open the 122nd session of the Executive Board and welcomed all participants, including the new Board members from China, Iraq, Malawi, Mexico, Namibia, New Zealand and the United States of America. Regrettably, some documents for the current session had been issued late; however, he had received assurances from the Secretariat that steps were being taken to avoid any recurrence of that state of affairs.

In drawing up the provisional agenda, the Secretariat and the Officers of the Board had decided to defer some proposals until future Board sessions. Item 5 of the provisional agenda should be deleted, as there was no proposed amendment to the Financial Regulations and Financial Rules. He suggested that consideration of a draft resolution on multilingualism, currently scheduled for discussion under item 8, "Matters for information", should be transferred to item 6, "Management matters".

**It was so agreed.**

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, Armenia and the Republic of Moldova, aligned themselves with his statement. In September 2007, Portugal, the country then holding the Presidency of the European Union, had asked the Director-General to include in the agenda for the Board's 122nd session an item on monitoring the implementation of the health-related Millennium Development Goals. On 6 November 2007, the Director-General, in a communication to Members of WHO, had recommended that consideration of the question should be deferred until the 123rd session. The European Union was worried about the slow progress made with the implementation of the Goals, especially those relating to health supposed to be achieved by 2015, only seven years away. The European Union's current initiative would enable annual discussion of the Goals on the basis of detailed reports from WHO, and improve coordination with other United Nations agencies. Accordingly, he formally requested the Board to approve the inclusion of the item in the agenda for its current session, so that it could be considered at the Sixty-first World Health Assembly with the first annual discussion in May 2009.

Dr WRIGHT (United States of America) said that climate change and health was a complex issue, discussion of which he could not presently support because the Secretariat had made document EB122/4 available only three days before the start of the session. Discussion on the agenda item should be delayed until the end of the session in order to give his country the necessary time to thoroughly review the document and the related draft resolution.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) supported the proposal concerning discussion of the Millennium Development Goals. His Government had advocated the inclusion of climate change and health in the agenda. Climate change and health was the theme of World Health Day in 2008. He therefore proposed that a preliminary discussion on the item should be scheduled on the agenda, with a more detailed discussion of the relevant draft resolution later in the session.

Mr McKERNAN (New Zealand) supported that proposal.

Dr VOLJČ (Slovenia), speaking on behalf of the Member States of the European Union, said that the European Community, its Member States and the European Commission worked closely with WHO. As agreed in the exchange of letters in 2000 between WHO and the Community on the consolidation and intensification of cooperation, and without prejudice to any future general agreement between WHO and the European Community, the European Commission attended the sessions of the Board as an observer. However, under Rule 4 of the Board's Rules of Procedure, such representatives were not automatically invited to participate in subcommittees or other subdivisions of the Board such as drafting groups and working groups. He accordingly proposed that, at the 122nd session of the Board, the European Commission should be invited to participate without vote in the deliberations of the subcommittees or other subdivisions of the Board and committees falling within the Community's competence and, in particular, those covered by agenda items 4.1 to 4.13.

Mr BURCI (Legal Counsel) noted that at previous sessions the Board had agreed to such requests on the understanding that the European Community would participate only in drafting or working groups on items regarding which it had competence, namely those just cited, and that either the European Union or the European Community would take the floor, so as to avoid any overlap.

The CHAIRMAN said that he took it that the Board wished to include in its agenda an item entitled "Monitoring of health-related Millennium Development Goals", and to accept the proposal by the member for Slovenia concerning the participation of the European Community.

**It was so agreed.**

After a brief discussion in which Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) and Dr WRIGHT (United States of America) participated, the CHAIRMAN said that he took it that the Board wished to postpone the discussion of agenda item 4.1, "Climate change and health", from the first to the second day of its current session.

**It was so agreed.**

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

Referring to the preliminary timetable contained in document EB122/DIV/2, the CHAIRMAN suggested that the meeting planned for the Darling Foundation Committee should be cancelled, in view of the proposal to disestablish the Committee.

**It was so agreed.**

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



The CHAIRMAN announced that item 7.1, "Appointment of the Regional Director for the Americas", would be taken up one day earlier than scheduled. He took it that the Board agreed to the proposed timetable, as amended, allowing for possible adjustments.

**It was so agreed.**

## **2. REPORT BY THE DIRECTOR-GENERAL:** Item 2 of the Agenda (Document EB122/2)

The DIRECTOR-GENERAL drew attention to the threat to health posed by instability and civil unrest, which disrupted routine health services and compromised special initiatives. In particular, support for health services was needed in Kenya and in the Gaza Strip. She commended the Government of Iraq's survey of family health, which would draw the attention of world leaders to the effects of conflict on health services.

She agreed with previous speakers that the late release of documents compromised the ability of the Executive Board to prepare for an efficiently conducted Health Assembly, and assured Members that she would review the issue to ensure the timely issuance of documentation for future sessions.

New estimates from UNAIDS and WHO indicated that the number of people dying from AIDS-related illnesses had declined over the past two years, owing in part to preventive efforts and the expansion of coverage with antiretroviral therapy. Nevertheless, the annual number of new infections outpaced the expansion of access to treatment, mother-to-child transmission of HIV was still a problem, and high-risk groups were being ignored by some governments.

Efforts to control tuberculosis were yielding results, as the annual global incidence appeared to have stabilized or was declining in some parts of the world. Multidrug-resistant tuberculosis was, however, a particular concern in some areas, and the recent emergence of extensively drug-resistant tuberculosis was alarming, as it was difficult to detect and extremely expensive to treat.

The burdens of HIV/AIDS, tuberculosis and malaria were highest in Africa. Progress in combating those diseases would therefore not be measured in terms of global averages but by improvement in the health of the African people. The political and public profile of malaria had risen; international commitment was strong, with coherent implementation of strategies. Artemisinin-based combination therapies were effective and safe but they cost 20 to 40 times more than conventional treatments, placing an intolerable burden on impoverished rural families. UNITAID, an international facility for purchasing medicines and diagnostics for AIDS, tuberculosis and malaria, funded by a levy on airline tickets, paid for large quantities of products and guaranteed a large, predictable market, thereby providing an incentive for improving products. An average reduction in the price of HIV/AIDS medicines of 40% had been brokered. A mechanism was being considered for improving access to artemisinin-based combination therapies, with heavily subsidized prices at the point of manufacture. Once the price of the best products became competitive, ineffective, substandard or counterfeit products would be driven off the market.

Progress had also been made in combating neglected tropical diseases, through cost-effective strategies. Mass preventive chemotherapy, for instance, had eliminated lymphatic filariasis in China and Egypt in 2007, and other countries were close to achieving that goal.

Globalization and urbanization had introduced a common dimension to health problems. Governments in all regions were concerned about emerging and epidemic-prone diseases and recognized the significance of the International Health Regulations (2005) and the increasing incidence of chronic diseases. The health-related Millennium Development Goals had been on the agenda of each of the Regional Committee sessions, all of which signalled difficulty in meeting the goal for reducing maternal mortality. That situation would change only when more women had access to skilled birth attendants and emergency obstetric care, and when the broad social and economic determinants of maternal mortality had been addressed. Countries in all regions had recognized the need to strengthen health systems and health delivery and to ensure the financing of health care.

The past year had been marked by three significant developments: an increasing recognition by development partners, United Nations agencies and funding facilities of the need to invest in health systems; the acceptance of climate change as a reality by world leaders, which must be followed by recognition of the likely impact on human health of extreme weather events; and the revival of the values, principles and approaches of primary health care in achieving the health-related Millennium Development Goals.

Member States had mandated some reforms in order to improve the Organization's performance. In response, she had improved coordination of the work of WHO at all levels, and she thanked the Regional Directors and WHO country representatives for their cooperation. She was committed to results-based performance and financial discipline and to modernizing the managerial and administrative procedures of WHO in order to meet rapidly evolving challenges. The global management system, which would become operational in 2008, would greatly increase transparency and accountability in the management of programme and human resources. Implementation would be closely monitored.

Commenting on specific items on the agenda, she drew attention to eradication of poliomyelitis and dracunculiasis. Efforts to attain those two goals were hindered by substantial funding gaps. The progress made towards eradication of dracunculiasis demonstrated the power of behavioural change to reduce disease incidence and its importance in preventing many chronic diseases. Two other reports showed how the intergovernmental meeting on pandemic influenza had sought a timely, transparent, equitable system for sharing viruses and benefits, and how the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property had sought to influence the dynamics of supply and demand in industries that were largely driven by market forces. Other reports outlined strategies to reduce the harmful use of alcohol; the international migration of health personnel; female genital mutilation; and the health needs of migrants.

The report on the global immunization strategy showed that the obstacles to full coverage encountered in the 1980s had been overcome, with record-breaking progress made in 2006. Immunization was the best means of protecting populations that were hard to reach, even in the absence of a well-functioning health system, and immunization programmes could also deliver other interventions such as bednets, vitamin A supplements and deworming tablets. Strong support was being provided by governments and the GAVI Alliance, and more vaccines were being delivered, stimulating research and development into new vaccines and the involvement of more manufacturers in developing countries. The immunization strategy had also led to more comprehensive disease surveillance and monitoring systems. Between two and three million deaths were being prevented each year. The achievements of the past year indicated that many problems that constrained progress could be overcome, that equitable coverage could be achieved, and that the drive towards such coverage brought ancillary benefits that laid the foundations for additional progress.

Dr SHINOZAKI (Japan), in congratulating the Director-General on the excellent results achieved, referred to pandemic influenza preparedness and public health, innovation and intellectual property and progress made against HIV/AIDS, tuberculosis and malaria. Further effort was needed in order to achieve the Millennium Development Goals, particularly in maternal and child health in Africa, through strengthened health systems and revitalized primary health care.

In 2008, Japan would be hosting the Fourth Tokyo International Conference on African Development and the G8 Hokkaido Toyako Summit, at which health issues would be discussed, as had been the case at the Kyushu-Okinawa Summit in 2000, which had led to the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria. In the areas of maternal and child health and tuberculosis, his Government's philosophy of human security had improved health conditions in Japan.

He noted progress towards organizational reform and the new global management system. In the light of the various organizations and emerging partnerships involved in improving the global health situation, WHO should cooperate closely with the directors of the regional offices.

Dr GWENIGALE (Liberia), speaking on behalf of the Member States of the African Region, welcomed the report's emphasis on issues affecting Africa and requested a regular review of the implementation of the agenda in that connection. He commended WHO's success in coordinating effective immunization against measles in Africa, which had resulted in a 91% decline in the number of deaths – from 396 000 to less than 36 000 – from the disease in the Region between 2002 and 2006, thereby meeting the 2010 target to reduce deaths from measles by 90% four years early. The importance of targeted public health interventions in the most affected regions had thereby been demonstrated, and should be replicated in the case of other diseases that disproportionately affected developing countries. He urged greater cooperation between nongovernmental organizations, the private sector and Member States in order to eradicate measles in Africa by 2010, and the need for WHO to participate in United Nations reform to ensure effectiveness of programmes in individual countries. The Organization should remain the lead agency on health issues. All agencies working in health should align their cooperation strategies with national health plans in order to strengthen national health systems.

Dr VOLJČ (Slovenia), speaking on behalf of the European Union, Norway, the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process, and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and Ukraine, Armenia and the Republic of Moldova, acknowledged the Organization's achievements in 2007, and the smooth adoption of the Programme budget 2008–2009 and the Medium-term strategic plan 2008–2013 by the Sixtieth World Health Assembly. He particularly welcomed strategic objective 5 in the medium-term plan; the formal entry into force of the International Health Regulations (2005); the positive outcome of the second session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control, in particular the adoption of the guidelines on protection from exposure to tobacco smoke;<sup>1</sup> and the decision to set up an intergovernmental negotiating body to negotiate a protocol on illicit trade in tobacco products.<sup>2</sup>

The European Union had participated in the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property. The significant achievements made must be translated into political commitments and beneficial change. He emphasized the global strategy and plan of action for all countries. Regarding the Intergovernmental Meeting on Pandemic Influenza Preparedness, a new transparent and effective system should be set up for the sharing of viruses and of derived benefits, in order to prevent future pandemics of avian influenza, and strengthen global health security. Immediate measures were called for, before the next Intergovernmental Meeting, for a fast and adequate response in the case of a pandemic outbreak of avian influenza. More stringent negotiation methods were also required at such meetings.

He supported the resolution proposed by the United Kingdom and others on climate change and health. WHO needed to look ahead in order to assess and manage the associated risks to public health, particularly for countries least able to adapt. He also welcomed WHO's choice of "protecting health from climate change" as the theme for World Health Day 2008. Progress towards achieving the Millennium Development Goals remained a high priority for the European Union. The slow progress towards the Goals, particularly on maternal, newborn and child health, HIV/AIDS, and sexual and reproductive health, was a concern. Monitoring the implementation of the Goals should be discussed by the Board. The European Union would support WHO in that monitoring, in coordination with other United Nations agencies and in the spirit of United Nations reform. Using existing mechanisms would avoid significant budget implications.

Initiatives such as the International Health Partnership reflected the need for greater coordination between countries, donors and the international health agencies. WHO would show leadership and commitment to United Nations reform through the success of existing pilot initiatives.

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<sup>1</sup> Decision FCTC/COP2(7).

<sup>2</sup> Decision FCTC/COP2(12).

He supported integrated primary health care as a way to strengthen health systems and welcomed the intention of the Regional Office for Europe to hold a ministerial conference on health systems in June 2008. Equal access to health care and equal opportunities to lead a healthy lifestyle should be key elements to improving health systems. The primary health sector should be used for tackling serious threats.

The international community should take more account of regional experience with regard to the migration of health workers through coordinated efforts by WHO with other international organizations. National legislation should also give greater consideration to the health of migrants. Access to treatment and preventive health care for migrants and their families were essential human rights, and promoted their integration and the well-being of the whole population.

Resolution WHA60.23 had given higher priority to the prevention and control of noncommunicable diseases, which were important in both developing and developed countries. A tight focus was needed on the main risk factors, including the harmful use of alcohol, and their severe impact on societies and economies. WHO should develop a global, evidence-based strategy.

Female genital mutilation continued to hamper the rights of women, girls and infants to the highest attainable standard of health. He commended WHO's work on the matter and supported the cooperation between WHO, UNICEF and UNFPA while looking forward to the revised joint statement. He also urged further action, especially research and evidence-based advocacy.

He welcomed the report on WHO publications and its potential for additional efficiency and savings. Balance was nevertheless needed for specific cases. Evidence presented must be indisputable, but WHO would sometimes have to challenge policies that were detrimental to health.

Welcoming the report on partnerships, he asked what criteria would govern the prioritization of prospective partnerships. It was important to avoid duplication of work on international health issues. WHO should maintain its focus on areas where it had a natural part to play and could exercise its leading role undisputed. Only united endeavours could make the world a healthier place.

Mr CORDOVA VILLALOBOS (alternate to Dr Hernández Ávila, Mexico) said that Mexico would continue the implementation of International Health Regulations (2005) and preparation for the possibility of pandemic influenza. Coordinated action from all sectors of society was needed. Demographic and epidemiological changes had forced Mexico to refocus public health policies; health care was a priority and would become a State policy with increased funding. Mexico was establishing a unified health system, balancing preventive and curative medicine and focusing on anticipating potential harm. Mexico had adopted the WHO guidelines in developing a national plan for preparedness and response to pandemic influenza.

His Government had promoted a pharmaceutical policy governing the supply, rational use and availability of medicines. It encouraged the commercialization of generic medicines, which broadened access to low-cost medicines of proven quality.

Given the urgency of raising a new generation of Mexicans with a better standard of health, all children born in Mexico since December 2006 without social security coverage were being registered for a new generation medical insurance scheme that provided full coverage, including for their families, and free health care. More than 800 000 children and their families had joined the scheme in the past year. Progress had also been made in promoting the Alliance for a Healthy Mexico.

Thanks to progress in the health-care system, federal emergency and disaster units had been able to apply effective sanitation measures in the flood-stricken states of Tabasco and Chiapas. He thanked WHO and all supporting countries.

He invited all Member States to attend two global events planned to be held in Mexico in 2008: the World Conference on Injury Prevention and Safety Promotion, to be held in Mérida in March, and the International AIDS Conference in Mexico City in August.

Dr AL-HASNAWI (Iraq) thanked the Director-General for her remarks about the Iraqi family health survey, which had been conducted in difficult circumstances and completed through the support of WHO and the European Union. The Ministry of Health would use the data obtained, in particular those on death resulting from violence, as the evidence base to develop and reform the health system.

Mr LI Baodong (China) remarked that the Director-General's report provided a comprehensive analysis of health challenges and the countermeasures needed. WHO had made significant progress in respect of avian and pandemic influenza and the implementation of the International Health Regulations (2005). Human health was threatened by a deteriorating environment, emergence of infectious diseases and increasing public health emergencies. Public health had become a global socioeconomic and security issue, and the international community was increasingly looking to WHO, as the global leader in health matters, to develop measures to combat disease and improve the quality of human life. Governments prioritized the prevention and control of H5N1 avian influenza and pandemic influenza, which demanded close international cooperation, including full implementation of the Regulations. Technical support from WHO for that purpose was needed, especially for developing countries.

China had prioritized pandemic influenza preparedness and implementation of the Regulations. It had improved the legal framework and emergency response, identified focal points, established intersectoral coordination and enhanced capacity. It had also conducted risk assessments and was increasing finance to emergency response and the public health system. China was exchanging information with other Member States for dealing jointly with public health emergencies. WHO should strengthen collaboration with Member States and relevant organizations and play a leading role in global public health and in the attainment of the Millennium Development Goals.

Dr ABDESSELEM (Tunisia) said that the deteriorating health situation in the occupied territories was of grave concern. In the Gaza Strip, many health facilities had ceased functioning and the recent loss of the electricity supply had led to the closure of operating theatres. He called on WHO to help resolve the situation and requested the Director-General to report on the matter to the Sixty-first World Health Assembly.

Professor SOHN Myongsei (Republic of Korea) observed that sustainability was a key theme underpinning the Director-General's address. WHO's 60 years of experience should provide perspectives for future work. In 1980, WHO had declared the eradication of smallpox. Focus on the diseases and public health problems that threatened global health must be sustained until similar successes had been achieved. Great progress had been made towards eradicating dracunculiasis and other diseases and there was encouraging news in the fight against HIV/AIDS, tuberculosis and malaria. However, the momentum of prevention and control activities must be maintained until complete success had been assured.

In addressing the health effects of climate change, sustainability would again be essential. The selection of "Protecting health from climate change" as the theme for World Health Day 2008, would help to raise awareness. WHO should lead in promoting research and building capacity in order to assess the health impacts of climate change, which threatened the attainment of the Millennium Development Goals. Member States would require technical support in order to implement the mitigation measures needed. Budgetary allocations to such support should therefore be reviewed.

Dr DAHL-REGIS (Bahamas) welcomed the success of the global immunization strategy, which had been due to coordination at all levels, political will and the establishment of partnerships. Experience thus gathered should be applied to attaining the Millennium Development Goals. She saluted WHO's focus on Africa and looked forward to its work in her own region, especially in similar areas such as Hispaniola.

Professor SALANIPONI (Malawi) expressed appreciation for comments in respect of strengthening of health systems. WHO must continue to support that area and pay attention to the negative impact of migration of health personnel. He looked forward to WHO's continued support to Africa.

Dr SINGAY (Bhutan), speaking on behalf of the Board members from the South-East Asia Region, welcomed the strengthening of health systems, the revival of primary health care and the

initiative on protecting health from climate change, including the selected topic for World Health Day 2008. The Region's Member States emphasized the social determinants of health, emergency preparedness and essential medicines, and acknowledged the support received from WHO.

Dr SUPARI (Indonesia) welcomed progress made on pandemic influenza preparedness and looked forward to the establishment of a more transparent and equitable mechanism for the sharing of viruses and benefits. A comprehensive review should be undertaken before addressing climate change and its health impacts. There was considerable information on the effects of global warming on the endemicity and epidemicity of tropical diseases such as malaria and dengue, which were prevalent in developing countries. Interventions in the area of climate change should bring about a reduction of those debilitating diseases. She welcomed the Director-General's focus on health concerns in Iraq and in Africa.

Dr AHMADZAI (Afghanistan), referring to the comments of the member for Tunisia concerning health conditions in the Gaza Strip, observed that malfunctioning of hospitals and lack of medical facilities in countries with conflicts put civilian lives at risk. His country was still suffering the effects of a long war and was not in a position to absorb a massive influx of repatriated refugees. He requested that that issue be addressed at the Sixty-first World Health Assembly.

Dr OUSMAN (alternate to Mr Miguil, Djibouti) commended the focus on the health problems of developing countries, in particular those in Africa. Health was a priority in Djibouti, which had for example hosted a regional workshop concerning health in the countries of the Horn of Africa in November 2006.

He endorsed the comments made by the member for Tunisia. WHO should take urgent action to assist those in the Gaza Strip and other populations affected by conflicts.

Dr ANTEZANA ARANÍBAR (Bolivia)<sup>1</sup> observed that the discussions had revealed a conflict between the objective of controlling various diseases that caused high mortality and health budgets that were not growing at a sufficient rate to achieve that goal. Health was not the exclusive responsibility of the health ministry or of WHO but a multisectoral issue, and many of its social determinants fell outside the purview of the health sector. Improving the health situation therefore required commitment by government as a whole.

The growth of chronic diseases as life expectancy increased should be taken into account for work in the medium and long term. Migration was another growing problem; improving the living and health conditions in developing countries could have a positive impact on migratory flows. The support offered by WHO should go beyond rhetoric, documents and resolutions, and be clear, immediate and lasting.

Dr ANGOT (Office International des Epizooties) said that his organization was collaborating closely with WHO on the basis of an agreement signed in 2003 on various subjects, including zoonoses, avian influenza and antimicrobial resistance. In the area of avian influenza, together with FAO it had established a network of expertise.

In response to the need to step up surveillance of animal diseases, his organization had assessed veterinary services in its 172 member countries and territories in order to identify weaknesses and improve sanitary standards with regard to animal health. A meeting on zoonoses control would be held in February 2008 at the Athens office of the WHO Mediterranean Zoonoses Control Programme. Climate change was linked to the emergence of diseases, three quarters of which were of animal origin.

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

The DIRECTOR-GENERAL said that she had listened attentively and thanked all members and representatives for their comments, recommendations and suggestions. The Secretariat would ensure that the Organization continued to address the topics of importance to members.

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

## **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)<sup>1</sup> 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

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<sup>1</sup> 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)<sup>1</sup> 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

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<sup>1</sup> 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.<sup>1</sup>**

**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

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<sup>1</sup> 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)<sup>1</sup> 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.**

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<sup>1</sup> 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),<sup>1</sup>

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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<sup>1</sup> 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-Straits 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-Straits 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.**

### **THIRD MEETING**

**Tuesday, 22 January 2008, at 09:10**

**Chairman:** Dr B. SADASIVAN (Singapore)

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

**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) (continued)

Dr AHMADZAI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that implementation of the International Health Regulations (2005) was the collective responsibility of all States Parties and their partners. Transparency could not be compromised nor overreaction justified. Meeting the requirements of the Regulations nevertheless required time, commitment and willingness to change. The areas of work that aimed to support Member States in his Region were global partnership, strengthening national capacity, preventing and responding to international public health emergencies, and legal issues and partnership. The Regional Office was providing support to Member States in formulating national plans of action to achieve those goals. Building capacity was required for epidemiological surveillance and response, public health laboratories and at designated points of entry. Provision of the necessary equipment, logistics and communication tools should be ensured, together with the fostering of global, regional and national partnerships. The Secretariat should work with countries in assessing existing capacities and in providing technical and financial support.

Dr CHEW Suok Kai (alternate to Dr Sadasivan, Singapore) commented that the Regulations reflected the interdependence of all countries of the world and their collective responsibility for global health security. Each Member State had obligations under the Regulations, and his country was ensuring that those obligations were met. He supported the draft resolution contained in the document under discussion.

Dr VOLJČ (Slovenia), speaking on behalf of the European Union, the countries of the European Free Trade Association, members of the European Economic Area, Iceland, Norway and Switzerland, the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process, potential candidates Albania, Bosnia and Herzegovina and Montenegro, and also Armenia, Georgia, the Republic of Moldova and Ukraine, recalled resolution WHA60.28 on pandemic influenza preparedness. Implementation of the Regulations would allow establishment and strengthening of a shared surveillance, alert and response system. The Regulations implied mutual trust, transparency, political commitment, solidarity and international partnership.

The European Union had aligned European legislation on communicable diseases with the Regulations and established a committee in order to discuss actions for implementation with WHO, the European Commission and the European Centre for Disease Prevention and Control.

He recalled expected result 1.4 of strategic objective 1 of WHO's medium-term strategic plan (on provision of policy and technical support). He welcomed the provision by the Secretariat of documents on its web site and the organization of meetings that helped Member States to build their capacities and increase capacity to prevent and respond to health events. National focal points should ensure communication between national authorities and WHO, especially for notification of events.

That information should remain confidential; however, there was currently no secure system. He welcomed initiatives to improve secure protocols and operating procedures for confidential electronic communication, including between WHO headquarters and the regional offices. A protocol should be drawn up for all such secure communication. Member States, national focal points and WHO contact points should be trained in the use of the decision instrument presented in Annex 2 of the Regulations. The communication system should also apply to notifications, and other reports on the assessment of public health risks, in accordance with Articles 8 and 9 of the Regulations. He suggested a standard operating procedure for communication and coordination; States Parties should provide assessments at regional level, distinguishing between public health emergencies and other communications.

Countries needed more guidance from the Secretariat in assessing and designating ports and airports as points of entry. The information given by a Member State for implementation of health measures in ships and aircraft covered by Article 41 should be proportional to the objectives of the Regulations. The use of personal data, covered by Article 45, should be commensurate with the benefit to public health.

The European Union emphasized partnerships between Member States and international organizations in order to facilitate inspections and timely public health measures. He looked forward to a web site detailing points of entry and also WHO guidance on implementing Article 21 of the Regulations concerning ground crossings.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that his Government had supported efforts to revise the International Health Regulations. They should be applied universally for the good of all people. The Secretariat should help Member States to develop the core capacities required for the implementation of the revised Regulations. Member States must meet their obligations under the Regulations by transparently sharing information about outbreaks of diseases that they were required to report, such as H5N1 avian influenza and other novel influenza strains, which posed serious global threats.

He looked forward to the analysis of the application of the Regulations to the management of health risks, referred to in paragraph 13 of document EB122/8. Turning to the draft resolution in the report, he preferred annual rather than two-yearly progress reports but simply requested the Secretariat to implement a mechanism by which it could provide more frequent progress reports on the implementation of the Regulations. His Government was willing to share with its international partners its own implementation experience, in the quest for global health security. He supported the draft resolution.

Professor SALANIPONI (Malawi), speaking on behalf of the Member States of the African Region, requested further information on the challenges related to the implementation of the International Health Regulations (2005), and on the actions taken.

In the African Region, the Regulations were being implemented within the context of the regional Integrated Disease Surveillance and Response strategy and, to date, 45 of the 46 Member States had designated national focal points. In May and June 2007, the Regional Office had organized briefings for focal points and control officers from 42 countries, was revising the technical guidelines to incorporate the Regulations and was providing technical assistance in developing and implementing national plans of action. The International Health Regulations (2005) Roster of Experts included several experts from the Region.

Mobilizing adequate resources to implement the Regulations was a major challenge to be met by 2012. He therefore proposed the addition to the draft resolution of a subparagraph 4(2) that would read “to provide support to Member States with the most vulnerable health systems in strengthening core capacity requirements for surveillance and response at airports, ports and ground crossings, paying special attention to the sub-Saharan Africa laboratory network”.

Mr GAUTO (alternate to Dr Dullak Peña, Paraguay) said that the entry into force of the International Health Regulations (2005) in June 2007, a major step in the global fight against disease, required a universally applicable legal instrument. Stressing the Director-General’s comment that the



global surveillance system must have no gaps or weak spots, he proposed replacing the words “timely and effective” with “timely, effective and universal” in paragraph 1 of the draft resolution.

The inability in parts of the world to respond to public health threats placed hundreds or thousands of lives at risk. WHO was attempting to bridge the gap through agreements with countries which, however, lacked legal competence in that area. How could those potential threats be identified and addressed? Could one country develop the necessary institutional capacity of another to comply with the Regulations, pursuant to their Article 13? While regretting that the draft resolution submitted by his country had been rejected without adequate discussion or amendment, he called on Board members to accept his amendment to the draft resolution under consideration.

Dr LARIOS LÓPEZ (alternate to Dr Maza Brizuela, El Salvador), endorsing the comments made by the members for the United States of America and Paraguay, urged that assistance was provided to territories not covered by the provisions of the International Health Regulations (2005). Areas or territories not listed as States Parties to the Regulations should join the global disease control system by designating or establishing focal points in universal application of the Regulations. His Government called on the Director-General and the Executive Board to facilitate communication and collaboration between such States, areas, territories and the Organization, including its Member States, so as to ensure the full and global implementation of the Regulations.

Dr MENESES GONZÁLEZ (alternate to Dr Hernández Ávila, Mexico) said that in 2006 Mexico had begun to apply the International Health Regulations (2005) with measures to prevent a potential influenza pandemic. Working groups and a focal point – the Intelligence Unit for Health Emergencies – had been set up, with measures to strengthen the entry into force of the Regulations in cooperation with PAHO. Studies would be conducted in order to enforce the annexes of the Regulations and further efforts would strengthen the national health system and epidemiological surveillance systems. Mexico was working with countries of the Region towards the effective implementation of the Regulations. He endorsed the draft resolution.

Dr CARVALHO (Sao Tomé and Príncipe), recalling that the Regulations provided the legal basis for the attainment of health for all, emphasized that many countries remained excluded from the network. He supported the amendments proposed by the member for Paraguay.

Mr DE SILVA (Sri Lanka), speaking on behalf of the Member States of the South-East Asia Region, supported the draft resolution and noted that the scope of the revised Regulations included biological and chemical threats and noncommunicable diseases. The Regulations had been formally implemented in the South-East Asia Region in 2007 and all countries had established focal points; field epidemiology training programmes had been introduced in India, Indonesia and Thailand, and would be extended to the other countries of the Region; core capacity building was under way in surveillance, alert and response operations and infection control; and the laboratory network was being strengthened at country level.

Further capacity building was required, notably at ports of entry and among primary health care workers; communication needed improving within WHO; it might be necessary to set up a separate fund at headquarters and in the regional offices; and stronger commitment was necessary for information exchange, sharing of biological samples and cross-border collaboration. Universal application of the Regulations should and could be achieved under the existing provisions without overstepping the Organization’s mandate.

Mr LI Baodong (China) commended progress in the implementation of the Regulations. China had established a coordination committee to implement the Regulations, involving the ministries of health and foreign affairs. It was reviewing existing laws and regulations; and had incorporated surveillance and capacity building in its public emergency response plan. Ports of entry and exit quarantine facilities had been developed; assessment and notification procedures of public health emergencies of international concern had improved; and on the issue of highly pathogenic avian

influenza and influenza pandemic control, China had strengthened its cooperation with other Contracting Parties and with WHO, through the provision of information and samples of virus strains. China would share its experience and strengthen cooperation, and would submit its first implementation report to the Sixty-first World Health Assembly, in accordance with resolution WHA58.3. More support and guidance would help developing countries to strengthen capacity building and improve communication with the Organization.

He supported the amendment proposed by the member for Sri Lanka. As the amendment proposed by the member for Paraguay failed to reflect fully the principles enshrined in Articles 2 and 3 of the Regulations, he proposed adding the words “reaffirm its commitments to implement fully the International Health Regulations (2005), in accordance with the purpose and scope set out in Article 2 and the principles embodied in Article 3”.

Mr GAUTO (alternate to Dr Dullak Peña, Paraguay) considered the word “universal” to be clear and concise but was willing to examine the proposal just made upon its submission in writing.

Ms HUNT (Belize)<sup>1</sup> recalled that, at the 117th session of the Executive Board, she had asked the Director-General to explain how WHO proposed to deal with Taiwan since it was neither a Member nor an observer. Given the increasing possibility of a new pandemic, she repeated the question.

The health authorities of Taiwan had sent nearly 60 communications to WHO on health issues, but all had gone unanswered. Through direct communication with WHO, Taiwan aimed to promote better health practices for its people and to protect life and human dignity. The health authorities in Taiwan had thought that the universal application of the International Health Regulations would bring such benefits, but the situation had actually worsened.

Member States should encourage the Secretariat to facilitate communication and collaboration, not just for Taiwan but for all small States, islands and territories, in order to ensure full global implementation of the Regulations, leaving no gaps. Any policy restricting direct interaction between Taiwan and WHO should not be a reason to leave a gap in the global disease prevention network. Since China had no jurisdiction on that territory, how could it address health issues there? Governments should help the Secretariat to find a solution acceptable to all parties.

Mr ALCÁZAR (Brazil)<sup>1</sup> expressed concern about the wording in paragraph 5 of the report, on which there was not full consensus. No definition was given of “global public health security” and, in spite of the intentional link made in the report, the concept of security had not been mentioned in the International Health Regulations (2005). He asked what “the goal of international public health security” was, and indeed when it should be “fully met”. He asked the Board to clarify the definitions before the Health Assembly considered the matter.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that the concept of global health security was very important and had been chosen as the focus of World Health Day 2007. The Health Assembly resolution on health security could be of use in clarifying the matter.

Mr LI Baodong (China) said that any suggestion of gaps in the implementation of the International Health Regulations (2005) in China was groundless. China closely cooperated with the Secretariat and was implementing all aspects of the Regulations. He had written to the Secretariat detailing the measures taken by China in that regard. The international community, including WHO and the United Nations, had already drawn conclusions on the issue of Taiwan and his Government had explained its position. A few countries were politicizing the issue and wasting time.

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

Mr GAUTO (alternate to Dr Dullak Peña, Paraguay) asked how China planned to implement the International Health Regulations (2005) in Taiwan, to improve the human resources of Taiwan and to make notifications, since it lacked jurisdiction there. The sovereignty of Taiwan over its own territory was recognized by some 25 countries. The authorities in Taiwan had informed him that there was no open channel of communication with China. That gap in the implementation of the Regulations would affect everybody in the event of an outbreak. The Executive Board would be responsible if there could not be effective and timely communication. The issue of combating disease and epidemics required a mechanism to cover the question of Taiwan.

Dr HEYMANN (Assistant Director-General) thanked Member States for their support of the International Health Regulations (2005). Universality was enshrined in them, which the Secretariat ensured through interaction with Member States. Implementation had begun on 15 June 2007 with a simulation exercise between the Director-General, Regional Directors and staff in the regions and countries. Since then, focal points had been appointed in most countries and regional focal points had regularly tested communications with national focal points. Implementation for avian influenza had begun one year earlier and all H5N1 activities were covered by the Regulations. On 15 June 2008 an international health security exercise was to be carried out by WHO, highlighting problems in implementing the Regulations.

The Secretariat would endeavour to define public health security in the draft resolution and the report to be submitted to the Health Assembly, and to include a reference to the resolution on health security. *The world health report 2007* gave a clear definition of public health security.<sup>1</sup>

Mr ALCÁZAR (Brazil)<sup>2</sup> said that, although *The world health report* contained a definition of global health security, it was not an agreed final definition. That should be made clear in the report.

Professor SHIRALIYEV (Azerbaijan) said that there were many other zones of conflict in the world with problems similar to those of Taiwan where WHO and other organizations could not carry out monitoring. The principles of the United Nations recognized the sovereignty and territorial integrity of States, but there was nothing to stop areas resolving their own health issues with neighbouring countries. WHO and other organizations should talk about the other areas of conflict, all of which should consider how to apply the International Health Regulations (2005).

Mr MIGUIL (Djibouti) agreed with the previous speaker that the International Health Regulations (2005) must be applied in accordance with international provisions. Universality should not be used to contravene the Constitution of WHO. The proposal by the member for China was sensible and he supported the unity of China. The Executive Board should not become a political body. The authorities in Taiwan did not seem willing to collaborate, and were using their health situation to divide the international community. The Executive Board was not the place for that nor was the Health Assembly.

The DIRECTOR-GENERAL said that she was mindful of the principle of universality and the need to leave no gaps in the system, in order to protect the world from the spread of diseases. She would diligently implement Articles 2 and 3 of the International Health Regulations (2005). However, the Secretariat was also bound by other Health Assembly policies, including the “one China” policy. Practical solutions could, she was confident, be found to enable WHO to carry out its mandate in every area of the world while respecting the sovereign rights of Member States. The Memorandum of Understanding concluded with China provided a firm foundation for action in the event of an outbreak

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<sup>1</sup> *The world health report 2007: A safer future: global public health security in the 21st century*. Geneva, World Health Organization, 2007.

