THIRTEENTH MEETING

Saturday, 23 January 2009, at 09:00

Chairman: Dr S. ZARAMBA (Uganda)

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

Viral hepatitis: Item 4.12 of the Agenda (Document EB126/15) (continued from the ninth meeting)

Mrs ESCOREL DE MORAES (adviser to Dr Buss, Brazil) introduced a draft resolution on viral hepatitis proposed by Brazil, Colombia and Indonesia, which was a revision of the draft resolution proposed by Brazil at the ninth meeting and which read:

> The Executive Board,
> Having considered the report on viral hepatitis,[1]
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> RECOMMENDS to the Sixty-third World Health Assembly the adoption of the following resolution:
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> > The Sixty-third World Health Assembly,
> > Having considered the report on viral hepatitis;
> > Taking into account the fact that some 2000 million people have been infected by hepatitis B virus and that about 350 million people live with a chronic form of the disease;
> > Considering that hepatitis C is still not preventable by vaccination and around 80% of hepatitis C virus infections become a chronic infection;
> > Considering the seriousness of viral hepatitis as a global public health problem and the need for advocacy to both governments and populations for action on health promotion, disease prevention, diagnosis and treatment;
> > Expressing concern at the lack of progress in the prevention and control of viral hepatitis in developing countries, in particular in the sub-Saharan African region, due to the lack of access to affordable treatments as well as an integrated approach to the management of the disease;
> > Considering the need for a global approach to all forms of viral hepatitis – with a special focus on viral hepatitis B and C, which have the higher rates of morbidity;
> > Recalling that one route of transmission of hepatitis B and C viruses is parenteral and that the Health Assembly in resolution WHA28.72 on utilization and supply of human blood and blood products recommended the development of national public services for blood donation and in resolution WHA58.13 agreed to the establishment of an annual World Blood Donor Day, and that in both resolutions the Health Assembly recognized the need for safe blood be available to blood recipients;
> > Reaffirming resolution WHA45.17 on immunization and vaccine quality which urged Member States to include hepatitis B vaccines in national immunization programmes;

[1] Document EB126/15.

Considering the need to reduce the liver cancer mortality rates and that viral hepatitides are responsible for 78% of cases of primary liver cancer;

Considering the collaborative linkages between viral hepatitis and the prevention and control of infectious diseases like HIV and other related sexually transmitted and bloodborne infections;

Recognizing the need to reduce incidence to prevent and control viral hepatitis, to increase access to correct diagnosis and to provide appropriate treatment programmes in all regions,

1. RESOLVES that 28 July shall be designated as the World Hepatitis Day in order to provide an opportunity for education and greater understanding of viral hepatitis as a global public health problem, and to stimulate the strengthening of preventive and control measures of this disease in Member States;

2. URGES Member States:

(1) to implement and/or improve epidemiological surveillance systems in order to generate reliable information for guiding prevention and control measures;

(2) to support or enable an integrated and cost-effective approach to the prevention, control and management of viral hepatitis considering the linkages with associated coinfection such as HIV through multisectoral collaboration among health and educational institutions, nongovernmental organizations and civil society, including measures that strengthen safety and quality and the regulation of blood systems;

(3) to incorporate in their specific contexts the policies, strategies and tools recommended by WHO in order to define and implement preventive actions, diagnostic measures and the provision of assistance to the population affected by viral hepatitis;

(4) to strengthen national health systems to effectively address prevention and control of viral hepatitis through the provision of health promotion and national surveillance, including tools for prevention, diagnosis and treatment for viral hepatitis, vaccination, information, communication and injection safety;

(4bis) to provide vaccination strategies, infection-control measures, and means for injection safety for health-care workers;

(5) to use national and international resources, either human or financial, to provide technical support to strengthen health systems in order to adequately provide local populations with the most cost-effective and affordable interventions that suit the needs of local epidemiological situations;

(6) to consider, as necessary, national legislative mechanisms for the use of the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to promote access to specific pharmaceutical products;[1]

(7) to consider, whenever necessary, using existing administrative and legal means in order to promote access to preventive, diagnostic and treatment technologies against viral hepatitis;

(8) to develop and implement monitoring and evaluation tools related to preventive, diagnostic and treatment activities;

[1] The WTO General Council in its Decision of 30 August 2003 (i.e. on Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health) decided that "'pharmaceutical product' means any patented product, or product manufactured through a patented process, of the pharmaceutical sector needed to address the public health problems as recognized in paragraph 1 of the Declaration. It is understood that active ingredients necessary for its manufacture and diagnostic kits needed for its use would be included."

(9) to implement and/or improve epidemiological surveillance systems in order to generate reliable information for guiding prevention and control measures;
(10) to promote the celebration of 28 July each year as the World Hepatitis Day;

3. REQUESTS the Director-General:
(1) to establish in collaboration with Member States the necessary guidelines, time-bound goals, strategies and tools for the prevention and control of viral hepatitis;
(2) to provide the necessary support to the development of scientific research related to the prevention, diagnosis and treatment of viral hepatitis;
(3) to improve the assessment of economic impact and estimate the burden of viral hepatitis in the world;
(4) to support, as appropriate, resource-constrained Member States in conducting events to mark World Hepatitis Day;
(5) to invite international organizations and financial institutions to give support to strengthen capacity in developing countries for increasing the use of reliable diagnostic and treatment methods suitable to local epidemiological situations and health systems;
(6) to encourage international organizations and financial institutions to assign resources for the prevention and control of viral hepatitis, providing technical support to countries in an equitable, and most efficient and suitable manner;
(6 bis) to collaborate with other organizations in the United Nations system, partners, international organizations and other relevant stakeholders in enhancing access to affordable treatments in developing countries;
(7) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on the implementation of this resolution.

The financial and administrative implications remained as indicated in the ninth meeting. She stressed the need to raise awareness of the disease as a global public health problem and for action on health promotion and prevention, diagnosis and control of viral hepatitis by governments. In order to galvanize action, it was proposed to designate 28 July as World Hepatitis Day. The date had been chosen to honour and commemorate the birth of Nobel Laureate Dr Baruch Blumberg, who had discovered the hepatitis B virus and developed the first hepatitis B vaccine. The report cited some of the compelling evidence for designating such a day. Progress had been made in preventing hepatitis B through immunization of infants, but coverage at birth remained low. The fact that the likelihood of progression to chronic infection was the same whether hepatitis infection was symptomatic or asymptomatic pointed to the importance of diagnostic tools. Capacity had to be built in developing countries in order to increase the use of prevention and control methods, and access was needed to affordable vaccines and medicines. Expressing appreciation of the constructive approach during the informal consultations on the text, she urged the Board to adopt the draft resolution.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, affirmed the clear need to increase efforts to prevent and control viral hepatitis. He supported the draft resolution. Nevertheless, ways should be found to minimize the costs and human resource requirements associated with a World Hepatitis Day. It might, for example, be sensible to focus WHO's financial support on countries with resource constraints. The financial implications should be kept considerably lower than those submitted with the previous draft resolution. He asked the Secretariat to provide information to the forthcoming Health Assembly on the costs of WHO's existing "world days" in order to assist Member States in their consideration of future world days. Paragraphs 2(1) and 2(9) were identical; one should be deleted.

