

FIFTH MEETING

Wednesday, 20 January 2010, at 09:10

Chairman: Dr S. ZARAMBA (Uganda)

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

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 4.1 of the Agenda (Documents EB126/4 and EB126/INF.DOC./1)

The CHAIRMAN, introducing the item, drew attention to the report on pandemic influenza preparedness contained in document EB126/4; document EB126/INF.DOC./1 had already been referred to in the discussion of agenda item 4.2, Implementation of the International Health Regulations (2005), at the second meeting.

Dr KÖKÉNY (Hungary), speaking on behalf 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, Montenegro and Serbia, as well as Ukraine, the Republic of Moldova and Armenia aligned themselves with his statement. He expressed appreciation for the Secretariat's efforts to reach agreement on the outstanding elements of the Pandemic Influenza Preparedness Framework. The two-day consultation with Member States, held in October 2009 and facilitated by the Director-General, had been an appropriate means of deepening understanding of Member States' positions on the sharing of influenza viruses and access to vaccines and other benefits. He welcomed the Secretariat's follow-up and the update on the pandemic influenza A (H1N1) 2009 virus contained in document EB126/INF.DOC./1.

One of the main objectives of preparing for pandemic influenza was to strengthen public health collaboration through improved sharing of viruses, better surveillance, greater transfer of technology and know-how, and broader access to vaccines and other benefits. International collaboration during the pandemic (H1N1) 2009, particularly the free and transparent sharing of viruses within the WHO system, had been vital to a rapid and effective global response. Lessons were to be learnt from the situation and should be fed into any future deliberations. Member States had recognized the need for transparent and efficient sharing of virus samples with WHO and among themselves as required.

In general, intellectual property rights played an important role in promoting innovation and investment by the private sector. Those issues must be handled in close collaboration with the competent organizations, such as WIPO and WTO, in compliance with existing international agreements and regulations. Measures adopted should strengthen WHO's credibility and role as the leading health agency in the multilateral system. The process of agreeing the Framework was complex, and he acknowledged the difficult position of the Director-General in that regard.

He expressed support for the Secretariat's intention of improving access to vaccines, especially in countries with no production capacity of their own and whose health systems needed strengthening. Access to vaccines was based, inter alia, on availability of viral information or virus material, international collaboration between Member States and manufacturers, capacity for research and development, production capacity, and the commitment to engage in capacity building, following WHO guidelines. So far, sharing of viruses had allowed vaccines to be produced. Continuous collaboration with manufacturers was therefore crucial to supporting public health actions, particularly with regard to sharing viruses and knowledge. Countries had contributed to the objectives of the

Framework by sharing viruses isolated from cases identified through their surveillance systems at early stages.

Collaboration within the WHO Global Influenza Surveillance Network should be guided by the principle of free and transparent circulation of virus samples. The European Union strongly supported the agreed potential package of benefits, as set out in Section 6 of the Framework, but remained concerned about the potential consequences of a mandatory linkage between benefits and virus transfers. Collaborative and voluntary arrangements with industry and other partners should be further explored.

Although much of the Framework had been agreed and was already being used to good effect, several important issues had yet to be resolved. He encouraged the Director-General to implement the agreed parts of the Framework and to work with Member States, regional economic integration organizations and other stakeholders to reach agreement on the outstanding elements. The European Union remained fully committed to achieving that aim during the Sixty-third World Health Assembly.

Ms SUJATHA RAO (India) expressed support for virus sharing within the WHO Global Influenza Surveillance Network, on the understanding that it would benefit global public health and would be matched by an equal and simultaneous commitment to share benefits. Virus sharing and the sharing of benefits should be treated on an equal footing and must have the same level of commitment, obligation and enforceability. Both should have the same legal status: either mandatory or optional. Genetic material should be part of Pandemic Influenza Preparedness (PIP) Biological Materials. The Standard Material Transfer Agreement should be linked to the Framework, which could contain all provisions on benefit sharing. No intellectual property rights should be obtained by anybody in respect of samples shared within the WHO mechanism.