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

of dangerous diseases in Taiwan. WHO had a good record of responding to outbreaks as in the case of severe acute respiratory syndrome. The Secretariat would pursue the Organization's policies while seeking to improve the application of the Regulations.

The CHAIRMAN said that there had been three proposed amendments to the draft resolution. Since the member for Paraguay had requested that the amendments be submitted in writing, he suggested that the Board return to the item to consider the draft resolution when the texts were ready.

**It was so agreed.**

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

**Climate change and health:** Item 4.1 of the Agenda (Document EB122/4)

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) introduced a draft resolution on climate change and health proposed by Germany, the Netherlands, New Zealand and the United Kingdom of Great Britain and Northern Ireland. The following Member States had also indicated that they wished to be included as sponsors: Australia, Austria, Belgium, China, Denmark, France, Japan, Kenya, Liberia, Lithuania, Malawi, Mexico, Monaco, Peru, Portugal, Slovenia, Spain, Sri Lanka and Turkey. The draft resolution read as follows:

The Executive Board,  
Having considered the report on climate change and health,<sup>1</sup>

RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,

Recalling resolution WHA51.29 on the protection of human health from threats related to climate change and stratospheric ozone depletion and acknowledging and welcoming the work carried out so far by WHO in pursuit of it;

Recognizing that, in the interim, the scientific evidence of the effect of the increase in atmospheric greenhouse gases, and of the potential consequences for human health, has considerably strengthened;

Noting with concern the recent findings of the Intergovernmental Panel on Climate Change that the effects of temperature increases are already being observed on some aspects of human health; that the net global effect of projected climate change on human health is expected to be negative, especially in developing countries; and that exposure to projected climate change is likely to affect the health status of millions of people, through increases in malnutrition, in death, disease and injury due to extreme weather events, in the burden of diarrhoeal disease, in the frequency of cardio-respiratory diseases, and through altered distribution of some infectious disease vectors;

Noting further that climate change could jeopardize achievement of the Millennium Development Goals, including the health-related Goals, and undermine the efforts of the Secretariat and Member States to improve global health security and reduce health inequalities globally;

Recognizing the importance of addressing in a timely fashion the health impacts resulting from the climate change which is already unavoidable due to past emissions of greenhouse gases, and the need to assist Member States in assessing the implications of

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<sup>1</sup> Document EB122/4.

climate change for health and health systems in their country, in identifying appropriate strategies and measures for addressing these, in building capacity in the health sector to do so and in working with government and nongovernmental partners to raise awareness of the health impacts of climate change in their country and take action to address them;

Further recognizing that strengthening health systems to enable them to deal with both gradual changes and sudden shocks is a fundamental priority in terms of addressing the direct and indirect effects of climate change for health;

1. REQUESTS the Director-General:

- (1) to continue to draw to the attention of the public and policymakers the serious threat of climate change to global health security and to the achievement of the health-related Millennium Development Goals, and to work with United Nations Framework Convention on Climate Change secretariat, WMO, FAO, UNEP, UNDP and other appropriate organizations of the United Nations, in the context of United Nations reform initiatives, and with national and international agencies, to ensure that these health impacts and their resource implications are understood and can be taken into account in further developing national and international responses to climate change;
- (2) to engage actively in the UNFCCC Nairobi Work Programme on Impacts, Vulnerability and Adaptation to Climate Change, in order to ensure its relevance to the health sector, and to keep Member States informed about the work programme in order to facilitate their participation in it as appropriate and access to the benefits of its outputs;
- (3) to continue, in close cooperation with appropriate United Nations organizations, other agencies and funding bodies, and Member States, to develop capacity to assess the risks from climate change for human health and to implement effective response measures, by promoting further research and pilot projects in this area, including on:
  - the scale and nature of health vulnerability to climate change;
  - relevant health protection strategies and measures and their effectiveness including cost-effectiveness;
  - the health impacts of potential adaptation and mitigation measures in other sectors such as water resources, land use, and transport, in particular where these could have positive benefits for health protection;
  - decision-support and other tools for assessing vulnerability and health impacts and targeting measures appropriately;
  - assessment of the likely financial costs and other resources necessary for health protection from climate change;
- (4) to consult Member States on the preparation of an action plan for scaling up WHO's technical support to Member States for assessing and addressing the implications of climate change for health and health systems, including practical tools and methodologies and mechanisms for facilitating exchange of information and best practice and coordination between Member States, and to present a draft action plan to the 124th session of the Executive Board.

In her address, the Director-General had referred to the serious consequences of climate change linked to human health. Health leaders had a responsibility to improve the health and well-being of their populations and must therefore develop an understanding of those consequences for health and health systems, raise the awareness of ministries and health-care professionals, and promote sustainable action at all levels. The draft resolution was not prescriptive and might need refining. The Board's discussions led to a shared understanding of priorities, articulating how Member States proposed to work with the Secretariat to develop policy on climate change and health. Adoption of the draft resolution would lay the foundations for future action.

Dr JEAN LOUIS (Madagascar), speaking on behalf of the Member States of the African Region, cited WHO figures on the increase in morbidity and mortality attributable to climate change since 2000. Around 28% of those deaths were in Africa. If measures were not taken, emissions of greenhouse gases in developing countries could soon overtake those of developed countries. The incidence of malaria had risen sharply in some African countries as a consequence of rising temperatures. Climate change had already caused severe drought, leading to malnutrition and adverse environmental, entomological and parasitological effects. Tropical storms and rising sea levels were threatening the viability of some small island nations. The Kyoto Protocol to the United Nations Framework Convention on Climate Change, with its concrete recommendations, had been adopted after international and regional consultations. At a conference on health and the environment scheduled for March 2008 the relationship between climate change, health and the environment would be examined further.

Madagascar had formulated a policy for managing risks of natural disasters, developed emergency preparedness plans, and established regional stocks of medicines.

Challenges facing the African Region included the sharing of renewable energy sources, raising popular awareness about climate change, and finding measures that could contribute to mitigation and adaptation at the local level. Interdisciplinary studies were being conducted in Madagascar linking global warming to the resurgence of dengue and chikungunya fevers and the relation between rising sea temperatures and blooms of toxic algae that threatened the marine food chain.

Dr BIN SHAKAR (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, in 2002, the Regional Committee for the Eastern Mediterranean had requested the Regional Director to continue to support Member States in developing national policies and capacity to deal with environmental hazards. WHO should gather scientific evidence on the impact of climate change on health – in particular water shortages, and should provide support for awareness raising and advocacy of appropriate policies. He underlined the need to implement the actions listed in the report. WHO should collaborate with the meteorology sector to promote the use of weather forecasting for health protection and capitalize on the momentum in favour of mitigating the effects of and adapting to climate change. International solidarity, including provision of resources, was essential. Climate change was a long-term threat and WHO should tackle health concerns as part of the global response. He was pleased to note the theme of World Health Day 2008.

Professor AYDIN (Turkey) said that, despite widespread discussion of climate change in the media and in scientific circles, there was insufficient awareness of the consequences for public health. WHO should lead in placing the issue on the public health agenda. Turkey was a sponsor of the draft resolution.

Mr TOURÉ (Mali) said that Mali had experienced many of the adverse effects of climate change, including altered distribution of diseases such as malaria and meningitis. Malaria was increasing in the north of the country. Mali's strategy for adaptation was to mitigate the effects of climate change on the health of the population, within a framework of sustainable development and poverty reduction. Mali had ratified the Kyoto Protocol in 2002. The countries of the Region were aware of the challenges and were working to find solutions. He supported the draft resolution.

Dr SUGIURA (alternate to Dr Shinozaki, Japan) supported placing health protection at the centre of the debate on climate change and setting up a framework for exchange of information on the impact of climate change on health. Member States should collect and analyse health data in conjunction with the scientific information provided by the Intergovernmental Panel on Climate Change. WHO's regional offices should review those data and report back to Member States. He requested clarification on which departments within the Secretariat were dealing with the health effects of climate change, and on WHO's collaboration with the Intergovernmental Panel. Japan wished to sponsor the draft resolution, but the terms used in the text should be aligned with those used

in the Secretariat's report; for example, the term "health protection" in the draft resolution should be replaced by "public health security". Further evidence of the health impacts of climate change and WHO's global leadership in that area were needed.

Dr MATHESON (alternate to Mr McKernan, New Zealand) stressed that health responses to climate change must be both specific to particular threats, and general, for example, through strengthened health systems. His Government's Ministry of Health and other departments would ensure that their activities were carbon neutral. At the fifty-eighth session of the Regional Committee for the Western Pacific (Jeju, Republic of Korea, 10-14 September 2007), many small island States in the Pacific had expressed their concern about the health effects of climate change and the threat it posed to their very existence. He welcomed WHO's action on climate change and health.

Mr ABDOO (alternate to Dr Wright, United States of America) said that the United States was tackling the effects of climate change through regulation, public-private partnerships, incentives and investment in new technologies. The Government's policy was based on science, encouraged research on technological development, invited global participation, and promoted growth and prosperity. The country had spent some US\$ 37 000 million in those areas since 2001. The Fourth Assessment Report of the Intergovernmental Panel on Climate Change provided up-to-date scientific information in conditional language that conveyed the evolution of climate science and characterized outcomes in terms of the levels of confidence. The Secretariat's report had stripped the qualifying language from some of the Panel's conclusions, as in paragraphs 5 and 7. There were no robust scientific data to support the view expressed in paragraph 7 that mitigating the effects of climate change could have direct health benefits. The report asserted that the beef industry was a major emitter of greenhouse gases and that, by eating foods lower in the food chain, consumers could reduce the risk of climate change and the incidence of noncommunicable diseases. Such conclusions did not appear anywhere in the peer-reviewed scientific literature and should not appear in the Secretariat's documents.

He proposed amendments to the resolution set out in the draft resolution, taking as a basis the language used in the Intergovernmental Panel's report. In the third preambular paragraph, the last phrase, beginning "and that exposure to projected climate change", should be deleted. It misrepresented the Panel's findings and went beyond scientific consensus. Chapter 8 of the Panel's report expressed only a medium level of confidence regarding the effect of climate change on the burden of diarrhoeal disease and the altered distribution of some disease vectors. It asserted a high level of confidence concerning increased cardiorespiratory morbidity and mortality associated with ground-level ozone or smog, but noted that few studies on ozone had been conducted in regions outside Europe and North America. Data from other regions were needed. In the fifth preambular paragraph, the words "which is already unavoidable due to past emissions of greenhouse gases" should be deleted since they too misrepresented the lack of scientific consensus in the Panel's report. In paragraph 1(3), the words "to continue, in close cooperation with" should be replaced by "to continue close cooperation with". WHO should collaborate with appropriate United Nations organizations rather than initiating separate activities in the area of climate change and health. In paragraph 1(4), the words "an action plan for scaling up" and the phrase "and to present a draft action plan to the 124th session of the Executive Board" should be deleted. While the United States supported WHO's work on the effects of climate change on health, an action plan for consideration by the governing bodies was not necessary. The Secretariat should prepare a workplan for their activities in protecting health from climate change.

Mr MIGUIL (Djibouti) said that climate change concerned all countries, and should be studied further. WHO should cooperate with specialist institutions. The report should refer to conventions on climate change, and to the recommendations of the United Nations Climate Change Conference (Bali, Indonesia, 3-14 December 2007). Djibouti wished to sponsor the draft resolution on climate change and health.

Dr KANDUN (alternate to Dr Supari, Indonesia) said that much information was available on how global warming affected the endemicity and epidemicity of tropical diseases, such as malaria and dengue fever, which were still prevalent in developing countries.

The rise in mean temperature of 1.824 °C recorded in Indonesia, the largest archipelago country in the world, between 1980 and 1999 had led to sea levels rising in some locations by 8 mm every year. If Indonesia failed to respond by reducing greenhouse gas emissions, the sea level was likely to rise by 60 cm by 2070. Moreover, some 53.3% of the 1429 disasters recorded between 2003 and 2005 had been hydrometrological disasters.

At their 25th meeting (Thimpu, 31 August 2007) health ministers of the South-East Asia Region had concluded that climate change posed a major threat to global public health in the Region, and had called on WHO to support the formulation of a regional strategy to combat the resulting adverse health impacts.

He supported the draft resolution. In developing an action plan the Secretariat might consider the draft regional framework for action elaborated at the Regional Workshop on Climate Change and Health (Bali, Indonesia, December 2007).

Mr DE SILVA (Sri Lanka), expressed the South-East Asia Region's support for the draft resolution. South-East Asia was most vulnerable to the impact of global warming and climate change. The health of hundreds of millions of people was at risk from extreme weather events such as heat waves, storms, floods, and projected rises in sea level. Bhutan, India and Nepal were at particular risk of flooding, landslides, rock avalanches and reduced water availability as a result of rapid glacier melt in the Himalayas.

Water and sanitation programmes in countries of the South-East Asia Region were contributing to the achievement of the Millennium Development Goals; the estimated number of deaths from diarrhoeal diseases in the South-East Asia Region had fallen from about 980 000 cases in 1999 to 504 000 in 2005. Such progress could be negated if the climate changed abruptly, since reduced availability of drinking-water, disturbed rainfall patterns and floods could lead to more frequent outbreaks of diarrhoeal diseases. Warmer temperatures would encourage vector-borne diseases, such as malaria and dengue fever.

The countries of the Region were disseminating information on the links between climate change and human health. A workshop on assessing vulnerability to climate change had been held in Kuala Lumpur in 2007; and Bangladesh, India, Indonesia and Nepal had each organized relevant national workshops in November 2007. WHO should provide technical support in order to identify the impact of climate change on health.

Referring to the position of the United States of America, he noted that policies should be developed on the basis of the evidence currently available. To wait until conclusive evidence was obtained would be to put human health at further risk.

Dr VOLJČ (Slovenia) said that the Member States of the European Union and Norway, a member of the European Economic Area, the candidate countries Croatia, Turkey and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process, and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and also Armenia, the Republic of Moldova and Ukraine, aligned themselves with his statement. He welcomed the discussion on climate change, which was arguably the most ominous challenge to public health in the 21st century. Climate change would continue to have an impact on the health of millions of people, and the public health community had to find solutions. It was important to invest in health systems and build capacity. He urged support for WHO's efforts to alleviate the health impacts of climate change, and supported the draft resolution.

Professor SALANIPONI (Malawi) said that climate change brought extreme weather patterns that affected the health of populations. In Africa, heat waves, storms, droughts and floods were increasing crop failure, leading to hunger, starvation and malnutrition. A higher incidence of vector-borne diseases had also been associated with the changing pattern.



Although Malawi had fertile agricultural soils, it was experiencing problems associated with climate change, including loss of soil fertility, soil erosion, deforestation, water depletion, pollution and loss of biodiversity. The unpredictable climate was detrimental to the lives of humans and animals. He supported the draft resolution.

Dr REN Minghui (alternate to Mr Li Baodong, China) said that climate change was an issue of international concern, the worsening global climate would cause diseases and threaten human health and social development, and achievement of the Millennium Development Goals. He supported the draft resolution and noted with satisfaction the theme of World Health Day 2008.

China suffered from the adverse effects of climate change, and had prioritized the issue. A steering group had been set up in response; legislation and regulations had been enacted with a view to a national plan; and the impact of climate change on human health topped China's research agenda.

The international community needed to take concerted action. Developing countries faced a lack of resources and weak infrastructure. The international community should formulate policies to assist them. The Secretariat should support Member States in carrying out assessments and applied research in developing countries in reducing the impact of climate change on health.

Mr FISKER (Denmark) said that climate change and health would be a focus of world attention in the years to come. Protecting human health should be at the centre of the climate debate, and he commended the report's focus on response to health threats caused by natural disasters, and on long-term prevention. It complemented the current process within the United Nations Framework Convention on Climate Change.

Denmark was a sponsor of the draft resolution and he supported retaining the reference therein to the observations of the Intergovernmental Panel on Climate Change, which reflected scientific consensus. He welcomed the proposal for an action plan for scaling up WHO's technical support for health and health systems relating to climate change. The action plan would be appropriate in the run-up to the Fifteenth United Nations Conference on Climate Change scheduled to be held in Copenhagen in December 2009.

Professor SOHN Myongsei (Republic of Korea) welcomed the dialogue on climate change and health. His country wished to sponsor the draft resolution, which reflected WHO's perspective on climate change, and set out the initial steps to be taken. The Republic of Korea was alarmed by the consequences of climate change in the Western Pacific Region, including public health consequences, such as those for the control of vector-borne diseases. The Regional Office for the Western Pacific and its Member States in the Region had identified specific regional issues and appropriate strategies. He thanked the Regional Director for developing a workplan that would set standards. The regional committees should strengthen their leadership in order to specify the concerns of each Region.

Professor PEREIRA MIGUEL (Portugal) welcomed the work of the Intergovernmental Panel on Climate Change, and called for action. Portugal had suffered a heat wave in 2003 that had increased morbidity and mortality. A heat wave contingency plan had been formulated, and health and surveillance mechanisms put in place. Subsequent heat waves had had fewer health impacts. Portugal was a sponsor of the draft resolution. He emphasized continued work by the Secretariat and Member States in order to assess the health risks of climate change and implement response.

Dr FORSTER (Namibia) said that there was evidence that weather patterns in Namibia had become more haphazard during the previous decade, leading to both prolonged spells of drought and floods. The frequency of disease outbreaks had also increased. Diseases such as malaria and meningococcal meningitis had re-emerged. A more proactive approach by all to climate change and health was needed. He supported the draft resolution.

Dr MENESES GONZÁLEZ (alternate to Dr Hernández Ávila, Mexico) noted that awareness of the impact of climate change on health was increasing. His Government had prioritized the issue, which had been included in the development plan for 2006–2012 and in the health sector programme for 2007–2012. Impact assessment, disease prevention and health promotion activities were all being undertaken, but research investment was required in order to identify risks and solutions. Mexico supported the draft resolution.

Dr DAHL-REGIS (Bahamas) requested that a reference to small island developing States should be inserted in the third preambular paragraph of the draft resolution, after the words “developing countries”. The member for the United States of America had made a valid point about data; however, as the member for Sri Lanka had pointed out, waiting for such data to be produced might cause delay in addressing public health risks. Mitigation measures should include technology transfer and the sharing of information by intersectoral experts and relate their findings specifically to health.

Dr GWENIGALE (Liberia) pointed out that the effects of climate change on health were already being felt in some countries, including his own. He endorsed the draft resolution and opposed any amendment that would weaken it. The Board should first vote on the resolution and amend it only if it was rejected.

Mr VALLEJOS (Peru) supported the draft resolution. The Secretariat’s report summarized the growing evidence that climate change posed a health risk. Skin cancer, which was linked to depletion of the ozone layer, should also be cited as a public health problem.

Peru was vulnerable to climate change and its impact on public health. It was grappling with the effects of deforestation, the El Niño phenomenon, brutal cold fronts from the Antarctic, drought and flooding. A ministry for the environment was being established with a view to consolidating government action. He requested WHO’s support in that endeavour.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that there was strong support for the draft resolution as currently worded. Some of the amendments proposed by the United States could nevertheless be incorporated without weakening the text, notably those to the fifth preambular paragraph and to paragraph 1(3). The current wording of the third preambular paragraph, however, was drawn from the “Summary for policy-makers” in the fourth report of the Intergovernmental Panel on Climate Change, and it did not in any way alter the sense of that document. Implementation of paragraph 1(4) needed coordinated action, and the sponsors could not accept the deletion of all reference to an action plan but would agree instead to request the preparation of a workplan. With those minor adjustments, the sponsors hoped that the draft resolution could be adopted by consensus.

Mr ABDOO (alternate to Dr Wright, United States of America) said that the amendments he had proposed were intended to align it more closely with the scientific consensus set out in the report of the Intergovernmental Panel. That report, not only in the summary for policy-makers but also in chapter 8, on human health, referred to the effects of climate change that could be likely with a high, medium or low level of confidence. Aligning the third preambular paragraph with scientific knowledge would ensure that the effects of climate change on health were neither understated nor overstated. The draft resolution would thus be strengthened and make it clear that the Secretariat was following scientific findings in recommendations for its own work and that of Member States. He sought agreement to his proposed amendments to the third preambular paragraph.

Dr DAHL-REGIS (Bahamas) renewed her appeal for a reference in the draft resolution to small island developing States, which had particular vulnerabilities distinct from general references to the problems of developing countries.

Dr GWENIGALE (Liberia) endorsed that proposal, which would strengthen the draft resolution, and re-emphasized that no amendments should weaken the text.

Ms PATTERSON (Australia)<sup>1</sup> said that WHO's expertise could be used to raise awareness and strengthen public health systems in order to cope with threats posed by climate change and contribute to research on protective health measures. However, WHO should not take on a role in developing mitigation strategies, as suggested in paragraph 7 of the report. Her country was concerned by some assertions, particularly the claim that eating foods grown locally would reduce greenhouse gas emissions. The calculation of agricultural emissions must take account of energy used at all points of the supply chain, not just related emissions to transport. Australia wished to sponsor the draft resolution.

Mr SCHOLTEN (Germany)<sup>1</sup> said that his Government was funding the WHO European Centre for Environment and Health, located in Bonn, and could provide additional funding in order to emphasize climate change and health.

Ms PRANGTIP KANCHANAHATTAKIJ (Thailand)<sup>1</sup> said that action and cooperation at all levels were vital to build resilience of vulnerable communities and should be seen as the joint responsibility of all States. Studies showed that the impact of climate change was greatest among populations that had the least capacity to prepare and adapt and that must be addressed.

She proposed amendments to the draft resolution. In the third preambular paragraph, the words "and vulnerable local communities which have the least capacity to prepare for and adapt to it" should be inserted after "especially in developing countries". In the fourth preambular paragraph, a footnote should clarify the meaning of "global health security", i.e. protection against public health risks and threats that did not respect borders. In the fifth preambular paragraph, after the words "greenhouse gases", the words "and further recognizing that solutions to the health impacts of climate change should be seen as a joint responsibility of all States" should be added. The word "comprehensive" should be inserted before "strategies and measures".

Mr BURCI (Legal Counsel) pointed out that the representative of Thailand was not a member of the Board, and under Rule 3 of the Rules of Procedure, proposals or amendments put forward by non-members must be seconded by at least one Board member.

Dr SINGAY (Bhutan) was pleased with WHO's proactive role in highlighting the adverse effects of climate change on health. Health ministries should coordinate with other sectors. He supported and seconded the amendments proposed by Thailand to the draft resolution.

Mr ALCÁZAR (Brazil)<sup>1</sup> said that WHO should take account of the global consensus that the warming of the climate system was unequivocal and caused by human activity, and would affect the most fundamental determinants of health. Action must be taken, using clear and universally understood terms and concepts. The use of the word "threat" in the report and in the draft resolution was inappropriate: it expressed an intention, whereas "risk" expressed a possibility. There was no agreed definition of "public health security" and the term should not be used. The first and fourth preambular paragraphs and paragraph 1 of the draft resolution should be modified accordingly.

Dr ANTEZANA ARANÍBAR (Bolivia)<sup>1</sup> observed that 2007 had brought heightened awareness of the existence of global warming, which was destroying the environment. Politicians and artists were also drawing attention to the issue. It was the actions of individuals and societies that would ultimately determine whether the environment remained healthy.

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

The draft resolution seemed to have garnered the support of all, but the amendments proposed should be translated into all official languages. It was unfortunate that the many developing countries, including his own, that had sponsored the draft resolution were not listed.

Mr ZIMYANIN (Russian Federation)<sup>1</sup> said that he shared the views expressed by the representative of Australia and the member for the United States. He, too, advocated precision with regard to scientific information. He supported the proposed amendments.

The CHAIRMAN suggested that interested members should meet to prepare a revised draft resolution for consideration by the Board at its next meeting, on the understanding, as stated by the member for Liberia, that the text should not be weakened by any changes.

**It was so agreed.**

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

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

## **FOURTH MEETING**

**Tuesday, 22 January 2008, at 14:10**

**Chairman:** Dr B. SADASIVAN (Singapore)

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

**Climate change and health:** Item 4.1 of the Agenda (Document EB122/4) (continued)

Dr HEYMANN (Assistant Director-General) thanked speakers for their suggestions and guidance. It was clear from the accumulating evidence that climate change would affect the health of everyone, especially the poorest. The effects were projected to increase in all countries and regions. That would require all public health authorities to take into account the potential impact of climate change on human health. The preparation of a workplan with Member States would encourage activities and research that would place health issues at the centre of the climate change agenda. The Secretariat had therefore selected “Protecting health from climate change” as the theme for World Health Day 2008. The Organization would continue to collaborate with the Intergovernmental Panel on Climate Change, promote research, and produce evidence. The Secretariat would align its report more closely with the findings of the Intergovernmental Panel and Member States’ comments when preparing a revised document for the Health Assembly, with particular attention paid to paragraph 7. The relevant references from peer-reviewed literature would, where necessary, validate the evidence provided.

The CHAIRMAN announced that the informal group convened had reached consensus on the text of a draft resolution. A final version would be made available to the Board the following morning and he therefore proposed that any further discussion on the subject should be postponed accordingly.

**It was so agreed.**

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

**Prevention and control of noncommunicable diseases: implementation of the global strategy:** Item 4.6 of the Agenda (Document EB122/9)

Dr VOLJČ (Slovenia), speaking on behalf of the Member States of the European Union, the European Free Trade Association countries Iceland and Norway that were also members of the European Economic Area, and Switzerland, said that the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process, and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and also Armenia, Georgia and Ukraine, aligned themselves with his statement. He acknowledged the priority accorded by the Director-General to the dramatically increasing burden of noncommunicable and chronic diseases. The strengthening of health systems called for concerted global action. The focus should be on the main risk factors, on challenges in the areas of mental and environmental health, and on promoting healthy lifestyles, especially for poor people and disadvantaged populations. Those elements should be dealt with, using a coherent multisectoral approach. WHO’s action plan for the prevention and control of noncommunicable diseases constituted a strong and integrated approach to implementing the global strategy. It had been issued late, thereby limiting Member States’ ability to

give it due consideration. He therefore proposed the convening of an informal consultation on the action plan, to be held before the Sixty-first World Health Assembly. In addition to Member States, the consultation should involve all relevant stakeholders, including representatives of international partners, in order to concert action. The Secretariat should give support and priority to all efforts aimed at preventing and treating noncommunicable diseases, as set out in the draft action plan.

Dr SUGIURA (alternate to Dr Shinozaki, Japan) welcomed the draft action plan. A training programme on noncommunicable diseases had operated in Japan since 2005 for health professionals involved in the prevention and control of noncommunicable diseases in the Western Pacific Region and a communications network was being established. A health promotion movement using quantitative indicators had also been set up increasing awareness of healthy lifestyles. Japan was willing to share its experience in that area.

Regarding the action plan, he pointed out that objectives 1 and 2 were interrelated in terms of national awareness raising and establishing policies. Member States should improve their surveillance and diagnostic systems, with technical support from the Secretariat. The WHO Framework Convention on Tobacco Control provided a good basis for implementation of objective 3. As to objective 5, the number of diseases targeted might make it difficult to establish suitable partnerships. WHO's expertise in the area would qualify it to assume a leadership role.

Dr BIN SHAKAR (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that noncommunicable diseases accounted for an estimated 52% of the total burden of disease in the Region; that figure was expected to rise to 60% by 2020. The root causes of the global epidemic of noncommunicable diseases were smoking, unhealthy diet and physical inactivity. Although their impact varied between populations, they were responsible for some 75% of chronic disease conditions. Humanitarian crises affecting the Region inhibited governments' ability to address the escalating problem posed by noncommunicable diseases. In health emergencies affecting displaced populations and refugees, preparedness was as important for noncommunicable diseases as it was for communicable ones.

The Secretariat was raising awareness among Member States on the magnitude of that public health problem; and providing technical support for the framing of national policies by bringing together regional and global experts in order to identify effective prevention and control mechanisms. Countries of the Region were formulating national dietary guidelines and introducing a regional cancer control strategy.

He therefore urged WHO and other partners, including the private sector and nongovernmental organizations, to assist in resource mobilization, particularly in developing countries where the twofold burden of communicable and noncommunicable diseases was causing huge loss of life and lifelong disabilities.

Dr JEAN LOUIS (Madagascar), speaking on behalf of the Member States of the African Region, welcomed the fact that the Health Assembly had recognized the extent to which noncommunicable diseases were undermining development, particularly in the African Region. Public health services struggled to cope with the additional burden of increased morbidity and mortality occasioned by those diseases. Most Member States had begun to treat noncommunicable diseases as a priority area. In the African Region, 27 countries were developing surveillance systems based on WHO's STEPwise approach and the Global student health survey in order to evaluate risk factors. Data included the prevalence of noncommunicable diseases among 13 to 15 year-olds in seven African countries.

A framework document on the elaboration of national programmes and on dealing with sickle-cell disease had been adopted at the Fifty-sixth session of the Regional Committee for Africa.<sup>1</sup>

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<sup>1</sup> Document AFR/RC56/17.

Cancer registers had been established in 12 countries. At its subsequent session, the Regional Committee had adopted a resolution on prevention and control of diabetes and a strategy to eliminate avoidable blindness.<sup>1</sup>

Madagascar was implementing prevention and control of noncommunicable diseases through elaboration of a national policy; approval of standard procedures for treatment at primary health-care level; pilot projects for the prevention of cervical cancer; fluoridization of iodized salt; and improved dental, oral and ocular health at community level and in schools. As long as countries refused to prioritize such diseases, allocated resources would remain inadequate.

Dr JAKSONS (Latvia) acknowledged the report's improvements. The draft action plan must be translated into concrete actions and working documents, which would require the participation of all Member States.

Objective 2 of the action plan needed a more precise description of activities. For example, there was no mention of providing access to essential medicines, although objective 4 suggested that such access should be further studied. Objective 3 required a more general statement of the public health issues. Where alcohol was concerned, less was better; that premise was in line with the promotion of healthy lifestyles and societies advocated by the European Union. It was not enough merely to encourage people to avoid drinking to intoxication or resorting to substitutes for alcohol. Latvia was willing to participate in the drafting of a resolution.

Mr FISKER (Denmark) said that the increase in the burden of noncommunicable diseases emphasized the urgent priority to implement the global strategy. He welcomed the Board's agenda that included progress reports on health promotion in a globalized world, and infant and young child nutrition; and particularly the fact that the harmful use of alcohol was the subject of a draft resolution. Issues such as mental health were also important.

He favoured a horizontal approach to tackling risk factors of chronic diseases and their long-term consequences. The draft action plan constituted a promising platform for further action. He supported the suggestion made by the member for Slovenia for an informal consultation in order to allow Member States and stakeholders to discuss the draft action plan before its submission to the forthcoming Health Assembly.

Mr KWON Jun-wook (alternate to Professor Sohn Myongsei, Republic of Korea) supported the draft action plan but drew attention to the medical and organizational relationship between mental health and noncommunicable diseases. He proposed clarifying the distinction between mental health and noncommunicable diseases with text that might also address the comment by the previous speaker on that issue. After the first occurrence of the phrase "noncommunicable diseases" in paragraph 1 a footnote should be inserted, to read:

"From a medical perspective, the concept of noncommunicable disease encompasses a vast range of conditions, including mental conditions. For practical purposes, however, the extensive work by WHO relating specifically to mental health has been compartmentalized from the work concerning other noncommunicable diseases, such as the four categories of disease highlighted herein: cardiovascular disease, cancer, chronic respiratory disease and diabetes."

Dr REN Minghui (alternate to Mr Li Baodong, China) welcomed the report and draft action plan. The activities and measures proposed and the strategies and workplans would provide guidance and impetus. Most developing countries faced with the difficulty of controlling communicable diseases with limited resources had neglected noncommunicable diseases. WHO should mobilize

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<sup>1</sup> Resolution AFR/RC57/R4.

resources and increase efforts in national planning and programming, information, capacity building, health promotion and clinical prevention.

China had included cardiovascular disease and malignant cancers in national programmes and was determined to fully utilize existing resources and strengthen multisectoral cooperation.

Dr FORSTER (Namibia) said that Africa was disproportionately affected by the two-fold burden of communicable and noncommunicable diseases and action was needed on both fronts in order to achieve long-term health outcomes. He welcomed the draft action plan particularly the section entitled "Relationship to existing strategies and plans". With regard to objective 1, the Secretariat should make available advocacy material and, at the request of Member States, provide guidance or technical assistance for local production of appropriate material.

Surveillance, research and evaluation should be given more prominence. He commended objective 5 and urged partners to increase technical support and funding for prevention and control with an emphasis on the four most common risk factors. That section should request the Secretariat to establish collaboration with governments and the private sector in order to improve access to medicines and technologies for noncommunicable diseases in developing countries. The plan should include monitoring and outcome indicators, building on progress made in national surveys on risk surveillance through WHO's STEPwise approach. Namibia looked forward to the updated plan at the Sixty-first World Health Assembly.

Mr McKERNAN (New Zealand) welcomed the progress made on implementing resolution WHA60.23. The draft action plan brought together evidence on risk factors and interventions in the key areas of tobacco control, diet and physical activity, and the harmful use of alcohol. New Zealand supported the position of the European Union: the plan should be strengthened through broader consultation involving all Member States and stakeholders before the Sixty-first World Health Assembly. A process should ensure that the plan became a useful tool for reducing the burden of noncommunicable diseases.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) fully supported the objectives in the draft action plan. The prevention of noncommunicable diseases needed a balance between individual and government action in order to change behaviours. Governments could create an environment to help individuals make healthy lifestyle choices. They could encourage sport in schools, physical activity throughout life, and work with the food industry in order to reduce salt content. In the United Kingdom, 75% of the salt consumed was hidden in processed foods, so that without government action it would be difficult for individuals to reduce their salt intake. He would provide specific comments on the plan directly to the Secretariat, and also during the informal consultation process proposed by Slovenia.

He emphasized three particular areas: tackling underlying health inequalities; infant and child nutrition, in particular breastfeeding; and the need to include a set of recommendations, as agreed at the Health Assembly, on the promotion and marketing of foods and beverages to children. Finally, the term "strengthening health systems" was for many people synonymous with "strengthening health-care systems". A broader approach was needed, since there was a limit to what health-care systems could do to prevent noncommunicable diseases, with multisectoral involvement from partners not naturally oriented to health goals. In health-care systems, wider participation should be built in from the start, so that the focus was not just on the treatment and care of patients.

Dr WRIGHT (United States of America) said that the increasing two-fold burden of disease faced by developing countries gave importance to a prevention and control strategy for noncommunicable diseases. For that reason, he requested that discussion of the item should be postponed until the Board's 124th session in January 2009. The document concerned had been distributed only four days before the start of the current session. Every global strategy reflected a commitment and investment by Member States, and they needed more time to make the present strategy as effective, measurable and evidence-based as possible. The Secretariat, in collaboration with



other stakeholders, including the private sector, could help Member States strengthen their capacity to measure the growing disease burden, and especially the prevalence and impact of chronic diseases. His Government would continue to address the problem of noncommunicable diseases, which accounted for seven out of 10 deaths in the country and affected the quality of life of 90 million Americans. His country looked forward to sharing its experience and expertise worldwide.

Dr AHMADZAI (Afghanistan) noted that two Health Assembly resolutions had addressed the elimination of avoidable blindness, which was included as a strategic objective in WHO's Medium-term strategic plan 2008–2013. However, the draft action plan for noncommunicable disease prevention and control did not specifically address visual impairment. The Board should request the Secretariat to develop a plan of action for the prevention of avoidable blindness, to be submitted to the Board at its 124th session.

Professor PEREIRA MIGUEL (Portugal) welcomed the draft action plan, which would help prioritize the prevention and control of noncommunicable diseases at the national and global levels. His country aligned itself with the declaration by the member for Slovenia and supported the proposal for a consultation between Member States before the next Health Assembly. Portugal supported the proposal by the Republic of Korea that mental health should be covered in the action plan, as it was in the European Strategy for the Prevention and Control of Noncommunicable Diseases, approved in 2006. Mental health problems were prevalent globally, causing high levels of morbidity, disability and suffering. There were risk factors shared with noncommunicable diseases, such as harmful use of alcohol and lack of physical activity.

Professor SALANIPONI (Malawi) expressed his country's growing concern over the view that Africa should give priority to communicable rather than noncommunicable diseases. To do so would result in noncommunicable diseases in Africa attracting less attention than they merited. Unless WHO helped to raise countries' awareness of the importance of noncommunicable diseases, Africa might well be overtaken by events, with the determinants and implications of such diseases outweighing the impact of communicable diseases. To accord insufficient attention to noncommunicable diseases would fail to respect one of the Director-General's priorities: Africa.