Ms BILLINGS (alternate to Dr Dodds, Canada) supported the draft resolution, which should help to raise awareness of the disease as a global public health problem. The text had been greatly

improved through the informal consultation process. She also supported the designation of 28 July as World Hepatitis Day but had noted the concern expressed by the previous speaker.

Dr KENYA-MUGISHA (alternate to Dr Zaramba, Uganda), speaking on behalf of the Member States of the African Region, welcomed the draft resolution. Prevention and control of viral hepatitis needed to be improved. However, he, too, was concerned about the costs associated with a World Hepatitis Day. WHO has several such commemorative days, and it was clearly not possible to have one for every disease. Efforts and resources would be better directed to the implementation of hepatitis prevention and control programmes. If a decision were taken to designate the day, it should be left to Member States to decide whether to observe it.

Dr MOHAMED (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, supported the draft resolution, including the proposal to designate a World Hepatitis Day. It had been many years since the development of the first hepatitis B vaccine, yet immunization coverage remained low. The designation of such world days helped to raise awareness of the diseases concerned and should accelerate the adoption of prevention and control methods. Increased availability and access to affordable antiviral agents against hepatitis B and C viruses would also greatly improve the situation.

Dr GIMÉNEZ (Paraguay) supported the revised draft resolution, which took into account his Government's suggestions. The actions proposed therein should make a significant contribution to the prevention and control of viral hepatitis. He supported the designation of a World Hepatitis Day, which was a symbolic gesture and should help to raise the profile of the disease.

Dr DAHL-REGIS (Bahamas) commended the efforts made to revise the draft resolution. However, she shared the concern expressed by the members for Hungary and Uganda in respect of the designation of a World Hepatitis Day and suggested that such days should be re-evaluated after a specified period of time to determine whether they remained relevant.

Dr TAKEI (adviser to Dr Omi, Japan) underscored the importance of hepatitis control and expressed support for the draft resolution.

Mrs ESCOREL DE MORAES (adviser to Dr Buss, Brazil) thanked members for their support of the draft resolution. A commemorative day was not possible for each disease, but it was vital to increase hepatitis prevention, diagnosis and treatment, and a World Hepatitis Day would be an important means of raising awareness of the disease worldwide, of increasing knowledge that people could unknowingly be carriers and that the disease could be fatal, and of publicizing measures for prevention and control. Member States should be free to determine how much emphasis they gave to the day.

In reply to a request for clarification from Dr DAHL-REGIS (Bahamas), Mr BURCI (Legal Counsel) said that the designation of a WHO world day represented a political statement by the Health Assembly, drawing attention to the importance of a certain public health matter. The designation of such days did have resource implications for the Secretariat, which was obliged to promote appropriate activities to mark them. Although there was no legal obligation for Member States to observe them, the proclamation by the Health Assembly carried the expectation that they would organize awareness-raising activities around such days.

Dr HANDOJO MULJONO (adviser to Dr Sedyaningsih, Indonesia) voiced strong support for the designation of a World Hepatitis Day, which would raise awareness of viral hepatitis as a serious global public health problem. Treatment was expensive and not always effective: prevention was the best and most affordable means of control, and raising awareness was an essential part of prevention.

The designation of the day would encourage Member States to generate awareness in order to prevent the disease and forestall development of infection from acute to chronic forms.

Dr BABB-SCHAEFER (Barbados)[1] expressed support for the draft resolution, including the designation of a World Hepatitis Day.

Dr NAKORN PREMSRI (Thailand)[1] commended the draft resolution but suggested that some textual improvement was required. He proposed that paragraph 2(8) should be amended by replacing the words "tools related to preventive, diagnostic and treatment activities" with "in order to assess progress towards reducing the burden from viral hepatitis and to guide evidence-based policy decisions". In paragraph 3(3), "global and regional" should be inserted before "economic impact" and "estimate the" and "in the world" should be deleted. Finally, he proposed that paragraphs 3(5) and 3(6) should be combined and amended to read "to mobilize support from international organizations, financial institutions, and other partners in strengthening surveillance, prevention, control, diagnosis and management of viral hepatitis to developing countries in an equitable manner".

Dr DAHL-REGIS (Bahamas) said that the points raised by the representative of Thailand were already covered by the text. The draft resolution was sound and she recommended that the Board approve it.

Dr HANDOJO MULJONO (alternate to Dr Sedyaningsih, Indonesia) was in favour of leaving subparagraph 2(8) unchanged in order to retain the emphasis on the need for all countries to develop appropriate technical tools for preventing viral hepatitis. The Director-General should be requested to provide support to countries requiring technical assistance.

The CHAIRMAN said that the representative of Thailand should have put forward his amendments in the drafting group. In any case, as the member for the Bahamas had noted, his points appeared already to be covered.

Dr GIMÉNEZ (Paraguay) said that the amendments proposed by the representative of Thailand were indeed already reflected in the text, and appealed to him to withdraw them so that the Board could proceed to the approval of the draft resolution as it stood.

The DIRECTOR-GENERAL said that there appeared to be consensus on the substance of the draft resolution, except on the subject of the proposed World Hepatitis Day. The member for Uganda had just indicated informally that paragraph 2(10) would be acceptable if wording similar to that used in resolution WHA60.18 on World Malaria Day were inserted. The subparagraph would then read: "to promote the celebration each year of 28 July, or such other day or days as individual Member States may decide, as the World Hepatitis Day". She had taken note of the members' comments about world days.

Dr DAHL-REGIS (Bahamas) and Mrs ESCOREL DE MORAES (alternate to Dr Buss, Brazil) supported the suggested amendment of subparagraph 2(10).

The resolution, as amended, was adopted.[2]

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

[2] Resolution EB126.R16.

2. MANAGEMENT MATTERS: Item 7 of the agenda (continued)

Reports of the committees of the Executive Board: Item 7.5 of the Agenda

- **Standing Committee on Nongovernmental Organizations** (Documents EB126/28 and EB126/28 Add.1)

Dr MOHAMED (Oman), speaking in his capacity as Chairman of the Standing Committee on Nongovernmental Organizations, presented the report, drawing particular attention to section IV, which contained the Committee's recommendations in the form of a draft resolution and a draft decision, for consideration by the Board. He expressed the Committee's appreciation of the work of the applicant organizations and those whose activities had been reviewed.

The CHAIRMAN invited the Board to consider the draft resolution contained in document EB126/28.

The resolution was adopted.[1]

The CHAIRMAN invited the Board to consider the draft decision contained in document EB126/28.