Further to the two-day consultation facilitated by the Director-General in October 2009, in accordance with resolution WHA62.10, she requested that an appropriate Member-driven process be established to finalize outstanding issues at an early date and urged Member States to engage constructively in the process, guided by the accepted principle of sharing viruses and benefits on an equal footing.

WHO had shown leadership in containing the pandemic (H1N1) 2009. The experience gained in terms of sharing materials could contribute to a practical model to resolve outstanding issues. Developing countries must have access to research, data and technology in order to generate products, contributing to overall accessibility and affordability.

WHO had facilitated global capacity building for pandemic influenza vaccine manufacture, and some 12 countries had made substantial donations to its vaccine stockpile, which would benefit 95 countries identified by WHO. She drew attention to the fact that countries wishing to import vaccines from global manufacturers were required to enter into detailed, confidential contractual agreements that greatly favoured manufacturers and contained obligations that were neither transparent nor ethical and went against the principles of equity. WHO should share information on the agreements entered into with manufacturers in order to enable Member States purchasing vaccines to ensure that they did not commit themselves to terms and conditions that could later be cited as precedents.

The 95 countries identified were currently being provided with only one fifth of the vaccine required to vaccinate high-risk groups. To avoid delays in vaccination, Member States were therefore forced to procure additional vaccine from private manufacturers. The possibility of diverting vaccine from countries with large stockpiles to poorer countries could not be ruled out. WHO should disseminate information on the utility of vaccines in the face of a pandemic that had lasted more than nine months, with several surges in cases around the world, and on acquired population immunity, all in the context of the availability of a medicine that could decrease morbidity and mortality rates if administered early.

In the light of press reports that members of the Strategic Advisory Group of Experts had had financial links to pharmaceutical companies engaged in developing the pandemic (H1N1) 2009 vaccine and claims that the pandemic situation had been exaggerated, the Secretariat should speak out in order to ensure that its credibility and actions were not tarnished in the public perception.

Although WHO's stockpiles of vaccines, medicines and other supplies were useful in the short term, long-term sustainability of supply should be ensured by expanding global capacity for manufacturing influenza vaccine, including production in developing countries. Technology transfer and capacity building should therefore be given high priority.

Dr SEDYANINGSIH (Indonesia), highlighting the health and socioeconomic impacts of pandemic influenza, emphasized the need for a global response to a global problem, as clearly illustrated by the pandemic (H1N1) 2009. The possibility of a pandemic virus emerging from strains other than H5N1 and H1N1 should be kept in view.

Capacity to deal with a pandemic depended on achieving collective public health goals and having skilled and well-equipped health workers on the ground. Overcoming widespread shortages of and lack of access to health resources was also crucial in responding effectively to pandemic influenza and, in turn, achieving the health-related Millennium Development Goals. International cooperation could ensure equitable distribution of diagnostic tools, vaccines, medicines and supplies to all countries, on the basis of public health risk.

The Intergovernmental Meeting on Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and Other Benefits had made significant progress, particularly in terms of Member States' commitment to share viruses and benefits on an equal footing, which had led to the recognition that sharing covered both global pandemic risk assessment and risk response. The mechanisms adopted by the Intergovernmental Meeting, such as the Influenza Virus Traceability Mechanism, would be vital in ensuring a reliable global system to tackle future pandemics, but it was important that the Pandemic Influenza Preparedness Framework was finalized and implemented. She therefore encouraged Member States to participate actively in the negotiations on outstanding issues. It was to be hoped that the Board would break the impasse on those issues at its current session, so that faster progress could be made towards establishing a permanent, fair, sustainable, equitable and more predictable global system to ensure an effective response to future pandemics. She expressed appreciation to the Director-General for her efforts to bridge differences between Member States.