Dr MENESES GONZÁLEZ (alternate to Dr Hernández Ávila, Mexico) said that Mexico was experiencing an increasing burden of noncommunicable diseases. Type 2 diabetes was spreading and 9% of adults over the age of 40 were currently diabetic. The increasing morbidity burden and mortality levels in many countries were threatening to result in high levels of social expenditure and a collapse of health services. In addition there was also the indirect cost borne by families. Mexico had established a six-year programme to diagnose, prevent and control type 2 diabetes with the aim of: changing behaviour and attitudes; training health staff; integrating health services; improving infrastructure, the supply of drugs and medical equipment; and ensuring universal health insurance.

He welcomed the Secretariat's draft action plan, which reflected the real situation at country level and set out best practices in public health in order to cope with noncommunicable diseases. However, the section on nutrition should mention action such as the health labelling of processed food in order to enable people to select healthier foods when shopping. Much of the guidance on public health actions was already being developed in Mexico. Meeting the challenges set out in the plan would depend on adequate resources and the willingness of countries to abide by their commitments. In the revised version of the document, incorporating all comments made in the Board, the proposed actions should be aligned with actions already set out in existing Health Assembly resolutions. Mexico would share with other countries its experience in the promotion of healthy living and the prevention and control of chronic noncommunicable diseases with other countries.

Dr ABABII (Republic of Moldova) emphasized the implementation of a global strategy on noncommunicable diseases. His country supported the statement made by the member for Slovenia.

He also supported actions by the Regional Office for Europe on the issue. Noncommunicable diseases were leading to increased morbidity and mortality in the European Region, and accounted for more than 80% of all deaths. He noted that elements of the decision taken at the high-level conference on noncommunicable diseases held in Moscow in October 2007 had been incorporated into the draft resolution. His country had taken basic measures to prevent the main noncommunicable diseases, namely: cardiovascular diseases, cancer, chronic respiratory disease and diabetes. It was working on nutrition and lifestyle, and improving early diagnosis, care and treatment, and rehabilitation. It supported the proposal for a consultation before the next Health Assembly.

Dr ABEYKOON (alternate to Mr de Silva, Sri Lanka) said that in 2007 the Regional Committee for South-East Asia had endorsed the regional framework for prevention and control of noncommunicable diseases.<sup>1</sup> The Regional Office had found that existing information systems in most countries were not able to ensure the tracking of noncommunicable diseases in order to reach the goal of reducing related deaths globally by 20% in 10 years. He requested support from the Secretariat for studies on the burden of disease, and upgrading databases and registration systems on mortality due to noncommunicable diseases.

The report did not specify references to behavioural change, nor distinguish between primary and secondary prevention, which involved different strategies, efforts and costs. It might also highlight links between noncommunicable and communicable diseases, such as that between tuberculosis and smoking. A multisectoral approach was needed and the Secretariat should develop actions in order to strengthen health systems and mobilize support from other sectors.

Mr VALLEJOS (Peru), declaring his support in principle for the proposal made by the member for Slovenia, announced that Peru would be hosting the next biennial meeting of the *Conjunto de Acciones para la Reducción Multifactorial de Enfermedades No Transmisibles* (the CARMEN network), a PAHO initiative to promote the integrated prevention and control of noncommunicable diseases. The network helped produce policies, standards and regulations intended to reduce the prevalence of risk factors and determinants associated with such diseases throughout the Region. Its four main lines of action were health policy and advocacy, health promotion, surveillance, and integrated management of diseases and risk factors. It integrated capacity building and training, operational research, resource mobilization, and communication and social marketing. Since the launch of Peru's national programme for the prevention of blindness and cataract in 2007, operations had already been carried out on 5000 of the 80 000 recorded cases of cataract blindness, with 90% of patients fully recovering their eyesight. The country's mental health plan was helping the many households left fatherless in the wave of terrorism that had claimed more than 20 000 lives. Peru had also gathered data on the prevalence of noncommunicable diseases and risk factors; it had implemented a surveillance system covering analysis of data on mortality and hospital admissions due to noncommunicable diseases; and it had conducted specialized screening for cancers. A mass communication campaign was needed in order to promote healthy lifestyles and foster a culture of health.

Professor AYDIN (Turkey), referring to the annex to document EB122/9, stated that Turkey would be hosting the third general meeting of the Global Alliance against Chronic Respiratory Diseases in Istanbul in March 2008.

Mr MACMULLAN (Consumers International), speaking at the invitation of the CHAIRMAN, said that his global federation represented more than 220 consumer organizations from 115 countries. Resolution WHA60.23 had requested the Director-General to develop "a set of recommendations on marketing of foods and non-alcoholic beverages to children". He asked the Executive Board to honour

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<sup>1</sup> Resolution SEA/RC60/R4.

that resolution by ensuring that WHO developed those recommendations, together with regulations to protect children and adolescents. The Regional Committee for Europe had already adopted the Second WHO Action Plan for Food and Nutrition Policy (2007–2012) in September 2007, stressing the need to “ensure adequate control of the marketing of foods and beverages to children and establish independent monitoring and enforcement mechanisms”; and the Regional Committee for the Eastern Mediterranean at its fifty-fourth session in Cairo in October 2007 had in resolution EM/RC54/R.9 recognized the need for “regulatory [...] responses to counterbalance the adverse public health impact of food marketing to children and adolescents”. WHO must take global action in order to prevent disparities around the world, with irresponsible marketing shifting to areas with the fewest controls and the most vulnerable customers. He urged the Secretariat to develop global policies to protect children and adolescents from the marketing of food and non-alcoholic beverages. These policies could be best achieved by an international code on marketing.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN and representing his federation of 129 national nursing associations, said that success in reducing the major risk factors for emerging epidemics of cardiovascular disease, cancer, chronic respiratory disease and diabetes – including obesity, sedentary lifestyles, tobacco use and alcohol abuse – would hinge on the full and effective deployment of the world’s 13 million working nurses. Studies had shown that nurses had been crucial in lipid management programmes, which led to lower serum cholesterol, lipoprotein and triglyceride concentrations and promoted a better diet, exercise and adherence to treatment regimens, thereby reducing risk factors, morbidity and mortality.

WHO, governments and others should invest in strengthening the nursing workforce because effective implementation of the global strategy would depend on sufficient numbers of skilled nurses and other health workers operating in efficient health systems.

Dr BENZIAN (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, said that the Federation, the global representative body of the dental profession in more than 140 countries, had repeatedly highlighted oral health as a key to general health. Evidence linked oral disease to systemic disease, and oral diseases shared risk factors and determinants with other chronic diseases. He drew attention to resolution WHA60.17 on oral health, and to the highly relevant guidelines in its associated action plan. The Federation called for renewed commitment to integrated control and prevention of oral disease, especially in deprived communities. Federation members and oral health professionals worldwide were keen partners in implementing Health Assembly policy recommendations, and offered their expertise in oral health promotion. He announced the conference for oral health in the Americas, organized through PAHO, which was scheduled for November 2008.

He stressed the importance his Federation attached to a well-resourced global oral health unit at WHO headquarters, not least in the light of the oral health implications set out in the report.

Mr RIGBY (International Association for the Study of Obesity), speaking at the invitation of the CHAIRMAN, said that the Association coordinated the Global Alliance for the Prevention of Obesity and Related Chronic Diseases and its partners, the International Union of Nutritional Sciences, the International Diabetes Federation, the World Heart Federation and the International Paediatric Association. Welcoming the draft WHO action plan, he recalled the strong conviction expressed by Member States at the Sixtieth World Health Assembly that sustained, far-reaching actions were needed to cope with noncommunicable diseases. The declaration by the Caribbean Community at its September 2007 summit of Heads of Government, entitled “Uniting to stop the epidemic of chronic NCDs”, recognized obesity as a principal cause of noncommunicable diseases. Health ministers needed the support of other ministries, their heads of government, and society as a whole.

Echoing the comments of the representative of Consumers International on action to tackle the marketing of certain foods and beverages to children and adolescents, he said that regulation was a clear responsibility of Member States but national regulation could not control the cross-border nature of global marketing and the influence of marketing techniques using global communication media.

WHO must provide leadership and support to ensure that recommendations for international standards were developed, applied and sustained.

He commended the draft action plan, but it was unclear why the responsibility for preparing a regulatory framework and mechanisms to limit the marketing of food and non-alcoholic beverages to children appeared in objective 3 under the heading “Action for Member States” and not under “Action for the Secretariat”. Member States, with the support of the Secretariat, should consider a future intergovernmental drafting group in order to elaborate the recommendations on marketing referred to in paragraph 2(6) of resolution WHA60.23.

Mr AITKEN (Assistant Director-General ad interim) said that the various points raised would all be taken into account in the revision of document EB122/9. WHO was meanwhile working on the subject of food marketing to children, and consultations were expected to take place in 2009. Although staffing of the Department of oral health had unfortunately been affected by extended sick leave, competent short-term professional staff had been recruited as replacements and would remain until the forthcoming Health Assembly.

Finally, in regard to the concerns expressed by the member for the United States of America about the shortness of notice of the document, the point had been well taken; others had noted that point but were interested in making progress on the substance of the matter at hand. Member States could, as in the past when documents had been delivered late and the Health Assembly had needed to see a plan of action, be allowed time to reflect on the document and then be given a formal opportunity to send written comments in, say, a month’s time. A one-day consultation could be held thereafter to reflect on the comments made during the present session of the Board and those submitted in writing, and a new document would be submitted to the Sixty-first World Health Assembly. It would then, of course, be for the Health Assembly to decide whether to take it any further.

Dr WRIGHT (United States of America) said that his delegation could, in the interests of compromise, accept those recommendations.

The CHAIRMAN said that he took it that the Board wished to follow the procedure and timetable suggested by the Secretariat for further consideration of the draft global strategy on noncommunicable diseases.

**It was so decided.<sup>1</sup>**

**Strategies to reduce the harmful use of alcohol:** Item 4.7 of the Agenda (Documents EB122/10 and EB122/10 Corr.1)

The CHAIRMAN invited the Board to consider the following draft resolution, proposed by Kenya and Rwanda and cosponsored by Algeria, Austria, Belgium, Bulgaria, China, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Hungary, Ireland, Italy, Latvia, Lesotho, Liberia, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Madagascar, Malawi, Mali, Malta, Namibia, Netherlands, New Zealand, Norway, Poland, Portugal, Romania, Sao Tome and Principe, Slovenia, South Africa, Sweden, Switzerland and United Kingdom of Great Britain and Northern Ireland.

The Executive Board,

Having considered the report on strategies to reduce the harmful use of alcohol;<sup>2</sup>

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<sup>1</sup> Decision EB122(11).

<sup>2</sup> Documents EB122/10 and EB122/10 Corr.1.

RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,

Having considered the report on strategies to reduce the harmful use of alcohol and noting that the report contains further guidance on strategies and policy element options to reduce harmful use of alcohol;

Reaffirming resolutions WHA32.40,<sup>1</sup> WHA36.12,<sup>2</sup> WHA42.20<sup>3</sup> and WHA57.16;<sup>4</sup>

Recalling resolution WHA58.26 on public-health problems caused by harmful use of alcohol and decision WHA60(10);

Noting the report by the Secretariat presented to the Sixtieth World Health Assembly on evidence-based strategies and interventions to reduce alcohol-related harm, including the addendum on a global assessment of public health problems caused by harmful use of alcohol;<sup>5</sup>

Noting the second report of the WHO Expert Committee on Problems Related to Alcohol Consumption<sup>6</sup> and acknowledging that effective strategies and interventions that target both the population at large, vulnerable groups, individuals and specific problems are available and should be optimally combined in order to reduce alcohol-related harm;

Mindful that such strategies and interventions must be implemented in a way that takes into account different national, religious and cultural contexts, including national public health problems, needs and priorities, as well as differences in Member States' resources, capacities and capabilities;

Deeply concerned by the extent of public health problems associated with harmful use of alcohol, including injuries and violence, and possible links to certain communicable diseases which add to the disease burden, notably in the developing world;

Mindful about intensifying international cooperation in reducing public-health problems caused by the harmful use of alcohol, and to mobilize the necessary support at global and regional levels;

1. URGES Member States:

- (1) to collaborate with the Secretariat in developing a draft global strategy on harmful use of alcohol based on all evidence and best practices, to support and complement public health policies in Member States, with special emphasis on an integrated approach to protect at-risk populations, youth and people hurt by harmful drinking of others;
- (2) to develop, in interaction with relevant stakeholders, national monitoring systems on alcohol consumption, its health and social consequences and the policy responses, and report regularly to WHO's regional and global information systems;
- (3) to consider strengthening national responses, as appropriate and where necessary, to public health problems caused by harmful use of alcohol, taking advantage of evidence on effectiveness and cost-effectiveness of strategies and interventions to reduce alcohol-related harm generated in different contexts;

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<sup>1</sup> Development of the WHO programme on alcohol-related problems.

<sup>2</sup> Alcohol consumption and alcohol-related problems: development of national policies and programmes.

<sup>3</sup> Prevention and control of drug and alcohol abuse.

<sup>4</sup> Health promotion and healthy lifestyles.

<sup>5</sup> Documents A60/14 and A60/14 Add.1.

<sup>6</sup> WHO Technical Report Series, No. 944, 2007.

2. REQUESTS the Director-General:
- (1) to develop a draft global strategy to reduce harmful use of alcohol that is based on all available evidence and existing best practices and that addresses relevant policy options, taking into account different national, religious and cultural contexts, including national public health problems, needs and priorities, as well as differences in Member State resources, capacities and capabilities;
  - (2) to comprehensively include ongoing and emerging regional, subregional and national processes as vital contributions to a global strategy;
  - (3) to collaborate with Member States during the entire process, and actively consult with intergovernmental organizations, health professionals, nongovernmental organizations and economic operators on ways they could contribute to reducing harmful use of alcohol;
  - (5) to present to the Sixty-third World Health Assembly a draft global strategy to reduce harmful use of alcohol, through the Executive Board.

The financial and administrative implications were as follows:

<b>1. Resolution</b> Strategies to reduce the harmful use of alcohol: call for a global strategy	
<b>2. Linkage to programme budget</b>	
Strategic objective:	Organization-wide expected result:
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.	6.4. Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease or death associated with alcohol, drugs and other psychoactive substance use, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.
<b>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</b>	
The resolution is linked to the above-mentioned expected result and its indicators, including number of policies, strategies and recommendations developed in order to provide support to Member States in preventing or reducing public health problems caused by alcohol and other psychoactive substance use. The resolution requests the development of a draft global strategy to reduce harmful use of alcohol, provides guidance on the process of the draft development and sets out the requirements for reporting to the Health Assembly.	
<b>3. Financial implications</b>	
<b>(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)</b>	
The estimated maximum cost to the Secretariat for developing a draft global strategy based on all available evidence and existing best practices and in collaboration with Member States and in active consultation with relevant stakeholders for the period 2008–2010 is US\$ 1 940 000	
<b>(b) Estimated cost for the current biennium (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant) US\$ 1 720 000</b>	
<b>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the current biennium? US\$ 430 000.</b>	
<b>(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)</b>	
Additional funding is expected from core contributions and other sources.	

**4. Administrative implications****(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)**

Headquarters, with close collaboration with all regional offices.

**(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)**

One full-time staff member in the professional category for one year at US\$ 230 000 per year is required in addition to those staff members needed to fill positions whose cost has already been budgeted in the workplan and the Programme budget 2008–2009.

**(c) Time frame (indicate broad time frames for implementation)**

Two and a half years (2008–2010), after which a draft global strategy to reduce harmful use of alcohol will be submitted to the Health Assembly.

Ms SEBUDANDI (alternate to Dr Ntawukuriryayo, Rwanda), speaking on behalf of the Member States of the African Region, said that the harmful use of alcohol was a major problem needing to be taken up by all States. It was responsible for deaths and serious injuries in road traffic accidents, the spread of HIV infection and tuberculosis, acts of violence including suicides and family violence, and other adverse health effects such as mental illness. The economic and social cost, including for law enforcement, was considerable. Alcohol use in the workplace and illegally produced alcohol were matters of concern. The campaign to prevent and mitigate the effects of the harmful use of alcohol included the State, nongovernmental organizations, the private sector and academics, but respective responsibilities were unclear. States should, in adopting policies, take into account the nation's religious and cultural context, its needs and priorities.

Member States in the African Region had prepared the present draft resolution, which had won the support of many other States elsewhere. The text took into account the recommendations of the Sixtieth World Health Assembly and an informal consultation among Member States, held at WHO headquarters in December 2007. The draft resolution, containing universal guidelines, sought contributions from all, leading to a draft global strategy to reduce the harmful use of alcohol. She called upon the Board to adopt the draft resolution by consensus.

Dr VOLJČ (Slovenia), speaking on behalf of the Member States of the European Union, said that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia, and the countries of the Stabilisation and Association Process, and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, the European Free Trade Area countries Iceland and Norway, members of the European Economic Area and Switzerland, together with Armenia, Georgia, the Republic of Moldova and Ukraine, aligned themselves with his statement.

The report showed the devastating health, social and economic consequences of the harmful use of alcohol and stressed the common features of alcohol use in all societies. It summarized potential strategies and policies to reduce the burden of harmful alcohol use, which was associated with a wide range of social and economic problems. The health burden facing low- and middle-income countries was large in absolute terms, and weakened vulnerable health systems.

Alcohol consumption per capita in Europe was the highest in the world, responsible for an estimated 195 000 deaths every year. The total direct cost of alcohol use in the European Union countries in 2003 had been put at €125 000 million, or 1.3% of gross domestic product. The indirect cost was even higher. In 2005, the Regional Committee for Europe had adopted the Framework for alcohol policy. Other regional committees had since followed suit. In 2006, the European Union had adopted a strategy to reduce alcohol-related harm in Europe. Further strategic initiatives were still required and should take into account existing measures to prevent and control other determinants of

noncommunicable diseases. He focused on the link between the harmful use of alcohol and other health and social problems, including HIV/AIDS, tuberculosis, violence, conflict or post-conflict situations, poverty and malnutrition.

Alcohol-related harm was influenced by many different factors, and policies should involve organizations representing patients and consumers, family and young people's organizations, health professionals, teachers and educators, together with the media, advertisers, the alcoholic beverages industry, retailers and caterers.

WHO's continued leadership and support at all levels were vital for sustained progress. He expressed his support for the draft resolution, particularly the request to the Director-General to work closely with Member States in developing the proposed strategy, and the deadline of the Sixty-third World Health Assembly in 2010 for its submission.

Dr SHINOZAKI (Japan) expressed his support for the draft resolution. Each Member State should respond to problems caused by alcohol with policies adapted to its economic, social and cultural context. Information exchange should include the nature of current problems and their causes, the burden of alcohol-related disease and the responses employed.

Japan had introduced policy measures on underage drinking and drink-driving. In a 1996 survey, 43.9% of male students and 34.9% of female students in the 10th grade, aged around 16 years, had reported use of alcohol in the previous month. Thanks to government measures including increased penalties for selling alcoholic beverages to minors, stricter age checks and preventive campaigns, that figure had decreased to 30.5% for males and 30.1% for females by 2004.

The alcohol limit for drivers had been reduced from 0.25 mg/litre to 0.15 mg/litre. Causing death or injury by reckless driving had been added to the Penal Code in 2001, and other penalties for reckless driving had been increased. Deaths in road traffic accidents had fallen from 1161 in 2000 to 395 in 2007.

Dr AL-HASNAWI (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the original proposal to adopt a framework convention to combat the harmful use of alcohol appeared to have given way to one for a global strategy. Such a strategy would increase the momentum of alcohol-control activities and promote compliance, although it would have to be adapted to the needs of each region.

The global assessment of public health problems caused by harmful use of alcohol, submitted to the Sixtieth World Health Assembly in 2007,<sup>1</sup> indicated much lower per capita alcohol consumption in the Eastern Mediterranean Region than elsewhere, mainly attributable to religious beliefs. However, alcohol consumption was spread unevenly across population groups and strategies to combat the harmful use of alcohol should emphasize young people and other vulnerable groups.

The Regional Committee for the Eastern Mediterranean had adopted a resolution on the public health problems of alcohol consumption in the Region at its fifty-third session in 2006.<sup>2</sup> It had agreed that promotion of healthier lifestyles was feasible. However, pricing measures, curbs on sales of alcohol to minors and measures to combat drink-driving could not be applied throughout the Region. The new global strategy should take regional differences into account and support the implementation of regional resolutions.

The global strategy should focus on alcohol, but measures to combat other mind-altering substances that endangered public health were also important. The health systems of most Eastern Mediterranean countries would require support in developing capacity to manage alcohol dependence and related health problems. In October 2007, the sixth Eastern Mediterranean Regional Advisory Panel on Drug Abuse had endorsed the application of the Alcohol, Smoking and Substance

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<sup>1</sup> Document A60/14 Add.1.

<sup>2</sup> Resolution EM/RC53/R.5.



Involvement Screening Test, which would help to screen and manage alcohol problems in young people.

He supported the measures outlined in paragraph 1 of the draft resolution. However, many of the strategies proposed in the Secretariat's report would not be applicable to his Region, particularly strategies 13–17. The document should be revised before submission to the Sixty-first World Health Assembly, with the addition of a footnote before paragraph 13, indicating that the strategies described in paragraphs 13–17 might be adopted in countries where alcoholic beverage production, distribution and consumption were not legally banned.

Mr TINAJERO (alternate to Dr Hernández Ávila, Mexico), speaking on behalf of the Member States of the Region of the Americas, stressed that the harmful use of alcohol could cause serious health problems and lead to premature death. Unregulated alcoholic beverages, which were not subject to any quality control, were of particular concern. The proposed global strategy gave Member States flexibility to take account of differing national, religious and cultural contexts.

He suggested the following amendments: at the end of the seventh preambular paragraph, the words “notably in the developing world” should be replaced by “in both developing and developed countries”; since the harmful use of alcohol was a serious problem for both developed and developing countries. Existing paragraph 2(3) should be amended to read “to collaborate and consult with Member States, as well as with intergovernmental organizations ...”; and a new paragraph 2(2) should be introduced, reading: “the draft global strategy will be composed of a set of proposed measures recommended for States to implement at the national level, taking into account the national circumstances of each country”, with existing paragraphs 2(3) and 2(4) being renumbered accordingly.

Dr BLOOMFIELD (alternate to Mr McKernan, New Zealand) said that his country had actively supported regional work to reduce the harmful use of alcohol and welcomed similar global action. The diverse views of Member States on the issue had been well canvassed at the Sixtieth World Health Assembly, and a global strategy to reduce the harmful use of alcohol should build on regional work already undertaken. He supported the draft resolution, which provided clear guidance to the Secretariat and a realistic time frame.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that prevention was the key to tackling problems related to the harmful use of any substance, alcohol included. Research was also essential in educating young people on the benefits of delaying their first use of alcohol and in raising awareness among all age groups about the serious impact of alcohol abuse. Public health strategies and policies should be practicable, measurable, sustainable and evidence-based.

Traditional and home-produced alcoholic beverages were widely consumed and a global strategy must include ways to mitigate the health risks they posed. He took the term “economic operators”, used in paragraph 2(3) of the draft resolution, to mean the alcoholic beverage industry, retailers, restaurants and other private-sector stakeholders, all of whom must be involved in the development of a global strategy. He supported the draft resolution.

Dr JAKSONS (Latvia) expressed support for the draft resolution and WHO's global approach, which recognized the importance of different national policies. He was pleased with the emphasis on reducing the harmful use of alcohol, rather than simply limiting the consequences of such use. Recalling the unmanageable number of amendments proposed during the discussion of an earlier draft resolution by the Sixtieth World Health Assembly, he encouraged members to leave the draft resolution in its current form as far as possible.

Professor AYDIN (Turkey), supporting the draft resolution, said that all children and adolescents had the right to grow up in an environment free of the unfavourable effects of alcohol consumption. He emphasized education in order to reduce the health, social and economic burden of alcohol consumption among young people and of the combined use of drugs and alcohol.

He highlighted strengthening national surveillance systems and monitoring alcohol consumption and resulting social and health problems. National strategies and support from manufacturers, distributors and marketers would be crucial to reducing the harmful use of alcohol. Unfortunately, there seemed to be no clear will on the part of national authorities to combat harmful alcohol use or reduce consumption. Decisive action was needed.

Dr REN Minghui (alternate to Mr Li Baodong, China) said that the report provided an objective analysis. China supported law enforcement to reduce drink-driving, control the marketing of alcoholic beverages to children and young people, and reduce illegally produced alcohol. However, policies aimed at reducing alcohol consumption must take account of cultural factors.

China had formulated regulations on alcohol control, including standardized alcohol marketing and distribution. WHO should promote research into the disease burden and health impact caused by harmful alcohol use in order to provide more evidence for policy making and strategy development. The Secretariat should provide more support to developing countries in raising public awareness, training health professionals, and monitoring trends, including conducting epidemiological surveys. He supported the draft resolution.

Dr DAHL-REGIS (Bahamas), speaking on behalf of the member countries of the Caribbean Community, supported the draft resolution, which took account of differences in Member States' resources and capabilities. A global strategy on the harmful use of alcohol should recognize the need for country-specific approaches.

Dr ABEYKOON (alternate to Mr de Silva, Sri Lanka), speaking on behalf of the Member States of the South-East Asia Region, highlighted the problems posed by alcohol abuse in South-East Asia, particularly in rural areas where alcohol consumption, previously low, was on the rise, with adverse effects on the lives of individuals and families. Government awareness was increasing and each country had adopted its own control policies.

A gradual shift in national policies was occurring. Alcohol had previously been considered a source of revenue, a view actively promoted by ministries of finance, trade and commerce, but the focus was now moving to prevention and control of the harmful use of alcohol in promotion of public health and socioeconomic development. In Thailand, the proceeds from a tax levied on cigarettes and alcohol were channelled into health promotion, and Sri Lanka had established a national alcohol and tobacco authority.

The Regional Office for South-East Asia played an active advocacy role at the highest level of government. Prevention strategies had been proposed at high-level meetings in the Region and should be taken into account in preparing a future global strategy. The Secretariat should continue to provide technical support to enable the countries of the Region to assess the harm caused by alcohol use and launch evidence-based interventions, targeting women and adolescents in particular. He supported the draft resolution.

Ms DÍAZ RODRÍGUEZ (Cuba)<sup>1</sup> said that reducing the harmful use of alcohol was not always the top priority for developing countries, but was nevertheless important. She expressed support for the draft resolution and had submitted comments during the drafting process. Cuba had welcomed the outcome of the informal meeting held on 3 December 2007, leading towards a draft global strategy, which would not be a binding instrument and which would take account of the priorities, problems and needs of individual countries. In continuing the process in the Health Assembly, the Board's recommendation should enjoy full support and should reflect the understanding reached at the December 2007 meeting. She supported the amendments to the draft resolution proposed by Mexico.

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

Dr SHEVYREVA (Russian Federation)<sup>1</sup> said that, given the scale of the problem of alcohol consumption in the world and its direct link to ensuring the health of future generations, alcohol-related public health problems should be tackled as soon as possible through a coordinated global strategy. That would assist the Russian Federation in formulating its own national strategy and reinforce its international contribution.

Mr DEL PICÓ (Chile)<sup>1</sup> endorsed the views expressed in the report. Harmful use of alcohol could cause permanent health problems, premature mortality and increased morbidity, and serious consequences for individuals, families and society. The proposed format for a global strategy gave Member States sufficient flexibility to adopt measures appropriate to their institutional and cultural characteristics. The strategy should be prudent and well-balanced, so as to avoid undesired counterproductive effects. Policies should take account of the social, economic, political and cultural factors involved.

Ms SEBUDANDI (alternate to Dr Ntawukurirayo, Rwanda) was grateful to Board members for their support for the draft resolution. In the interests of consensus, she could accept the amendments put forward by Mexico.

Dr VOLJČ (Slovenia), speaking on behalf of the European Union, said that the draft resolution showed flexibility and reflected the different views and requests of members. The European Union welcomed the amendments put forward by Mexico.

Dr BLOOMFIELD (alternate to Mr McKernan, New Zealand), recalling his experience as chairman the drafting group on the topic at the Sixtieth World Health Assembly, endorsed the comments of the member for Latvia. The amendments put forward by the member for Mexico appeared to be acceptable, but it might be prudent to avoid proposing further amendments as that might open up lengthy discussion on the draft resolution, on which broad agreement had already been reached.

Mr AITKEN (Assistant Director-General ad interim) confirmed that the comments by the member for Iraq would duly be taken into account in preparing the report for the Sixty-first World Health Assembly. In response to the comments by the member for the United States of America, he said that consultations with the alcohol industry were next due to be held on 20 and 21 February 2008 and would continue as appropriate. He thanked Rwanda and the other countries involved for their work in preparing the draft resolution.

Dr KEAN (Executive Director, Office of the Director-General) read out the amendments proposed by Mexico. In the seventh preambular paragraph, the words: “notably in the developing world” would be replaced with “in both developing and developed countries”. A new paragraph 2(2) would read: “the draft global strategy will be composed of a set of proposed measures recommended for States to implement at the national level, taking into account the national circumstances of each country”. Current paragraph 2(2) would then become 2(3). Current paragraph 2(3) would become 2(4) and would be amended to read: “to collaborate and consult with Member States as well as with international organizations ...”. New paragraph 2(2) also took into account the wording requested by the member for Iraq.

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

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

<sup>2</sup> Resolution EB122.R2.

**Public health, innovation and intellectual property: draft global strategy and plan of action:**  
Item 4.9 of the Agenda (Document EB122/12)

Mr HOHMAN (alternate to Dr Wright, United States of America) enquired whether the dates of the next meeting of the subgroup of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property had been confirmed.

Dr AL-HASNAWI (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed appreciation for the work accomplished by the Intergovernmental Working Group in developing a global strategy and plan of action. Member States of the Region had met in August 2007, and submitted an extensive and substantive report to the Secretariat. At the second session of the Intergovernmental Working Group, 33 delegates from 19 countries had participated. The Working Group aimed to produce a strategy and action plan in time for the Sixty-first World Health Assembly.

Recognizable progress had been made, but consensus had not been reached on the basic principle that the right of everyone to enjoy the highest attainable standard of physical and mental health should be recognized as a fundamental human right in instruments of international human rights. Another concern was that the Working Group should not restrict itself to a list of diseases, but maintain an open approach that allowed for future needs.

Ms TJIPURA (alternate to Dr Forster, Namibia), speaking on behalf of the Member States of the African Region, recalled that the draft strategy and plan of action had been discussed at the fifty-seventh session of the Regional Committee for Africa. The African countries had also participated in the second session of the Intergovernmental Working Group. They were concerned at the slow progress but remained hopeful that the draft strategy and plan of action would be finalized before the next Health Assembly. All parties should focus on the original reason for the Working Group, namely, the millions of poor people around the globe who suffered because they could not afford health care.

Dr REN Minghui (alternate to Mr Li Baodong, China) welcomed in principle the draft action plan produced by the Intergovernmental Working Group. The subject of public health, innovation and intellectual property was wide-ranging, significant and closely connected to public health security, scientific innovation and trade. It raised questions about how to balance public health interests against commercial interests. His Government attached great importance to the issue and supported respect for innovation and the protection of intellectual property rights, while also appreciating public health needs. The Working Group should ensure that developing countries had access to appropriate medicines and technologies. Further work was needed to support innovation and the development of medicines, as well as to establish a mechanism to separate research and development from the pricing of medicines so that developing countries would have equal access to health products and technologies. Referring to the draft plan of action,<sup>1</sup> he suggested that the responsibilities of Member States, the measures to be taken, and the specific performance indicators should be identified under the specific actions and progress indicators. The parties responsible for establishing monitoring and reporting systems should also be identified. Traditional medicines should be included among the priorities for research and development.

Mgr TOMASI (Holy See), speaking at the invitation of the CHAIRMAN, said that the Holy See had been pleased to participate in both sessions of the Intergovernmental Working Group with the aim of finding a more equitable approach to public health, innovation and intellectual property. With regard to competition and pricing of medicines consistent with public health, he emphasized removal

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<sup>1</sup> Document A/PHI/IGWG/2/2.

of tariffs and taxes on health-care products and monitoring their supply and distribution chain. Health workers of the Catholic Church and of other civil society organizations often reported difficulties in gaining access to medications, diagnostic tools and other life-saving resources on which high tariffs were charged, or which were not released by customs authorities until long after their expiry dates. Religious organizations, as participants in strengthening health-care delivery, should be included among the stakeholders identified in the draft plan of action.

The Working Group had not discussed the severe lack of both medicines formulated specifically for children and paediatric diagnostic tools. More targeted planning should be undertaken to address the discrepancy in access to treatment for adults and for children living in low- and middle-income countries.

Mr OLDHAM (Chairman, Intergovernmental Working Group on Public Health, Innovation and Intellectual Property), responding to the comment by the member for the United States of America, said that the proposed dates for the subgroup meeting were 17–19 March 2008. He thanked all members for their comments. The secretariat of the Working Group would work hard to ensure that the draft strategy and plan were completed when the second session resumed.

**The Board noted the report.**

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

## **FIFTH MEETING**

**Wednesday, 23 January 2008, at 09:10**

**Chairman:** Dr B. SADASIVAN (Singapore)

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

**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) (continued from the third meeting)

The CHAIRMAN invited the Board to consider the revised draft resolution on implementation of the International Health Regulations (2005), which read:

The Executive Board,  
Having considered the report on the implementation of the International Health Regulations (2005),<sup>1</sup>

RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:<sup>2</sup>

The Sixty-first World Health Assembly,  
Having considered the report on the implementation of the International Health Regulations (2005);

Recalling resolution WHA58.3 on revision of the International Health Regulations, which decided that the Sixty-first World Health Assembly would consider the schedule for the submission of further reports by States Parties and the Director-General on the implementation of the International Health Regulations (2005) and the first review of their functioning, pursuant to paragraphs 1 and 2 of Article 54 of the Regulations;

Underscoring the importance of establishing a schedule to review and evaluate the functioning of Annex 2, pursuant to paragraph 3 of Article 54 of the International Health Regulations (2005);

Mindful of the request to the Director-General in resolution WHA59.2 on application of the International Health Regulations (2005) to report to the Sixtieth World Health Assembly and annually thereafter on progress achieved in providing support to Member States on compliance with, and implementation of, the International Health Regulations (2005);

Recognizing the need to rationalize reporting on all aspects of implementation of the International Health Regulations (2005) in order to facilitate the work of the Health Assembly,

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<sup>1</sup> Document EB122/8.

<sup>2</sup> See document EB122/8 Add.1 for the financial and administrative implications for the Secretariat of this resolution.

1. REAFFIRMS its commitment to the timely, ~~and~~ effective **and universal** [Paraguay] implementation of the International Health Regulations (2005);

[or]

1. **REAFFIRMS its commitment to implement fully the International Health Regulations (2005) in accordance with the purpose and scope set out in Article 2 and the principles embodied in Article 3 of the Regulations; [China]**

2. DECIDES:

- (1) in accordance with paragraph 1 of Article 54 of the International Health Regulations (2005), that States Parties and the Director-General shall report to the Health Assembly on the implementation of the Regulations biennially, with the next report to be submitted to the Sixty-third World Health Assembly;
- (2) in accordance with paragraph 2 of Article 54 of the International Health Regulations (2005), that the first review of the functioning of the Regulations shall be made by the Sixty-third World Health Assembly;
- (3) in accordance with paragraph 3 of Article 54 of the International Health Regulations (2005), that the first review and evaluation of the functioning of Annex 2 shall be submitted to the Sixty-third World Health Assembly for its consideration;

3. URGES Member States:

- (1) to ensure that the contact details of the centre that has been designated as the National IHR Focal Point are complete and up to date and to encourage relevant staff within the centre to access and use the Event Information Site on the WHO web site;
- (2) to take steps to ensure that the national core capacity requirements specified in Annex 1 to the Regulations are put in place, strengthened and maintained, in accordance with Articles 5 and 13 of the International Health Regulations (2005);
- (3) to designate an expert, if they have not already done so, for the IHR Roster of Experts, in accordance with Article 47 of the International Health Regulations (2005);
- (4) to continue to support each other and collaborate with WHO in the implementation of the International Health Regulations (2005), in accordance with resolution WHA58.3 and relevant provisions of those Regulations;

4. REQUESTS the Director-General:

- (1) to submit every two years a single report, including information provided by States Parties and about the Secretariat's activities, to the Health Assembly for its consideration, pursuant to paragraph 1 of Article 54 of the International Health Regulations (2005);
- (2) **to provide support to Member States with most vulnerable health systems in strengthening core capacity requirements for surveillance and response at airports, ports and ground crossings, paying special attention to the sub-Saharan Africa laboratory network [Malawi, on behalf of the 46 Member States of the African Region].**

Mr BURCI (Legal Counsel) said that two mutually exclusive, competing amendments for paragraph 1 of the draft decision had been proposed by Paraguay and China, respectively. If neither of the amendments was withdrawn, the Board would have to proceed to a vote on the issue. In that event, in accordance with Rule 37 of the Rules of Procedure of the Executive Board, the Board would first vote on the amendment furthest removed from the substance of the original proposal. He suggested

that the Chairman might first enquire whether either of the two delegations was prepared to withdraw its proposed amendment, or whether they were prepared to explore a compromise formulation.