The decision was adopted.[2]

- **Foundations and awards** (Document EB126/29)

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 2010 to Dr Faissal Abdul Raheem Mohammed Shaheen (Saudi Arabia). The laureate will receive 2500 Swiss francs.[3]

Ihsan Doğramacı Family Health Foundation Prize

The CHAIRMAN, noting that the Ihsan Doğramacı Family Health Foundation Selection Panel had met on 19 January 2010 under his chairmanship, said that, following a thorough discussion, the Panel had concluded that it was not in a position to propose a candidate for the Prize in 2010. It had recommended that, in future, the Secretariat should determine whether candidates were eligible for the Prize under the WHO rules and not forward to the Selection Panel any proposals for candidates who were ineligible.

[1] Resolution EB126.R17.

[2] Decision EB126(5).

[3] Decision EB126(6).

Sasakawa Health Prize

Decision: The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel, awarded the Sasakawa Health Prize for 2010 to Dr Du Xueping (China). The laureate will receive US$ 30 000.[1]

United Arab Emirates Health Foundation Prize

Decision: The Executive Board, having considered the report of the United Arab Emirates Health Foundation Selection Panel, awarded the United Arab Emirates Health Foundation Prize for 2010 jointly to the National Center for Diabetes, Endocrinology and Genetics of Jordan and the Early Childhood Intervention Programme of Alentejo, Portugal. The laureates will each receive US$ 20 000.[2]

Dr LEE Jong-wook Memorial Prize for Public Health

Decision: The Executive Board, having considered the report of the Dr LEE Jong-wook Memorial Prize Selection Panel, awarded the Dr LEE Jong-wook Memorial Prize for Public Health for 2010 to Action for AIDS, Singapore. The laureate will receive US$ 85 000.[3]

3. MATTERS FOR INFORMATION: Item 9 of the Agenda

Reports of advisory bodies: Item 9.1 of the Agenda

- **Advisory Committee on Health Research** (Document EB126/36)

The Board noted the report.

- **Expert committees and study groups** (Documents EB126/37 and EB126/37 Add.1)

Ms EMMERLING (European Union) welcomed the report of the Study Group on Tobacco Products Regulation. The suggested approach of regulating the concentrations of selected carcinogenic substances in smokeless tobacco products might, however, encourage a wrong perception of risk. The setting of upper limits for individual toxicological components did not obviate the harmful effect of tobacco products.

Dr BETTCHER (Tobacco Free Initiative) replied that the Study Group had emphasized the preliminary nature of its recommendation, which was intended for the consideration of regulators and should not be construed as a harm-reduction strategy. Some jurisdictions had banned smokeless tobacco products altogether. The recommendation had not yet been tested adequately or considered by regulators, and the comments of the representative of the European Union would be conveyed to the Study Group.

[1] Decision EB126(7).

[2] Decision EB126(8).

[3] Decision EB126(9).

The CHAIRMAN thanked the experts who had taken part in the Joint FAO/WHO Expert Committee on Food Additives and the Study Group on Tobacco Products Regulation and requested the Secretariat to follow up on their recommendations.

The Board noted the reports.

4. **PROGRESS REPORTS:** Item 10 of the Agenda (Documents EB126/38 and EB126/38 Add.1)

A. Poliomyelitis: mechanism for management of potential risks to eradication (resolution WHA61.1)

The DIRECTOR-GENERAL said that the Global Polio Eradication Initiative was possibly the international community's most important public health initiative. It had broad support from Member States, development partners, foundations and the four spearheading agencies: Rotary International, which she thanked for its continuing commitment; UNICEF; the Centers for Disease Control and Prevention (Georgia, Atlanta, United States of America); and WHO. One lesson learnt from smallpox eradication was that the final effort was perhaps the most difficult and costly. A renewed commitment was needed to finish the job; without it, poliomyelitis would return. She thanked the governments of Afghanistan, India, Nigeria and Pakistan, the four remaining endemic countries, for their continuing political commitment and investment. They were working closely with the Secretariat to identify the obstacles to eradication and determine how best to overcome them. Poliovirus had been reintroduced in some countries, primarily in Africa, and they, too, were committed to the eradication goal. Recalling that the Health Assembly had recognized the need for an independent external review to determine the exact status of the disease and how best to achieve eradication, she thanked the countries that had taken part in the review and her colleagues in the Regions and countries for their support.

Dr AYLWARD (Global Polio Eradication Initiative) recalled that, shortly after taking office, the Director-General had intensified efforts to eradicate poliomyelitis. The Health Assembly had adopted resolution WHA60.14 on a mechanism to manage the risks to eradication. In the absence of the expected results of those efforts, however, the subsequent Health Assembly had adopted resolution WHA61.1, requesting the Director-General to develop a strategy to reinvigorate the initiative in order to ensure a successful conclusion. The Programme of Work 2009 of the Global Polio Eradication Initiative, drawn up in response to that request, had seen the development of new vaccine and tactical approaches, together with an independent evaluation to assess poliomyelitis eradication activities in the remaining affected countries. A consultation on the evaluation team's major findings, summarized in the report in document EB126/38 Add.1, concluded that important progress had been made towards eradicating the disease and that the Global Polio Eradication Initiative should draw up, on the basis of those findings, a new programme of work for 2010–2012. The new programme would be submitted to the Sixty-third World Health Assembly for consideration.

Dr MOHAMED (Oman), speaking in his capacity as chairman of the independent evaluation team, expressed appreciation to the countries and the WHO regional offices visited for their support. The team's five subteams, comprising experts in a range of disciplines, had visited the four endemic countries, and Angola and southern Sudan, two of the countries most affected by reintroduction of poliovirus. Their reports had been published on the web site of the Global Polio Eradication Initiative. In India, the team reported impeccable fieldwork and had concluded that eradication was feasible, provided that certain administrative, management, security and technical issues were addressed. The particular challenge was the size of the population: even if vaccination coverage reached 95%, millions would remain unvaccinated. The team also noted significant gaps in immunity in children, possibly related to factors such as sanitation and exposure to other viruses. More research

was needed on that and several other matters, notably the use of bivalent oral poliovirus vaccine and mucosal immunity. Routine vaccination under the Expanded Programme on Immunization needed to be strengthened. He was optimistic about the prospect of eradicating poliomyelitis in India.

In Nigeria, the situation appeared to have improved. He recalled that Nigeria's decision to suspend vaccination in 2002–2003 had been a major factor in the reintroduction of poliovirus in numerous other countries. However, the work of the various actors involved in eradication efforts in the country was paying dividends. Saudi Arabia had made a significant contribution, particularly in Muslim areas, through, for instance, vaccination of hajj pilgrims. Effective mobilization of the more than 700 local government bodies had been a key element in the eradication initiative. Issues such as selection of and permits for vaccinators, while comparatively minor, nevertheless had an impact on progress and required further attention in Nigeria, Pakistan and Afghanistan. As in India, strengthening routine immunization in Nigeria was essential, particularly in preparation for the post-eradication era, when national immunization days would be less frequent.