Dr KABULUZI (Malawi), speaking on behalf of the Member States of the African Region, echoed appreciation for the Director-General's efforts to find agreement on elements of the Pandemic Influenza Preparedness Framework that remained outstanding despite the progress made by the Intergovernmental Meeting. It was his understanding, however, that the two-day consultation held in October 2009 had been a brainstorming session, rather than a negotiating meeting. The Director-General's proposal to separate access to benefits from virus sharing represented a major departure from the approach adopted by the Intergovernmental Meeting, which had considered both benefit sharing and virus sharing as aspects of the Standard Material Transfer Agreement.

Given the effort already invested and agreements reached, a new intergovernmental process should be established with the mandate of finalizing the remaining issues. He reaffirmed his Region's commitment to working with other Member States to that end. A viable solution would entail the creation of an international mechanism to ensure access to benefits and sharing of viruses on an equal footing, particularly in view of the many challenges his Region faced, both technically and financially.

Professor HAQUE (Bangladesh), welcoming support for a more sustainable, predictable and structured system for sharing viruses and benefits as well as the opportunity to exchange information on outstanding issues provided by the two-day consultation held in October 2009, said that, in accordance with the "equal footing" principle, the Standard Material Transfer Agreement should apply equally to benefit and virus sharing, and to all laboratories and entities within and outside the WHO Global Influenza Surveillance Network. It should be the only legally binding instrument within the Pandemic Influenza Preparedness Framework to govern the transfer and use of PIP Biological Materials and products developed from them, and should not be limited to influenza vaccine manufacturers.

Benefit sharing should not be considered voluntary by any entity receiving and using PIP Biological Materials. The provisions on benefit sharing should be clearly outlined in the Standard

Material Transfer Agreement. He expressed the concern that the middle ground suggested in paragraph 8(b)(ii) of document EB126/4 might lead to further ad hoc arrangements based on tailor-made specific contributions, rather than sustainable solutions. With regard to intellectual property rights, there was some merit in the proposals outlined in Appendices 2 and 3 of the Annex to the same report. The Doha Declaration on the TRIPS Agreement and Public Health provided an authoritative document to guide further negotiations on intellectual property rights within the Framework.

There remained other unresolved issues that should be addressed in future negotiations. Some of the conclusions drawn in document EB126/4 did not necessarily capture the views of all Member States and might prejudice the outcome of further negotiations on the Framework. He expressed support for taking negotiations to their logical conclusion and stressed the need for further open-ended consultations, which he requested the Director-General to facilitate, before the Sixty-third World Health Assembly, with a view to narrowing divergences on the remaining issues. He also stressed the need to agree on a mechanism for virus and benefit sharing under the Framework, without which countries were unable to formulate national virus sharing policies. The National Influenza Centre in Bangladesh stood ready to share isolates with other WHO centres, as long as the benefits of sharing viruses were clear, concrete and sustainable, with equitable provision for developing countries, especially those affected by the disease. He expressed support for the points made by the member for India.

Ms TOELUPE (Samoa) commended the progress made on the outstanding elements of the Pandemic Influenza Preparedness Framework. The development and current distribution of the pandemic (H1N1) 2009 vaccine suggested that events had occurred that either pre-empted the proposals made in document EB126/4 or underscored the importance of their being subjected to careful assessment before acceptance. She broadly supported the draft Standard Material Transfer Agreement, but expressed reservations regarding section 3.5, as under-resourced providers might not be in a position to be fully aware of their rights and obligations with regard to intellectual property. Acknowledging the difficulty of meeting urgent demands for vaccine while allowing for the needs of influenza vaccine manufacturers, she commended the Secretariat's work on developing guiding principles for benefit sharing arrangements with manufacturers. She also highlighted the work done by the Regional Office for the Western Pacific to assist small island nations in that regard.

Mrs CHISTYAKOVA (adviser to Dr Starodubov, Russian Federation) said that, thanks to the application of the International Health Regulations (2005), timely information on the pandemic (H1N1) 2009 had been received, enabling all countries to take the necessary measures. Her Government's actions had been primarily geared to developing and producing vaccines, producing sufficient quantities of effective antiviral medicines, ensuring that treatment centres (including intensive care units) were properly prepared, and providing the public with information on individual and social prevention measures. Particular attention had been devoted to the manufacture and safety of vaccines. One live and three inactivated virus vaccines had been in production since November 2009, following full preclinical and clinical research and registration, and more than five million people had been vaccinated. Monitoring, which would continue throughout the vaccination period, had revealed that the vaccines had no significant side-effects.