Mr GAUTO (alternate to Dr Dullak Peña, Paraguay) said that his delegation maintained its proposal, considering that the word “universal” should be acceptable to all, since it was a concept that underpinned the International Health Regulations (2005). He recalled that the member for China had said that the amendment proposed by Paraguay would be acceptable to him, provided that he could add further clarifications to the text of the amendment. Since the two proposals could be complementary, he proposed, in a spirit of compromise, that they should be merged into one proposal reading: “reaffirms its commitment to the timely, effective and universal implementation of the International Health Regulations (2005) in accordance with the purpose and scope set out in Article 2 and the principles embodied in Article 3 of the Regulations”.

Dr REN Minghui (alternate to Mr Li Baodong, China) regretted that the member for Paraguay had provided a partial interpretation of the statement made the previous day by China. His Government reiterated strong support for the comprehensive draft resolution which required no amendments. The delegation of Paraguay, in introducing its proposal the day before, had attempted to bring the issue of Taiwan into the draft resolution. That politically motivated proposal, aimed at interfering in China’s domestic affairs, was totally unacceptable to China. The proposal made by China had already been adopted by consensus – including by Paraguay – in resolution WHA58.3, and would surely be accepted by the Board. He observed that China’s proposal also integrated the principle of universal application, as well as the principles of the United Nations Charter and of international law, and the sovereign right of countries to legislate and implement health legislation.

Mr GAUTO (alternate to Dr Dullak Peña, Paraguay) emphasized that Paraguay fully respected the sovereignty of China and had no desire to interfere in its internal affairs. As the International Health Regulations (2005) should be applied everywhere it was logical to introduce the word “universal”, which was simple and understandable to all. His Government had no hidden agenda. As China seemed to be merely seeking to challenge Paraguay’s viewpoint, his delegation would object to the Chinese proposal. He had no objections to a vote on the issue, if necessary, but suggested consulting other members on their views to avoid any misunderstandings.

The CHAIRMAN said that a substantive debate had already been held on the International Health Regulations (2005) and recalled that the present discussion concerned the related draft resolution. In view of the prevailing situation, he invited the Board to vote on the proposals.

Mr BURCI (Legal Counsel), explaining the voting procedure, expressed the view that, in accordance with Rule 37, the amendment proposed by China, which was furthest removed from the substance of the original proposal, should be voted on first.

Mr GAUTO (alternate to Dr Dullak Peña, Paraguay) and Dr REN Minghui (alternate to Mr Li Baodong, China) requested a roll-call vote.

Mr HOHMAN (alternate to Dr Wright, United States of America) asked whether the proposal by China would only replace the text proposed by Paraguay in paragraph 1, rather than the entire paragraph.

Mr BURCI (Legal Counsel) noted that the vote concerned the amendment proposed by China to paragraph 1 of the draft resolution.

**A vote was taken by roll-call, the names of the Member States being called in the English alphabetical order, starting with Jamaica, as determined by lot.**



**The result of the vote was as follows:**

**In favour:** Afghanistan, Azerbaijan, Bahamas, Bhutan, China, Djibouti, Indonesia, Iraq, Japan, Liberia, Madagascar, Malawi, Mali, Mexico, Namibia, New Zealand, Peru, Republic of Korea, Rwanda, Singapore, Sri Lanka, Tunisia, Turkey, United Arab Emirates, United States of America.

**Against:** El Salvador, Paraguay, Sao Tome and Principe.

**Abstaining:** Denmark, Latvia, Portugal, Slovenia, United Kingdom of Great Britain and Northern Ireland.

**Absent:** Republic of Moldova.

**The amendment was therefore approved by 25 votes to 3, with 5 abstentions.**

Mr BURCI (Legal Counsel), at the request of Mr HOHMAN (United States of America), provided clarification about the rules on explanation of vote in the Executive Board. He noted that statements in explanation of vote were explicitly allowed by the Rules of Procedure of the World Health Assembly; however, the Rules of Procedure of the Executive Board were silent in that respect. At the same time, delegations were in practice sometimes given the opportunity to explain their vote after the adoption of resolutions, without that being challenged. If there was a challenge, however, the Board would have to decide.

Mr GAUTO (alternate to Dr Dullak Peña, Paraguay) conceded that there were no explicit rules on the matter but believed in rules of courtesy.

Dr GWENIGALE (Liberia), observing that the Board had specific agenda items to discuss but that the process was being delayed by interruptions, expressed the view that countries should not speak in explanation of vote.

Turning to subparagraph 4(2), the CHAIRMAN, seeing no objection, took it that the Board endorsed the amendment proposed by Malawi on behalf of the Member States of the African Region.

**It was so agreed.**

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

**Climate change and health:** Item 4.1 of the Agenda (Document EB122/4) (continued from the fourth meeting)

The CHAIRMAN drew attention to a revised draft resolution on climate change and health, proposed by New Zealand and the United Kingdom of Great Britain and Northern Ireland, and cosponsored by Germany and the Netherlands, and associated financial and administrative implications which read:

The Executive Board,  
Having considered the report on climate change and health,<sup>2</sup>

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<sup>1</sup> Resolution EB122.R3.

<sup>2</sup> Document EB122/4.

RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,

Recalling resolution WHA51.29 on the protection of human health from threats related to climate change and stratospheric ozone depletion and acknowledging and welcoming the work carried out so far by WHO in pursuit of it;

Recognizing that, in the interim, the scientific evidence of the effect of the increase in atmospheric greenhouse gases, and of the potential consequences for human health, has considerably strengthened;

Noting with concern the recent findings of the Intergovernmental Panel on Climate Change that the effects of temperature increases are already being observed on some aspects of human health; that the net global effect of projected climate change on human health is expected to be negative, especially in developing countries, small island developing States and vulnerable local communities which have the least capacity to prepare for and adapt to such change, and that exposure to projected climate change could affect the health status of millions of people, through increases in malnutrition, in death, disease and injury due to extreme weather events, in the burden of diarrhoeal disease, in the frequency of cardiorespiratory diseases, and through altered distribution of some infectious disease vectors;

Noting further that climate change could jeopardize achievement of the Millennium Development Goals, including the health-related Goals, and undermine the efforts of the Secretariat and Member States to improve public health and reduce health inequalities globally;

Recognizing the importance of addressing in a timely fashion the health impacts resulting from climate change due to the cumulative effects of emissions of greenhouse gases, and further recognizing that solutions to the health impacts of climate change should be seen as a joint responsibility of all States;

Recognizing the need to assist Member States in assessing the implications of climate change for health and health systems in their country, in identifying appropriate and comprehensive strategies and measures for addressing these, in building capacity in the health sector to do so and in working with government and nongovernmental partners to raise awareness of the health impacts of climate change in their country and take action to address them;

Further recognizing that strengthening health systems to enable them to deal with both gradual changes and sudden shocks is a fundamental priority in terms of addressing the direct and indirect effects of climate change for health,

1. REQUESTS the Director-General:

(1) to continue to draw to the attention of the public and policymakers the serious threat of climate change to global health security and to the achievement of the health-related Millennium Development Goals, and to work with the United Nations Framework Convention on Climate Change secretariat, WMO, FAO, UNEP, UNDP and other appropriate organizations of the United Nations, in the context of United Nations reform initiatives, and with national and international agencies, to ensure that these health impacts and their resource implications are understood and can be taken into account in further developing national and international responses to climate change;

(2) to engage actively in the UNFCCC Nairobi Work Programme on Impacts, Vulnerability and Adaptation to Climate Change, in order to ensure its relevance to the health sector, and to keep Member States informed about the work programme in order to facilitate their participation in it as appropriate and access to the benefits of its outputs;

(3) to continue close cooperation with appropriate United Nations organizations, other agencies and funding bodies, and Member States, to develop capacity to assess the risks from climate change for human health and to implement effective response measures, by promoting further research and pilot projects in this area, including work on:

- health vulnerability to climate change and the scale and nature thereof;
- health protection strategies and measures relating to climate change and their effectiveness, including cost-effectiveness;
- the health impacts of potential adaptation and mitigation measures in other sectors such as water resources, land use, and transport, in particular where these could have positive benefits for health protection;
- decision-support and other tools, such as surveillance and monitoring, for assessing vulnerability and health impacts and targeting measures appropriately;
- assessment of the likely financial costs and other resources necessary for health protection from climate change;

(4) to consult Member States on the preparation of a workplan for scaling up WHO's technical support to Member States for assessing and addressing the implications of climate change for health and health systems, including practical tools and methodologies and mechanisms for facilitating exchange of information and best practice and coordination between Member States, and to present a draft workplan to the Executive Board at its 124th session.

## **1. Resolution** Climate change and health

### **2. Linkage to programme budget**

Strategic objective:

8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.

Organization-wide expected result:

1. Evidence-based assessments made, and norms and guidance formulated and updated on major environmental hazards to health (e.g., poor air quality, chemical substances, electromagnetic fields, radon, poor-quality drinking-water and waste-water reuse); technical support provided for the implementation of international environmental agreements and for monitoring progress towards achievement of the Millennium Development Goals.

3. Technical assistance and support provided to Member States for strengthening occupational and environmental health policy-making, planning of preventive interventions, service delivery and surveillance.

5. Health-sector leadership enhanced for creating a healthier environment and changing policies in all sectors so as to tackle the root causes of environmental threats to health, through means such as responding to emerging and re-emerging consequences of development on environmental health, climate change, and altered patterns of consumption and production and to the damaging effect of evolving technologies.

**(Briefly indicate the linkage with expected results, indicators, targets, baseline)**

Strengthened work on health protection from climate change is consistent with the expected results for strategic objective 8; full implementation of the resolution would be reflected as a specific element within the indicators and targets for the three Organization-wide expected results mentioned above.

**3. Financial implications**

**(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)**

The first three operative paragraphs of the draft resolution are open-ended, while the remaining paragraph calls for a draft workplan to be presented to the Executive Board at its session in January 2009. On this basis, the costs are estimated only for the duration of the biennium 2008–2009.

**(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)**

Estimated costs for the current biennium are US\$ 6.4 million. For staff, we estimate the cost to be US\$ 3.4 million, of which US\$ 1.5 million will be incurred at headquarters, and US\$ 1.9 million across the six WHO regions. For activities, we estimate the cost to be US\$ 3 million, of which US\$ 1 million will be incurred at headquarters and US\$ 2 million in the regions.

**(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?**

The total cost can be subsumed under the Programme budget 2008–2009, which was planned taking into account the increasing concern over the health effects of climate change.

**(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)**

Not applicable.

**4. Administrative implications**

**(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)**

Implementation of the global programme will be Organization-wide, with activities at global, regional and country levels. Headquarters will play a standard-setting, guidance-providing and coordination role, and will support the implementation of activities.

**(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant)**

From mid-2008, we estimate that four additional staff members (full-time equivalents) will be needed at headquarters (skills profiles sought concern policy and technical development in climate change and health). Each regional office should have a full-time project officer responsible for the integration of climate change into operational programmes. This will require the addition of four staff (full-time equivalents). The required skills profiles cover project management and environmental health.

**(c) Time frames (indicate broad time frames for implementation)**

The current biennium.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that Italy, Latvia, Luxembourg, Republic of Korea, Romania, Slovakia and Sweden were also cosponsors of the draft resolution and should be added to the list.

Mrs VALLE ÁLVAREZ (alternate to Dr Hernández Ávila, Mexico), Professor PEREIRA MIGUEL (Portugal), Dr SINGAY (Bhutan), Mr FISKER (Denmark) and Dr ANTEZANA ARANÍBAR (Bolivia)<sup>1</sup> said that their countries also sponsored the draft resolution and asked to be added to the list.

Mr ALCÁZAR (Brazil)<sup>1</sup> reiterated his suggestion of the previous day to replace the word “threat” with “risk” wherever it appeared in the draft resolution. He was ready to support the draft resolution subject to that amendment.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), seconded by Dr DAHL-REGIS (Bahamas), proposed that the Board should consider the amendment suggested by Mr Alcázar.

**It was so agreed.**

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

**Health of migrants:** Item 4.8 of the Agenda (Document EB122/11)

The CHAIRMAN drew attention to the draft resolution on the health of migrants, proposed by Portugal and cosponsored by Austria, the Czech Republic, Denmark, Finland, Germany, Hungary, Ireland, Italy, Kenya, Latvia, Luxembourg, Mexico, Slovakia, Slovenia, Spain, Sri Lanka, and the United Kingdom of Great Britain and Northern Ireland, and the associated financial and administrative implications which read:

The Executive Board,  
Having considered the report on health of migrants,<sup>3</sup>

RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,  
Having considered the report on health of migrants;  
Recalling the United Nations General Assembly resolution 58/208 underlining the need for a high-level dialogue to discuss the multidimensional aspects of international migration and development (New York, 23 December 2003);  
Recalling the first plenary session of the United Nations General Assembly on migration issues and the conclusions of the High-Level Dialogue on Migration and Development (New York, 14–15 September 2006) with their focus on ways to maximize the development benefits of migration and to minimize its negative impacts;  
Recalling resolutions WHA57.19 and WHA58.17 on International migration of health personnel: a challenge for health systems in developing countries, calling for support to the strengthening of health systems, in particular human resources for health;  
Cognizant of the Bratislava Declaration on Health, Human Rights and Migration issued at the 8th Conference of European Health Ministers (Bratislava, 23 November 2007), which recognized that well-managed health measures for migrants, including

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

<sup>2</sup> Resolution EB122.R4.

<sup>3</sup> Document EB122/11.

public health measures, promote the well-being of all and can facilitate the integration and participation of migrants within the host countries;

Taking note of the Conclusions on Health and Migration in the European Union, adopted by the Council of the European Union (Brussels, 6 December 2007), which welcomed the approach to migrants' health as a powerful determinant of integration, intercultural dialogue, social cohesion, and sustainable development;

Recognizing the need for WHO to tackle the issues of health and migration as a critical part of the broader agenda on migration and development;

Recognizing that health outcomes are influenced by the multiple dimensions of migration;

Noting that people on the move experience increased health risks;

Recognizing the scarcity of information specific to migrants' health status and access to health services and the consequences thereof for health systems;

Noting that the existence of economic, political, social and environmental determinants of migrants' health underlines the need to develop intersectoral public policies that can influence both the migration process and its health consequences;

Mindful of the need for promoting mechanisms of social protection in health that can constitute instruments of inclusiveness for migrants;

Acknowledging that the health of migrants is an increasingly important public health matter both for Member States and for the work of the Secretariat;

Noting that Member States facing the challenges of migration have an increasing need to formulate and implement strategies for improving the health of migrants;

Noting that health and migration policies have to consider gender aspects and the specific needs of women and men;

Recognizing that health and migration policies can contribute to development and to achievement of the Millennium Development Goals,

1. CALLS UPON Member States:

- (1) to promote migrant-sensitive health policies;
- (2) to promote equitable access to health protection and care for migrants, subject to national laws and practice, and devise mechanisms for enhancing social protection in health for migrants;
- (3) to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;
- (4) to meet migrants' health needs better by identifying gaps in service delivery;
- (5) to document best practices for meeting migrants' health needs in countries of origin or return, transit and destination, and to encourage generation of information on health issues arising from migration;
- (6) to develop and promote the sharing of data on migrants' health and knowledge of the effectiveness of interventions to improve migrants' health;
- (7) to raise health service providers' cultural and gender sensitivity to migrants' health issues;
- (8) to train health professionals to deal with the health issues associated with population movements;
- (9) to promote international cooperation on migrants' health among countries of origin or return, transit and destination;
- (10) to promote the strengthening of health systems in the countries of origin, as appropriate, within cooperation and development programmes, in order to prevent disease and ill health;
- (11) to contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium Development Goals;

2. REQUESTS the Director-General:
- (1) to promote migrants' health on the international health agenda;
  - (2) to explore policy options and approaches for improving the health of migrants;
  - (3) to analyse the major challenges to health associated with migration;
  - (4) to support the development of regional and national assessments of migrants' health status and access to health care;
  - (5) to promote the inclusion of migrants' health in the development of regional and national health strategies;
  - (6) to draw up guidance for filling the gaps in data on migrants' health and to document Member States' best practices and lessons learnt in dealing with migrants' health issues;
  - (7) to promote dialogue and cooperation on migrants' health among countries of origin or return, transit and destination, within the framework of the implementation of their health strategies;
  - (8) to give consideration to the health of migrants in the light of the health in all policies approach, with special emphasis on employment and social policies and those on cooperation and development;
  - (9) to promote interagency, interregional and international cooperation on migrants' health with an emphasis on developing partnerships with other organizations;
  - (10) to encourage the exchange of information through a technical network of collaborating centers, academic institutions and other key partners in order to further research into migrants' health and to enhance capacity for technical cooperation;
  - (11) to submit to the Sixty-third World Health Assembly, through the Executive Board, a report on the implementation of this resolution.

<b>1. Resolution</b> Health of migrants	
<b>2. Linkage to programme budget</b>	
Strategic objective: 5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.	Organization-wide expected result: 3. Norms and standards developed, capacity built and technical support provided to Member States for assessing needs and for planning and implementing interventions during the transition and recovery phases of conflicts and disasters.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
WHO's activities in support of the health of migrants have links with strategic objectives 7, 8 and 10.	
<b>3. Financial implications</b>	
(a) <b>Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)</b> US\$ 2 400 000 over a period of four years.	
(b) <b>Estimated cost for the current biennium (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)</b> US\$ 1 200 000 at global, regional and country levels.	
(c) <b>Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the current biennium?</b> US\$ 586 000.	
(d) <b>For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)</b> Costs will be met through income from voluntary contributions aimed at supporting work in this field.	

**4. Administrative implications****(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)**

Headquarters, regional offices and, in the African and Eastern Mediterranean regions, country offices in countries facing major challenges as a result of AFRO and EMRO migration.

**(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)**

Three experts in public health and migration: one at headquarters and two based in the African and Eastern Mediterranean regions, where migration and its consequences for health are having the greatest impact.

**(c) Time frames (indicate broad time frames for implementation)**

Two of the public health experts will be recruited during the biennium 2008–2009, one at the global level and the other at the regional level. Technical cooperation activities will be performed over the next two bienniums. The second regional public health expert will be recruited during the biennium 2010–2011.

Mr DE SILVA (Sri Lanka) supported the draft resolution. The health of the many migrant workers from the South-East Asia Region working in the Middle East and elsewhere was a great concern. An informal working group held before the previous Health Assembly had highlighted the need to put the issue on the international health agenda.

Dr VOLJČ (Slovenia) said that he was speaking on behalf of the European Union, and that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia, and the countries of the Stabilisation and Association Process, and potential candidates Albania, Bosnia and Herzegovina, Serbia, and the European Free Trade Association countries Iceland and Norway, members of the European Economic Area, and Ukraine and Armenia, aligned themselves with his statement. International migration was a critical matter also relevant to attainment of the Millennium Development Goals. All Member States were concerned, and the Secretariat's report summarized the important issues. He welcomed the emphasis in the draft resolution on the need for coordination, particularly between the competent United Nations agencies. Knowledge of the topic should be mapped and best practices shared. He also welcomed the support for vulnerable populations such as migrants through the promotion of non-discriminatory, comprehensive and culture- and gender-sensitive national policies. In the area of health, such an approach favoured cultural dialogue, integration and sustainable development. In view of paragraphs 17 and 21 of the report, he underlined that, in all European Union Member States, legal migrants and nationals enjoyed equal access to health services. Undocumented or irregular migrants could also use health services, at least in emergencies.

The Council of the European Union had recommended the strengthening of health systems in countries of origin through cooperation and development programmes and reducing the global deficit of health-care professionals. It had encouraged its Member States to cooperate with the relevant international organizations, WHO in particular.

Dr BIN SHAKAR (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the issue was important to the Region, as many migrants came to its higher-income countries. Those migrants often had healthy environmental conditions with provision for medical check-ups. The health statistics of those countries provided information on migrants' use of health services. Preventive care and emergency medical services were reportedly provided free. Some countries were seeking technical support from WHO in considering social insurance schemes for contracted migrant workers.



Data were lacking on a second category, internal migrants, often unskilled manual workers. They were among the poorest classes in countries beset by high levels of poverty. Those workers lacked formal health coverage, they were at high risk by the nature of their work and vulnerable because of inadequate shelter, unhealthy food and environmental hazards.

The Secretariat should provide technical support to Member States in dealing with the equitable access to health care of both categories of migrants as well as their socioeconomic conditions, for which some countries would also need financial support. WHO should concert with other international organizations such as ILO, and highlight the multidimensional issues involved in order to help countries deal with the root causes of internal migration by such means as education, employment and development projects in deprived areas.

Mrs VALLE ÁLVAREZ (alternate to Dr Hernández Ávila, Mexico), stating that her observations had the support of the delegations of El Salvador, Peru and the Bolivarian Republic of Venezuela, noted that the terms “legal” and “illegal” migrants had been used in the report, which was unacceptable and presented a negative image. People were not illegal; their actions might be. If migrants lacked the necessary documents, they could be called “undocumented” migrants in an “irregular” situation. She asked the Secretariat to revise the report in that regard.

Although several bilateral, regional and multilateral forums dealt with migration, there was still disagreement on how to reconcile the management of migration with protecting the rights of all migrants. It was important to overturn the negative perception of migrants, who made a positive contribution both to their own countries and to the economic, political, social and cultural life of receiving countries. Countries of origin and of destination should share responsibility for providing access to health services. Migrants in an “irregular” situation were vulnerable owing to low social standing, particularly concerning education and health. Bilateral and multilateral collaboration should be broadened to prevent the disability and premature death of migrants and their families. Lack of access to basic health services was a key issue. “Irregular” migrants were unable to seek medical treatment for fear of being arrested and deported. Women and girls sometimes faced sexual abuse and had no access to legal or reproductive health services. Latin American and Caribbean countries encouraged a new broad understanding of migration, and promoted its positive contribution. That approach should rest on the principle of shared responsibility, integrate the causes and effects of migration, and make the migrant central to any health policy.

She encouraged any country that had not yet done so to ratify the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, which contained useful tools for protecting the rights of migrants, including access to basic health services.

Dr SUGIURA (alternate to Dr Shinozaki, Japan) said that Japan recognized the importance of migrants’ health and endorsed a public health approach. It had no objections to the draft resolution. However, the definition of migrants in the report was too broad to enable the setting of targets for action. For example, refugees from conflict and disaster areas were distinct from migrant workers. The workplace would provide a useful point for integrated health service delivery and health promotion among migrant workers. WHO should further analyse the available data on migrants and identify suitable partners for action.

Professor PEREIRA MIGUEL (Portugal), recalling that Portugal had requested inclusion of the item on the agenda and had proposed the draft resolution, said that migrants’ health affected all WHO regions, warranted attention at all levels and should be viewed from a public health perspective. All countries, whether of origin, transit or destination of migrants, must promote migrants’ health as a key to health for all. The conclusions on health and migration adopted by the European Union in December 2007, following a high-level international conference, provided a sound basis for future action in Europe and elsewhere. The conference had focused on better health for all in an inclusive society, providing the political vision and scientific basis that would place migrants’ health on the European Union and global health agendas. WHO headquarters and the Regional Office for Europe

had provided support for the conference; the Council of Europe, the International Centre for Health and Migration and the International Organization for Migration had also contributed.

The Secretariat's report provided overview, reviewed principles for a public health approach, and suggested strategies. Issues relevant to health of migrants in the context of primary health care included provision of vaccination, care for mothers, children and the elderly, and mental and occupational health needs. The Board should progress to an active quest for solutions, and he therefore urged the adoption of the draft resolution, noting that El Salvador, Indonesia, Lithuania, Mali, Moldova, Norway, Republic of Korea, Switzerland and Turkey had indicated that they wished to be sponsors, demonstrating the widespread interest in the subject. Although there were resource limitations everywhere and health systems were struggling to cope, the actions proposed in the draft resolution seemed feasible in the short term.

Dr REN Minghui (alternate to Mr Li Baodong, China) supported a public-health approach to the health of migrants as a component of health improvements for the whole population. Paragraph 2 of the report defined migration as comprising population movements across international borders and within States. However, the remainder of the report related only to the former category. It should be made clear that management of migration within States was a matter for national governments. He supported the draft resolution in principle, although mention of European regional activities in the fourth and fifth preambular paragraphs was not appropriate and should be deleted.

Dr KANDUN (alternate to Dr Supari, Indonesia) commented that voluntary and forced population movements were increasing and were a concern at local, national and regional levels. For example, millions of Indonesians were working outside the country. Indonesia endorsed the view, expressed in paragraph 6 of the report, that migrants were generally more vulnerable to health problems and hazards than the general population in the host country, and were also subject to the stresses of new environments and re-acclimatizing on their return home. Indonesia also endorsed the principles of a public health approach for migrants set out in paragraph 5 and was pleased to sponsor the draft resolution.

Ms KENNELLY (alternate to Dr Wright, United States of America) said that, as a country of immigrants, the United States cared deeply about migrants' health and recognized its importance for WHO. Her Government's efforts included community and migrant health centres, which provided a wide range of services to uninsured, low-income families, regardless of their ability to pay. Civil society organizations also provided health care to needy populations, including migrants. All migrants, regardless of their immigration status, had access to emergency health care.

She had some concerns in respect of the report and the draft resolution. The report failed to distinguish between the many types of migrants, which might include international visitors, students, legal immigrants, refugees and undocumented immigrants – categories that needed different interventions. Further, its consideration of countries of origin and of destination oversimplified the global migration phenomenon. Most countries both sent and received migrants, and there was significant migration between developing countries. Paragraph 5 of the report referred to ensuring migrants' right to health, but there was no established right of migrants to health. The United States did not support rights-based approaches, which did little to provide practical solutions for improving health. It also opposed the idea of compulsory Government-run health care for migrants, although, as indicated, it offered governmental programmes to those in need. The report did not take into account the range of health systems in Member States. In the United States, for example, there was no national health service – the health system was privatized and migrants with health insurance had the same access to services as insured nationals. She could not agree with the suggestion made in paragraph 13 that health assessments for prospective migrants, which were necessary to protect public health and safety and, in some cases, allowed migrants to be provided with medical support on arrival, posed challenges to human rights. The Secretariat should consider those points in revising the document before its submission to the Health Assembly and in further discussions on the matter.

WHO should continue to work in areas in which it had a clear mandate and the necessary expertise, including health of migrants. However, it should not move into broader areas related to migration and development, or national migration policies in progress towards the attainment of the Millennium Development Goals. The United States wished to propose extensive amendments to the draft resolution which, in the interests of efficiency, could be discussed in an informal drafting group.

Dr DE CARVALHO (Sao Tome and Principe), speaking on behalf of the Member States of the African Region, observed that since the Alma-Ata Conference, there had been increasing recognition of the right to health, including access to integrated health services regardless of immigration status. Different strategies were needed for different categories of migrants, including refugees and undocumented migrants, who generally lacked access to health services that were culturally suited to their needs. Countries would need support in developing appropriate policies. He endorsed the strategies set out in paragraph 21 of the report and urged support for the draft resolution.

Dr MAZA BRIZUELA (El Salvador), noting that his country was a sponsor of the draft resolution, stressed the health of migrants for their integration within host countries. The health of migrants was a basic component of societal structure and emphasis should be given to the benefits of migration for development. He endorsed the comment by the member for Mexico concerning the term “illegal” in the report, which should be changed.

Dr SALANIPONI (Malawi) requested that the Secretariat, through its country offices, should support Member States in Africa in carrying out situation analyses in order to assess the health status of migrants, particularly in refugee settlements and prisons. The results would help Member States’ work on migrants’ health. He supported the draft resolution.

Mrs VALLE ÁLVAREZ (alternate to Dr Hernández Ávila, Mexico) said that all sponsors of the draft resolution could attend the meeting of the drafting group suggested by the United States of America. In the interests of clarity and transparency, she requested the member for the United States to read out her amendments to the draft resolution.

Ms KENNELLY (alternate to Dr Wright, United States of America) proposed that the fifth and sixth preambular paragraphs should be deleted. The seventh preambular paragraph should be amended to read: “Recognizing the need for additional data on health and migration”. In the eighth preambular paragraph, the word “are” should be replaced with “can be”. The ninth and tenth preambular paragraphs should be deleted. The eleventh preambular paragraph should be amended to read: “Noting the need to develop intersectoral public policies for the health of migrants”. The twelfth preambular paragraph should be deleted. As migrants’ health had always been an important public health matter, the words “increasingly important public health matter” should be deleted from the thirteenth preambular paragraph. In the modern era all States had to address migration, and the words “facing the challenges of migration” should therefore be deleted from the fourteenth preambular paragraph, as should the word “increasing”. The fifteenth preambular paragraph should be amended to read: “Noting that health policies should consider the specific needs of men and women”. The words “and migration” should be deleted from the sixteenth preambular paragraph.

Paragraph 1(4) should be amended to read: “to better identify gaps in service delivery”. In paragraph 1(5), the word “generation” should be replaced by “sharing”. The word “professional” should be added after “providers,” in paragraph 1(7). The phrase “among countries of origin or return, transit and destination” should be deleted from paragraph 1(9). Paragraph 1(10) was redundant and should be deleted. The words “where appropriate” should be added at the end of paragraph 2(5), and in paragraph 2(6) the words “draw up guidance for filling the gaps in” should be replaced with “help collect and disseminate”. The words “among countries of origin or return, transit and destination” should be deleted from paragraph 2(7), and the words “with special emphasis on employment and social policies and those on cooperation and development” should be deleted from paragraph 2(8).

Dr DAHL-REGIS (Bahamas) said that, as the health of migrants was a complex issue, it would be preferable to consider the many amendments suggested by the United States in a drafting group.

Professor PEREIRA MIGUEL (Portugal) supported the convening of an informal drafting group.

Mrs VALLE ÁLVAREZ (alternate to Dr Hernández Ávila, Mexico) requested that the drafting group should meet at a time that would enable as many sponsors as possible to attend; interpretation should be provided.

The CHAIRMAN said that he took it that the Board wished to refer the draft resolution to an informal drafting group.

**It was so agreed.**

Ms DUKE (Australia)<sup>1</sup> noted that the World Migration Report 2005, published by the International Organization for Migration, had identified migrants' health as a critical issue for policy-makers. Most countries were simultaneously countries of origin, transit and destination. About half Australia's population had either been born overseas or had at least one parent born overseas; some 5% of its population migrated. Her country's migration programme served a wide array of migrants, from refugees fleeing persecution to highly-skilled professionals. Their needs were considered in the assessment of overall health needs. Legal migrants had the same access as Australian citizens to primary health care, subsidized medication, and acute care through public hospitals.

It was important to avoid generalizations about migrants and their health issues, since needs would vary in different contexts and countries, and entitlements to public-health systems might depend upon the nature and period of the migrant's stay. The discussion required a more specific definition of the term "migrants", the contextualization of health-care needs and the identification of challenges involved. She agreed with the member for the United States that such definition issues should be considered in preparing further documentation for the Health Assembly. Health assessments for prospective migrants should not be seen as a challenge to basic human rights. In many countries, such health assessments did not necessarily preclude entry for those with health problems; their purpose was to minimize public health and safety risks. In Australia, the assessments enabled many migrants with medical problems entering for humanitarian reasons to be provided immediate medical support. She requested clarification of "securing equitable access to health services for migrants" in paragraph 17 of the report. Specifically, to what categories of health services and migrants did it refer? It would also be useful to identify underlying policy objectives.

She supported the draft resolution with improved wording. The reference to "countries of origin, transit and destination" was not specific, and the meaning of the term "migrant" should be clarified. Referring to the ninth preambular paragraph, she pointed out that not all people on the move experienced increased health risks.

Dr SOPIDA CHAVANICHKUL (Thailand)<sup>1</sup> said that, as migrants often faced health problems and also socioeconomic and employment constraints, improving their health did not lie with the health sector alone. The capacity of each Member State to deal with migrants' health should also be taken into account. He endorsed the views expressed by the member for Japan regarding the focus on health of migrants in the workplace, and on primary health care and health promotion.

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

Ms WISEMAN (Canada)<sup>1</sup> strongly supported WHO's efforts to raise the profile of migrant health on the international agenda. However, the broad definition of the term "migrants" in the report did not differentiate access to health care for various subgroups of migrants and their health needs, or the locus of responsibility for the provision of health care. The definition should be clarified. She shared the concerns raised regarding paragraph 13 and some assumptions made in the report, such as the association of elevated health risks with all migrants. Canadian research had shown that immigrants were, on average, healthier than the populations in both their countries of origin and destination. Future work on health and migration should focus more on the definition of issues and links to WHO's existing initiatives. The need for WHO to collaborate with other international organizations should be reflected in the report. Canada looked forward to participating in the discussions on the draft resolution in the informal drafting group.

Dr ANTEZÁNA ARANÍBAR (Bolivia)<sup>1</sup> said that migration required a multisectoral and integrated approach at country level. Migratory flows had changed over time. Reasons for migration included poverty, the political situation and "brain-drain". Regulations were needed in order to enable developing countries to retain skilled professionals and foster development.

Migrants should not be penalized for having to abandon their country in order to escape harsh living conditions. They should have access to a full range of health services, not just emergency care. Their mental health should also be given due consideration. He supported the draft resolution, with some of the amendments suggested. The contribution by the United States was useful, and he looked forward to seeing the proposed changes in writing.

Mgr TOMASI (Holy See), speaking at the invitation of the CHAIRMAN, said that organizations worldwide sponsored by the Catholic Church offered migrants, refugees and displaced persons health care, material and legal assistance, emotional and spiritual support. The Holy See could thus observe at first hand migrants' particular vulnerability to disease and their inequitable access to preventive and curative health services. It welcomed the report's public-health approach to migrants' health, its attention to their vulnerability to occupational health hazards and preserving the integrity of migrant families. Pope Benedict XVI had remarked that, if immigrant families were not assured of real prospects of inclusion and participation, they could hardly be expected to develop harmoniously. WHO should accordingly recognize the integrity of the migrant family as a basic public health principle.

Ms WEEKERS (International Organization for Migration) said that events such as the High-level Dialogue on International Migration and Development held in September 2006 by the United Nations General Assembly attested to the recognition of migration issues and their management as key challenges for governments and agencies. Her organization promoted the physical, mental and social well-being of all types of migrants and advocated health policies and practices that encompassed all members of communities. Migration was an unstoppable process and also served to mitigate chronic population decline and labour shortages in many industrialized nations.

Addressing migrants' well-being was of long-term benefit to societies, contributing to stability and enhancing development. Conversely, discrimination, xenophobia and marginalization were exacerbated when host societies perceived migrants as vectors of disease. Her organization would continue its collaboration with WHO with a view to improving the health of migrants, along the lines of the strategies laid out in the report and highlighted in the draft resolution.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN and also on behalf of FDI World Dental Federation, the International Pharmaceutical Federation and The World Medical Association, Inc., said that the World Health Professions Alliance

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

that they formed expressed the collective views of more than 25 million health professionals. Migrants often responded to precarious living and working conditions and traumatic experiences through a combination of stress and other symptoms that needed adequate treatment by health professionals. Their legal status was an important health determinant, especially for undocumented migrants, who faced additional barriers to access to health care. In some countries, health professionals were encouraged or even compelled to furnish the authorities with personal details of such migrants or to denounce them, thereby blatantly violating the principle of patient confidentiality. Children of undocumented migrants could start life at a disadvantage and face exclusion from access to health services such as immunization, and from schooling.

Migrant health professionals often experienced discrimination in the form of low pay, job insecurity, menial assignments and heavy workloads. The organizations for which he spoke advocated a code of ethical recruitment and equal opportunity. Almost half all migrants worldwide were women, often exposed to gender-based violence and other abuse owing to their precarious status, and encountered difficulties in accessing sexual and reproductive health-care services. Countries should develop human rights assessments, incorporating a gender perspective, in order to take account of the right of all migrants to the highest attainable standard of health, regardless of their legal and social status.

Dr ALWAN (Assistant Director-General) thanked speakers for their valuable comments especially on terminology, the need for better definitions, distinctions between the various types of migrants and review of available data. Those comments would be taken into account in revising the report and the issues raised regarding the draft resolution would be discussed during the meeting of the informal drafting group.

The CHAIRMAN took it that the Board wished to take note of the report on health of migrants, on the understanding that the informal drafting group would attempt to prepare a revised version of the relevant draft resolution for the Board's consideration.