Afghanistan and Pakistan had been considered together from an epidemiological point of view, as the areas of highest transmission in the two countries were adjacent. The principal obstacle to eradication efforts in the region was the political and security situation, although some managerial aspects also needed to be improved. Technical issues presented no barriers to poliomyelitis eradication in either country.

In Angola and Sudan, where the team members had examined the international spread of wild poliovirus to previously poliomyelitis-free areas, the resources allocated to vaccination and other control measures were not commensurate with the seriousness of the epidemiological situation and needed to be increased markedly. The team had recommended that poliovirus transmission should be considered to have been re-established in those areas and that the situation should be dealt with accordingly. Among other measures, it had also recommended the vaccination of travellers, given the ease with which poliovirus could spread internationally. If poliomyelitis was to be eradicated, vigilance was necessary throughout the world, not only in endemic countries. It was vital not to lose impetus when the goal was in sight.

Dr BUSS (Brazil) asked whether any event was planned to mark the thirtieth anniversary of the eradication of smallpox. Celebrating such a major public health achievement for WHO and the international community would re-energize efforts to eradicate poliomyelitis.

The DIRECTOR-GENERAL replied that a commemorative event would be held on the first day of the Sixty-third World Health Assembly.

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, said that they were firmly committed to the goal of poliomyelitis eradication and had demonstrated by their determined efforts that poliovirus transmission could be halted. The African countries had been supportive of the independent evaluation and had generally agreed with the conclusions and recommendations of the evaluation team. However, they were dismayed by the omission of some information from the report and by some observations made by the evaluation team. For example, the team had failed to acknowledge the efforts of African leaders, including traditional, cultural and religious leaders, to mobilize popular support for the eradication effort. In addition, the team claimed that the focus on strengthening the health system in Angola had had negative effects on poliomyelitis eradication efforts, when, in fact, those measures should have a highly beneficial effect on immunization, which would ultimately facilitate poliomyelitis eradication. It was to be hoped that the relevant portion of the report would be revised to reflect that point of view.

The recommendations of the evaluation team did not adequately reflect the specific situation in the Region. Although the team's report correctly emphasized the importance of strengthening routine immunization programmes, it failed to recognize the added value of supplementary immunization activities in a region such as Africa, where routine vaccination coverage was weak and the level of immunity in the population insufficient. The value of preventive supplementary immunization campaigns had been conclusively demonstrated between 1999 and 2002, when the number of

countries affected by poliomyelitis in the Region had fallen from 17 to 3. Accordingly, he appealed for additional resources to be provided to the Region in order to enable it to organize at least two such campaigns in the course of three consecutive years.

The countries of the Region had invested considerable resources of their own in eradication efforts and would continue to do so. Nevertheless, in order to surmount the remaining challenges, they would require additional support from the international community. Expressing gratitude for the support provided thus far, he reaffirmed the commitment of the countries of the Region to the goal of a world free of poliomyelitis.

Dr ABDESSELEM (Tunisia), speaking on behalf of the Member States of the Eastern Mediterranean Region, observed that in order to progress towards eradication in countries such as Afghanistan, it would be necessary to enhance efforts to immunize children in security-compromised areas. It was also necessary to safeguard the efforts made to eradicate poliomyelitis in countries of the Region that were currently free of the disease. Work was needed to prevent any further transmission of poliovirus and to fill the gaps where vaccination had been insufficient. To that end, coordination of efforts would be needed both among the countries of the Region and between the Region and other WHO regions.

Ms BILLINGS (alternate to Dr Dodds, Canada) said that her Government remained committed to the goal of eradication and encouraged Member States to provide support, particularly financial, to the Global Polio Eradication Initiative at the current critical juncture in the efforts to stamp out poliomyelitis. She looked forward to the Initiative's new programme of work and encouraged the Director-General to explore ways of improving countries' accountability at national and international levels, which should include more monitoring by the Initiative's main stakeholders. She welcomed the Initiative's efforts to strengthen dialogue with its donors through a balanced approach that would not compromise the technical integrity and effectiveness of its programme of work.

Mr CHAWDHRY (adviser to Ms Sujatha Rao, India) expressed appreciation for the positive comments made about India in the independent evaluation report and for the evaluation team's incisive scrutiny of his Government's poliomyelitis eradication programme. India was on the verge of success in the eradication campaign: wild poliovirus type 2 had been eliminated from the country and wild poliovirus types 1 and 3 from 26 states and 7 territories, and, even in the two northern states where the disease remained endemic, transmission of wild poliovirus types 1 and 3 had been interrupted in most districts. India had developed a new plan in 2009 to achieve high vaccination coverage among the highest-risk populations. The plan would also seek to strengthen routine immunization services and to address factors contributing to poliovirus transmission, such as water and sanitation conditions.

India had conducted research and surveys to assess antibodies against polioviruses among children in the highest-risk areas. The findings of those studies were being used in India and other countries to guide programmatic decisions that would have a direct impact on the achievement of poliomyelitis eradication, both in India and globally. Bivalent oral poliovirus vaccine (against virus types 1 and 3) had been developed and licensed for use based on research studies conducted in India during 2009, and the vaccine had gone into use in the state of Bihar in January 2010. The bivalent vaccine would simplify supplementary immunization activities, as the two virus types that continued to circulate could be targeted simultaneously. Political, administrative and technical commitment to eradication was high. The Government had consistently ensured adequate funding for the poliomyelitis programme and had already committed more than US$ 225 million to cover its cost in 2010–2011.

Dr REITENBACH (adviser to Dr Seeba, Germany) stressed that, although the number of poliomyelitis cases worldwide had decreased by more than 99%, as long as one child remained infected, children in all countries were at risk, as evidenced by the high number of new imported cases in 2008 and 2009. Her country had been committed for years to fighting poliomyelitis, and was one of the largest bilateral donors to that cause, having contributed close to US$ 300 million since the

beginning of the eradication campaign. She supported the approach of the final phase of the campaign, namely focusing on strengthening countries' efforts to stop transmission, on supporting their health systems in the delivery of routine immunization and on developing and expanding surveillance and monitoring systems. With the continued financial, political and technical support of all governmental and nongovernmental bodies concerned, it would be possible to achieve global poliomyelitis eradication. She called on all stakeholders to identify ambitious and realistic targets based on sound and transparent planning and budgeting, and to demonstrate the necessary political will to fill the funding gap, facilitate vaccination campaigns and ensure that vaccination programmes were carried out in all affected countries.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that tribute should be paid to all the thousands of dedicated front-line public health workers who had maintained the momentum of poliomyelitis eradication programmes. It was essential to remain vigilant so as to protect the gains made so far, while seeking progress on the last 1% of poliomyelitis cases. In tackling those cases, it was important to understand the different and complex contexts in which they occurred. Where appropriate, it was important to pursue stronger linkages with child and maternal health programmes and to improve water quality and sanitation. Efforts were needed to prepare a realistic and detailed budget for the new programme of work, in order to meet the funding shortfall and address the additional costs arising from the international spread of the disease and the reintroduction of poliovirus into countries previously free of poliomyelitis. His Government remained committed to working with its partners until poliomyelitis was eradicated.