She expressed support for the Secretariat's efforts to provide access to vaccines, including for developing countries, through transfer of technology for vaccine manufacture to interested countries, and to examine the issue of supplying vaccines to other countries, particularly within the Commonwealth of Independent States. She welcomed the draft Standard Material Transfer Agreement, but suggested that "H1N1" should be inserted after "H5N1" in article 2 and that the words "and national biosafety standards" should be inserted after "WHO guidelines" in article 3.1.2. The Russian Federation would actively participate in finalizing the Standard Material Transfer Agreement and other documents. She suggested that full and prompt updates on the situation with regard to the pandemic (H1N1) 2009 should be posted on the WHO web site in all the Organization's official languages, and welcomed the leading role played by WHO in responding to the pandemic and the range of measures taken at the international level to minimize its consequences.

Dr MOHAMED (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the pandemic (H1N1) 2009 should be assessed from the standpoint of transparency in the exchange of clinical samples and cooperation among international organizations. Any deviation from standard practices could threaten international health cooperation and undermine trust in international activities. Consideration should also be given to how the situation might have evolved if the virus had demonstrated greater virulence.

The pandemic (H1N1) 2009 vaccine had been prepared in a record time of less than six months from the discovery of the new virus, something that would not have been possible without a rapid exchange of samples. He commended the countries and organizations that had provided the fundamental materials for the creation of vaccines. Ensuring that countries had fair access to vaccines at affordable prices was a matter of concern to Members in the Region, and it was to be hoped that a fixed and known percentage of the vaccines produced for any future pandemic would be allocated to each country on the basis of its population, in order to ensure equitable distribution. Special arrangements should be made for particular countries with limited resources and those with special needs.

Intellectual property should not be an issue when dealing with an influenza pandemic, because such an emergency threatened human civilization. He endorsed the position taken by the Intergovernmental Meeting on the matter and recalled resolution WHA62.10 which requested the Director-General to facilitate the finalization of the Standard Material Transfer Agreement.

Dr OMI (Japan) reminded the Board of two inescapable facts. One was that intellectual property rights must be considered as an important incentive for innovation, since without the prospect of such rights the private sector would not be motivated to invest in research. The other was that developing countries with limited resources also had to have equitable access to high-quality medicines. Reconciling those positions would require flexibility on both sides. The countries rich in resources had done much, but should do a little more, trying their best to make technical or financial contributions, but on a voluntary, not mandatory, basis. In that connection, his Government had decided to donate US\$ 10.8 million to WHO to use for whatever pandemic-related purpose it deemed fit, including procuring vaccines for countries with limited resources.

Much progress had been made in the sharing of samples, and he understood that the Secretariat was monitoring the sharing process. The Organization should monitor not only sample sharing but also the contributions being made by the private sector and by Member States. A clearer picture of trends in that area would help the international community in its efforts to secure a level playing field for all.

He also agreed with the Director-General's view, as expressed in paragraph 8(c) of document EB126/4, that Member States should view the issue of intellectual property rights as only one among many other issues.

Mr ALBUQUERQUE E SILVA (adviser to Dr Buss, Brazil) observed that any future framework to be agreed should provide for the rapid, systematic and timely sharing of viruses with pandemic potential, a fair and equitable sharing of benefits, transfer of technology and global improvement of laboratory capacity, especially in the developing countries. Benefit sharing was a right of Member States and any agreement on it should be binding and enforceable and not limited to individual vaccine manufacturers.

Member States and the Secretariat should make every effort to reconvene a negotiating body in order to reach an agreement, if possible before the Sixty-third World Health Assembly. Financial and logistical considerations should not hinder the endeavour to find a solution.