**It was so agreed.**

(For adoption of the resolution, see summary record of the seventh meeting, section 1.)

**Health technologies:** Item 4.10 of the Agenda (Document EB122/13)

Professor SALANIPONI (Malawi), speaking on behalf of the Member States of the African Region, asked why the Secretariat's report focused specifically on medical devices, thereby failing to put forward a strategy for primary health care reflecting the scope of health technologies as defined in paragraph 2 of the document. The term "health technologies" did not just encompass medicines, vaccines and medical devices but also the delivery of health services. Despite progress with blood safety and diagnostic imaging, essential health technologies were one of the weakest components of health systems in the African Region. In 1999 a health technology strategy for the African Region had been formulated.<sup>1</sup> Blood safety policies had been developed in 42 of the 46 countries of the Region, emphasizing quality management; recruitment of blood donors and screening for transmissible infections in blood transfusions had been improved; a regional network for public health and clinical laboratories had been established; and studies on incidents in public hospitals and the private sector had been launched. Five countries of the Region were implementing national policies for the management of health technology. The main challenges faced were the multiplicity of trademarks of health and medical devices; lack of coordination among the many stakeholders in the field; cost and lack of equipment; lack of laboratory policies; low awareness among health authorities of the potential

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<sup>1</sup> Document AFR/RC49/12.

benefits of telematics; slow implementation of national policies on blood safety; blood shortages; and inadequate transfusion services. The Secretariat should work with Member States to design an appropriate health technology package for primary health care in the African Region.

Dr JAKSONS (Latvia) said that the report clearly explained what the Secretariat was doing in response to actions requested in resolution WHA60.29. At the Board's 121st session, agreement had been reached on the list of essential technologies. The Secretariat had proposed mechanisms, analytical tools and technical standards, but they would have to respond to different systems and levels of care, and address cost effectiveness and capacities and would therefore require a multidimensional approach and the involvement of experts. Data sets and appropriate guidelines would be needed for the next session of the Board. A timetable should be set to allow Member States to provide input.

Dr SINGAY (Bhutan) said that the Member States of the South-East Asia Region welcomed the Secretariat's support in choosing and making adequate use of medical technologies. Activities would include prequalification of priority medical devices and management of information on technologies.

The Member States of the Region had been assessing their needs for medical technologies, in particular, medical devices, in terms of effectiveness, quality, safety, cost, rational use, availability, access at all levels of health systems and ensuring the sustainability of operations. Effective management and strong regulatory support would ensure compliance with established standards. Establishing national institutes for health technologies and partnerships between governments, health care providers, industries, patient associations and scientific and technical organizations would optimize use of those devices.

Ms VELÁZQUEZ BERUMEN (alternate to Dr Hernández Ávila, Mexico) requested that all references to health technologies other than medical devices should be removed from the report, as resolution WHA60.29 referred specifically to those technologies. Furthermore, in paragraph 3, the wording from "on blood transfusion medicine" to the end of the paragraph should be deleted; only organizations specifically concerned with medical devices should be mentioned; and only they should serve on expert committees to set standards. Paragraph 4 should specify that assessments of needs for medical devices should be based on epidemiological data on morbidity and mortality. In paragraph 5, the reference to "the traceability of health products ... and organs for transplantation" should be replaced by a reference to harmonization of technovigilance and nomenclature systems. Paragraph 6 should include reference to the wide diversity of tools that had been developed by both the Secretariat and Member States. Nongovernmental organizations and experts in the use of medical devices were prepared to participate in the implementation of resolution WHA60.29, and to help in formulating policies.

Dr REN Minghui (alternate to Mr Li Baodong, China) said that overuse or inadequate use of medical devices affected the operation of health systems. China had assessed the use of medical devices and had standards for acquiring them. In collaboration with the Secretariat, the Ministry of Health was collecting information on the quality, safety and effectiveness of health technologies, as a basis for national policy and setting up monitoring systems. Furthermore, guidance on the use of such technologies was being provided at the grass-roots level. His country supported the establishment of collaborating centres in Member States to develop standards for assessing and monitoring medical devices. Guidance should also be given on the planning and use of high-technology products.

Dr AHMADZAI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that challenges to health technology in the Region related to regulations, access monitoring, management and maintenance. The Regional Committee, in resolution EM/RC53/R.7, had called upon Member States to collect and update information, formulate plans and establish centres for assessing, selecting and managing medical devices. WHO should provide guidelines in order to determine which technologies were needed at various levels of health care and promote the establishment of centres of excellence.

Professor SOHN Myongsei (Republic of Korea), noting that the term “health technologies” covered a range of issues and that standard setting was one of WHO’s core functions, said that the term should also encompass certain forms of complementary, alternative or traditional medicine. In many Member States, such forms of medicine provided health services compatible with the spirit of primary health care. Therefore, norms, standards and guidelines for those types of medicine should not be neglected.

Dr JEAN LOUIS (Madagascar) presented his country’s five-year plan for ensuring health services for all, its current situation and objectives, strategies and priorities set forth in the plan.

Dr WRIGHT (United States of America) agreed with the remarks of the member for Mexico with respect to the scope of medical technology. Use of safe, high-quality health technology could make a decisive contribution. The quality, safety and efficacy of health technologies required good manufacturing and regulatory practices, which Member States should set up with the support of the Secretariat. The report presented a mix of activities and concepts from several WHO programmes that fell outside the scope of resolution WHA60.29; he requested a concise but complete explanation of how the Director-General planned to implement that resolution.

Dr ALCÁZAR (Brazil)<sup>1</sup> expressed surprise that the report only mentioned “health technologies” in the abstract, without considering the concept of public health. In the same way, the definition in paragraph 2 was only *a* definition; it was not *the* definition. If the report was to be of use when considered by the Health Assembly, it should focus on public health.

Dr ANTEZANA ARANÍBAR (Bolivia),<sup>1</sup> endorsing the comments of the previous speaker, said that the technology that had been described as “appropriate” in 1978, at the time of the Alma-Ata International Conference on Primary Health Care, had evolved subsequently. He distinguished between priorities for public health and those for health care in general, as medical technology was costly and often unavailable to whole populations.

Dr NORDSTRÖM (Assistant Director-General) said that, although the report focused on medical devices, effective use of health technologies was also important in primary health care. The emphasis, as requested in resolution WHA60.29, was on medical devices. He noted the comments made by the member for Malawi. In response to the comments of the member for Latvia, he suggested that the WHO web site should be used to communicate developments, share guidelines, report on technical support to countries and describe the results of monitoring. In response to the member for Mexico, he said that the list of partners in paragraph 3 of the document was not exhaustive; the best possible expertise and most relevant stakeholders would be sought. He thanked the members for Afghanistan, Bhutan, China and Madagascar for sharing their experiences with the Board; the Secretariat would make the best possible use of that information.

**The Board noted the report.**

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

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



## 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)<sup>1</sup> 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)<sup>1</sup> 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.

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<sup>1</sup> 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*,<sup>1</sup> 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

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<sup>1</sup> *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)<sup>1</sup> 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

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<sup>1</sup> 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 FISKER (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.**

## **SEVENTH MEETING**

**Thursday, 24 January 2008, at 09:10**

**Chairman:** Dr B. SADASIVAN (Singapore)

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

**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) (continued from the fifth meeting)

Mr HOHMAN (alternate to Dr Wright, United States of America) recalled that he had asked for clarification during the discussion of the proposed amendments to the resolution on the implementation of the International Health Regulations (2005), adopted as resolution EB122.R3, and had been assured that the choice before the Board was between only the amendment to the original paragraph proposed by Paraguay and the alternative paragraph proposed by China, which therefore did not concern the original paragraph. He had therefore understood that, as a result of the previous day's vote on the amendments proposed to paragraph 1, there would be two paragraphs in the final text: the original paragraph 1 without the amendment proposed by Paraguay, reaffirming commitment to the "timely and effective" implementation of the International Health Regulations (2005), followed by the new paragraph proposed by China. That not being the case, he sought an explanation.

The CHAIRMAN, after consulting the Legal Counsel, said that, because China and Paraguay had proposed competing amendments to the same paragraph, accepting one amendment meant automatically excluding the other. Following a request for the proposed amendments to be presented in writing, the document discussed the previous day had shown both proposed amendments as alternatives, as they would appear in the resolution.

On occasion, he would have to seek a legal opinion and share it with members of the Board. Legal language was complex, and different interpretations could lead to misunderstandings. Unless otherwise advised by the members of the Board, he would follow and diligently apply the legal advice given.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that he would not press the matter further, but suggested that the legal advice given the previous day had been misleading. There would be another opportunity to deal with the resolution at the Health Assembly.

Mr BURCI (Legal Counsel) said that he regretted any misunderstanding over the amendments voted on, but confirmed that there had been two competing amendments to paragraph 1, which had been presented according to normal procedure: one after the other, with "or" between them. Voting to accept the proposal of China meant that the alternative proposal had lapsed and did not require a vote. It also meant that the original paragraph was replaced by the amendment adopted by the Board.

The CHAIRMAN asked whether, in the light of that clarification, the member for the United States would have voted any differently.

Mr HOHMAN (alternate to Dr Wright, United States of America) replied that his vote would not have been affected.

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

Dr REN Minghui (alternate to Mr Li Baodong, China) welcomed the efforts made by WHO since 2004 to implement resolutions WHA57.19 and WHA58.17 with a view to mitigating the impact of the international migration of health personnel on developing countries' health systems. Between 1978 and 2003, only 23.3% of medical students who had left China, mainly for developed countries, had returned after completing their studies. As a result, the Chinese health system was seriously understaffed. Appealing to WHO to raise awareness on the issue, he said that too little had been done so far. Drawing up a global code of practice, with consensus, would be useful. International awareness and dialogue should be increased by promoting cooperation between low- and high-income countries.

Mr DE SILVA (Sri Lanka) said that, although the migration of health personnel could benefit countries both of origin and of destination, it was a challenge for countries with an acute shortage of personnel and fragile health systems. He supported the Secretariat's response to resolution WHA57.19 through a global code of practice on the international recruitment of health personnel and working with the Global Health Workforce Alliance to set up a consultation process with Member States. Developing countries had become a nursery for health-care professionals in the developed world. Education was free in Sri Lanka, but, once trained, few of the best health-care professionals remained in the country. Developed countries should devise a system to ensure that health-care professionals served their own countries for at least a few years. A code of practice alone would not improve the situation since greater awareness was needed. Developing countries would be unable to meet the Millennium Development Goals without the necessary health-care professionals.

Dr VOLJČ (Slovenia) said that he was speaking on behalf of the European Union, the European Free Trade Association countries Iceland and Norway, members of the European Economic Area, and Switzerland. The candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process, and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Ukraine, Armenia, Georgia and the Republic of Moldova, aligned themselves with his statement.

International migration of health personnel had increased significantly since the Health Assembly's consideration of the issue in 2004, resulting in a loss of human resources for countries of origin, often developing countries. That affected both the development of those countries and the quality of their national health systems. Countries of origin should invest in policies to improve working conditions, and recipient countries should reconsider their training strategies. If migrating health personnel returned to their country of origin, they could benefit themselves and their national health systems. The European Union recognized the need for comprehensive strategies in order to mitigate the adverse effects of the migration of health personnel. The Secretariat should emphasize improved statistics and information for decision-making and provide support to Member States by collating best practices. Improved health workforce planning required a global approach based on greater cooperation between key stakeholders. The Secretariat should report on the impact of the recently adopted ethical codes of practice, which was mentioned in its report to the Health Assembly in May. On that basis, WHO should prioritize elaboration of a global code of practice on the international recruitment of health personnel in order to strengthen national health systems in countries both of origin and of destination.

Dr SUGIURA (alternate to Dr Shinozaki, Japan) recognized the complexity of the issues, which involved political, economic, labour and educational aspects and depended on both national and individual decisions. The four-pillar approach developed by WHO and its cooperation with ILO and the International Organization for Migration were appreciated. There was a need for transparent coordination between countries, based on regional or global codes of practice, and prompt establishment of those codes. Collaboration between Member States and the Secretariat in collection

of data on migration of health personnel was essential. Member States must be committed to retaining their own health professionals and to empowering them through training and education.

Mr FISKER (Denmark) welcomed the information on initiatives provided in the report. Migration was provoked by a combination of “push” and “pull” factors and, despite its negative effects, its benefits should not be neglected, notably the experience acquired by migrants and the money they sent home while working abroad. He distinguished between health personnel migration and active recruitment abroad. An individual’s education should be no bar to the freedom to live and work anywhere. Given the acute shortage of health-care providers in a number of countries, however, WHO’s efforts to evolve principles for a global code of practice were appreciated.

Dr DAHL-REGIS (Bahamas) noted with appreciation the follow-up to resolution WHA57.19. She supported efforts to develop the global code of practice and requested all relevant documents, including the Commonwealth Code of Practice for the International Recruitment of Health Workers, to be considered. The problem was marked in the Caribbean and she wished to know how her country could participate in regional efforts. She asked whether a health workforce observatory had been established in her region and whether it would provide information on destination of migration and patterns of migration to and from her country.

Mr MIGUIL (Djibouti) said that the issue under consideration had been debated at the First Global Conference on Task Shifting (Addis Ababa, 8–10 January 2008). It was essential to move away from a bureaucratic approach and implement effective policies and a global code of practice. Developed countries had failed in their own training policies and were resorting to an arsenal of measures in order to recruit qualified health personnel from developing countries, at the expense of the latter’s health-care training systems and quality of health care. Time and investment devoted to training was thus wasted to the detriment of national health policies and action plans.

Migration of health personnel clearly harmed the developing world, assisted by the selective immigration policies practised by OECD countries. His Government called for an immediate end to such policies and suggested some form of financial, technical and material compensation. The discriminatory policies applied in some countries should be ended, as the same salaries and working conditions should apply to both migrant health personnel and nationals. He urged the Board to take an unequivocal position that would contribute to socioeconomic policies of the developing countries, and rapidly produce a global code of practice.

Dr ABABII (Republic of Moldova) said that half his country’s health personnel had been lost to migration in the preceding 10 years, jeopardizing the country’s ability to meet the relevant Millennium Development Goals. A unified database was needed to provide reliable information on migrating health personnel. Steps had been taken and budgeted for in Moldova in order to train health personnel. Incentives had also been introduced for young specialists to work in rural areas, and to retain highly qualified personnel. In the face of disappointing results, however, his Government had consulted developed countries to which its specialists were migrating, asking them to monitor immigration flows and observe equitable principles of international recruitment. Otherwise, compensation should be provided in respect of the training of specialists.

Developed and developing countries must work together. A global code of practice and other international cooperation agreements were vital. The statements made by previous speakers reflected the importance of the issue to the health community and the specific measures needed.

Ms KENNELLY (alternate to Dr Wright, United States of America) expressed appreciation of WHO’s work on migration of health personnel and looked forward to further research. International cooperation would be needed to find sustainable solutions to overcome shortages of health personnel, a serious concern for developing countries. Migration was influenced by various “push” and “pull” factors. The Secretariat could not cover all these, but it could support the development of national capacities to analyse and estimate human resource needs; expand local training and career



development opportunities; identify activities related to recruitment and retention of health personnel; and encourage national policies that broadened the tasks undertaken by different categories of health worker.

The United States of America was working with WHO in Ethiopia, Haiti, Malawi, Namibia, Rwanda, Uganda and Zambia through the President's Emergency Plan for AIDS Relief in order to assess clinical practice, regulatory frameworks and certification mechanisms for the realignment of tasks. In 2006, it had provided US\$ 350 million for workforce and health system development.

The Secretariat's report required some revision before submission to the Health Assembly. For example, it might include discussion of South-South migration of health workers. Further, paragraph 7 referred to OECD statistics on foreign-born workforces that included North-North migration, for example between Canada and the United States of America, which might therefore be of limited use. The report might also usefully include a balanced discussion on the benefits of migration and a reference to the right of individuals to leave their country of origin. Migration of health workers posed challenges and ethical dilemmas that distinguished it from other categories of migration. However, individuals should not be denied the right to migrate because of their chosen profession. Moreover, migration was not the primary source of shortages of health workers. Since movement of health workers could not be blocked realistically, governments, the private sector and other interested parties must concentrate on strengthening human resources in all countries.

Consultation with Member States on the proposed global code of practice for the recruitment of health personnel was essential and should take into account the wide range of health care and immigration systems. She could not agree that codes of practice for the ethical recruitment of health workers carried the weight of "soft law" as asserted in paragraph 16 of the report. A WHO code would be non-binding and would therefore not be a law of any type. Moreover, it would not "manage" migration, as mentioned in paragraph 15. Nevertheless, codes of practice could prove useful as voluntary guidelines for interested countries, particularly as fair labour practices. WHO should also encourage voluntary public-private partnerships to further strengthen health resources in developing countries. Developing countries should be encouraged to consider mechanisms to ensure that individuals trained at public expense repaid the cost of that training financially or through public service. A WHO code must not lead to discrimination against the hiring of health personnel from certain developing countries, especially those of Africa. WHO should advocate equal opportunity policies.

She requested further information on the funding of the Global Health Workers Alliance and the budgetary implications of its activities, since her delegation's questions in that regard at the Fifty-ninth World Health Assembly had not been answered.

Ms WISEMAN (Canada)<sup>1</sup> observed that there was a global shortage of health workers and their international migration posed a number of ethical concerns. A multifaceted approach was needed, which should include increased training, improved recruitment practices, and measures to retain health personnel. Canada supported WHO's efforts to improve the collection and sharing of information and frame policies for health workforce development through collaboration. Member States should develop a global code of practice for the recruitment of health personnel. Canada requested information on the proposed schedule for the guiding principles and the code.

Mr ALCÁZAR (Brazil),<sup>1</sup> endorsing the comments made by the members for Djibouti and Iraq, agreed that migration of health personnel was of particular importance for developing countries. He expressed deep disappointment at the attitude taken by the member for the United States of America. The report did not really suggest a way forward; although a global code would be useful, what was needed was a global strategy for elaborating policies, in particular to tackle the "push" factors driving

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

migration. He therefore proposed that the Secretariat should be requested to draft a global strategy for consideration at the Sixty-first World Health Assembly.

Mr DEL PICÓ (Chile)<sup>1</sup> supported further studies with technical and financial support from WHO. Information on migration of health workers should be included in national databases. WHO should consider policies regarding migration of health personnel in conjunction with its human resources policies. Member States should establish teams to monitor and analyse migration flows, to include a gender focus and devise appropriate policies.

Mgr TOMASI (Holy See), speaking at the invitation of the CHAIRMAN, welcomed the attention to better information on health worker migration and developing policy responses with a global code of practice. The Secretariat and Member States should intensify their analysis of migration flows and devise mechanisms to prevent exacerbation. Health-care workers often cited poor working conditions, low pay and inadequate clinical infrastructures as reasons for migrating. Staff in health-care facilities sponsored by religious organizations provided a substantial proportion of care in developing countries, often reaching vulnerable populations, yet they often earned less than those working in government facilities. WHO should promote the improvement of working conditions, levels of pay and access to in-service training for health workers in low-income countries. Such actions would advance progress towards Millennium Development Goals and renew emphasis on human dignity and the common good.

Ms THORSON (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN and on behalf of professional organizations in the fields of dentistry, nursing, pharmacy and medicine that were members of the World Health Professions Alliance, welcomed the progress made since the Health Assembly's first discussion of the migration of health personnel in 2004. The WHO-administered Global Health Workforce Alliance had grown into an effective body that was driving global action.

She supported the four main areas for action mentioned in the report. However, despite progress, health personnel migration had not yet changed significantly. She emphasized national action on international guidelines, policies and codes and sharing best practices. Migration was a symptom of dysfunctional health systems in sending and receiving countries. Focusing on migration alone would not be enough. The Secretariat, Member States and other stakeholders must strengthen health infrastructures and training capacities. The goal should be self-sufficiency in health human resources.

She drew attention to the Global Forum on Human Resources for Health to be held in Kampala in March 2008, and called on WHO and other interested parties to participate and encourage the retention of skilled health personnel by their countries of origin.

Dr NORDSTRÖM (Assistant Director-General) thanked speakers for their comments. The Secretariat had intensified efforts regarding migration, planning and management, and gathering and sharing of data on human resources for health. It had also established regional observatories to gather data and collaborate with countries, and he would provide the member for the Bahamas with information on the observatory in Latin America. WHO had been working closely with OECD, and the migration data available were improving and provided information on South-South, North-North and South-North migration flows. WHO was also active in the area of training and much had been learnt from the implementation of the memorandum of understanding on migration of health personnel between South Africa and the United Kingdom of Great Britain and Northern Ireland. Its success had been partly due to increased training of health personnel in the latter. Retention of skilled personnel was linked with conditions of service, socioeconomic conditions and the management of the public

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

and private health sectors. Migration could not be treated in isolation and WHO was therefore establishing partnerships with such key stakeholders as Brazil, Canada, the Global Health Workforce Alliance, and the United States President's Emergency Plan for AIDS Relief, and was focusing on action at the country level. The Alliance was included in WHO's Programme budget and funded through voluntary contributions from Norway, the United Kingdom and the Bill & Melinda Gates Foundation.

*The world health report 2006*<sup>1</sup> had raised awareness of the crisis in human resources for health. The Global Forum on Human Resources for Health in March 2008 would review and propose policies and strategies to improve the situation. There were both benefits and drawbacks of migration but the right to migrate and ethical recruitment practices were important principles to be observed.

The Secretariat had already undertaken some analyses of current migration flows and experiences with existing measures. If the Board wished the Sixty-first World Health Assembly to consider the matter, it would need to request inclusion of the item during its discussion of item 6.7 of its agenda. The Secretariat was suggesting that consultations with Member States on developing a global code of practice for the recruitment of health personnel should begin in early 2008 and that a draft code should be submitted to the Board at its 124th session in January 2009 and then, should the Board approve it, to the Sixty-second World Health Assembly in May 2009.

Professor SALANIPONI (Malawi) said that he had heard mention of both benefits and drawbacks of the migration of health personnel. As far as the countries of Africa were concerned, there were nothing but drawbacks.

**The Board noted the report.**

**Health of migrants:** Item 4.8 of the Agenda (Document EB122/11) (continued from the fifth meeting)

The CHAIRMAN drew attention to a revised draft resolution on the health of migrants, proposed by a working group, together with its financial and administrative implications, which read:

The Executive Board,  
Having considered the report on health of migrants,<sup>2</sup>

RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,  
Having considered the report on health of migrants;  
Recalling the United Nations General Assembly resolution 58/208 underlining the need for a high-level dialogue ~~on to discuss~~ the multidimensional aspects of international migration and development (New York, 23 December 2003);  
Recalling the first plenary session of the United Nations General Assembly on migration issues and the conclusions of the High-Level Dialogue on Migration and Development (New York, 14–15 September 2006) with their focus on ways to maximize the development benefits of migration and to minimize its negative impacts;

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

<sup>2</sup> Document EB122/11.

**Recognizing that the revised International Health Regulations (2005) include provisions relating to international passenger transport;**

Recalling resolutions WHA57.19 and WHA58.17 on International migration of health personnel: a challenge for health systems in developing countries, calling for support to the strengthening of health systems, in particular human resources for health;

~~Cognizant of the Bratislava Declaration on Health, Human Rights and Migration issued at the 8th Conference of European Health Ministers (Bratislava, 23 November 2007), which recognized that well-managed health measures for migrants, including public health measures, promote the well-being of all and can facilitate the integration and participation of migrants within the host countries;~~

~~Taking note of the Conclusions on Health and Migration in the European Union, adopted by the Council of the European Union (Brussels, 6 December 2007), which welcomed the approach to migrants' health as a powerful determinant of integration, intercultural dialogue, social cohesion, and sustainable development;~~

Recognizing the need for WHO **to consider the health needs of migrants in the framework** ~~WHO to tackle the issues of health and migration as a critical part of the broader agenda on migration and development;~~

Recognizing that health outcomes **can be** ~~are~~ influenced by the multiple dimensions of migration;

Noting that some groups of migrants experience ~~people on the move may experience~~ increased health risks;

Recognizing **the need for additional data on** migrant's health and **their** access to health **care** ~~scarcity of information specific to migrants' health status and access to health services and the consequences thereof to health systems to substantiate evidence based policies for health systems;~~

~~Noting that the existence of economic, political, social and environmental determinants of migrants' health underlines Taking into account the need to address determinants of migrants' health and the need to develop intersectoral public policies that can influence both the migration process and its health consequences to address health determinants and protect their migrants' health. of migrants for the health of migrants~~

**Taking into account the determinants of migrants' health in developing intersectoral policies to protect their health;**

Mindful of the ~~need for promoting mechanisms~~ **role of health in promoting social inclusion** ~~of social protection in health that can constitute instruments of inclusiveness for migrants;~~

Acknowledging that the health of migrants is an ~~increasingly~~ important public health matter both for Member States and for the work of the Secretariat;

Noting that Member States ~~facing the challenges of migration have an increasing~~ need to formulate and implement strategies for improving the health of migrants;

Noting that **policies addressing migrants' health should be sensitive** to the specific **health** ~~and migration policies should have to consider gender aspects and the specific~~ needs of women, men **and children;**

Recognizing that health ~~and migration~~ policies can contribute to development and to achievement of the Millennium Development Goals,

1. CALLS UPON Member States:

- (1) to promote migrant-sensitive health policies;
- (2) to promote equitable access to health **promotion** ~~protection~~ and care for migrants, subject to national laws and practice, and devise mechanisms for enhancing the health ~~social protection in health~~ for of migrants;

- (3) to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;
- (4) to ~~meet migrants' health needs better by identifying the gaps in service delivery~~ **in order to improve the health of all populations, including migrants;**
- (5) ~~to document best practices for meeting migrants' health needs in countries of origin or return, transit and destination, and to encourage generation sharing of information on health issues arising from migration;~~
- (5) **to gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination; throughout the entire migration process, and to encourage gathering of information on health issues arising from migration.**
- (6) ~~to develop and promote the sharing of data on migrants' health and knowledge of the effectiveness of interventions to improve migrants' health;~~
- (7) to raise health service providers' and **professionals'** cultural and gender sensitivity to migrants' health issues;
- (8) to train health professionals to deal with the health issues associated with population movements;
- (9) to promote bilateral and multilateral ~~international~~ cooperation on migrants' health among countries involved in the whole migratory process;
- (10) ~~to promote the strengthening of health systems in developing countries the countries of origin, as appropriate, within cooperation and development programmes, in order to prevent disease and ill health;~~
- (11) to contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium Development Goals;

2. REQUESTS the Director-General:

- (1) to promote migrants' health on the international health agenda **in collaboration with other relevant international organizations;**
- (2) to explore policy options and approaches for improving the health of migrants;
- (3) to analyse the major challenges to health associated with migration;
- (4) to support the development of regional and national assessments of migrants' health status and access to health care;
- (5) to promote the inclusion of migrants' health in the development of regional and national health strategies **where appropriate;**
- (6) **to help collect and disseminate** ~~draw up guidance for filling the gaps in data on migrants' health and to document Member States' best practices and lessons learnt in dealing with migrants' health issues;~~
- (7) to promote dialogue and cooperation on migrants' health among **all Member States involved in the migratory process,** ~~among countries of origin or return, transit and destination,~~ within the framework of the implementation of their health strategies;
- (8) ~~to give consideration to the health of migrants in the light of the health in all policies approach, with special emphasis on employment and social policies and those on cooperation and development;~~
- (9) to promote interagency, interregional and international cooperation on migrants' health with an emphasis on developing partnerships with other organizations **and considering the impact of other policies;**
- (10) to encourage the exchange of information through a technical network of collaborating centres, academic institutions and other key partners in order to

further research into migrants' health and to enhance capacity for technical cooperation;

(11) to submit to the Sixty-third World Health Assembly, through the Executive Board, a report on the implementation of this resolution.

<b>1. Resolution</b> Health of migrants
<b>2. Linkage to programme budget</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> Strategic objective:   5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact. </div> <div style="width: 45%;"> Organization-wide expected result:   3. Norms and standards developed, capacity built and technical support provided to Member States for assessing needs and for planning and implementing interventions during the transition and recovery phases of conflicts and disasters. </div> </div> <p style="text-align: center;"><b>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</b></p> <p>WHO's activities in support of the health of migrants have links with strategic objectives 7, 8 and 10.</p>
<b>3. Financial implications</b>  <p><b>(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)</b>  US\$ 2 400 000 over a period of four years.</p> <p><b>(b) Estimated cost for the current biennium (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)</b>  US\$ 1 200 000 at global, regional and country levels.</p> <p><b>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the current biennium? US\$ 586 000.</b></p> <p><b>(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)</b>  Costs will be met through income from voluntary contributions aimed at supporting work in this field.</p>
<b>4. Administrative implications</b>  <p><b>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)</b>  Headquarters, regional offices and, in the African and Eastern Mediterranean regions, country offices in countries facing major challenges as a result of AFRO and EMRO migration.</p> <p><b>(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)</b>  Three experts in public health and migration: one at headquarters and two based in the African and Eastern Mediterranean regions, where migration and its consequences for health are having the greatest impact.</p> <p><b>(c) Time frames (indicate broad time frames for implementation)</b>  Two of the public health experts will be recruited during the biennium 2008–2009, one at the global level and the other at the regional level. Technical cooperation activities will be performed over the next two bienniums. The second regional public health expert will be recruited during the biennium 2010–2011.</p>

In response to a request for clarification from Ms KENNELLY (alternate to Dr Wright, United States of America), Professor PEREIRA MIGUEL (Portugal) confirmed that the working group had agreed to use the wording “countries of origin or return, transit and destination” in paragraph 1(5). He added that the French version of paragraph 1(9) should be aligned with the English text.

Mr TINAJERO (alternate to Dr Hernández Ávila, Mexico) reiterated the importance that his country attached to ensuring migrants’ right to health. He thanked Portugal for taking the lead on the issue, and expressed support for the draft resolution.

Ms KENNELLY (alternate to Dr Wright, United States of America) said that it was the view of her Government that countries had the right to differentiate medical benefits beyond emergency care on the basis of immigration status. That consideration had not been reflected in the report.

Dr KEAN (Executive Director, Office of the Director-General) assured the member for Portugal that the French version of paragraph 1(9) would be aligned with the English text.

**The resolution was adopted.<sup>1</sup>**

**Global immunization strategy:** Item 4.11 of the Agenda (Documents EB122/14 and EB122/14 Add.1) (continued from the sixth meeting)

The CHAIRMAN drew attention to a revised draft resolution on the global immunization strategy, incorporating amendments proposed by China, Denmark, Netherlands, New Zealand, Portugal, Republic of Korea and Tunisia, together with its financial and administrative implications, which read:

The Executive Board,  
Having considered the report on the global immunization strategy,<sup>2</sup>

RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:<sup>3</sup>

The Sixty-first World Health Assembly,  
Having considered the report on the global immunization strategy;  
Applauding the remarkable investments in human and financial resources made by Member States and partner agencies in support of vaccines and immunization as well as the launch of innovative financing mechanisms such as the International Finance Facility for Immunisation, and the advance market commitment for a pneumococcal conjugate vaccine through the GAVI Alliance;

Recalling resolution WHA56.20 on reducing global measles mortality, and commending Member States’ and their partners’ success in exceeding the goal of reducing deaths worldwide due to measles by 50% by the end of 2005 compared with the 1999 level;

Commending also Member States’ and their partners’ progress in increasing the availability, affordability and uptake of hepatitis B vaccine worldwide;

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<sup>1</sup> Resolution EB122.R5.

<sup>2</sup> Document EB122/14.

<sup>3</sup> See document EB122/14 Add.1 for the financial and administrative implications for the Secretariat of the resolution.

Encouraged by the progress in molecular biology and genetics that is accelerating the discovery and development of new vaccines and by the increasing number of developing-country manufacturers producing vaccines that meet WHO requirements for vaccines of assured quality;

Alarmed that many developing countries are not on track to meet the internationally agreed target in Millennium Development Goal 4 for reducing the under-five mortality rate;

**Concerned about the failure to make available necessary resources for introduction of new vaccines especially in the middle-income countries; [Tunisia]**

Stressing the vital role that vaccine and immunization programmes can play in reducing infant mortality and in facilitating the delivery of a package of life-saving interventions,

1. URGES Member States:

- (1) to implement fully the strategy for reducing measles mortality in order to achieve the goal set in the Global Immunization Vision and Strategy 2006–2015 of a 90% reduction in the global measles mortality rate between 2000 and 2010;
- (2) to enhance efforts to improve delivery of high-quality immunization services in order to achieve the target of equitable coverage of at least 80% in all districts by 2010 set in the Global Immunization Vision and Strategy 2006–2015;
- (3) to further expand access to, and coverage of, available **and cost-beneficial [Netherlands, seconded by Denmark and Portugal]** new life-saving vaccines of assured quality, **in accordance with national priorities, [New Zealand]** for all target populations in order to accelerate the achievement of Millennium Development Goal 4;
- (4) **to develop, strengthen and/or maintain surveillance systems for vaccine-related adverse events; [Republic of Korea]**

2. REQUESTS the Director-General:

- (1) to work with Member States to sustain political commitment at all levels for achieving high immunization coverage rates with all available vaccines **that have proven to have a positive cost-benefit balance for a particular (sub)population [Netherlands, seconded by Denmark and Portugal];**
- (2) to collaborate with international partners, including UNICEF and the GAVI Alliance, in order to continue to mobilize the financial resources required to achieve this objective and in order to ensure that all Member States have access to sufficient supplies of affordable vaccines of assured quality;
- (3) **to approach 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; [Tunisia]**
- (4) **to take measures, as appropriate, to help developing countries to establish and strengthen the capacity of vaccine research, development and production, with the aim of ensuring vaccine supplies, reducing vaccine prices and improving access to affordable vaccines; [China]**
- (5) **to provide guidelines and technical support to Member States for the minimization of vaccine-related adverse events; [Republic of Korea]**
- (36) to facilitate scientific, technical and financial investments into the research and development of safe and effective vaccines against poverty-related and neglected diseases;
- (47) to monitor progress towards achievement of global immunization goals and report on such progress to the Sixty-fourth World Health Assembly.



Mr HOHMAN (alternate to Dr Wright, United States of America) said that the seventh preambular paragraph, proposed by Tunisia, would be more succinct if it were amended to read: “Concerned there are insufficient resources for introduction of new vaccines, especially in low- and middle-income countries”.

Dr ABDESSELEM (Tunisia) said that he had no objection to that proposal.

Mr HOHMAN (alternate to Dr Wright, United States of America), referring to paragraph 1(3), suggested that “cost-beneficial” should be replaced with “cost-effective”.

The CHAIRMAN noted that there were no objections to that suggestion.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that the terms “particular (sub)population” and “cost-benefit balance” in paragraph 2(1) were not clear. Moreover, he was unsure whether the Director-General was in a position to determine which vaccines had proven to have a positive cost-benefit balance. He suggested that the text might be simplified by amending it to read: “to work with Member States to sustain political commitment at all levels for achieving high immunization coverage rates with all available cost-effective vaccines”.

Professor PEREIRA MIGUEL (Portugal) and Mr FISKE (Denmark) agreed to that wording.

Mr HOHMAN (alternate to Dr Wright, United States of America), referring to paragraph 2(3), wondered whether the Director-General would be in a position to ensure that all Member States had access to sufficient supplies of affordable vaccines of assured quality. He also had some concerns regarding paragraph 2(4), and would propose new wording to replace both paragraphs, to read: “to collaborate with international partners, donors, vaccine producers and other concerned parties to strengthen vaccine research, development and regulatory capacity in low- and middle-income countries, with the aim of increasing the supply of affordable vaccines of assured quality”.

Dr GWENIGALE (Liberia) pointed out that some middle-income countries would not qualify for funding from the GAVI Alliance, and required additional support in order to supply vaccines. That idea might not be conveyed if the words “to mobilize necessary resources in order to support” were deleted from paragraph 2(3).

Dr REN Minghui (alternate to Mr Li Baodong, China) said that he could not accept the amendment proposed by the member for the United States, which altered the emphasis of paragraph 2(4). The intent of that paragraph was to strengthen the vaccine research, development and production capabilities of developing countries, rather than the regulation of vaccines.

Dr ABDESSELEM (Tunisia) said that the amendment proposed by the member for the United States of America did not reflect two important elements of paragraph 2(3): the mobilization of necessary resources and access to sufficient supplies of vaccines.

Mr HOHMAN (alternate to Dr Wright, United States of America) noted that the new paragraph he had suggested referred to strengthening vaccine research and development as well as regulatory capacity. Regarding the concerns expressed by the members for Liberia and Tunisia, he pointed out that paragraph 2(2) referred to mobilization of financial resources. He suggested that the phrase “and in order to ensure that all Member States have access to sufficient supplies of affordable vaccines of assured quality” should be deleted from that paragraph, as he was unsure whether that was a feasible request to make of the Director-General.