Ms NATTHANIT SRIMASERN (Thailand)[1] expressed concern that by 31 December 2009 more than 1500 poliomyelitis cases had been reported, many of them from countries where the disease was not endemic; the situation was not progressing well. The fact that in some cases imported virus had persisted for more than 12 months represented a major threat for international spread of the disease. The re-establishment of poliovirus in non-endemic areas served as a reminder of the crucial role of high-quality surveillance of acute flaccid paralysis, rapid response to imported cases and maintenance of high levels of routine oral poliovirus vaccine coverage as well as supplementary immunization activities. The international spread of wild poliovirus demonstrated the need for full implementation of the International Health Regulations (2005) in order to facilitate timely reporting and rapid containment of the disease.

Ms BLACKWOOD (United States of America)[1] applauded the progress made by Afghanistan, India, Nigeria and Pakistan. The hard work and dedication of the many public health workers had reduced cases of poliomyelitis by 99% worldwide, an astonishing achievement, but the world faced the last and most difficult steps. The number of cases had remained stubbornly static and the virus had reappeared in countries where it had previously been stamped out. The independent evaluation provided an opportunity to consider whether the strategies that had served well for the first 99% of cases were the best ones for tackling the last 1%, or whether there might be an even better way of sustaining political will and translating it into effective action, attracting the needed resources, and monitoring and assessing the efforts invested. The approach adopted would have an impact beyond the elimination of an ancient scourge. More than ever, global health was understood as an important factor in stability, growth and development. Eradicating poliomyelitis would set a positive example for the elimination of other threats to global public health, and thus scaling back without finishing the job must not be allowed to happen.

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

Ms LANTERI (Monaco)[1] said that her Government remained strongly committed to continuing the fight towards eradication and would maintain in 2010 the level of its financial contribution to the Global Polio Eradication Initiative.

Mr BA (Organization of the Islamic Conference), speaking at the invitation of the CHAIRMAN, said that since 2005 his organization had worked tirelessly to contribute to the eradication of poliomyelitis in its member countries, notably Afghanistan, Nigeria and Pakistan. It had also worked closely with WHO in order to stop transmission of poliovirus to neighbouring countries. It had set up a special fund for the eradication of communicable diseases and was pursuing campaigns of awareness-raising and mass vaccination of children under the age of five years. It had established close links with religious and local communities in order to encourage acceptance of vaccination campaigns undertaken by WHO and national authorities, had endeavoured to facilitate access for vaccination teams in security-compromised areas of Afghanistan and Pakistan, and was working with the governments of several African countries in which poliovirus had recently been introduced to promote public awareness of the urgent need to vaccinate children. His Organization stood ready to cooperate with all partners in the effort to eradicate poliomyelitis.

Ms YAHAYA (Nigeria)[1] recalled that, at the 124th session of the Board, her Government had pledged to do its best to reverse the spread of wild poliovirus originating from within its borders. She welcomed the comments in the independent evaluation report on Nigeria's progress in reducing poliomyelitis cases. That success had been achieved thanks to the commitment at all levels of government and the participation of traditional, cultural and faith-based communities, as well as the steadfast support of the international community. In order to sustain momentum towards eradication, Nigeria would need ongoing technical support and additional resources from WHO and its partners.

Mr KÖBLER (Rotary International), speaking at the invitation of the CHAIRMAN, said that recent progress in the global eradication of poliomyelitis inspired hope and optimism. In Nigeria, cases caused by wild poliovirus type 1 had decreased by 90% owing to the active involvement of government and traditional leaders. He encouraged those leaders to continue to promote immunization in order to achieve poliomyelitis eradication. In India, transmission of poliovirus was contained in 2% of the country; a multisectoral approach would be essential to stop transmission in the remaining areas.

Rotary International looked forward to the finalization of the programme of work of the Global Polio Eradication Initiative for 2010–2012. That programme should include clear milestones for addressing the remaining challenges, including ongoing transmission of poliovirus in Angola and Chad, for which the national leaders should cooperate fully to implement effective immunization activities; outbreaks in previously poliomyelitis-free countries, which highlighted the need to bolster routine immunization programmes; and reaching and vaccinating children in conflict-affected areas, particularly in Afghanistan and Pakistan. "Days of tranquillity" to allow safe passage for vaccination teams were essential.

Rotarians remained fully committed to achieving a poliomyelitis-free world, having already contributed more than US$ 850 million to the cause, and called on all international partners, especially the governments of the G8 countries, to ensure the funding needed to maintain poliomyelitis eradication programmes. Rotary International would continue to work at all levels to ensure that leaders were aware of their vital role in eradication strategies. WHO had an essential role to play in encouraging Member States to vaccinate all children and in asking ministers of health from poliomyelitis-affected countries to report on their eradication efforts at the forthcoming Health Assembly.

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

The CHAIRMAN paid tribute to Rotary International and reaffirmed his personal commitment as a Rotarian to work towards poliomyelitis eradication.

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

Dr KENYA-MUGISHA (alternate to Dr Zaramba, Uganda), speaking on behalf of the Member States of the African Region, welcomed the progress made in controlling human African trypanosomiasis. The challenges that remained included: shortage of skilled personnel; inadequate health infrastructure; lack of diagnostic tools and machines; low coverage of the at-risk population, insufficient case detection and disease surveillance; poor community awareness and participation in control activities; severe side effects of medicines and difficulties in patient follow-up; and increased drug resistance.

Human African trypanosomiasis still occurred in 35 countries in the Region and more than 36 million people remained at risk. The Member States of the Region requested the Secretariat and other partners to continue to provide support to affected countries in overcoming the two main technical obstacles to elimination of the disease: lack of inexpensive diagnostic tests that could be easily used in the field and the absence of a new, cheaper, safer and easily administered antitrypanosomal agent to cure both forms of the disease. Expressing strong support for the integrated approach advocated in the progress report, he noted that the Regional Committee for Africa had selected human African trypanosomiasis as a neglected tropical disease targeted for elimination.