Dr SEDYANINGSIH (Indonesia) suggested that the Board's decision on the item should be taken at the following meeting in the light of the results of ongoing consultations.

Dr LIU Peilong (China)¹ said that his Government, as a major developing-country contributor of virus strains, strongly advocated the equitable distribution of the public health and economic benefits that arose from the sharing of such strains. At the same time, it hoped that the developed countries would be able to offer more financial and technical assistance to developing countries.

With regard to the Standard Material Transfer Agreement, he agreed with the suggestion of a stepwise approach, as described in paragraph 8(a)(i) of document EB126/4. In the area of benefit sharing, he endorsed the draft guiding principles contained in the Annex to the same document, but pointed out that, as vaccine manufacturing capacity varied greatly among countries, with 97% of it being concentrated in the developed world, it might not be possible to adopt fully uniform benefit-sharing arrangements. Thus, individual manufacturers should be allowed to make specific voluntary contributions based on their respective capacities and strengths. China stood ready to make a contribution to the international stock of vaccines, as conditions permitted.

The issue of intellectual property rights should not be an impediment to measures that Member States wanted to take to protect public health. He agreed with WHO's compromise proposal, under which any entity receiving Pandemic Influenza Preparedness Biological Materials would be permitted to seek intellectual property rights derived from the use of such Materials and would be urged to grant to WHO a non-exclusive, royalty-free, sub-licensable licence with respect to such rights.

Mr ROSALES LOZADA (Plurinational State of Bolivia)¹ observed that much substantive work remained to be done if a substantive agreement was to be reached. Paragraphs 8(a), (b) and (c) of document EB126/4 should not be regarded as reflecting a consensus, as the Framework was still under negotiation. It would be precipitate, for example, to claim consensus to the effect that the Standard Material Transfer Agreement would apply only within the WHO Global Influenza Surveillance Network, as described in paragraph 8(a)(ii). In the context of intellectual property, a fundamental concern was the underlying possibility that the future network to be created would permit the patenting of living entities. Since his country's Constitution prohibited all forms of private protection for the exclusive exploitation of plants, animals, microorganisms and any living material, he would have difficulty in accepting the patenting of viruses or any constituent parts thereof.

It was important to restart a formal and participative negotiation process. Holding informal consultations, as had been done up to the present, would not bring the matter to a conclusion.

Dr GOPEE (Mauritius) expressed gratitude to the Director-General for the clear guidance provided, through the Regional Office for Africa, for the elaboration of the Emergency Preparedness Plan, which had allowed Mauritius to cope with the pandemic. However, Mauritius had not yet received any firm indication of how soon the pandemic (H1N1) 2009 vaccine would be made available as a result of WHO's negotiations with the manufacturers. That was a concern because the country would be entering its influenza season in May or June 2010. Moreover, he shared the concerns raised by the member for India about media reports on links between pharmaceutical companies and the members of the Strategic Advisory Group of Experts. Rumours of that nature could adversely influence views on whether WHO's promotion of vaccination was well-founded. The Director-General should address the issue and provide the necessary guidance on which the small island developing States such as Mauritius strongly depended, owing to their limited human and financial resources.

Ms TRUCILLO (Uruguay)¹ said that the negotiations should continue, leading, it was to be hoped, to the conclusion of an agreement that provided for enhanced access by countries to the vaccines that would be so necessary if the current pandemic should worsen or a new one occur. In Uruguay, the cost of the pandemic (H1N1) 2009 vaccine was double that of the seasonal influenza

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

vaccine and the country currently did not have an adequate stock. Fortunately the impact of the pandemic had been moderate, but it was necessary to be prepared for new emergencies.

Mr ADAM (Israel)¹ said that the decisions taken by the Director-General had been correct and appropriate in the crisis of 2009, when knowledge about the influenza A (H1N1) 2009 virus had been insufficient. He encouraged her to act on vaccine prices and seek to lead efforts to reduce them worldwide. Rather than a marketplace where the buying and selling sides interacted, the vaccines market in 2009 had unjustifiably been one where the sellers had simply dictated to the buyers. It could have been different if WHO had intervened.