The DIRECTOR-GENERAL said that there was duplication in the draft resolution since the issue of resource mobilization was addressed in paragraphs 2(2) and 2(3). While she would do her

utmost, she could not, in reality, ensure that all Member States had access to sufficient affordable vaccines.

The CHAIRMAN invited interested parties to consult informally with a view to formulating acceptable wording for paragraphs 2(2) to 2(4).

**It was so agreed.**

(For adoption of the resolution see section 3 below.)

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

**Appointment of the Regional Director for the Americas:** Item 7.1 of the Agenda (Document EB122/23)

Dr SINGAY (Bhutan), Rapporteur, read out the resolution on the appointment of the Regional Director for the Americas adopted by the Board in open session:<sup>1</sup>

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

1. APPOINTS Dr Mirta Roses Periago as Regional Director for the Americas as from 1 February 2008;
2. AUTHORIZES the Director-General to issue a contract to Dr Mirta Roses Periago for a period of five years as from 1 February 2008, subject to the provisions of the Staff Regulations and Staff Rules.

The CHAIRMAN congratulated Dr Roses Periago on her re-appointment and conveyed the Executive Board's best wishes for continuing success in her endeavours.

Dr ROSES PERIAGO (Regional Director for the Americas) thanked the Board and reaffirmed her commitment to the well-being of the peoples of the Region of the Americas. She accepted the appointment with humility, mindful of the values and principles that guided her in support of WHO's policies and the needs of the countries of the Americas served by PAHO. PAHO stood ready to tackle new and global public health challenges, through coordinated collective action. Preparing the countries of the Region was one of PAHO's main objectives. As health improved, inequities would be eliminated and resources freed to respond to emerging challenges such as climate change, population ageing and migration. WHO's six key objectives – promoting development; fostering health security; strengthening health systems; harnessing research, information and evidence; enhancing partnerships; and improving performance – were fundamental, as was the synergy between regional and global priorities.

She emphasized the thirtieth anniversary of the Alma-Ata conference, which had launched the WHO strategy for primary health care and the ambitious goal of health for all. That noble goal remained elusive, owing largely to social structures that perpetuated inequality and poverty. PAHO

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<sup>1</sup> Resolution EB122.R6.

was committed to the fight against inequity and social exclusion, and prioritized primary health. The Region was proud of the success of the International Conference on Health for Development: Rights, Facts and Realities, organized by Argentina with WHO and other partners.

There was great opportunity for solidarity and cooperation within the extended WHO family. For example, the European Region was launching an annual vaccination week modelled on Vaccination Week in the Americas, which was in its fifth year. Support and solidarity were exemplified by the “3 by 5” initiative on HIV/AIDS. The XVII International AIDS Conference would take place in Mexico City, the first time such a conference had been held in Latin America. She expressed appreciation for the backing not only of the Director-General and her fellow regional directors, but also of the extraordinary staff of the Regional Office. With the support of Member States and dedicated health workers, she would be able to meet the expectations of the peoples of the Americas, make the Millennium Development Goals a reality, for families and communities that were invisible to the rest of the world, and improve well-being and development of vulnerable populations.

The DIRECTOR-GENERAL recalled that when the Regional Director had taken office five years earlier, a central theme in her vision for better health in the Americas had been equity and the accountability of governments for the health of their citizens. She had prioritized strengthening of health services, and a primary health care approach as a means of fostering equity in attaining the health-related Millennium Development Goals. She had spoken of her humility. She had degrees in medicine, surgery and tropical medicine and public health, with an emphasis on infectious diseases and epidemiology. Her early work as a field epidemiologist had brought her face-to-face with suffering in many parts of Latin America, experiences that had shaped her leadership style. She defended the health interests of the poor and marginalized and insisted that “invisible” people be given a face and a voice, and the care they deserved. The people of the Americas were fortunate to have such a dedicated leader who sought fair and sustainable solutions through the primary health care approach. She looked forward to their close collaboration.

### **3. TECHNICAL AND HEALTH MATTERS (resumed)**

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

Mr HOHMAN (alternate to Dr Wright, United States of America) said that, following consultations with the members for China and Tunisia, informal agreement had been reached on the proposed amendments. In paragraph 2(2), the words “and in order to ensure that all Member States have access to sufficient supplies of affordable vaccines of assured quality” should be deleted. Paragraph 2(3) would read: “to collaborate with international partners and donors as well as vaccine producers to mobilize necessary resources to support low- and middle-income countries with the aim of increasing the supply of affordable vaccines of assured quality”. Paragraph 2(4) would read: “to take measures, as appropriate, to assist developing countries to establish and strengthen their capacity for vaccine research, development and regulation for the purpose of improving the output of vaccine production, with the aim of increasing the supply of affordable vaccines of assured quality”.

The CHAIRMAN said that he took it that the Board agreed with those proposals and with the amendment proposed by the member for the Republic of Korea to paragraph 2(5), which read: “to provide guidelines and technical support to Member States for the minimization of vaccine-related adverse events”.

**It was so agreed.**

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

**Monitoring of health-related Millennium Development Goals:** Item 4.14 of the Agenda (Documents EB122/33 and EB122/33 Add.1)

The CHAIRMAN, introducing the item, drew attention to a draft resolution on monitoring of the implementation of the health-related Millennium Development Goals, proposed by Slovenia and also sponsored by Austria, Belgium, Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Monaco, the Netherlands, Poland, Portugal, Romania, Slovakia, Spain, Sweden and the United Kingdom of Great Britain and Northern Ireland, together with its financial and administrative implications, which read:

The Executive Board,  
Having considered the report on monitoring of health-related Millennium Development Goals,<sup>2</sup>

RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,  
Having considered the report on monitoring of health-related Millennium Development Goals,

Recalling the 2005 World Summit Outcome and the commitments taken by the international community to implement fully the Millennium Development Goals;

Concerned by the lack of progress, especially in the sub-Saharan African countries, in the implementation of the Millennium Development Goals and, in particular, the health-related Goals 4, 5 and 6;

Recalling the General Assembly resolution 60/265 dated 12 July 2006 on follow-up to the development outcome of the 2005 World Summit, including the Millennium Development Goals and other internationally agreed development goals, and WHO's Medium-term strategic plan 2008–2013, particularly the objectives 2, 4, 7 and 12;

1. DECIDES to include regularly an item on the agenda of the Health Assembly on the monitoring of the implementation of the health-related Millennium Development Goals;
2. REQUESTS the Director-General:
  - (1) to identify major obstacles to the full implementation of the Millennium Development Goals and ways to overcome those obstacles;
  - (2) to that effect, to cooperate closely with all other United Nations and international organizations involved in the process of implementing the Millennium Development Goals;
  - (3) to submit annually a report on the status of the implementation of the health-related Millennium Development Goals, and in particular Goals 4, 5 and 6, through the Executive Board to the Health Assembly.

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<sup>1</sup> Resolution EB122.R7.

<sup>2</sup> Document EB122/33.

<b>1. Resolution</b> Monitoring of the implementation of the health-related Millennium Development Goals	
<b>2. Linkage to programme budget</b>	
Strategic objective:	Organization-wide expected result:
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.	5. Better knowledge and evidence for health decision-making assured through consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health research policy and coordination, including with regard to ethical conduct.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
Link to production of global analytical reports.	
<b>3. Financial implications</b>	
<b>(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)</b>	
For the period 2009–2015: US\$ 700 000 at US\$ 100 000 per year. Annually, staff costs will be US\$ 75 000 and publication costs US\$ 25 000.	
<b>(b) Estimated cost for the current biennium (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)</b>	
US\$ 100 000 in 2009 for production at headquarters of the report on implementation.	
<b>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the current biennium?</b>	
None.	
<b>(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)</b>	
Funding will be needed through core contributions.	
<b>4. Administrative implications</b>	
<b>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)</b>	
Headquarters.	
<b>(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant)</b>	
Two staff workers are required for three months each, representing a 0.5 full-time equivalent.	
<b>(c) Time frames (indicate broad time frames for implementation)</b>	
The first annual report will be submitted in 2009; this will continue until 2015.	

Dr FORSTER (Namibia), speaking on behalf of the Member States of the African Region, said that regular monitoring of progress towards achieving the Goals was essential, and welcomed the setting up of the Global Health Observatory. Achievement of the Goals by 2015 would largely depend on progress made on the African continent. The expenditure of most African countries for health, however, fell far short of the minimum required according to the Commission on Macroeconomics

and Health, and those countries were exploring mechanisms for additional financing, such as social insurance. Those should be complemented by external funding. Monitoring and data generation in African countries should be strengthened by consensus about the indicators to be monitored and by building the necessary systems and human capacity.

He proposed adding a paragraph to the draft resolution, to become subparagraph 2(3), reading: “to provide technical assistance to Member States to strengthen national monitoring and information systems related to the Millennium Development Goals”.

Dr REN Minghui (alternate to Mr Li Baodong, China) said that the report recorded global progress, especially in reducing mortality among children under five and in improving access to treatment for HIV/AIDS. The health-related Millennium Development Goals were being met with the participation of civil society and the private sector and through new types of global partnership, but in low-income countries, weak health systems and shortages of funds were still serious obstacles. In monitoring achievement of the Goals, WHO should identify weaknesses and difficulties and take proactive measures to support Member States. In China, implementation of the Goals involved consultations with many departments in the Government; he therefore proposed that consideration of the draft resolution be postponed until the next meeting.

Dr VOLJČ (Slovenia) said that he was speaking on behalf of the European Union, European Free Trade Association member Norway, European Economic Area member Switzerland, the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, and the countries of the Stabilisation and Association Process, and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia. Armenia, the Republic of Moldova, and Ukraine, and Kenya, Madagascar, Mali and Rwanda aligned themselves with his statement. The title of the draft resolution should be amended to read “Monitoring of the achievement of the health-related Millennium Development Goals” and that the word “implementation” should be replaced by “achievement” throughout the draft resolution. He congratulated the Secretariat on the report.

In order to speed up achievement of the health-related Millennium Development Goals, he suggested that health ministers should meet annually at the time of the Health Assembly to discuss the main obstacles and possible solutions to achieving them. That would be in line with United Nations General Assembly resolution 60/265 and with objectives 2, 4, 7 and 12 of WHO’s Medium-term strategic plan 2008–2013. The activities of other agencies related to achieving the Goals should be taken into account. The proposed annual meetings would mandate WHO to intensify its support to countries in achieving the Goals.

Dr AHMADZAI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that achieving the health-related Millennium Development Goals by 2015 would be a major challenge for several countries in his Region owing to protracted emergency situations, a lack of good health-care services and resources, and low literacy rates. Nevertheless, in his country, rates of infant and child mortality had been reduced substantially. Greater efforts to increase early and exclusive breastfeeding were needed. Six of the Region’s 10 priority countries were progressing toward the goal for improving maternal health. The Stop TB Strategy in the Region had been scaled up, and coverage of directly observed therapy was more than 95%.

The estimated prevalence of HIV infection in the general population had remained stable. However, only 6% of persons who needed antiretroviral medicines had access to them. The reported malaria figures were lower than the estimated actual figures because of poor reporting systems. Well-functioning information systems, regular health surveys and health systems research were essential for monitoring of the health-related Goals. Countries with a heavy burden of health problems often had poor information systems, and monitoring was a challenge.

He urged WHO to help to strengthen information systems for efficient monitoring of health systems. As only seven years remained before the target date for achieving the health-related Goals, the Director-General should be asked to report annually on progress to both the Executive Board and the Health Assembly.

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

## **EIGHTH MEETING**

**Thursday, 24 January 2008, at 14:10**

**Chairman:** Dr B. SADASIVAN (Singapore)

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

**Monitoring of health-related Millennium Development Goals:** Item 4.14 of the Agenda (Document EB122/33) (continued)

Dr INOUE (alternate to Dr Shinozaki, Japan), supported the draft resolution and welcomed the proposal by the member for Slovenia to include an item on monitoring of the health-related Millennium Development Goals on the Board's agenda. Annual reporting would identify deficiencies, geographical areas most in need and steps to be taken. Further discussion on the Goals would take place at the Fourth Tokyo International Conference on African Development and the forthcoming G8 Summit meeting, to be hosted by Japan in May and July 2008 respectively.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that his Government's commitment to achieving the Millennium Development Goals was demonstrated by the Prime Minister's call for higher-income countries to take action on the development emergency, and by its support for the International Health Partnership in September 2007, aimed at tackling weak health systems. Good primary health care was crucial to those efforts, and he looked forward to coverage of the topic in *The world health report 2008*. He noted the significant progress made in some areas, and the concern, however, that many health-related Goals were "off-track"; and he fully supported the need for regular reporting to the Health Assembly.

Mr McKERNAN (New Zealand) said that attainment of the health-related Millennium Development Goals needed to be monitored by WHO, with concise annual reports to the Health Assembly using modern data-compilation techniques; and integrated in the Organization's medium-term strategic plan and programme of work. With respect to Goal 4 (reduce child mortality), he noted the excellent progress made on reducing measles mortality and morbidity, and the need to increase support for breastfeeding. More could be achieved through universal application of low-cost, uncomplicated interventions of that kind than through focusing on the latest technology, which often reached only a fraction of the population. With respect to all three Goals, a monitoring framework should pay particular attention to progress by the poorest countries and communities. New Zealand supported the draft resolution with the amendment proposed by Namibia.

Mr TOURÉ (Mali) underscored the importance of the health-related Millennium Development Goals to African countries, where mortality and morbidity among women and children continued to take a heavy toll. He applauded the progress made, for which monitoring was essential. However, much remained to be done. Mali supported the draft resolution, of which it was a sponsor.

Dr AL-HASNAWI (Iraq) supported the draft resolution but wished to propose two amendments. The first involved insertion of four new paragraphs between the third and fourth preambular paragraphs of the resolution contained in the draft resolution to read:



“Recognizing the urgent need to improve the performance of health systems in order to reach the health-related Millennium Development Goals;

Recognizing that it is often the poor, women and other vulnerable groups that lack access to health services and that pro-poor health strategies are needed for the reaching of the health Millennium Development Goals;

Recognizing that the reaching of the health Millennium Development Goals needs more effective aid in line with the Paris Declaration on aid effectiveness and scaling-up of aid;

Recalling recent commitments taken by Member States towards prioritization of health and in support of health system strengthening”.

The second concerned insertion of an additional five lines at the end of paragraph 2(3), to read: “In particular there is the need to monitor progress in availability and equitable accessibility of services, especially to the poor and vulnerable groups, improvement in access to essential medicines, addressing the shortage of skilled health workers, and better financing of national health plans”.

Dr MENESES GONZÁLEZ (alternate to Dr Hernández Ávila, Mexico) pledged his country’s full support to achieving the health-related Millennium Development Goals – one of the Organization’s most important tasks. He endorsed the draft resolution and supported strengthened monitoring of the health-related Goals.

Dr KANDUN (alternate to Dr Supari, Indonesia) said that each health objective achieved led to new and more demanding objectives being set. Great inequalities still existed within and between countries, and many low-income countries could fail to attain the Millennium Development Goals by 2015. Monitoring progress was essential, as were adequate resources and baseline data against which to measure that progress. Indonesia supported the draft resolution.

Dr EVANS (Assistant Director-General) thanked members of the Board for their support. Their comments would be incorporated into the next phase of work on that important agenda item.

Dr VOLJČ (Slovenia), reporting on behalf of the European Union Member States, said that the informal discussions on the draft resolution held with the delegation of China had been constructive yet inconclusive. The European Union Presidency had no mandate to decide unilaterally whether proposed solutions were acceptable and would have to consult its Member States before reaching an agreement. He therefore requested the Chairman to defer a decision until the next meeting.

Dr REN Minghui (alternate to Mr Li Baodong, China) said that the consultations with the European Union Presidency had been fruitful. His delegation was keen to discuss the topic in the framework of WHO, either in the Executive Board or at the Health Assembly. There had been insufficient time to consult the relevant government departments in China, and a decision should be deferred until the next meeting.

Mr HOHMAN (alternate to Dr Wright, United States of America) asked whether a revised version of the draft resolution reflecting the various proposed amendments could be issued in time for the next meeting.

The CHAIRMAN said that the Secretariat had noted the request from the United States of America. He took it that the Board wished to defer further discussion of the subitem until the following meeting.

**It was so agreed.**

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

## 2. MANAGEMENT MATTERS: Item 6 of the Agenda

### **Director-General of the World Health Organization:** Item 6.1 of the Agenda (Document EB122/17)

Dr GWENIGALE (Liberia), speaking on behalf of the Member States of the African Region, proposed that, as the Organization had never in its 60-year history elected a Director-General from the African, South-East Asia or Eastern Mediterranean regions, an additional operative paragraph should be added to resolution EB97.R10, to follow the list of seven criteria to be fulfilled by candidates nominated for the post set forth in paragraph 1 to read: “ENSURES geographic rotation to promote fairness, equity and the international character of the Organization in conformity with Articles 31–37 of the Constitution of WHO”. Geographical rotation was a requirement in the appointment of WHO staff, and the Executive Board and Health Assembly should follow suit. The topic had been under consideration since November 2006, not because of any dissatisfaction with the current Director-General, but in the interests of ensuring fair treatment for those in all six regions who were qualified to head the Organization.

Dr INOUE (alternate to Dr Shinozaki, Japan) said that he understood the rationale behind the proposal to change current practice, but the changes might do more harm than good. The focus should remain on the candidates’ technical and administrative capacities. It would be detrimental to the authority and leadership of the Director-General – and, hence, to the performance of the Organization – if he or she were elected on the basis of criteria that were irrelevant to those capacities. Furthermore, no region had suffered as a result of current practices; no Director-General past or present had, as far as he knew, favoured their own regions over others. If geographical criteria were incorporated into the process of proposal and nomination, the current composition of the Executive Board would become an issue: if, for instance, the shortlist consisted of one candidate from each region, a candidate from a region with fewer votes would be more likely to fall in the first round of voting.

Professor SALANIPONI (Malawi) said that the Director-General, as head of the Secretariat, acted as the Organization’s de facto spokesperson and leader, just as the Secretary-General of the United Nations, according to that organization’s Charter, was its “chief administrative officer”. Secretaries-General were nominated by the Security Council and appointed by the General Assembly, but they could not be nationals of any State that was a permanent member of the Security Council; and the accepted practice of regional rotation had resulted in candidates from every region being appointed to the post. Heading WHO was a less exacting task than heading the United Nations. Accordingly, Malawi strongly urged the Board to follow the United Nations model. The only alternative would be to change the Constitution: in effectively excluding candidates from the African, South-East Asia and Eastern Mediterranean regions, the current system was lacking in transparency and equity, and needed reform.

Dr VOLJČ (Slovenia), speaking on behalf of the Member States of the European Union, the European Free Trade Area countries Iceland and Norway and Switzerland, said that the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process, and potential candidates Albania, Bosnia and Herzegovina, and Montenegro, and also Ukraine, the Republic of Moldova and Armenia, aligned themselves with his statement.

The selection of a Director-General was a complex issue that could not be resolved merely by introducing geographical rotation. The main criteria must be the personal and professional qualities of the candidates. The European Union would prefer to seek a solution within the existing procedure and not to prolong the debate. Of the options set forth in the Secretariat’s report, it preferred Option 1, namely to continue the current method of selection. Detailed analysis, would be needed to determine the political and legal consequences of introducing geographical rotation. The European Union supported the statement made by the member for Japan.

Ms BLACKWOOD (alternate to Dr Wright, United States of America) supported the statements by the members for Japan and Slovenia. The current election system had served the Organization well, producing highly qualified candidates from different regions, consistent with the procedures of other specialized agencies. Her country would take all relevant factors into account when examining applications for the post of Director-General, including equitable regional representation, but the primary criterion had to be the competence and experience of the individual candidate.

Dr AHMADZAI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, sought consensus at the current session, so that the matter could be transmitted to the Sixty-first World Health Assembly for action. In the current system, the degree of national support made available to candidates affected their prospects: candidates from small or poor countries stood less chance of being elected.

Referring to the Secretariat's report, it was not sufficient to give special consideration to candidates from certain regions or to ensure that all regions were represented on the shortlist. The nomination of a single candidate from each region merely transferred responsibility for selection from the Executive Board to the regional committees. Nor was it acceptable to elect a Director-General from each Region in turn, as was done with the officers of committees, since the Director-General served a much longer term.

The Member States of the Region considered that the next Director-General should be elected from one of the three regions that had never had a successful candidate – Africa, South-East Asia and the Eastern Mediterranean; thereafter elected from one of the two remaining regions, and finally from the last remaining region, thereby ensuring that every region had provided at least one Director-General.

Mr KWON Jun-wook (alternate to Professor Sohn Myongsei, Republic of Korea) said that the current election procedure should be retained. WHO's Constitution stressed the need to maintain the efficiency, integrity and internationally representative character of the Secretariat at the highest level. The person selected as Director-General must therefore be the best of all the candidates, as had always been the case. The proposal to change the election procedure "in the interests of fairness and equity", as some members had put it, implied that the current procedure was inequitable, which was to do a disservice to the legacy and the continuing achievements of past and present Directors-General.

Mr McKERNAN (New Zealand) pointed out that there was considerable diversity even within regions; for true fairness and equity, it would be necessary to rotate the post of Director-General among all the Member States in turn. New Zealand was opposed to the principle of rotation: the candidate selected must be the one with the best credentials.

Dr OUSMAN (alternate to Mr Miguil, Djibouti) said the fact that three regions had not yet provided a Director-General was not attributable to any lack of competent candidates; he recalled that Africa had provided two recent Secretaries-General of the United Nations.

Dr SINGAY (Bhutan), speaking on behalf of the Member States of the South-East Asia Region, pointed out that the geographical criterion was intended to complement the other criteria for selection. It would not mean that candidates of lesser quality were considered. He supported the statements made by the members for Liberia, Malawi and Djibouti.

Dr BIN SHAKAR (United Arab Emirates) emphasized that the competence and ability of the candidate must be the most important criteria.

Dr AL-HASNAWI (Iraq) endorsed the statements made by the members for Malawi and the United Arab Emirates. It was inequitable to exclude regions that could provide perfectly acceptable candidates.

Dr ABDESSELEM (Tunisia) said that geographical rotation of the post of Director-General would increase equity and was also wholly compatible with the most important factor, namely the competence of the candidate.

Dr CHEW Suok Kai (alternate to Dr Sadasivan, Singapore) stressed the importance of the post of Director-General, responsible for promoting public health throughout the world and representing the entire world community in health matters. All regions must participate in decision-making, and mechanisms already ensured that that responsibility was fulfilled.

Geographical rotation for the post of Director-General would have major implications for the regional committees, some of which had had no opportunity to reach a regional consensus. Discussion of the issue should be suspended, perhaps for as long as two years, in order to allow the regional committees to agree on their own positions.

Dr GWENIGALE (Liberia) stressed that rotation was intended as an additional, not an alternative, criterion. The issue should be brought to the attention of the Health Assembly through the Executive Board; however, failing all else, other means might be necessary.

Mrs NYAGURA (Zimbabwe)<sup>1</sup> supported the statements made by the members for Liberia and Malawi. The technical competence of the candidate was important but it was not the only criterion. The current selection process was marked by lobbying campaigns that were unaffordable for poor countries. Geographical rotation would create a greater fairness.

Dr OGWELL (Kenya)<sup>1</sup> said that, under the current system, some governments conducted what amounted to intensive and costly election campaigns on behalf of their own candidates. WHO should adopt the practice of its parent organization, the United Nations, which used geographical rotation as a criterion. There were no grounds for fearing that certain regions would be unable to provide sufficiently qualified candidates. The Board should decide on the issue at its current session, so that the matter could be transmitted to the Health Assembly if found appropriate.

Dr DAHL-REGIS (Bahamas) said that every region had competent candidates, and it was not necessarily true that extensive resources increased a candidate's chances of being elected. However, equitable geographical distribution was valuable to small countries; without it, she herself would not currently be a member of the Executive Board.

The CHAIRMAN, summing up, said that there was no consensus among Board members, or within the regions. The issue was politically sensitive and might require members to consult their governments before any agreement could be reached. Nor was it clear how the principle of geographical rotation might be implemented in practice.

It had been pointed out that the issue could be brought directly before the Health Assembly, without going through the Board. However, it was unlikely that the Health Assembly could reach a decision on such a controversial matter without lengthy and divisive discussion, which might jeopardize the very principle that the proposed changes were intended to promote.

Dr GWENIGALE (Liberia) said that, if the issue of geographical rotation was brought before the Health Assembly, it would be settled once and for all: if the Health Assembly approved the principle, action would be taken to introduce it into the election process; if it did not approve it, there would be no further discussion of the idea.

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

The CHAIRMAN, supported by Dr INOUE (alternate to Dr Shinozaki, Japan), suggested that, since the next election of a Director-General was at least four years away, there was ample time for the regional committees to discuss the issue and reach a consensus, which would guide the Board in its later deliberations. He accordingly suggested that the Board should suspend consideration of the issue.

**It was so agreed.**

**United Nations reform process and WHO's role in harmonization of operational development activities at country level:** Item 6.2 of the Agenda (Documents EB122/3 and EB122/18)

Professor PEREIRA MIGUEL (Portugal), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, reported briefly on the Committee's discussion of the subitem, as set forth in paragraph 7 of document EB122/3. The Committee had recommended that the Board should take note of the report contained in document EB122/18.

Dr GWENIGALE (Liberia), speaking on behalf of the Member States of the African Region, requested more information on actions needed to enable the Director-General to ensure that at country level all United Nations agencies supported one national health plan through a joint United Nations country cooperation strategy on health. Thus Member States could identify appropriate reforms so that WHO could provide more effective leadership to all United Nations agencies. As long as each agency had its own assistance strategy on health matters at country level, no significant progress would be made in improving efficiency and effectiveness. The system of each agency or partnership imposing separate monitoring and evaluation requirements could not continue. The African Region also requested information from WHO on working towards a coordinated one-country support framework with other United Nations agencies.

Currently, technical assistance for health at country level was costly, disorganized, supply-driven and without accountability for poor performance. It adversely affected national governance systems and weakened vulnerable health systems. African health ministers were ready to work with the Director-General to halt the chaos at country level, and the Member States of the Region would provide the necessary leadership on national policies and strategies. If a review of WHO's Constitution was necessary to ensure the commitment of Member States at global level, such a review must be conducted, in order to reduce the current wastage of taxpayers' investments in health.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), speaking on behalf of the Member States of the European Union, said that the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process, and potential candidates Albania, Bosnia and Herzegovina, and Serbia, the European Free Trade Association countries Iceland and Norway, members of the European Economic Area, and Switzerland, as well as Ukraine, Armenia, Georgia and the Republic of Moldova, aligned themselves with his declaration.

The European Union welcomed WHO's involvement in the eight "Delivering as One" pilot initiatives. The toolkit for country office staff was useful and should be made available to health partnerships and United Nations partners. That process should be stepped up in 2008. The "Delivering as One" pilot initiatives and future moves in other countries, should be provided with support through the headquarters and regional levels of United Nations agencies. It should promote flexibility for system coherence as a whole. WHO should sign up to One United Nations plans, where they existed, as the overarching planning document for in-country United Nations activities.

The European Union was of the view that the reform process should not be used to introduce new conditionalities for development assistance. Efficiency gains should benefit country programmes. National ownership was the key element of One United Nations plans, and not a "one-size-fits-all" model. Welcoming the recent commitment by United Nations agency heads to harmonize business practices, he stressed the need for WHO to demonstrate administrative efficiency targets. The

Regional Office for the Americas was working closely with United Nations Regional Directors, a practice that should be encouraged in other WHO regions in order to improve system-wide coordination. Increased regional co-location should be examined.

Resolution WHA58.25 had specifically referred to United Nations General Assembly resolution 59/250 on the triennial comprehensive policy review. WHO should take note of that review for 2008–2011, which emphasized coherence, harmonization, efficiency and accountability at country level and contained stronger recommendations on interagency activities. He would welcome WHO's commitment to the new resolution.

Speaking on behalf of his own country, he emphasized increased coherence within the United Nations system in response to HIV/AIDS. In support of UNAIDS' response to the Global Task Team's recommendations, WHO should provide guidance and incentives to country-level staff for joint United Nations programming on HIV/AIDS. At global level, WHO should also report under the UNAIDS Unified Budget and Workplan performance framework.

In order to enable donors to increase the proportion and predictability of negotiated core voluntary contributions further reform was needed within WHO. A centralized fund-raising position was needed so that donors providing un-earmarked core voluntary contributions were positively recognized, and not pursued by individual departments for additional funding. He recognized the commitment of the Director-General to the International Health Partnership and related partnerships.

Dr BIN SHAKAR (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that increasing demands, especially for humanitarian assistance, human development and health security, had raised the international prominence of health issues. WHO should participate actively both in global and regional United Nations coordination mechanisms and in country-level coordination.

United Nations reform must be contextualized at country level in order to enable United Nations agencies to continue operating within their specific mandates in response to the specific needs of Member States.

Government leadership, discipline among agencies and donors, and communication with United Nations staff would be pivotal to reform. The guiding principle of United Nations reform should be the notion of "Delivering as One".

WHO should take forward the reform agenda with its partners in the United Nations system. He noted with satisfaction WHO's commitment to leading reforms of the United Nations health sector.

Mr MARTIN (Switzerland)<sup>1</sup> said that the report contained in document EB122/18 demonstrated WHO's will to implement the United Nations Development Assistance Framework and to take part in the triennial comprehensive policy review, for the benefit of developing countries. The review adopted in December 2007 by the United Nations General Assembly, also emphasized capacity building as a central function. He expressed support for WHO's efforts to promote gender equality and gender-specific approaches. WHO should allocate resources responsibly and monitor results obtained.

The new review recognized the responsibilities of Member States to address needs of the specialized agencies by paying regular and voluntary or additional contributions; the latter should ideally not be earmarked. He encouraged WHO to share its experience of negotiated core voluntary contributions with other organizations in the United Nations system.

Reducing maximum transaction costs would make the United Nations and WHO more effective. With regard to co-location, he emphasized that working under the same roof facilitated synergies between organizations and could strengthen the spirit of partnership. He congratulated WHO on its involvement in the "One United Nations" pilot initiatives, a demanding exercise that required people to question their existing convictions and ways of working. All levels of the Secretariat and all other

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

United Nations bodies should examine their activities and methods and adopt the “One United Nations” spirit.

The DIRECTOR-GENERAL thanked members for their guidance and assured the Board that WHO would remain committed to United Nations reform and would ensure that health matters were properly reflected on the international development agenda.

The comments made by the member for Liberia had emphasized country ownership and national health plans, founding principles of the International Health Partnership. Reduced transaction costs and avoiding additional work for overstretched organizations at national level were needed, particularly in developing countries. All United Nations agencies and, she believed, donors were aware of countries’ concerns. Reform would lead to changes in behaviour, in line with the principles set out in the Paris Declaration on Aid Effectiveness and the Rome Declaration on Harmonization.

Eight health-related United Nations agencies, including WHO, and one large foundation had been working together to support countries’ efforts to attain the Millennium Development Goals under the arrangement informally referred to as the “Health 8” initiative. No formal structure would be established for such cooperation, so no extra resources or mechanisms would be involved, but it demonstrated WHO’s recognition of the importance of working coherently with other organizations. At regional level, she was working closely with Regional Directors, and they with their counterparts. They were fully committed and had made significant progress, though more perhaps remained to be done.

United Nations reform had been a subject of discussion for three decades and had led to the inclusion of the subitem “Partnerships” on the Board’s agenda. If reforms were not put in place soon, the United Nations system risked losing all credibility. For the remainder of her tenure, reform would be her top priority.

**The Board noted the report.**

**Partnerships:** Item 6.3 of the Agenda (Documents EB122/3 and EB/122/19)

Professor PEREIRA MIGUEL (Portugal), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee had welcomed the initiative of the Secretariat in seeking guidance on partnerships and had expressed appreciation for the report. The Committee’s debate had highlighted the complexity of global trends in health and the implications of the increasing financial resources available through global health partnerships with regard to coordination and harmonization among partnerships, and between partnerships and WHO. The Committee had requested that the Secretariat should produce draft policy guidelines for consideration by the Board and had recommended that the Board should take note of the report contained in document EB122/19.

Dr AL-HASNAWI (Iraq), speaking on behalf of WHO’s Eastern Mediterranean Region, said that, as the report indicated, there had been dramatic changes in the health sector. Health had come to be recognized as a core element for social and economic development and partnerships had become essential at all levels. Countries in his Region could show encouraging examples of partnerships; for instance, significant external resources had been secured for the Polio Eradication Initiative to cover the provision of vaccines, operational expenses, supplemental immunization, and continued surveillance. WHO was supporting malaria elimination with interested agencies, such as the partnership with the Gulf Cooperation Council countries active in Yemen.

Nevertheless, coordination was becoming increasingly difficult in the Region. Guidelines should be adhered to. First, partnerships were intended to help countries to tackle health and development problems and therefore national ownership should be respected; countries should formulate and direct the strategic agendas. Secondly, an institutionalized mechanism to coordinate partners’ activities under national plans and existing regulation was needed. Thirdly, implementation

partners could contribute to joint strategic and operational national plans. All three elements were necessary for effective partnerships, the challenge being how to realize them at country level.

WHO's authority was critical to improving coordination of health partners at global, regional and country levels. Partnership resources fell outside the governance of the Health Assembly. Questions remained as to how to reconcile the contribution of partners with the important role of WHO. Partnerships should also support the work of WHO's Secretariat, not duplicate or weaken it. His Region proposed that the Director-General should undertake a study on partnership, its contribution to and relationship with WHO, its impact on WHO's governance and decision-making, and should propose solutions to improve synergy and partnership governance, for consideration by the Board. The Organization was urged to continue to engage in partnerships.

Dr STEIGER (alternate to Dr Wright, United States of America) said that, having attended and participated in Board discussions for some years, he had often reflected that they had little to say on the strategic direction of the Organization; he therefore welcomed the inclusion of the current agenda item. As others had observed, WHO involvement in external partnerships had grown significantly in recent years and many of them, such as the Polio Eradication Initiative and the Stop TB Partnership, had been remarkably beneficial to public health. However, WHO's leadership should develop a more defined set of policies to guide its involvement. The Director-General should personally review and approve each arrangement after consultation with the Board and after cost-benefit analysis, in order to better assess WHO's role in the political environment surrounding some initiatives. Furthermore, she should develop criteria for how and when to accept a hosting arrangement and a long-term strategy for each partnership.

Three current members of the Board and the Director-General had seats on the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria; those who sat on the boards of partnerships had a particular responsibility to ensure better coordination between the institutions involved. They should be voices for aid effectiveness, avoidance of duplication, and added value in each arrangement. It was interesting to note that, while the Board was called upon to approve any new prize instituted by the Organization, it was not required to approve multi-million-dollar partnerships. He supported the recommendation of the Programme, Budget and Administration Committee that the Director-General should present draft policy guidelines to the Board at its next meeting.

Dr INOUE (alternate to Dr Shinozaki, Japan) was pleased to see the important issue of partnerships placed on the Board's agenda for the first time. WHO had recently become just one of many actors in global health and, while the involvement of others in the field was positive, it also posed challenges for WHO. It could be inferred from the report that the proliferation of partners provided an opportunity for the Organization to focus on its core function and leave the remaining activities to other players. Additionally, many key partnerships with independent governance structures were included in WHO's budgeting and those financial arrangements should be brought into line with its own governance structure.

Dr FORSTER (Namibia), speaking on behalf of the Member States of the African Region, said that African countries were hosts of partnerships that had introduced additional resources, generated synergy, strengthened communication and increased stakeholder participation. However, partnerships required strong coordination and skills in African health ministries and throughout their health systems. Partnerships generated pressure on African countries to transform their organizations and operating cultures, a situation often exacerbated when skilled personnel moved on to work for the partners, and placed even more demands on WHO for technical assistance. In that regard, he expressed appreciation to WHO for having introduced new subregional offices in the African Region.

Increasingly partnerships were forged with stakeholders from civil society and the private sector, creating impetus for decentralized decision-making in national health systems. Partnerships were evolving and changing the way health business was conducted. All partners should work on the basis of the Paris Declaration on Aid Effectiveness: ownership, harmonization, alignment, results and mutual accountability (2005). There was a need for unified national health strategies; coordination



mechanisms and monitoring; and national codes of conduct for all partners working in countries. The challenges posed by partnerships were considerable. He supported the suggestion of the Programme, Budget and Administration Committee that WHO should produce draft policy guidelines on the Organization's engagement with partnerships which, he proposed, should be tabled at the Sixty-second World Health Assembly after consideration by the Board.