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

Mr KABULUZI (Malawi), speaking on behalf of the Member States of the African Region, said that lack of access to and awareness of sexual and reproductive health services, including family planning and screening and detection of cervical cancer, contributed to high morbidity and mortality from largely preventable sexual and reproductive health problems in the Region, particularly among women. The Regional Committee for Africa had, in 2004, adopted a road map for accelerating maternal health and a 10-year framework on family planning and reproductive health services, and a strategic partnership programme had been established between WHO and UNFPA and subsequently implemented in several countries in Africa; however, challenges remained. Sexual and reproductive health programmes had not been implemented in an integrated manner and had therefore failed to show the expected results, and HIV/AIDS had continued to increase the heavy burden of disease and death among women and children. Poverty and sociocultural factors such as gender inequity led to poor access and low use of sexual and reproductive health services. It was essential to improve understanding of those underlying sociocultural barriers in order to improve services in the Region.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), speaking also on behalf of the Governments of Denmark, Finland, Netherlands, Norway and Sweden, requested the Secretariat to include in its report to the Sixty-third World Health Assembly more comprehensive data on progress and outcomes, particularly in respect of the role of males and the promotion and provision of sexual and reproductive health information and services to men; the sexual and reproductive health and rights of young people, including access to contraception and, where needed, safe abortion services; the family planning needs of both married and unmarried women, especially in light of the link between the unmet needs for family planning and lack of progress in achieving the Millennium Development Goals; the prevention of unsafe abortion, which was a significant cause of morbidity and mortality among women; and the human rights dimension of sexual and reproductive health. In response to the request to the Director-General in resolution WHA57.12, the report should also summarize progress made in devoting organizational priority and resources to the strategy to

accelerate progress towards the attainment of international development goals and targets. He welcomed WHO's recent report on women and health.[1]

Ms NATTAYA THAENNIN (Thailand)[2] emphasized the need to improve information on sexual and reproductive health by integrating into population surveys and censuses. All health-related surveys, including those on reproductive health, should include socioeconomic data, such as income, expenditure and household assets, in order to monitor equity in reproductive health and access to services by different socioeconomic groups.

Mr HOHMAN (United States of America)[2] endorsed most of the comments made by the member for the United Kingdom and requested an update from the Director-General on her plans to fill the post of Director of the Organization's sexual and reproductive health programme.

Ms MAFUBELU (Assistant Director-General) said that the Secretariat would work with all countries that continued to face serious challenges in the area of sexual and reproductive health. Noting the comments made by the member for the United Kingdom, she said that the information requested would be included in the report to be submitted to the Health Assembly.

The DIRECTOR-GENERAL, responding to the question posed by the representative of the United States of America, explained that the post of Director to which he had referred was a shared post, with responsibility for managing both an internal WHO department and a cosponsored programme, which made the recruitment process more complicated and demanding. Given that filling the post needed careful review, she asked Member States to afford her flexibility and time to do so in an independent and coherent manner. She assured Member States that she was giving the matter the closest attention. WHO's recent report on women and health had highlighted many gaps in health services for women,[1] and it was her aim to develop a life-course approach for providing those services to women from preconception, by improving the health and nutrition of pregnant women, to old age.

D. Rapid scaling-up of health workforce production (resolution WHA59.23)

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, noted that the Region had the lowest ratio of health workers to population in the world. More than 800 000 additional doctors, nurses and midwives needed to be trained and deployed in order to achieve the recommended minimum coverage of 2.28 health workers per 1000 population. More than 30 countries in the Region had developed human resources policies or strategies, and a partnership initiative led by WHO had been launched in three pilot countries to accelerate the training of health workers and strengthen training institutions. The initiative sought to identify needs and support the elaboration of strategies to finance the development of human resources. Difficult economic situations and lack of sufficient funding in many countries, and weak leadership and poor management of human resources, were all challenges to the strategic coordination and planning that was needed to produce the required number of health workers.

Dr ABDI (Somalia) observed that the already high rates of emigration of trained and skilled health personnel from developing countries continued to rise and weaken the health systems in those countries. Following the Kampala Declaration, adopted at the first Global Forum on Human Resources for Health (Kampala, Uganda, 2–7 March 2008), many stakeholders had made commitments to supporting the training of health workers. That support was highly appreciated in the Eastern Mediterranean Region.

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[1] WHO. *Women and health: today's evidence tomorrow's agenda.* Geneva, World Health Organization, 2009.

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

Ms ORAPHAN SRISUKWATANA (Thailand)[1] commended the progress made in scaling-up of health workforce production. The strategy outlined in the progress report should be replicated elsewhere. Global health initiatives on human resources should also focus on increasing numbers at the primary care level. Emphasizing strategies to retain human resources, she said that global evidence had confirmed that local training, recruitment and placement of health workers were the most effective approaches to retention in rural environments.

Mrs CARRIER-WALKER (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that, unless the current crisis in the health workforce, in particular nurses, was urgently addressed, efforts for renewed focus on primary health care and achievement of the Millennium Development Goals would be jeopardized. The goal of increased production of health workers should also focus on the quality of training needed for patient care and improve outcomes. Approaches such as task shifting were welcome, although adding new cadres of workers could result in fragmented service; the Council had developed a set of principles for task shifting, which were available on its web site. She emphasized her organization's commitment to working with WHO and governments to address the current crisis.

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

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, said that the regional shortage of qualified health personnel was attributable to poor policy-making, planning and management, as well as the lack of needs-based training. In the case of nurses and midwives, the shortage was also the result of lack of regulation, uneven distribution, attrition through HIV/AIDS, and poor working conditions, all of which had a cumulative effect. In several anglophone countries, technical support had strengthened the capacity of nursing and midwifery management in primary health care, and resulted in the elaboration of health strategies and action plans. A similar capacity-building exercise was planned for francophone and lusophone countries. The implementation of WHO guidelines on nursing and midwifery care would be accelerated; some countries had received training support tailored to their specific health needs. Other measures included the development of a regulatory framework for the nursing and midwifery profession in the Region, the establishment of national databases of such personnel, and cooperation with other organizations to strengthen nursing and midwifery in the Region. The main challenges for the Region were shortages of qualified nurses and midwives, which impeded the effective implementation of national health policies; the lack of resources for the implementation of resolutions on nursing and midwifery; and poor remuneration of paramedical personnel, which encouraged emigration to countries that offered better salaries.

Dr AL HAJ HUSSEIN (alternate to Dr Said, Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the strategies for promoting nursing and midwifery in his Region focused on: workforce planning; educational reform, with establishment of family health nursing education and services within the primary health care context; strong, committed leadership; creation of favourable working conditions in order to discourage emigration; rapid expansion of the nursing and midwifery workforce; and retention of nurses and midwives. The Health Assembly in resolution WHA59.27 had included a call for the establishment of comprehensive programmes for the development of human resources which supported recruitment and retention, while ensuring a skilled and motivated nursing and midwifery workforce, a requirement that the Region's countries could not meet unless sufficient resources were allocated for that purpose. His country had recently established four new nursing colleges offering four-year programmes of study and the job description of nursing had also been upgraded. Nursing schools had been set up in areas where nurses were in short supply.

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

Mrs CARRIER-WALKER (International Council of Nurses), speaking at the invitation of the CHAIRMAN, welcomed efforts to optimize the contribution of nurses and midwives to the achievement of the health-related Millennium Development Goals. The critical shortages of health personnel, however, could result in the collapse of health-care systems; poor working conditions, including inadequate equipment and supplies, led to low morale and could compromise patient safety. The Council was campaigning to improve working environments and strengthen health systems. WHO's activities at country and regional levels were welcome, but governments and donors must enhance development of human resources in the health sector, through investment and greater involvement of nurses and midwives in policy-making.