Ms ARRINGTON AVIÑA (Mexico)¹ recalled that Mexico had shared the pandemic influenza A (H1N1) 2009 virus with the international community, considering that such an action would enable rapid development of a vaccine. Thereby, it had demonstrated its conviction that combating such a health emergency demanded international cooperation. However, Mexico had received no benefit from that good-faith gesture, and was concerned that, despite the existence of a formal mechanism to share information on influenza viruses at the global level and despite its having supported action to promote access to all types of benefits (including vaccines) for the countries that had contributed viruses, only a limited quantity of vaccine had to date been made available to a limited number of countries. Her country's supply of vaccine was limited, despite the commitments made by pharmaceutical companies. Nevertheless, Mexico was grateful to the Government of Canada for providing five million doses.

Much remained to be done to increase production capacity and improve access to vaccines against the present or future influenza viruses. She emphasized continued working with the Secretariat in order to strengthen international cooperation in that area. She called for the resumption of formal negotiations on the Framework, in order to reach an arrangement that would be of benefit to all. The viruses and genetic sequences needed for vaccine development should be considered global public goods.

The DIRECTOR-GENERAL, responding to the request made by the member for Indonesia, agreed that it would be sensible to defer a decision on the item to the following meeting, but maintained that the Board should hear all views still to be expressed in order to facilitate the informal consultations between members.

The CHAIRMAN said that he took it that the Board wished to hear the remaining views on the item but postpone taking a decision thereon until after the informal consultations had taken place.

It was so agreed.

Mr PISANI (International Federation of Pharmaceutical Manufacturers & Associations), speaking at the invitation of the CHAIRMAN, noted the quick and efficient global response to the pandemic (H1N1) 2009. Investment, research and development had led to the swift appearance of specifically-tailored pandemic (H1N1) 2009 vaccines, with approvals coming only three months after the declaration of a pandemic.

Members of his Federation had contributed significantly, for example providing more than 75% of the 200 million vaccine doses recommended for vulnerable countries. Other such actions by Member States and other stakeholders had led to the most comprehensive pandemic response ever seen.

Further efforts were needed to ensure a sustainable system and should build on the voluntary nature of the current system, which was able to respond to any scenario that could arise. Other health emergencies had also been managed through voluntary international collaboration and evidence

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

suggested that the same approach should continue to be applied in the pandemic influenza preparedness framework.

Ms SHASHIKANT (Christian Medical Commission (CMC) – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, noted that the pandemic (H1N1) 2009 had highlighted the need for a sustainable pandemic influenza preparedness framework that included benefit sharing. Access to critical materials during a pandemic was a challenge for developing countries but the availability of vaccines was still inadequate.

Noting the inequities in the current virus and benefit sharing system, which served to make vaccines readily available in developed countries but not in developing countries, she urged Member States to find a sustainable solution in a transparent framework. Under such a framework, commercial interests and profits should not take precedence over public health considerations; concrete equitable benefit sharing should be ensured between relevant entities and the WHO Global Influenza Surveillance Network; no biological materials contributed or parts thereof should be allowed to be patented; a mechanism should be developed enabling the transfer of technologies to developing countries through that Network; measures should be outlined to build capacity and increase developing-country participation in risk assessment and response; and an adequate proportion of the global supply of vaccines should be set aside under WHO's supervision for use in developing countries during pandemics, and made available at an affordable price.

The DIRECTOR-GENERAL, responding to comments made by the members for India and Mauritius on the subject of false media reporting, reassured the Board that she had firmly refuted the claims that had been made.