Mr TOURÉ (Mali) said that, given the scale of the health measures necessary for populations in the African Region, partnerships were indispensable. Many health initiatives were focused on specific illnesses, with little attention paid to strengthening health systems, whereas the two should be integrated. Synergies were needed between the different health initiatives where resources were limited, which was especially true in the context of time-consuming processes and procedures. He welcomed the new International Health Partnership, which could assist coordination and strengthen leadership in country programmes, together with WHO's catalytic role in scaling up interventions to achieve the Millennium Development Goals.

Strengthened partnerships with nongovernmental organizations were needed, but their activities should be firmly embedded in the policies of the countries in which they worked.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) agreed with the views expressed by the members for the United States of America and Namibia. WHO needed to show leadership and play a stronger coordinating role, ensuring that existing partnerships added value. WHO could phase out certain partnerships, either by incorporating them within core business or by disengaging from them. In the interests of saving time, he would submit detailed comments, based on bilateral discussions held with the Director-General in 2007, to the Secretariat in writing.

Mr FISHER (Denmark) echoed the views of previous speakers in stressing avoidance of duplication of work when dealing with the same international health issues in different forums, which could lead to a waste of resources. He welcomed the discussion on effective management and coordination of global health initiatives.

Global partnerships had been growing rapidly and included initiatives aimed at scaling up efforts to achieve the health-related Millennium Development Goals; those initiatives must not add to the complexity of global health and development assistance. He welcomed WHO's role in advising on coherence. The report highlighted the challenges related to WHO-hosted partnerships, some of which had implications for WHO's own governance systems. Accountability, transparency and efficiency must be ensured. He looked forward to the draft version of WHO's internal policy on partnerships at the next session of the Board.

WHO faced a longer-term strategic challenge relating to its role, which would be compounded by the actions of several significant partnerships that were disengaging from hosting arrangements with WHO. Member States needed to assure WHO's continued leadership, its normative and technical role, and its global role in policy reference and regulation. In that respect, WHO's role in the International Health Partnership could serve as a pathfinder. He welcomed the "Health 8" initiative, and increased information flows and collaboration between health partners. He looked forward to clarification on how those initiatives related to the broader architecture of global health.

The WHO governing bodies needed to debate global health aid, on the basis of the mandates and comparative advantages of the organizations and actors concerned.

Dr MATHESON (alternate to Mr McKernan, New Zealand) concurred with the views of previous speakers concerning the recommendations of the Programme, Budget and Administration Committee. WHO should play a leading and coordinating role in global health. He looked forward to the report that WHO was preparing on the management challenges presented by an increased number of players and of the implications for global health governance. He would be interested in better use of the Health Assembly in exploring the key issues, and asked whether a third committee (Committee C) might be created in order to examine the way in which the different health players could present their plans. Health ministers could thus readily engage in the decisions taken on health partnerships.

Mr MACPHEE (Canada)<sup>1</sup> welcomed the inclusion of the subitem on the agendas of the Board and the Programme, Budget and Administration Committee, and the Secretariat's preparation of a document to include the impact of partnership arrangements on WHO's programme budget and the general programme of work as a substantive item on the Board's agenda. Clear facts and figures would be essential for such a discussion. The Board and Member States should have access to the document well in advance of discussions on the subject.

Mr MCFARLANE (Australia)<sup>1</sup> agreed with previous speakers on the need for WHO to further analyse concrete actions on the array of global health partnerships. In line with the recommendation made by the Programme, Budget and Administration Committee that draft policy guidelines should be produced, a clear typology of the partnerships was needed with recommendations on either phasing out, integration or strengthening of partnerships. In addition, there should be a set of criteria for WHO's involvement, roles and responsibilities vis-à-vis partnerships. More information would be useful on how the Medium-term strategic plan 2008–2013, and especially the programme budget, would be linked with the provision of financing, administrative support and technical assistance by WHO to partnerships. He drew attention to the High-level Forum on Aid Effectiveness, to be held in Accra in September 2008, an opportunity for WHO and the donor community to align and harmonize global health partnerships.

Dr ANTEZANA ARANÍBAR (Bolivia)<sup>1</sup> expressed concern with certain aspects of developing a policy on partnerships. He agreed with the comments made by the member for the United States of America regarding the possible consequences of building partnerships without a clearly delineated framework; the Constitution provided that, where public health was concerned, WHO took the lead in establishing partnerships and in determining the priorities, mechanisms and actions to be taken. How was WHO to act in a situation where the rules it had framed were not acceptable to other partners, or where governments, which contributed two thirds of the budget, were not included in deciding how the budget should be allocated? Although such partnerships were entirely welcome, it was imperative to ensure that WHO did not become the junior partner, and that its freedom of action was not restricted in situations in which a partner was the major financial contributor.

Mr LAMB (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, expressed support for the directions taken by WHO in connection with partnerships. His own organization had adopted a similar approach, in recognition that the humanitarian challenges facing the world were beyond the capacity of any one government or organization. The theme of the 30th International Conference of the Red Cross and Red Crescent (Geneva, 26–30 November 2007) had been "Together for Humanity", and one of the challenges identified had been emergent and recurrent diseases. The Federation and WHO had built a strong partnership relevant to health challenges that were encapsulated in the joint letter signed by his Organization and WHO, in May 2005. It had been given additional substance at the regional level through other documents signed with four of WHO's six regional offices. It was to be hoped that all the regional offices would follow. The working relationship included the membership as a whole, involving participation in international partnerships in a number of health-related areas.

His organization prioritized provision of the tools needed for its national societies to work with their public authorities as auxiliaries. That relationship had been given fresh definition by the last International Conference. He noted that WHO was supporting the relationship established between health ministries and national societies to implement national strategies, for example in partnerships to address the avian and human influenza threat.

The Federation would also strive to strengthen its partnerships at the next Health Assembly. Between 14 and 16 May 2008, it would be hosting its global health forum, bringing together selected

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

national societies, experts from WHO and other organizations, and ministers and government representatives. The theme would be “Primary health care and the role of national societies”. It would focus, inter alia, on the contribution of volunteers in their communities and would assist governments, organizations, WHO and the Federation in strengthening primary health care. Those aspects of its work should be reflected in future Secretariat reports on partnerships.

Dr BALE (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, drew attention to areas in which his Federation provided technology and support for the development of partnerships. The Global Network for Neglected Disease Discovery would increase and accelerate research into potential new medicines and vaccines. The Sustainable Research and Development Funding Initiative was laying the foundations for adequate, sustainable and predictable funding for research and development into neglected diseases. The “Southern Skills” capacity development programme was exploring ways to harness industry and other expert resources to build skills capacity in affected areas. His organization was also studying the provision of expertise in order to build robust supply chains for therapeutic and preventive technologies in developing countries. In response to WHO’s new initiative on medicines for paediatric indications and new paediatric medicines, it was examining how the industry could increase the availability and affordability of medicines suitable for children. Regarding the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, the industry was supporting the development of new medicines and capacity building in developing countries.

Ms ARENDT LEHNERS (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, said that her organization welcomed the report’s analysis of the functioning of partnerships in enhancing the work of the global health community. She emphasized clear structures and safeguards, defined objectives, transparency and accountability and the avoidance of conflicts of interest.

Referring to the comment by the member for Slovenia regarding criteria governing the prioritization of prospective partnerships, she drew attention to the guidelines on working with the private sector which the Board had discussed at its 107th session. The report contained in document EB122/19 made no reference to those guidelines.

Given the increasing interaction between WHO and the private sector and the increasing tendency of large industries to undermine public policy-making, the guidelines and other mechanisms should be revised, with the participation of all relevant stakeholders in order to guarantee WHO’s integrity and independence.

The DIRECTOR-GENERAL thanked Board members, representatives of United Nations bodies and nongovernmental organizations for their valuable contributions. On the comments made by the member for the United States of America, she said that the decision on whether to bring that important matter to the attention of the governing bodies had been complex and difficult. However, given the current architecture of global health, failure to grasp that nettle would have amounted to a failure on her part. The Board’s discussion heralded an ongoing and lively debate, which would eventually clarify issues such as the criteria for entry and engagement and the challenges posed by dual governance. WHO was currently hosting 15 large partnerships with their own governance structures and managing more than 70 other initiatives, programmes and campaigns. Partnerships strengthened global public health and fostered political commitment, resources and skills; they also posed challenges on matters such as core competency. The advice offered by the Board would be taken into account in the Secretariat’s document for consideration by the Board at its 123rd session. A solution to the problem might not be found before the next Health Assembly, but the dialogue could continue.

In the integration of partners some progress was being made. In the case of the partnership between WHO and the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Board had taken a very responsible decision on how to proceed. The Global Fund, which was hosted by WHO, made a major contribution to global health; however, despite the continuing good working relationship

between the two organizations, problems associated with dual governance and United Nations rules and regulations, by which WHO was bound, were leading to tensions. Those regulations guarded against vested interests, but could engender delays that were not always acceptable to prospective or existing partners. One question was whether WHO staff members who were employed by a partner would continue to be bound by WHO's rules. In her view, it would be unthinkable for a Director-General to relinquish authority over several hundred staff members; in such circumstances it would be better for the partners to separate amicably. Those were some of the issues that would be taken up with WHO's existing partners. She would address the concerns raised by some Member States and the points she had been requested to explore, with a view to submitting a progress report to the Board at its 123rd session.

The CHAIRMAN took it that the Board wished to take note of the report and that the suggestion of the Programme, Budget and Administration Committee that the Secretariat should produce draft policy guidelines for consideration by the Executive Board was acceptable.

**It was so decided.**

**WHO publications:** Item 6.4 of the agenda (Documents EB122/3 and EB122/20)

Professor PEREIRA MIGUEL (Portugal), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, reported briefly on the Committee's discussion of the subitem, as set forth in paragraphs 14 and 15 of document EB122/3. The Committee had requested the Director-General to continue work on the issue and to provide the Committee, at its next meeting, with more detailed guidelines on how the policy would be implemented and evaluated. The Committee had also recommended that the Board should take note of the report.

**Dr Gwenigale took the Chair.**

Dr AL-HASNAWI (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the new publishing policy guidelines were clear and would help to ensure that WHO publications were relevant, especially to developing countries. Health professionals and ordinary citizens relied on WHO to provide up-to-date and reliable information on health issues; accordingly, Member States must also develop their research capacities and health information systems. Development and peer review should be continued, through expert consultations and review at country level. Executive clearance should remain the responsibility of the Assistant Directors-General and Regional Directors; there should be no need to burden the Director-General with that task. Member States expected to be consulted but also trusted WHO's judgement, as a body whose independence must be safeguarded. WHO should continue decentralization and devolve responsibilities for publications provided that quality was not compromised. Full use must be made of available scientific evidence in furthering WHO's guidance function and safeguarding its reputation as a reliable publisher.

Professor SOHN Myongsei (Republic of Korea) commended WHO's efforts to publish, both in print and on the Internet, objective and reliable information essential to global health. He also welcomed the initiative of devising the new publication policy and guidelines that stressed the importance of publications and the need to maintain the highest possible standards. On the issue of dissemination, paragraph 2 of the report stated that some members of the Committee had urged the Organization to make greater use of the Internet. Although the needs of readerships with no access to electronic communication should be taken into account, Internet publication had expanded access to essential health information. For example, since 2000 the *International digest of health legislation*, a WHO publication first issued 60 years previously, had been available online only. More information on health legislation could be provided without cost concerns, with access to legislation in the original language through hyperlinks: search engines permitted location and cross-referencing of specific

issues. The Republic of Korea urged that the raising of awareness of where and how information would be found should become a stated objective of WHO publications.

Professor SALANIPONI (Malawi), speaking on behalf of the Member States of the African Region, requested the Secretariat to provide more details that would enable the Board and the Health Assembly to monitor and evaluate the impact of WHO's publications on health outcomes. As WHO's publications accounted for about 15% of the Organization's total budget, equivalent to that of all its country activities, a comprehensive policy and strategy for such publications was needed. WHO should devise a cost-effective publications policy that promoted innovations in publication and strengthened peer-review mechanisms, with delegation of editorial decisions. The policy should also protect and hold accountable the Director-General and her staff. It should lay down clear standards in areas such as transparency, misconduct, peer review, editorial independence, standards of accuracy, intellectual property and multilingualism. The report provided a list of control measures that were putting undue pressure on the Director-General, Assistant Directors-General and Directors. The clearance procedures referred to in paragraphs 9, 12 and 13 of the report would be very time-consuming for the officers concerned. He asked the Secretariat to provide information on the impact of the policy proposals on the percentage of the WHO biennial budget earmarked for publications.

**Dr Sadasivan resumed the Chair.**

Mr NONO (alternate to Dr Shinozaki, Japan) said that objective and reliable public health information was essential. According to the report, WHO issued between 350 and 400 publications a year, with between 1.2 and 1.6 million copies distributed annually, 90% of them free of charge. Those publications must reach the people who needed them, and therefore ways must be found of counting downloads from the web site and the number of printed publications consulted. A general catalogue of WHO's publications with concise information and keywords for Internet search should be developed. Such publications should continue to be reliable and help Member States to improve their populations' health.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that his country had given its views in the Programme, Budget and Administration Committee and supported the latter's recommendations that the Director-General's continued work should include more detail on how the publication policy would be implemented and evaluated, and how publications from closely affiliated entities such as IARC fitted with that policy. The Director-General should consider establishing an executive secretariat function responsible for ensuring that publications and policy documents received the necessary review and clearance throughout WHO. Such a function might alleviate concerns such as those expressed by the member for Malawi regarding the potential burden placed on officials at Assistant Director-General level and above. Serious consideration should be given to that proposal.

Ms HENDRY (alternate to Sir Liam Donaldson, United Kingdom of Great Britain and Northern Ireland) welcomed the report, the hard data it contained, and the move to use more modern technology and to make savings. She asked when the new publications policy would come into effect. Paragraph 8 of the report referred to executive approval of a master list of planned publications; did that mean approval by the Board or by WHO's management? In the latter case, what should be the role of Member States? Lastly, it was stated that executive clearance would be required for final texts, which should be based on the best evidence and be of a high standard; however, "additional clearance" would be required in certain cases. WHO needed to be able to use examples that might be controversial and to describe different health systems in order to fulfil its normative role effectively. Further clarification on the implications of paragraph 13 of the report would be welcome.

Dr SINGAY (Bhutan), speaking on behalf of the Member States of the South-East Asia Region, said that it was not clear whether the report set out the new publications policy in full or a summary

thereof. The definition of “publication” contained in footnote 2 to page 1 of the report implied that “information products” might need to be reviewed by the Director-General’s Office. However, it was not clear whether they would also need to be included in the master list of publications, prepared up to two years in advance. WHO needed to specify how it would respond if emergency situations such as natural disasters or emerging health concerns arose. Clarifications were required on how the Organization intended to deal with a large volume of publications; the apparatus needed for implementing the new policy; how WHO would react if an urgent matter required the creation of a new publication or information product not included in the master list; and the timeframe for clearance of the master list. The Region’s overall impression was that the new policy was highly centralized. The Secretariat’s comments would therefore be appreciated.

Mr FISHER (Denmark) said that WHO had thus far performed excellently in the distribution of objective and reliable information. He supported the publication policy outlined in the report, which avoided the risk of censorship while securing the firm executive approval required for the continuing credibility and impact of WHO. The report was explicit on the question of executive clearance of publications dealing with politically sensitive issues. Technical issues could also be sensitive. Executive approval at WHO headquarters and in the regional offices should be organized so as to ensure that the Organization’s publishing activities were not delayed or halted.

Dr MENESES GONZÁLEZ (alternate to Dr Hernández Ávila, Mexico) stressed that WHO public health information was a public good and should be available not only to Member States but also to the academic community. The financial and environmental costs of publishing all documents in printed form should be reduced, where possible, through the use of technologies such as the Internet, which would also facilitate faster and wider dissemination of information.

He asked when it might be possible to access the planned collection of WHO publications in electronic format. He stressed the need for prompt and regularly updated information. In the area of health, developments could be exceptionally rapid and the policy should reflect that. The publications procedure should be improved throughout the Secretariat, including in regional and country offices.

Dr GWENIGALE (Liberia) expressed concern at the burden of responsibility placed on the Director-General. She had extensive responsibilities at the highest level and should not have to spend all her time overseeing editorial work. The new policy should relieve some of that burden.

Dr REN Minghui (alternate to Mr Li Baodong, China) said that China recognized the important role of WHO publications but noted that problems often arose with editing and distribution. Timeliness was critical, particularly where multilingualism was concerned; in 2007 the Chinese versions of some documents had been received only two weeks before World Health Day. WHO should give higher priority to the prompt translation of documents. Furthermore, experts in many organizations needed access to WHO publications that were not readily available; meanwhile, many publications were languishing in warehouses. An electronic library should be established so that Member States could download publications free of charge. Electronic publication would save money, as would the use of lower-quality paper. More care should be taken over editorial quality and control.

Dr JAKSONS (Latvia) said that WHO meetings generated quantities of information documents that were distributed round the world. He himself had received two identical sets of documentation for the Board’s current session. The Secretariat should pay closer attention to distribution in order to avoid unnecessary and wasteful duplication.

Mr ALCÁZAR (Brazil)<sup>1</sup> said that the rising cost of publications and greater use of the Internet should be considered in any revision of the WHO publications policy. He stressed the main purpose of the policy, namely to deliver information on health matters that was of relevance to Member States. He was concerned that political pressure might block the publication of important papers on relevant health issues. WHO had a crucial role to play in assessing, for instance, the impact of intellectual property on public health issues, and it must publish papers on those issues. While Member States should respect the Director-General's editorial independence, executive clearance and evaluation should be transparent, with Member States kept informed.

One of the Organization's publications to which the policy had presumably been applied, *The world health report 2007*,<sup>2</sup> made extensive use of concepts such as "threat", "collective defence" and "security agenda" – confrontational language that was more appropriate to the United Nations Security Council than to the International Health Regulations (2005). He drew attention to difficult concepts to define such as "health measures", which should not be taken as security measures; "event"; "public health emergency of international concern"; and "public health risk".

Mr DEL PICÓ (Chile)<sup>1</sup> agreed on the need to reduce the number of publications and recommended that WHO should review and rationalize its output, particularly since much of it was never read, either because of the subject matter or because too many or too few copies were produced. The quality of the web pages varied depending upon the language in which they appeared: the English pages tended to contain more information and be more up-to-date than those in other languages, particularly Spanish. All web pages should be of the same quality. Many people, including national experts, relied on the information on the WHO web site, and not all of them were familiar with other languages.

Dr EVANS (Assistant Director-General) thanked members for their useful comments, which, in essence, corresponded to the recommendations made by the Programme, Budget and Administration Committee. They had included suggestions on implementation, in particular on management of the balances between centralization and decentralization of publishing activities, and between workload and work capacity. Emphasis had been placed on the need for quality, accessibility, cost-effectiveness and streamlining of the publishing process. Evaluation and the clear criteria for monitoring the implementation of recommendations had also been stressed. Members had commented on effective management of the clearance process, given the range of publications produced by WHO.

The new WHO publishing policy guidelines responded to assessments of previous publishing performance and to the recommendations of the Programme, Budget and Administration Committee. They would continue to be updated in light of periodic evaluations and in line with the stated objectives.

In answer to specific questions, he pointed out that the master list for distribution was not fixed and was not approved by the Board or Member States. Rather, it was used for internal planning and designed to avoid duplication in distribution. It could also be revised to reflect particular needs and used to determine which publications were to be translated. In future, proposed publications and translation needs would be included in the Secretariat's workplans and would therefore be linked to expected results. The procedure should improve discipline in relation to publications. IARC and the Special Programme for Research and Training in Tropical Diseases had their own clearance and publishing policies, which were subject to review by their governing bodies. WHO had an electronic library, which was being organized to facilitate access to WHO publications on the Internet, all of which could be downloaded free of charge.

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

<sup>2</sup> *The world health report 2007 – A safer future: global public health security in the 21st century*. Geneva, World Health Organization, 2007.

The Secretariat would report back to the Programme, Budget and Administration Committee at its next meeting, and subsequently to the Board, on its efforts to implement the Committee's recommendations on WHO publications.

The DIRECTOR-GENERAL recalled that publishing at WHO headquarters had been highly centralized in the past but had recently been decentralized. The publishing policy review aimed to ensure that WHO was producing publications in accordance with its constitutional mandate, quality control and timeliness. The number and type of publications, and information on which units were publishing them, would be clarified. Topics for the world health reports, for example, were determined some two years ahead of publication. Balance must be struck between the need for executive clearance – quality control and respect for WHO's policies and priorities – and the workload that resulted. In some cases, where speed of publication had been essential, clearance procedures had not been fully adhered to. Publications were sometimes driven by Member States, sometimes by staff members, who might not always respect the need for objectivity. Whatever the political pressure, she would safeguard the editorial independence of WHO. The guidance given to Member States must be based on scientific evidence and objective expert advice. WHO should refuse funds offered for publishing if the publication concerned was not part of its core functions. In reply to the member for the United Kingdom of Great Britain and Northern Ireland, she explained that the governing bodies provided guidance on the overall publication policies and evaluated implementation of those policies.

On joining WHO, she too had been struck by the Organization's volume of publications and documents and by the storage costs. Quantity was perhaps too great – the 350 to 400 publications a year mentioned in paragraph 4 of the Secretariat's report included only those that carried an International Standard Book Number (ISBN) but not advocacy or meeting documents. WHO needed to consider fundamental questions such as quantity and expenditures. Was it a publishing house or library? Should it advocate for funding for its work as well as providing guidance? The representative of Chile had emphasized the need for equity across the official languages and for timely translation. The review would consider that and the translation resources available.

Decentralization was one of the Organization's assets, and she and the Regional Directors must take full responsibility for publications from their respective offices and be accountable to Member States for those products.

In reply to the member for the United States of America, she explained that all the documents for the governing body meetings were cleared by the Deputy Director-General and the Executive Director of the Director-General's Office.

Publications would be discussed at the senior management retreat in March 2008 and management activities would be reported to the governing bodies. She urged the Board to allow her enough room for manoeuvre in order to make the necessary decisions.

The CHAIRMAN took it that the Board wished to take note of the report, and that it accepted the request of the Programme, Budget and Administration Committee that the Director-General should continue work on the Organization's publishing policy and provide the Committee, at its next meeting, with more detailed guidelines on how the policy would be implemented and evaluated.

**It was so decided.**

**Method of work of the Health Assembly:** Item 6.5 of the Agenda (Documents EB122/3 and EB122/21)

Professor PEREIRA MIGUEL (Portugal), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, reported briefly on the Committee's discussion of the subitem as set forth in paragraphs 16 and 17 of document EB122/3. The Committee had recommended adoption by the Board of the draft resolution as amended by the Committee and attached as Annex 2 to document EB122/3.



Dr REN Minghui (alternate to Mr Li Baodong, China) said that, although China welcomed the efforts to improve the method of work of the Health Assembly, it was opposed to the proposal to abolish the Committee on Nominations where nominations were usually uncontested. Its abolition would not save a great deal of money or time. He recommended starting meetings punctually and avoiding repetitive discussion. China had been unable to make its views known in the Programme, Budget and Administration Committee, as it was not a member of that Committee.

Dr FORSTER (Namibia), speaking on behalf of the Member States of the African Region, welcomed the Secretariat's initiative to review the Rules of Procedure of the Health Assembly with a view to increasing efficiency. The time saved through the abolition of the Committee on Nominations should be put to productive use. The Region welcomed the intention to align the Rules of Procedure of the Health Assembly with those of the United Nations General Assembly where appropriate. It supported the draft resolution as amended by the Programme, Budget and Administration Committee and contained in Annex 2 to document EB122/3.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that his country supported the suggestions made by the Programme, Budget and Administration Committee, and also the amended draft resolution contained in Annex 2 to document EB122/3. His delegation supported the proposal for the abolition of the Committee on Nominations as that would help to streamline work on the opening day. He pointed out that the Committee on Nominations did not itself nominate the officers of the Health Assembly, but merely rubber-stamped the recommendations it had received from the regional committees.

Ms KRARUP (adviser to Mr Fisker, Denmark) supported the improved efficiency of the Health Assembly, including the proposal to abolish the Committee on Nominations. That efficiency would be further improved if a fixed time were set for the Director-General's speech, preferably on the first day of the event. Member States could then plan their schedules accordingly.

Mr McKERNAN (New Zealand) endorsed the comments made by the members for the United States of America and Denmark; any attempts to streamline the activities of the Health Assembly and devote the first day to high-level proceedings were welcome. To save even one hour on the first day would have a cost impact.

Dr GWENIGALE (Liberia) explained the Programme, Budget and Administration Committee had proposed that the Committee on Nominations should be abolished because the nomination process was merely a formality. The individuals who represented countries at the Health Assembly were recommended by their respective regions. Since it was really the regions that made the nominations and they were not voted on in the Committee on Nominations, there was no need for such a committee.

Dr REN Minghui (alternate to Mr Li Baodong, China) said that China was conversant, as a former member, with the way the Committee on Nominations worked. In the past, the Committee had never voted on nominations because it operated on the basis of consultations and consensus. That, however, did not mean that there would never be a need for a vote in the future.

Mr HOHMAN (alternate to Dr Wright, United States of America) asked whether it would be possible to assign to the General Committee the responsibilities currently attributed to the Committee on Nominations.

Mr BURCI (Legal Counsel) said that that would not be possible because the General Committee met only after the President and Vice-Presidents of the Health Assembly had been elected, and it was the Committee on Nominations that recommended which countries would serve on the General Committee.

After a discussion in which Dr DAHL-REGIS (Bahamas), Mr BURCI (Legal Counsel), Dr REN Minghui (alternate to Mr Li Baodong, China) and Dr KEAN (Executive Director, Office of the Director-General) participated, the CHAIRMAN suggested that the Board should vote on China's proposal to retain the Committee on Nominations.

Dr VOLJČ (Slovenia), speaking on behalf of the Member States of the European Union, requested that the meeting should be suspended to facilitate consultations among its members.

**The meeting was suspended at 18:55 and resumed at 19:10.**

Dr REN Minghui (alternate to Mr Li Baodong, China) said that, during the suspension, all members had pursued the goal of enhancing efficiency. He himself had originally thought that that could be done by abolishing the time-consuming Committee on Nominations. In fact, however, it was the General Committee that consumed a great deal of the Health Assembly's time. In withdrawing his proposal to abolish the Committee on Nomination, he recommended that, at its next meeting, the Programme, Budget and Administration Committee should instead consider how the meetings of the General Committee could be made more efficient.

Dr INOUE (alternate to Dr Shinozaki, Japan) said that unpredictable work patterns at the Health Assembly made it difficult to schedule health ministers' journeys to ensure that they attended high-level meetings. He welcomed China's proposal that the Programme, Budget and Administration Committee should discuss ways of making the General Committee more effective.

Dr VOLJČ (Slovenia) said that he also welcomed the proposal by the member for China.

**The resolution was adopted.<sup>1</sup>**

**The meeting rose at 19:15.**

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<sup>1</sup> Resolution EB122.R8.

## NINTH MEETING

Friday, 25 January 2008, at 09:15

Chairman: Dr B. SADASIVAN (Singapore)

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

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

The CHAIRMAN invited comments on the draft resolution as revised to incorporate the amendments proposed by an informal drafting group, which read:

The Executive Board,  
Having considered the report on female genital mutilation,<sup>1</sup>

RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:<sup>2</sup>

The Sixty-first World Health Assembly,  
Having considered the report on female genital mutilation;  
Recalling resolution WHA47.10 on Maternal and child health and family planning:  
traditional practices harmful to the health of women and children;  
Reaffirming ~~the goals and commitments contained in [Denmark]~~

OR

**Reaffirming the goals and commitments contained in [USA]**

OR

**Recalling [USA]**

the Beijing Declaration and Platform for Action of the Fourth World Conference on Women (Beijing, 1995), the Programme of Action of the International Conference on Population and Development (Cairo, 1994) and their five- and ten-year reviews **and related reports [USA]**, as well as the United Nations Millennium Declaration 2000 and the commitments relevant to the girl child made at the United Nations General Assembly special session on children (2002), and in United Nations General Assembly resolution 60/1 on the 2005 World Summit Outcome;

Affirming 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), ~~the African Charter on the Rights and Welfare of the Child (1990), and the Solemn Declaration on Gender Equality in Africa (2004)~~ constitute an important contribution to the legal framework for the protection and promotion of the human rights of girls and women, ~~including their right to the highest attainable standard of health~~ **and recognizing the importance African States**

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<sup>1</sup> Document EB122/15.

<sup>2</sup> See document EB122/15 Add.1 for the financial and administrative implications for the Secretariat of the resolution.

**attach to the African Charter on the Rights and Welfare of the Child (1990) and the Solemn Declaration on Gender Equality in Africa (2004) in this regard;**

Recognizing the entry into force of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted in Maputo on 11 July 2003, ~~which marks~~ **whose provisions on female genital mutilation mark** a significant milestone towards the abandonment ~~female genital mutilation of this practice;~~

Recalling also resolution 51/2 of the United Nations Commission on the Status of Women<sup>1</sup> on ending female genital mutilation (March 2007);

Recognizing that female genital mutilation violates the human rights of girls and women **including their right to the enjoyment of the highest attainable standard of physical and mental health;**

Noting that, whereas there is evidence of decline in the practice, it is still widespread in some parts of the world, with an estimated 100 million to 140 million girls and women having undergone the practice and at least another three million being at risk of undergoing the practice every year;

Deeply concerned about the serious health consequences of female genital mutilation; the risk of immediate complications, which include severe pain, shock, haemorrhage, tetanus, sepsis, urine retention, ulceration of the genital region and injury to adjacent genital tissue; the long-term consequences, which include increased risk of maternal morbidity, recurrent bladder and urinary tract infection, cysts, infertility and adverse psychological and sexual consequences; and increased risk of neonatal death for babies born to mothers having undergone female genital mutilation;

Also concerned about emerging evidence of an increase in carrying out female genital mutilation by medical personnel in all regions where it is practised;

Emphasizing that concerted action is needed in sectors such as education, finance, justice and women's affairs as well as in the health sector, and that many different kinds of actor must be engaged, from governments and international agencies to nongovernmental organizations, ~~(the last group including bodies representing health professionals and those concerned with human rights)~~

1. URGES all Member States:

- (1) to accelerate actions towards the elimination of female genital mutilation, including education and information necessary for full understanding of the gender, health and human rights dimensions of female genital mutilation;
- (2) to enact and enforce legislation to protect girls and women from all forms of violence, particularly female genital mutilation, and ensure ~~appropriate~~ implementation of laws prohibiting female genital mutilation by any person, including medical professionals;
- (3) to support and enhance community-based efforts to eliminate the practice **of female genital mutilation, particularly ensuring men's and local leaders' participation in the process to eliminate the practice;**
- (4) to work with all sectors of government, international agencies and nongovernmental organizations in support of the abandonment of the practice as a major contribution to attainment of the Millennium Development Goals on promoting gender equality and empowerment of women, reducing child mortality, and improving maternal health;
- (5) to formulate and promote guidelines for the care, particularly during childbirth, of girls and women who have undergone female genital mutilation;

<sup>1</sup> Document E/CN.6/2007/L.3.

(6) to develop or reinforce social and psychological support services and care and to take measures to improve health , including sexual and reproductive health care; [USA]

OR

care and services including those for sexual and reproductive health; [United Kingdom]  
in order to assist women and girls who are subjected to this violence; [Denmark]

2. REQUESTS the Director-General:

- (1) to ~~continue to provide~~ **increase** support to Member States for implementing actions to advocate for the elimination of female genital mutilation and other forms of violence against girls and women;
- (2) to work with partners both within and outside the United Nations system to promote actions to protect the human rights of girls and women;
- (3) to ~~continue to support~~ **increase support for** research on different aspects of female genital mutilation in order, **inter alia**, to ~~achieve support~~ its elimination;
- (4) to assist Member States with strengthening their health information systems for monitoring progress made towards elimination of female genital mutilation;
- (4-5) to report ~~regularly, at the least, every four~~ **every three** years, to the Health Assembly, **through the Executive Board**, on actions taken by **the WHO Secretariat**, Member States and other partners.

It had not proved possible to reach consensus on the draft resolution, although during the earlier discussions Board members had argued passionately for action on the topic and had considered that failure to adopt a resolution might reflect poorly on WHO.

Dr STEIGER (alternate to Dr Wright, United States of America) confirmed his country's wish to adopt a resolution on the topic. The United States Agency for International Development was financing relevant programmes in African countries and it was desirable for WHO to take a stand against female genital mutilation. He said that he regretted that consensus had not been reached on two paragraphs. His delegation had proposed text that it had hoped would prove acceptable: for the third preambular paragraph, including wording that had appeared in resolution WHA60.25; and for paragraph 1(6), including wording from the amendment proposed earlier by the delegations of Canada and Denmark. He was still willing to accept a text with that wording and to continue informal consultations with a view to achieving consensus.

Mr BERLING-RASMUSSEN (adviser to Mr Fisker, Denmark) said that the earlier debate had clearly shown the Board's concern about the practice. In the informal negotiations, one party had failed to agree with the views of a large number of members. After further clarification from the Director-General, the draft resolution should be referred back to the informal working group for further consideration.

The DIRECTOR-GENERAL said that the whole debate had shown agreement on the importance of the matter. Consultations on draft resolutions were the prerogative of Board members and Member States. However, several speakers from Member States and nongovernmental organizations had earlier indicated that it was important for WHO to sign the interagency statement that had been expected to be issued in March 2008. The statement was currently in draft form and she would need to examine it, taking into account any points that the Board might decide required further consideration. The outcome of the Board's deliberations might therefore have implications for her ability to sign that important statement.

The CHAIRMAN suggested that further time should be allowed for informal consultations. Failure to adopt a resolution might signal that the Board was not committed to a strong stand against female genital mutilation, which was clearly not the case. If consensus could not be achieved, the Board might wish to adopt the draft resolution, indicating that no agreement had been reached on the two paragraphs referred to by the member for the United States of America, in the hope that agreement could be reached before or at the Health Assembly or at the Board's next session. Such a procedure would at least indicate WHO's commitment to action to stop the practice.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), emphasizing the unanimous and passionate support by Board members for action to stop the practice, pointed out that it would be damaging to WHO if the Board failed to make an unequivocal statement at its present session. Such a failure might be interpreted as a lack of commitment on the part of the Board. It was also important to ensure that the Director-General was not constrained with regard to the signing of the interagency statement on behalf of WHO. Failure to agree on a text, or the adoption of a text in which certain paragraphs were still disputed, would make her position very difficult. The matter should be referred back to the informal working group, which should be urged to reach consensus.

**It was so agreed.**

(For adoption of the resolution, see summary record of the tenth meeting, section 1.)

**Monitoring of health-related Millennium Development Goals:** Item 4.14 of the Agenda (Document EB122/33) (continued from the eighth meeting, section 1)

The CHAIRMAN drew attention to a revised text of the draft resolution on the item, proposed by Slovenia and cosponsored by Austria, Belgium, Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Monaco, the Netherlands, Poland, Portugal, Romania, Slovakia, Spain, Sweden and the United Kingdom of Great Britain and Northern Ireland, which reflected the amendments proposed during the Board's seventh meeting and which read:

**Monitoring of the ~~implementation~~ achievement  
[Slovenia] of the health-related Millennium  
Development Goals**

The Executive Board,  
Having considered the report on monitoring of health-related Millennium Development Goals,<sup>1</sup>

RECOMMENDS to the Sixty-first World Health Assembly the adoption of the following resolution:<sup>2</sup>

The Sixty-first World Health Assembly,  
Having considered the report on monitoring of health-related Millennium Development Goals,

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<sup>1</sup> Document EB122/33.