F. Sustaining the elimination of iodine deficiency disorders (resolution WHA61.21)

Dr MOHAMED (Oman) noted that, despite cost-effective interventions, little progress had been made in the 20 years since the first resolution had been adopted on sustaining the elimination of iodine deficiency disorders. Referring to the country-level data provided in paragraph 17 of document EB126/38, he emphasized the need to monitor iodine status in the global population rather than focusing on individual countries. It was important to have worldwide data in order to understand the effectiveness of the intervention. With regard to the adjustment to the concentration of iodine in fortified salt referred to in paragraph 20 of the document, he questioned how frequently or how easily that could be achieved. It was not simply a matter for health ministers; it would require the cooperation of ministries of commerce and other bodies. He suggested that the Secretariat should consider joint initiatives with organizations such as FAO and the Codex Alimentarius Commission in order to provide low-cost global micronutrient fortification interventions that would produce significant impact.

Dr GIMÉNEZ (Paraguay) said that it was essential to monitor salt iodization plants and to provide consumers with access to information regarding iodized salt. Imports of iodized and non-iodized salt, whether for human or animal consumption or for industrial use, should also be monitored, in collaboration with customs agencies and other institutions.

Dr BRANCA (Nutrition for Health and Development) affirmed that the issue of monitoring was of great concern. Responding to the comments on the country-level data, he said that globally the reduction in the number of countries that still experienced iodine deficiency had been remarkable, having dropped from 110 to 47. WHO's estimates indicated that 70% of the global population currently had access to iodized salt, which was acknowledged to be the most cost-effective intervention for addressing iodine deficiencies. Hence, progress had been made, but much remained to be done. With regard to the adjustment of iodine concentrations in fortified salt, the experiences of Finland, Switzerland and other countries had shown that it was feasible. As to collaboration with other organizations, the Secretariat was working with the Codex Alimentarius Commission through the Network for Sustained Elimination of Iodine Deficiency.

G. Multilingualism: implementation of action plan (resolution WHA61.12)

Mrs PRAYAG-GUJADHUR (alternate to Dr Gopee, Mauritius), speaking on behalf of the Member States of the African Region, said that the increase in the number of statutory and technical publications in the Region's three official languages was encouraging. Within the Region, language services were provided for governing body and other high-level meetings, and data had been collected on translation and interpretation schools in preparation for future needs. Collaboration was being broadened with nongovernmental organizations and specialized bodies in the area of information access, storage and retrieval.

However, attaining language parity needed to be addressed in parallel with recruitment of human resources: knowledge of two or three languages should be a requirement when recruiting for many positions in the Organization, in particular within technical units that worked directly with Member States. The African Region was facing particular challenges in providing access to health knowledge to speakers of the thousands of vernacular languages, including unwritten languages, and in the careful staffing of language services in order to guarantee access to information in all the languages used in the Region.

Mr PELLET (adviser to Mr HOUSSIN, France) said that multilingualism was essential to WHO's work and to the success of its field operations, allowing effective communication with the populations and health personnel concerned. Multilingualism was not only required for translation of documents, but also for interpretation; it was regrettable that informal meetings or working groups were conducted without interpretation, thereby excluding delegations or regional groups from important discussions. He welcomed the consultations on translation priorities, but asked for clarification on how such priorities were determined at both regional and Organization levels. Multilingualism should be reflected not only in translations of published documents, but also during the drafting and discussion stages. He asked for the results of the pilot survey on staff language competencies, and encouraged all WHO staff to practice multilingualism in their work. He welcomed the appointment of a Special Coordinator for the promotion of WHO multilingualism, but asked what actions he had undertaken and what resources he had at his disposal; that information would facilitate useful discussions between the Coordinator and Member States. He thanked the interpreters for their excellent work during the week's meetings.

Dr BUSS (Brazil) welcomed the Organization's ePORTUGUÊSe initiative, which facilitated the work of health professionals in lusophone countries. One year previously, health ministers from the Community of Portuguese Speaking Countries had established a Strategic Plan in Health Cooperation to develop health systems and strengthen human resources; and Portuguese materials provided by WHO in that regard were of great importance. WHO had also signed an agreement with the Community in support of the Strategic Plan. He was grateful that the Organization had recognized the importance of multilingualism and the significance for lusophone health professionals of being able to train and work in their own language.

Mrs LANTERI (Monaco),[1] emphasizing the importance her country attached to multilingualism, noted with disappointment that the report did not fully reflect the spirit of resolution WHA61.12. With regard to consultation on translation priorities, it appeared that only two regions had been consulted; she asked whether wider consultation was planned. She wanted to know more about the work of the newly-appointed Special Coordinator. Concerning the content of the web site, she encouraged WHO to focus on the quality, not quantity, of information provided in other languages. Multilingualism within the Organization would also depend on the ability of staff to express themselves in more than one language; WHO might consider returning to the practice of producing original documents in languages other than English.

Dr MOHAMED (Oman), supporting the proposal to publish all documents in the six official languages, encouraged the Secretariat to consider innovative and creative ways of decreasing translation and publication costs, including the use of new technology.

Mr BARARUNYERETSE (Organisation internationale de la Francophonie), speaking at the invitation of the CHAIRMAN, commended progress made in implementing the resolution, but observed that much work remained to be done. The total number of translated pages was a useful

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

indicator, but parity between the six official languages should be assured. The consultations on translation priorities had been limited to headquarters and the Eastern Mediterranean and Western Pacific regions; they should be extended to other regions. He requested information on the role of the Special Coordinator and any actions he had already undertaken. Multilingualism should remain a priority within WHO, he suggested that a new draft resolution on the matter be tabled at the next session of the Health Assembly.

DR AL-SHORBAJI (Knowledge Management and Sharing), said that he had noted the comments made. A full and detailed report, in all the official languages, would be submitted to the next Health Assembly, with detailed statistics and information on current working methods and the requirements and needs of Member States. The role of the Special Coordinator was to coordinate actions such as the publication of technical and scientific documents, and to contribute to the management of WHO's web site. He collaborated with regional offices and Member States, through national focal points, to ensure that the needs of Members were considered. Many documents had already been translated into the official languages, as well as other languages, and that work would continue.

H. Health of migrants (resolution WHA61.17)

Dr DOS RAMOS (Sao Tome and Principe), speaking on behalf of the Member States of the African Region, welcomed the fact that the recommendations put forward jointly by WHO and the International Organization for Migration in several platforms covered various subjects, including the integration of migration issues into debates on foreign policy and global health. The number of international migrants in the African Region had been rising steadily: in 2005, it had represented 2% of Africa's total population. The migrant population of Africa comprised nearly all categories of migrants, usually persons who were marginalized in access to social welfare services and health care and who were particularly susceptible to disease. Several countries had undertaken research into other factors that exacerbated the situation of migrants such as legal status, housing problems, lack of education and food security and limited access to water and sanitation. WHO and its partners had taken steps to facilitate such access for displaced populations in different countries. The task was to focus attention on primary health care reforms as part of an overall process of strengthening health systems in order to guarantee universal access to health-care services.