Her Special Adviser on Pandemic Influenza had conducted a virtual press conference with the global media community and the media were to be thanked for reporting WHO's position fairly. Claims of a "fake" pandemic had been expressly refuted and it had been made clear that WHO's policy ensured that all members of the Strategic Advisory Group of Experts on immunization or other expert panels were required to make declarations of interests. Those declarations were then verified and shared among all members of expert groups, meaning that interests should always be clear when individual members made certain interventions or recommendations. Moreover, procedures were in place that excluded certain stakeholders from the decision-making process in order to ensure the integrity and independence of the groups concerned. If any expert did not provide a full disclosure of interests, an immediate investigation would be launched. The Secretariat had been conducting such investigations and was doing its utmost to counter misinformation and to protect the independent opinions of experts.

Ms SUJATHA RAO (India) said that the Director-General's explanation of the action taken to counter misinformation, which she welcomed, should be published in her country. As the Director-General's comments normally appeared only on the WHO web site, they should be transmitted to the media in India, where there was currently much complacency over the pandemic (H1N1) 2009 owing to the lower than expected number of deaths and the reports of collusion between WHO officials and pharmaceutical companies that had been published.

The DIRECTOR-GENERAL confirmed that she could send the information requested by the member for India to the IHR national focal points for transmission to the media.

It was the role of the media to help to disseminate the right message to the public as the basis for them to make informed decisions on particular issues. She stressed that she did not want to influence the media, but highlighted the importance of understanding the challenge faced by WHO to ensure that all views were adequately reported, as selective reporting could give rise to unnecessary difficulties in some countries.

(For continuation of the discussion, see summary record of the sixth meeting.)

Monitoring of the achievement of the health-related Millennium Development Goals: Item 4.4 of the Agenda (Document EB126/7)

The CHAIRMAN, introducing the item, drew attention to the following draft resolution proposed by Albania, Argentina, Armenia, Austria, Belgium, Bulgaria, Chile, Congo, Cyprus, Czech Republic, Denmark, Djibouti, Estonia, Finland, France, Gabon, Germany, Greece, Hungary, Ireland, Israel, Italy, Japan, Kenya, Latvia, Lithuania, Luxembourg, Malta, Mexico, Monaco, Netherlands, New Zealand, Niger, Nigeria, Norway, Oman, Paraguay, Peru, Poland, Portugal, Republic of Korea, Republic of Moldova, Romania, Rwanda, Senegal, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, United Kingdom of Great Britain and Northern Ireland, United States of America and Zimbabwe, which read:

The Executive Board,
Having considered the report on Monitoring achievement of the health-related Millennium Development Goals,¹

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

The Sixty-third World Health Assembly,

Having considered the report on monitoring achievement of the health-related Millennium Development Goals;

Recalling resolution WHA61.18 on monitoring of the achievement of the health-related Millennium Development Goals;

Recalling the outcomes of the major United Nations conferences and summits in the economic, social and related fields, especially those related to global health, in particular the 2005 World Summit Outcome and the commitments made by the international community to attain the Millennium Development Goals and the new commitments made during the United Nations High-Level Event on the Millennium Development Goals (New York, 25 September 2008);

Stressing the importance of achieving the health-related Millennium Development Goals, especially with the objective of ensuring socioeconomic development;

Welcoming the Ministerial Declaration adopted at the annual ministerial review held by the Economic and Social Council in 2009 on implementing the internationally agreed goals and commitments in regard to global public health;

Recalling United Nations General Assembly resolution 64/108 (10 December 2009) on global health and foreign policy;

Recognizing that the Millennium Development Goals are interlinked, and reiterating the Health Assembly's commitment to continued reinvigoration and strengthening of the global partnership for development, as a vital element for achieving these Goals, in particular those related to health;

Reaffirming the commitments by many developed countries to achieve the target of 0.7% of gross national income on official development assistance by 2015 and to reach 0.56% of gross national income for official development assistance by 2010, as well as the target of 0.15% to 0.20% for least developed countries, and urging those countries that have not yet done so to make concrete efforts in this regard in accordance with their commitments;

¹ Document EB126/7.