<sup>2</sup> ~~See document EB122/33 Add.1 for the financial and administrative implications of the Secretariat of this resolution.~~

Recalling the 2005 World Summit Outcome and the commitments taken by the international community to ~~implement~~ **achieve [Slovenia]** fully the Millennium Development Goals;

Concerned by the lack of progress, especially in the sub-Saharan African countries, in the ~~implementation~~ **achievement [Slovenia]** of the Millennium Development Goals and, in particular, the health-related Goals 4, 5 and 6;

**Recognizing the urgent need to improve the performance of health systems in order to reach the health-related Millennium Development Goals; [Iraq]**

**Recognizing that it is often poor people, women and other vulnerable groups that lack access to health services and that pro-poor health strategies are needed for the reaching of the health-related Millennium Development Goals; [Iraq]**

**Recognizing that the reaching of the health-related Millennium Development Goals need more effective aid in line with the Paris Declaration on Aid Effectiveness and scaling up of aid; [Iraq]**

**Recalling recent commitments taken by Member States towards prioritization of health and in support of health system strengthening;<sup>1</sup> [Iraq]**

Recalling the General Assembly resolution 60/265 dated 12 July 2006 on follow-up to the development outcome of the 2005 World Summit, including the Millennium Development Goals and other internationally agreed development goals, and WHO's Medium-term strategic plan 2008–2013, particularly the objectives 2, 4, 7 and 12;

1. DECIDES to include regularly an item on the agenda of the Health Assembly on the monitoring of the ~~implementation~~ **achievement [Slovenia]** of the health-related Millennium Development Goals;

2. REQUESTS the Director-General:

(1) to identify major obstacles to the full ~~implementation~~ **achievement [Slovenia]** of the Millennium Development Goals and ways to overcome those obstacles;

(2) to that effect, to cooperate closely with all other United Nations and international organizations involved in the process of ~~implementing~~ **achieving [Slovenia]** the Millennium Development Goals;

(3) **to provide technical assistance to Member States in order to strengthen national monitoring and information systems related to the Millennium Development Goals; [Namibia]**

~~(3-4)~~ **to submit annually a report on the status of the ~~implementation~~ achievement [Slovenia] of the health-related Millennium Development Goals, and in particular Goals 4, 5 and 6, through the Executive Board to the Health Assembly, in particular on monitoring progress in: availability and equitable accessibility of services especially to the poor and vulnerable groups, improvement in access to essential medicines, addressing the shortage of skilled health workers, and better financing of national health plans. [Iraq]**

Dr REN Minghui (alternate to Mr Li Baodong, China) welcomed the discussion and was in favour of WHO playing a greater role in efforts to attain the health-related Millennium Development Goals. The draft resolution had already taken account of certain delegations' comments; however, he reiterated that there had not been sufficient time for discussions within his Government. He was not,

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<sup>1</sup> Including the Abuja Declaration by Heads of State and Government of African countries, 2000, the Global Campaign for the Health Millennium Development Goals, International Health Partnership, Providing for Health, the Global Health Workforce Alliance. [Iraq]

therefore, in a position to comment further on the draft resolution. He proposed that discussion of the matter should be postponed until the Sixty-first World Health Assembly. In the meantime, he would supply additional comments on the draft resolution in order to facilitate its adoption by the Health Assembly.

Dr VOLJČ (Slovenia), speaking on behalf of the Member States of the European Union, said that, in view of the position taken by the Chinese delegation and after informal consultations, he supported the course of action proposed by the member for China. That would enable the Health Assembly to debate the matter fully on the basis of a report that identified the obstacles to progress and ways of overcoming them, and took into account the main thrust of the Board's discussions and the comments made by its members. The European Union would seek informal consultations with interested parties with a view to preparing for that debate and ensuring a successful outcome.

Dr AL-HASNAWI (Iraq) and Dr FORSTER (Namibia) supported the proposed procedure.

**It was so agreed.**

## **2. MANAGEMENT MATTERS:** Item 6 of the Agenda (continued)

### **Multilingualism: implementation of action plan:** Item 6.8 of the Agenda (Document EB122/29)

The CHAIRMAN drew attention to a draft resolution proposed by Mali and its associated financial and administrative implications for the Secretariat, which read:

The Executive Board recommends to the Sixty-first World Health Assembly the adoption of the following resolution:

The Sixty-first World Health Assembly,

Convinced of the relevance of the recommendations made in the report of the Joint Inspection Unit (JIU/REP/2003/4) of 2003 entitled Multilingualism and access to information: case study on the World Health Organization, which was submitted to the first meeting of the Programme, Budget and Administration Committee of the Executive Board;

Having considered the report by the Secretariat entitled Multilingualism: plan of action<sup>1</sup> and recalling the provisions relating to multilingualism contained in the Medium-term strategic plan 2008–2013 (WHA60.11);

Also recalling the resolutions and rules relating to language use in WHO, and in particular resolution WHA50.32 on respect for equality among the official languages and resolution WHA51.30 concerning the availability of governing body documents on the Internet and resolution EB105.R6 on the use of languages in WHO;

Considering that the universality of the organizations of the United Nations system is based on, among other things, language diversity and equality among the official and working languages chosen by the Member States;

Welcoming in this regard the resolution on multilingualism (A/RES/61/266) adopted by the United Nations General Assembly in May 2007;

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<sup>1</sup> Document EB121/6.



Commending the report by the Secretariat entitled Multilingualism: plan of action, contained in document EB121/6 submitted to the One hundred and twenty-first session of the Executive Board in May 2007;

1. REQUESTS the Director-General to implement, as rapidly as possible, the plan of action contained in the report, and in particular the following points:
  - (1) preparation, before the One hundred and twenty-fourth session of the Executive Board, of a timetable for implementation of the plan of action and a table showing the financial implications globally fitting within the framework of the Medium-term strategic plan 2008–2013;
  - (2) effective appointment of a coordinator whose functions are described in paragraph 11 of the above report, in any case before the One hundred and twenty-fourth session of the Executive Board;
  - (3) preparation of a strategy to set translation priorities, associating Member States by means of a mechanism of informal consultations to be defined;
  - (4) establishment of a multilingual team of editors, of equitable geographical distribution and taking into account the gender perspective, for the web site;
2. ALSO REQUESTS the Director-General to ensure:
  - (1) respect, within the framework of the Organization's recruitment policy, for linguistic diversity on the same terms as geographical distribution;
  - (2) establishment of a database to make it possible to determine in which official languages of the Organization members of WHO staff belonging to the P category are fluent;
  - (3) encouragement for and promotion of access to quality language training for all the Organization's staff;
3. REQUESTS the Director-General to report to the Sixty-second World Health Assembly on the implementation of this resolution, and to report biennially thereon.

<b>1. Resolution</b> Multilingualism: implementation of action plan	
<b>2. Linkage to programme budget</b>	
Strategic objective:	Organization-wide expected result:
12. To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work.	4. Essential multilingual health knowledge and advocacy material made accessible to Member States, health partners and other stakeholders through the effective exchange and sharing of knowledge.
<b>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</b>	
Increased access to public health information and information about WHO on the Organization's web site (accessible at <a href="http://www.who.int">www.who.int</a> ).	
Improved access to international health information in support of progress on global health priorities.	
Number of pages on WHO's web site translated into multiple languages.	

**3. Financial implications**

- (a) **Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)**

Recurrent biennial cost of US\$ 5 890 000.

- (b) **Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)** US\$ 5 960 000.

- (c) **Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?** US\$ 2 480 000.

- (d) **For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)**

Through the global staff development fund, voluntary contributions and Miscellaneous Income.

**4. Administrative implications**

- (a) **Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)**

In general, work will be undertaken at headquarters; however, language training will involve all offices in all regions.

- (b) **Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant)**

Coordinator for multilingualism (1 full-time equivalent); translator for preparation of translation strategy (0.25 full-time equivalent); Web editor (0.8 full-time equivalent); database development professional (0.25 full-time equivalent). Language training is normally outsourced.

- (c) **Time frames (indicate broad time frames for implementation)**

The resolution will be implemented during the current biennium.

Dr REN Minghui (alternate to Mr Li Baodong, China) commended the Secretariat's efforts to promote multilingualism. Although he supported the draft resolution in principle, he proposed the addition of two new subparagraphs in paragraph 2 to read: "to ensure equal respect for linguistic diversity at the WHO headquarters, regional offices and country offices"; and "to ensure that a health-care background is taken into account when recruiting language services staff".

Mr TOURÉ (Mali), speaking on behalf of the francophone Member States, seven of which were currently designated members of the Board, said that the draft resolution had been approved by 59 French-speaking Member States. The promotion of multilingualism contributed to WHO's mandate to disseminate information and knowledge. He emphasized the plan of action and the effective framework for its implementation and indicated priorities.

Mr TINAJERO (alternate to Dr Hernández Ávila, Mexico), speaking as the coordinator of the Americas group, emphasized the cultural and linguistic diversity that characterized that region. He stressed the importance of using the Organization's official languages in its publications and documents, and in its work at all levels. Multilingualism, as a means of promoting, protecting and preserving cultural and linguistic diversity, had been enshrined in many United Nations resolutions. However, it was crucial to translate the principle of multilingualism into practical action in order to enable enriched and wider access to the latest information. He gave particular support to the proposal to improve the different official language sections of the WHO web site. The Organization should continue to promote multilingualism in all its work and in criteria for staff recruitment and promotion.

Dr VOLJČ (Slovenia) said that he was speaking on behalf of the Member States of the European Union and the European Free Trade Association country Iceland, a member of the European Economic Area. The candidate countries Croatia, The former Yugoslav Republic of Macedonia, and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Armenia, the Republic of Moldova and Ukraine associated themselves with his statement. The proposed resolution, which the majority of European Union Member States were sponsoring, was in line with the report on the plan of action on multilingualism noted by the Board at its 121st session, and with the relevant points relating to multilingualism contained in the Medium-term strategic plan 2008–2013.

Dr AL-HASNAWI (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the plan of action on multilingualism as a good basis for further work. The Regional Office had done much in support of the plan, and the progress report should refer to that work in a region where three of the Organization's six official languages were spoken. English had become the default language of communication and publication in WHO, a trend that should be reversed. The other languages were used much less for several reasons. Moreover, local languages were virtually ignored simply because of the scarcity of financial resources, particularly for publishing. It was unclear how much funding had been allocated under the action plan to support those languages. He called for full cooperation and resource mobilization at a global level to support and promote multilingualism in WHO.

The Regional Committee had endorsed the regional strategy for knowledge management to support public health, with its strategic emphasis on supporting multilingualism.

He welcomed the plan to create an institutional repository to store WHO's products in digital form. He looked forward to the information becoming accessible on the web site, and on CD-ROM for those countries without high-speed Internet access. As many countries still had poor Internet access, WHO should continue to print and distribute hard copies of its publications to provide equal access to health information.

Dr STEIGER (alternate to Dr Wright, United States of America), speaking in Spanish, fully supported the promotion of multilingualism in WHO, and joined others in calling for an increase in the volume of documents available in different languages on the web site. However, it might be premature to adopt a new resolution so soon after the plan of action had become operational. He sought clarification from the Secretariat on whether a coordinator had already been appointed, whether a strategy to set translation priorities had been prepared, and whether a multilingual team of editors had been established. He had some difficulty with paragraph 2(1) of the draft resolution, since professional qualifications should be the most important criterion in any recruitment process. Sometimes the staff recruited for local offices did not speak any of the official languages, and the paragraph was not consistent with good policy, practice and WHO rules. Referring to paragraph 2(2), he could not support the request concerning the establishment of a database without a better understanding of the costs and benefits involved.

Dr JAKSONS (Latvia), speaking in Russian, shared the concerns of the previous speaker regarding paragraph 2(1): if gender balance, geographical distribution and linguistic diversity were all to be taken into account, sufficient attention might not be given to professional competence. What linguistic status would be accorded to candidates who spoke several of WHO's official languages but whose mother tongue was not one of those languages? More work was needed in order to determine the criteria for ensuring that the Organization's requirements for multilingualism were met.

Mr McKERNAN (New Zealand) welcomed the Secretariat's efforts to promote multilingualism. He broadly supported the draft resolution, but had some difficulty with paragraph 2(1), which might make it more difficult to attract and recruit the best people to the Organization. Although more could be done to promote multilingualism, the need for linguistic diversity should not be imposed as with geographical distribution and should be considered along with other professional attributes.

Mr JAHLAN (Monaco)<sup>1</sup> supported the draft resolution and highlighted the coordinator's responsibilities for actions to promote multilingualism. The Francophone Group sought a contact point for representatives of French-speaking countries at WHO, established in the Director-General's Office. Linguistic diversity should be taken into account in staff recruitment, and language training encouraged. Multilingual content on the WHO web site should be increased, facilitating wider access for health personnel, particularly at country level. As a new post was not being created, the word "appointment" in paragraph 1(2) should be replaced with "nomination", as in the French text.

Mr MENGA (Congo),<sup>1</sup> speaking in his capacity as the representative of Congo and president of the group of French-speaking ambassadors in Geneva, endorsed the comments made by the member for Mali and the representatives of Mexico and Slovenia. Multilingualism and parity between the official and working languages were key elements in enabling WHO to disseminate information to as many people as possible. WHO's technical support was vital to countries where other languages were spoken. Documents had to be made available in different languages and linguistic diversity associated with geographical representation had to be assured, in particular in the appointment of senior staff. He emphasized the promotion of multilingualism in the United Nations system. The draft resolution before the Board would provide an effective framework for implementation of the plan of action.

Mrs SCHAEER BOURBEAU (Switzerland)<sup>1</sup> said that multilingualism was central to the values of the United Nations, and joined others in supporting its promotion in WHO. The draft resolution, which Switzerland wished to sponsor, addressed important issues such as the translation of official documents, and recruitment policy and its effects.

Dr EVANS (Assistant Director-General) welcomed the comments made. The plan for multilingualism had been developed in response to the report of the United Nations Joint Inspection Unit over and above WHO's existing work in that area. It had been noted by the Board in May 2007 and had come into effect in January 2008. The request for a timetable was consistent with the implementation of the plan, and the Secretariat could report to the Board at its 124th session. A special coordinator on multilingualism had already been appointed. A committee had been established to set translation priorities, and would report to the Executive Board on the implementation of the plan. With regard to paragraph 1(4), the multilingual team of editors for the web site was almost complete; only one of the six editors still had to be appointed. Over and above the pre-eminence of professional qualifications, the current recruitment policy respected linguistic diversity; the current criteria for geographical representation were the best safeguards for guaranteeing that diversity. Regarding paragraph 2(2), it would be possible to establish a database on the linguistic diversity of the professional staff in WHO once the global management system had come into operation. Training in all official languages was offered to staff at headquarters; regional offices also offered training in their respective official languages.

The DIRECTOR-GENERAL, speaking in Chinese, thanked the members of the Board for their valuable recommendations on multilingualism. Responding in English to the questions about how WHO could ensure respect for linguistic diversity, as mandated in paragraph 2(1) of the draft resolution, she requested further guidance from Member States as to the implications of the term "linguistic diversity" itself; the phrase "on the same terms as geographical distribution" also needed to be better defined. The most important criteria for staff recruitment were experience, qualifications, competencies and integrity. Nothing in the draft resolution suggested that those criteria should not continue to be applied. At the same time, however, every effort must be made to ensure geographical and gender balance. Linguistic diversity should be promoted not only at headquarters but also at

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

regional and country levels, where there was often an even greater need for staff with specific language skills.

**The Board noted the progress report on the plan of action on multilingualism.**

Dr KEAN (Executive Director, Office of the Director-General) read out the amendments proposed to the draft resolution. The member for the United States of America had proposed that paragraph 2(1) should be deleted. The member for China had proposed that two new subparagraphs should be inserted in paragraph 2, the first to become new subparagraph 2(2) and to read “equal respect for linguistic diversity at the WHO headquarters, regional offices and country offices”, and the second to read “that health-care background is taken into account when recruiting WHO language services staff”.

Dr STEIGER (alternate to Dr Wright, United States of America) proposed the deletion of paragraphs 1(2) and 1(4), which were superfluous given that a coordinator had already been recruited and the multilingual team of web site editors was virtually complete.

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

**3. STAFFING MATTERS:** Item 7 of the Agenda (continued)

**Human resources: annual report:** Item 7.2 of the Agenda (EB122/3, EB122/24, EB122/24 Add.1 and EB122/24 Add.1 Corr.1)

Mrs EBBE-DUNCAN (alternate to Dr Gwenigale, Liberia), speaking on behalf of the Member States of the African Region, commended progress achieved with the global management system and related planning and management reforms. Managing staff performance enabled the Organization to respect promises made to its governing bodies. Improving the Organization’s performance meant improving staff performance leading to improved health outcomes.

In Africa, where the burden of various diseases was greatest, human resources for health were important. With Member States trying to expand health services to underserved or new districts or in post-conflict countries such as Liberia, WHO was being called on to provide expert support. In some instances, it was even asked to provide funds to employ local counterparts for such experts. In 2007, the Programme, Budget and Administration Committee had expressed concern over the large number of temporary employees in the African Region. Although moving staff to long-term positions would increase payroll costs, it was necessary if WHO was to carry out its duties. The concern raised by some Member States over the future financial burden of retired employees was valid, but many of those were contract workers unlikely to retire in the system. More important was the supervision of those employees and the monitoring of their effectiveness.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) welcomed the fact that WHO was taking the management and assessment of staff performance seriously. WHO’s effectiveness at country level depended on the competence and leadership of its country representatives. Getting the right people with the right skills into that job should therefore be a priority. Over the preceding year the Organization had improved recruitment of representatives at country level through an open and transparent process; however, further progress was needed, for example an independent agency to handle appointments. Once in post, representatives should receive

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<sup>1</sup> Resolution EB122.R9.

appropriate professional training. The WHO performance system must identify those representatives whose performance was unsatisfactory and then deal with the problem. The report did not make it clear whether human resources approaches such as management of staff performance were equally and consistently implemented across all regions, and he requested clarification on that point.

The review of the programme on Health Action in Crises had shown that short-term funding of positions at country level undermined WHO's capacity to assume not only its coordinating function but also its more active operational role in humanitarian action. That was a source of concern.

Mr TOURÉ (Mali) said that the complex issue of human resources concerned two main points: staff production and staff retention. All countries faced, in differing degrees, the same problems of the quantitative and qualitative inadequacy of human resources, low motivation, need for capacity building and lack of career development plans. A thorough analysis was needed and a human resources policy in the health field, in order for countries to clarify their vision and develop strategies for implementation. They would then have a basis for discussion with partners and stakeholders, thereby facilitating the mobilization of funds for human resources development. He welcomed the various initiatives being carried out in order to strengthen health systems, including the GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the International Health Partnership.

Ms BLACKWOOD (alternate to Dr Wright, United States of America) commended the Secretariat's efforts to improve human resources management and recruitment. She looked forward to the benefits expected from the global management system, including increased efficiency and effectiveness. Although the report described recruitment and outreach efforts in 2007, it failed to indicate action on underrepresentation and lack of representation of countries. Efforts should focus on those countries in 2008 and the results should be reported in 2009. She underscored the importance of comprehensive performance appraisal and noted the work in that regard.

Dr REN Minghui (alternate to Mr Li Baodong, China) said that the Secretariat should examine human resources issues in country offices, particularly recruitment of experts and appraisal of their performance. Steps had been taken to improve equitable geographical distribution; several workshops had been held in China recently. Lastly, the long-standing issue of under-representation of countries had to be addressed.

Dr DAHL-REGIS (Bahamas) said that every year she was saddened that at least nine countries of her Region were unrepresented within the Secretariat. For the past five years, her delegation had brought that fact to the attention of the Directing Council of PAHO, but to little avail. The need for development programmes at country, regional and headquarters levels to address that problem should be heeded. Competencies were available in the regions; in fact, nationals often did the work of visiting consultants. She stressed the benefits of geographical diversity and participation in promoting health within WHO. She supported the recommendation by the member for the United States of America to address the underrepresentation of a number of countries.

Mrs PRADHAN (Assistant Director-General) said that there had been many developments in the area of human resource management over the preceding three years. She agreed with the member for Liberia on the need to reduce the number of temporary staff within the Organization; the different types of contracts issued and terms and conditions of service applied had been rationalized. Such work would continue.

The global management system would integrate human resource planning into programme management, transforming the way the Organization functioned. The third area of reform – global learning and performance management – was a high priority; a global leadership programme had been set up, involving country representatives and other senior staff.

Board members had referred to the importance of ensuring that WHO had a good presence at country level. The Secretariat was working on a system to improve the recruitment of country

representatives, assessing the competencies required to tackle the health problems of specific countries.

Mr HENNING (Director, Human Resources Services), responding to the comment of the member from Liberia, said that a number of longer-term posts had recently been created in the Regional Office for Africa and that the trend would continue. Addressing the points raised by the member for the United Kingdom of Great Britain and Northern Ireland with regard to the competence and leadership qualities of country representatives, a new, more rigorous selection process would come into force in 2008. The competence of senior managers, including country representatives, would be evaluated within the global leadership programme, the next step of which would be a “360° evaluation”, one of the tools used to evaluate individual progress in the competencies of management and leadership.

The member for Mali had asked about technical competence and career development. The Global Learning Committee had requested the regions to formulate programmes to meet the needs of country offices, through, for example, provision of additional technical expertise to national staff. He would inform the member for the United States of America of the additional measures that had been taken. He recalled that, in 2006, the Board had approved a recruitment strategy to ensure representation of underrepresented and unrepresented countries. In response to the member for China, he said that evaluation and appraisal of experts would fall under the new, more rigorous consultant and expert policy of the global management system. The results of such appraisals would be available in a central database, to which all WHO offices would have access, thereby avoiding the possibility of recruiting consultants or experts who had not performed adequately during their period of employment within the Organization. In response to the comments of the member for the Bahamas, he said that both headquarters and PAHO had tried to attract candidates from the Caribbean countries; however, only two WHO collaborating centres had been active in supporting the recruitment strategy. Other sources would have to be sought to provide support in recruitment drives.

Dr DAHL-REGIS (Bahamas) asked the Secretariat to re-examine the figures with regard to the inadequate representation of the Caribbean countries at PAHO. She recommended that, if the strategy being used was not working, another should be tested.

The DIRECTOR-GENERAL said that the staff was WHO’s most important asset, and that salaries accounted for a large proportion of the budget; therefore, the talents and motivation of the staff must be maximized. Discussions had been held on the importance of performance appraisal, including meetings of senior management and a meeting in November 2007 of all WHO country representatives, who had agreed that a robust, fair, and transparent system was necessary. In new environments, new skills were needed. As “the face and voice of WHO”, country representatives needed training in diplomatic, leadership, technical and managerial skills. At the start of her term of office, she had noticed that at WHO good performance was seldom recognized and poor performance rarely censured; that attitude gave the wrong signals. She assured members that in the future no person who performed poorly would retain his or her position. She thanked those countries that had provided financial support to enable her to implement the new strategy smoothly.

Dr ANTEZANA ARANÍBAR (Bolivia)<sup>1</sup> said that competent, responsible staff formed the foundation for all the activities of the Organization. He asked for fuller information on WHO collaborating centres in developing countries whose potential was under-exploited. WHO should provide them with support through transfer of technical knowledge, and in the area of human resources management.

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**The Board noted the report.**

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

**Report of the International Civil Service Commission:** Item 7.3 of the Agenda (Documents EB122/3 and EB122/25)

**The Board noted the report.**

**Confirmation of amendments to the Staff Regulations and Staff Rules:** Item 7.4 of the Agenda (Documents EB122/3, EB122/30 and EB122/30 Add.1)

The CHAIRMAN invited the Board to consider the two draft resolutions set out in paragraph 13 of document EB122/30. The Programme, Budget and Administration Committee had recommended that the Board should adopt the two draft resolutions.

**The resolutions were adopted.<sup>1</sup>**

**Statement by the representative of the WHO staff associations:** Item 7.5 of the Agenda (Document EB122/INF.DOC./1)

Mr RATNAKARAN (representative of the WHO staff associations) highlighted: the need to extend improved staff/management consultation at headquarters to the regions and IARC; the lack of progress in harmonizing and streamlining selection procedures for fixed-term positions; the challenges posed by the imminent implementation of the global management system; the need to apply the Organization's policy on staff development and learning uniformly across all offices; and the need to strengthen the institution of Ombudsman. He reaffirmed the dedication of WHO's staff, as committed international civil servants, to the service of Member States and the health of their populations.

The DIRECTOR-GENERAL, expressing her gratitude to the representative of the WHO staff associations for his statement, reiterated the importance she attached to staff matters. She had participated, over the past 13 months, in the effort to enhance WHO's commitment to staff associations and would continue to do so. She recognized that, notwithstanding her commitment and that of the Regional Directors and IARC, the application of human resource management might be uneven in some areas. That would be considered so as to achieve further progress.

**The Board took note of the statement by the representative of the WHO staff associations.**

#### **4. MANAGEMENT MATTERS:** Item 6 of the Agenda (resumed)

**Reports of committees of the Executive Board:** Item 6.6 of the Agenda

- **Standing Committee on Nongovernmental Organizations** (Documents EB122/34 and EB122/34 Add.1)

Dr SINGAY (Bhutan), speaking in his capacity as Chairman of the Standing Committee on Nongovernmental Organizations, said that the Committee had considered applications for admission into official relations with WHO from four nongovernmental organizations. Additionally, it had reviewed information concerning four nongovernmental organizations that had been admitted into provisional official relations with WHO pursuant to decision EB120(3). The outcome of the Committee's discussions was set out in document EB122/34. He drew attention to the draft resolution and the draft decision contained in paragraphs 23 and 24 of document EB122/34. He expressed the

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<sup>1</sup> Resolutions EB122.R10 and EB122.R11.



Committee's appreciation of the work of the applicant nongovernmental organizations and of those organizations whose activities had been reviewed.

The CHAIRMAN invited the Board to consider the draft resolution contained in paragraph 23 of document EB122/24.

**The resolution was adopted.<sup>1</sup>**

The CHAIRMAN invited the Board to consider the draft decision contained in paragraph 24 of document EB122/24.

**The decision was adopted.<sup>2</sup>**

- **Foundations and awards** (Documents EB122/31, EB122/32 and EB122/35)

#### **Dr A.T. Shousha Foundation Prize**

**Decision:** The Executive Board, having considered the report of the Dr A.T. Shousha Foundation Committee, awarded the Dr A.T. Shousha Foundation Prize for 2008 to Professor Sayed Adeeb ul Hassan Rizvi (Pakistan) for his significant contribution to public health in the Eastern Mediterranean Region. The laureate will receive the equivalent of 2500 Swiss francs in United States dollars.<sup>3</sup>

#### **Sasakawa Health Prize**

**Decision:** The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel, awarded the Sasakawa Health Prize for 2008 to the Movement for Reintegration of People Affected by Hansen's disease (MORHAN), Brazil, for its outstanding innovative work in health development. The laureate will receive US\$ 40 000.<sup>4</sup>

#### **Francesco Pocchiari Fellowship**

**Decision:** The Executive Board, having considered the report of the Francesco Pocchiari Fellowship Selection Panel, awarded the Francesco Pocchiari Fellowship for 2008 to Dr Uranchimeg Davaatseren (Mongolia) and Dr Intesar Alsaidi (Yemen). The laureates will each receive US\$ 10 000.<sup>5</sup>

#### **United Arab Emirates Health Foundation Prize**

**Decision:** The Executive Board, having considered the report of the United Arab Emirates Health Foundation Selection Panel, awarded the United Arab Emirates Health Foundation Prize

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<sup>1</sup> Resolution EB122.R12.

<sup>2</sup> Decision EB122(1).

<sup>3</sup> Decision EB122(2).

<sup>4</sup> Decision EB122(3).

<sup>5</sup> Decision EB122(4).

for 2008 to the Children's Cancer Hospital, Cairo (Egypt) for its outstanding contribution to health development. The laureate will receive US\$ 40 000.<sup>1</sup>

#### **State of Kuwait Prize for Research in Health Promotion**

**Decision:** The Executive Board, having considered the report of the State of Kuwait Health Promotion Foundation Selection Panel, awarded the State of Kuwait Prize for Research in Health Promotion in 2008 to Dr Zaza Metreveli (Georgia) and Dr Chuon Chantopheas (Cambodia) for their outstanding contribution to health development. The laureates will each receive US\$ 20 000.<sup>2</sup>

#### **Dr Lee Jong-wook Memorial Prize for Public Health**

Professor SOHN Myongsei (Republic of Korea) thanked all those who had contributed to the establishment of the Dr Lee Jong-wook Memorial Prize for Public Health and, in particular, the Executive Board, for considering the proposal to institute the Prize within the Organization's framework. An award of US\$ 100 000 would be granted annually, starting in 2009, to persons or organizations for their contribution to research into and prevention, treatment and control of HIV/AIDS; research into and control of communicable diseases; or control of neglected tropical diseases.

He paid tribute to the late Director-General Dr Lee Jong-wook, who had dedicated 23 years of his life to the improvement of global health and to the betterment of the human condition.

**Decision:** The Executive Board, having considered the proposal of the Republic of Korea to establish an award for research in the areas of HIV/AIDS, communicable diseases and neglected tropical diseases, approved in principle the establishment of an award entitled the "Dr Lee Jong-wook Memorial Prize for Public Health", for which the proposed statutes are to be elaborated in cooperation with the Republic of Korea and submitted for the approval of the Board, together with recommendations for covering the administrative costs incurred with respect to such an award.<sup>3</sup>

The DIRECTOR-GENERAL thanked the Government of the Republic of Korea and the family of the late Dr Lee Jong-wook for their proposal to establish the Prize, and Member States for approving its establishment in memory of her predecessor.

#### **Darling Foundation Prize**

**Decision:** The Executive Board, having considered the report by the Director-General on administration and award of the Darling Foundation Prize: proposed dissolution, agrees to dissolve the Darling Foundation and requests the Director-General to take all necessary action to effect the dissolution subject to all approvals and action required under Swiss law.<sup>4</sup>

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<sup>1</sup> Decision EB122(5).

<sup>2</sup> Decision EB122(6).

<sup>3</sup> Decision EB122(7).

<sup>4</sup> Decision EB122(8).

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**Provisional agenda of the Sixty-first World Health Assembly and date and place of the 123rd session of the Executive Board:** Item 6.7 of the Agenda (Document EB122/22)

Dr YOUNES (Director ad interim, Office of Governing Bodies) said that the Secretariat had noted three amendments to the provisional agenda of the Sixty-first World Health Assembly, as contained in Annex 1 of document EB122/22. Two new subitems had been proposed for Committee A, under item 11, Technical and health matters: item 11.11, Climate change and health, and item 11.12, Monitoring of the achievement of the health-related Millennium Development Goals. The subitem entitled “Progress reports on technical and health matters” would thus become subitem 11.13. Regarding Committee B, under item 17, Management matters, the subitem Method of work of the Health Assembly would be numbered subitem 17.1, to be followed by a new subitem 17.2, Multilingualism: implementation of action plan.

Mr BIN SHAKAR (United Arab Emirates) proposed the insertion of an item on counterfeit medical products, which posed a serious threat to the poorest segments of the population. His country had witnessed the phenomenon in 2007, when thousands of counterfeit medical supplies had been discovered and seized. New national legislation should be introduced soon, focusing on the import and export of medical supplies and products, and the evaluation of such products in cases of fraud. The issue was a concern for the health community as a whole. Therefore, WHO, together with the International Medical Products Anti-Counterfeiting Taskforce, should, at the next Health Assembly, draw up a report and a proposal on standards for combating counterfeit products.

Dr ABDESSELEM (Tunisia) endorsed the proposal made by the United Arab Emirates. Since 2006 the Organization had taken many steps to tackle the problem, including the establishment of the Taskforce; the adoption of an international declaration on the issue; and the coordination by WHO of the work of other international, intergovernmental and nongovernmental organizations, drug manufacturers and distributors in that area. He emphasized the Taskforce’s activities in relation to regulations, support for regulatory authorities, new technologies and communication. All those achievements should be brought to the attention of health professionals and authorities worldwide so that the Taskforce could benefit from their feedback in contemplating future action.

Dr MENESES GONZÁLEZ (alternate to Dr Hernández Ávila, Mexico) asked for the latest version of the provisional agenda of the Sixty-first World Health Assembly and working documents to be posted on WHO’s web site, to enable them to be consulted at the earliest opportunity.

Dr YOUNES (Director ad interim, Office of Governing Bodies) confirmed that the provisional agenda, as approved by the Board, would be posted on the Organization’s web site after the current meeting, and that the site was updated regularly.

At the request of the members for the United Arab Emirates and Tunisia, a new subitem 11.13 would be inserted after the new subitem 11.12, and would be entitled “Counterfeit medical products”. The subitem entitled “Progress reports on technical and health matters” would thus become subitem 11.14.

The CHAIRMAN said that he took it that the Board wished to adopt the draft decision contained in paragraph 3 of document EB122/22, as amended.

**The decision was adopted.<sup>1</sup>**

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<sup>1</sup> Decision EB122(9).

The CHAIRMAN said that the Board should consider the date and place of its next session.

**Decision:** The Executive Board decided that its 123rd session should be convened on Monday, 26 May 2008, at WHO headquarters, Geneva, and should close no later than Thursday, 29 May 2008.<sup>1</sup>

## **5. MATTERS FOR INFORMATION: Item 8 of the Agenda**

### **Reports of advisory bodies: Item 8.1 of the Agenda**

- **Advisory Committee on Health Research (ACHR)** (Documents EB122/26 and EB122/26 Add.1)

Professor WHITWORTH (Chair of ACHR) expressed satisfaction at the progress made in developing WHO's research strategy, to be presented to the Sixty-second World Health Assembly in 2009. The extensive consultation involved all levels of the Organization and external stakeholders. Several themes had been identified: WHO should make research, particularly that with a direct impact on health outcomes in developing countries, a higher priority; research should go beyond basic science to focus on support, facilitating work in countries that could be "owned" by policy-makers; and staff should value research and incorporate it into their work. In addition to improving the way research was managed and organized within WHO, the strategy would serve to define WHO's niche and relative strength in the arena of global health research.

The announcement of WHO's research strategy would be a highlight of the Global Ministerial Forum on Research for Health (Bamako, 17–20 November 2008). The Forum would review progress made since the Ministerial Summit on Health Research in Mexico in 2004 and address some of the key recommendations of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property. It would highlight WHO's leadership in rallying support for the larger research agenda by bringing together the major supporters of research, and in directing relevant research. It would focus on the health challenges facing the African Region.

Acting on an ACHR recommendation, WHO had established a guidelines review committee to ensure that its recommendations, advice and guidelines were based on the best available scientific evidence, thereby enhancing WHO's leadership in setting norms and standards. The search portal of the International Clinical Trials Registry Platform provided convenient access to data from major registers worldwide. The initiative would help to strengthen public confidence in research through better transparency, accountability and access to clinical research results. The progress made with WHO's Evidence-Informed Policy Networks initiative was encouraging. National teams had been established in 25 countries in three WHO regions with strong support from national governments.

The second meeting of ACHR in 2007 had considered regional harmonization, so that regional and global advisory committees would identify activities of common interest, the development of guidelines and translation of research into practice. ACHR planned to broaden its membership to include representatives of the governing bodies of WHO's major research programmes. Its work programme would emphasize research on noncommunicable diseases, the impact of climate change on health, good scientific conduct and the research role of WHO collaborating centres.

Mr TOURÉ (Mali), speaking on behalf of the Member States of the African Region, supported the Evidence-Informed Policy Networks initiative, a mechanism that strengthened the knowledge base and assisted health policy decisions. The Global Ministerial Forum on Research for Health would

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<sup>1</sup> Decision EB122(10).

strengthen research for health, development and equity; health ministers from all Member States would be invited to participate. Attention should also be paid to the unique function of the Forum in maintaining high-level political commitment to research in improving health. Emphasis should be placed on indicators and data, and high-quality research in Africa should show how research could have an impact on health outcomes.

The Regional Committee for Africa had confirmed that Algeria would host the ministerial preparatory conference for the Bamako Global Forum. The purpose of the conference was to bring together ministers from the African Region, and all relevant stakeholders, in order to strengthen commitments and draft a common African declaration to be submitted to the Global Forum. The preparatory conference would focus on new approaches and examples of success in strengthening the capacity for research, health information and the management of knowledge in the Region. A regional preparatory consultation had been held by the Regional Office for Africa (Brazzaville, 24–28 November 2007).

The African group recommended that it should be involved more in the setting of the programme and objectives of the Global Forum. A ministerial session of the Forum and a section of the declaration should be devoted to the problems of research in Africa.

Professor WHITWORTH (Chair of ACHR) acknowledged Mali's commitment.

**The Board noted the reports.**

- **Expert committees and study groups** (Documents EB122/27 and EB122/28)

**The Board noted the reports.**

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

## **TENTH MEETING**

**Friday, 25 January 2008, at 14:10**

**Chairman:** Dr B. SADASIVAN (Singapore)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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<sup>1</sup> Resolution EB122.R13.

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

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

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

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

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

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

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

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



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

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

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

Some Member States had received support for preliminary studies on trade in health services. In 2006 the Regional Committee for Africa had adopted a resolution<sup>1</sup> urging Member States to promote dialogue with stakeholders at national level on the relationships between international trade and health, and to adopt policies, laws and regulations in response to issues identified. The Regional Office for Africa had prepared terms of reference for country-level studies on trade in health services. Difficulties remaining included lack of funding for research and capacity building in Member States.

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

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

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

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

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

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

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

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<sup>1</sup> Resolution AFR/RC56/R4.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**The Board took note of the reports.**

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

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

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

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

**The meeting rose at 16:50.**

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