Ms TRUCILLO (Uruguay)[1] said that her country accorded equality of rights to migrants. Migrants had access to health services on the same footing as Uruguayan citizens, and if they were unable to pay for them they could receive treatment free of charge. She called on the Director-General to pursue the efforts being made in that area and to ensure full implementation of resolution WHA61.17.

I. Climate change and health (resolution WHA61.19)

Ms TOELUPE (Samoa) requested details on what had been learnt or achieved during the special sessions that had been conducted during the last two Conferences of the Parties to the United Nations Framework Convention on Climate Change. At the Sixty-second World Health Assembly some Member States had requested the Director-General to provide assistance to the most vulnerable small island States in order to tackle the negative impacts of climate change; she asked why the report made no reference to any of WHO's programmes in that area.

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

Mrs PRAYAG-GUJAGHUR (alternate to Dr Gopee, Mauritius), speaking on behalf of the Member States of the African Region, said that climate change was increasingly posing a threat to all nations, although some regions were affected more than others. Serious natural disasters in the African region over recent years had led to outbreaks of disease outbreaks, malnutrition and food shortages. Technical and logistical support had been provided, and in July 2008 the Regional Office for Africa had supported the development of a framework for action for the protection of health from climate risks in Africa, covering areas such as public awareness-raising campaigns and strengthening the capacities of health systems. An important outcome of the First Inter-ministerial Conference on Health and Environment in Africa (jointly organized by WHO and UNEP in Libreville, 28–29 August 2008) had been the Libreville Declaration on Health and Environment in Africa.

Inadequate funding for core activities in the African continent was hampering a coordinated and effective international response, particularly in the crucial areas of adaptation, mitigation and capacity building. Industrialized and high-income economies must support Member States in the Region in terms of transferring technologies and mobilizing resources to mitigate the adverse effects of climate change. Small island developing States, including Mauritius, were particularly vulnerable to the health risks posed by the current and future impact of climate change, which were expected to increase over the coming years owing to natural disasters such as cyclones, floods and tsunamis.

Dr KÖKÉNY (Hungary), 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. It was essential to improve advocacy in order to empower health ministers to speak up about the links between climate change and health. WHO, in partnership with other organizations in the United Nations system, should give more advice on health systems in order to promote greater resilience and encourage a more coordinated response to climate change.

Reflection of the health dimension of climate change during negotiations remained inadequate, as did public awareness of the issue. Health systems should lead the way in reducing their carbon footprint. WHO should work closely with United Nations partners to highlight the increased health risks associated with climate change, following the example set in Cambodia where WHO and UNICEF were studying the impact of climate change on health, especially that of women and children. There was an urgent need to translate practical research into meaningful policy, and the health sector must have access to funds for climate change adaptation and mitigation. He looked forward to reports on the country projects that WHO had initiated in seven countries. The Secretariat and health ministers should continue to champion the benefits to health of action on climate change, emphasizing that shifting to a low-carbon economy led to better health. He welcomed the progress report and requested regular updates on the topic.

Dr ABDESSELEM (Tunisia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Regional Committee for the Eastern Mediterranean had adopted its own resolution on climate change and health[1] at its fifty-fifth session in October 2008. Countries in the Region were taking measures to strengthen their individual capacities but they would benefit from technical assistance from the Secretariat at the local level.

The DIRECTOR-GENERAL said that WHO would work closely with other United Nations agencies and partners on the important subject of climate change. Noting that the Copenhagen Conference had demonstrated a lack of appreciation of the impact of climate change on health, she said that WHO would continue improving advocacy to empower the relevant ministries. She

[1] Resolution EMR/RC55/R7.

acknowledged the fundamental importance of the resilience of health systems to early warning, detection, response and preparedness, and WHO efforts would focus on those areas.

J. Primary health care, including health system strengthening (resolution WHA62.12)

Dr TAKEI (alternate to Dr Omi, Japan) said that the lack of systematic approaches and of collaboration between different organizations and communities could undermine the important provision of health-care services through primary health care. In strengthening international responses to communicable diseases and to harmonize actions, health systems must make the most of existing resources by good management, governance and leadership.

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region, said that they welcomed the interest shown by WHO and various regions and countries in the promotion of primary health care and the strengthening of health systems. In September 2008, the Regional Committee for Africa at its fifty-eighth session had endorsed the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa,[1] which set out actions to be taken by Member States in nine priority areas. For the African Region, the principal challenge lay in lack of financing for overall strengthening of health systems; he therefore called for investments to be realigned towards that goal, with special attention to conflict and post-conflict countries.

Dr KESKİNKILIÇ (Turkey)[2] said that the organization of primary health care services lay at the core of strengthening health systems. It was to be hoped that *The world health report 2010* would provide analysis and indicate best practices at country level in line with the declarations and other texts prepared by the regional offices in order to encourage the reorganization of primary health care and to emphasize joint values. He also looked forward to the rapid creation of a technical advisory committee that would determine priority areas and prepare guidance documents for countries.

The Board took note of the reports.

5. CLOSURE OF THE SESSION: Item 11 of the Agenda

The DIRECTOR-GENERAL said that the session had coincided with two events of worldwide concern: the pandemic of influenza A (H1N1) 2009 and the devastating earthquake in Haiti. The United Nations had just put an end to its search and rescue efforts in Haiti, with the number of confirmed dead at more than 110 000. Work on recovery and reconstruction was already under way. She thanked all the many countries that were already providing assistance.

The Board's discussions had progressed slowly on items that had a clearly divisive political dimension, on which positions were firmly entrenched and agreement unlikely, but when the discussion had focused strictly on the interests and needs of public health, it had been excellent. A high point had been the unwavering commitment of Member States to achievement of the health-related Millennium Development Goals. On the treatment and prevention of pneumonia, WHO had been asked to play a strong leadership role: it would do so. The need to strengthen health systems, including information systems, had been repeatedly stressed, with primary health care being cited as the best approach. The urgency of doing everything possible to prevent noncommunicable diseases had been unanimously voiced, and WHO had been asked to explore ways to reduce the price of medicines for chronic care.

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[1] Resolution AFR/RC58/R3.

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

Following the bold collective action taken for tobacco control, the international community should take major steps forward by tackling the harmful use of alcohol and the marketing practices that contributed to childhood obesity. The views of Member States on the importance of food safety, tuberculosis control, blood safety and viral hepatitis had been noted. WHO had again been asked to seek ways to reduce the cost of treatment of hepatitis. While the stunning drop in measles mortality had been welcomed, hesitation had been expressed about setting a goal for global eradication. Member States had indicated that the job of poliomyelitis eradication needed to be finished. All the guidance provided by Member States on those and other subjects would be taken into account in preparing for the Sixty-third World Health Assembly.

After the customary exchange of courtesies, the CHAIRMAN declared the 126th session closed.

The meeting rose at 13:40.