Welcoming the commitments in the Paris Declaration and the Accra Agenda for Action to national ownership, alignment, harmonization and managing for results, and the experience of the International Health Partnership and others;

Noting the work of the Leading Group on Innovative Financing for Development and of the High-Level Task Force on Innovative International Financing for Health Systems, the additional pledges made by several countries to increase financing for health, and the announcements made by several countries at the United Nations General Assembly High-Level Meeting on Health (New York, 23 September 2009) to achieve universal access to affordable basic health care, including provision of free services for women and children at the point of use where countries choose, and financial mechanisms toward social health protection;

Expressing concern at the relatively slow progress in attaining the Millennium Development Goals, particularly in sub-Saharan Africa;

Expressing deep concern that maternal, newborn and child health and universal access to reproductive health remain constrained by health inequities, and for the slow progress in achieving Millennium Development Goals 4 and 5 on improving child and maternal health;

Welcoming the contribution of all relevant partners and progress achieved toward the goal of universal access to prevention, treatment, care and support related to HIV/AIDS;

Reaffirming WHO's leading role as the primary United Nations specialized agency for health, including its roles and functions with regard to health policy in accordance with its mandate;

Welcoming WHO's report on women and health¹ as important in advancing women's rights and gender equality, underlining the need to address women's health through comprehensive strategies targeting root causes of discrimination, stressing the importance of strengthening health systems to better respond to women's health needs in terms of access and comprehensiveness;

Recognizing that health systems based on the principles of tackling health inequalities through universal access, putting people at the centre of care, integrating health into broader public policy, and providing inclusive leadership for health are essential to achieving sustainable improvements in health;

Recognizing also the growing burden of noncommunicable diseases worldwide, the adverse impacts of the food, environmental, economic and financial crises on populations, in particular on the poorest and the most vulnerable ones, which may increase the level of malnutrition and reverse the achievement of Millennium Development Goal 1 (Eradicate extreme hunger and poverty) and the health-related Goals and the progress made in the past two decades,

1. URGES Member States:

- (1) to strengthen health systems so they deliver equitable health outcomes as a basis of a comprehensive approach towards achieving Millennium Development Goals 4, 5, and 6, underlining the need to build sustainable national health systems and strengthen national capacities through attention to, inter alia, service delivery, health systems financing, health workforce, health information systems, procurement and distribution of medicines, vaccines and technologies, sexual and reproductive health care and political will in leadership and governance;
- (2) to review policies, including those on recruitment, training and retention, that exacerbate the problem of the lack of health workers, and their imbalanced

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

distribution, within countries and throughout the world, in particular the shortage in sub-Saharan Africa, which undermines the health systems of developing countries;

(3) to reaffirm the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action, transparency, accountability, decentralization and community participation and empowerment, as the basis for strengthening health systems, through support for health and development;

(4) to take into account health equity in all national policies that address social determinants of health, and to consider developing and strengthening universal comprehensive social protection policies, including health promotion, disease prevention and health care, and promoting availability of and access to goods and services essential to health and well-being;

(5) to renew their commitment to prevent and eliminate maternal, newborn and child mortality and morbidity through effective continuum of care, and through strengthening health systems and through comprehensive and integrated strategies and programmes to address root causes of gender inequalities and lack of access to adequate care and reproductive health, including family planning and sexual health; by promoting respect for women's rights; and by scaling up efforts to achieve integrated management of newborn and child health care, including actions to address the main causes of child mortality;

(6) to expand significantly efforts towards meeting the goal of universal access to HIV prevention, treatment, care and support by 2010 and the goal to halt and reverse the spread of HIV/AIDS by 2015;

(7) to include in bilateral and multilateral initiatives on achieving the Millennium Development Goals, in particular in South-South cooperation initiatives, best practices in strengthening health services;

(8) to maximize synergies between the HIV/AIDS response and strengthening of health systems and social support;

(9) to enhance policies to address the challenges of malaria including monitoring of drug resistance in artemisinin-based combination therapy;

(10) to sustain and strengthen the gains made in combating tuberculosis, and to develop innovative strategies for tuberculosis prevention, detection and treatment, including means of dealing with new threats such as coinfection with HIV, multidrug-resistant tuberculosis or extensively drug-resistant tuberculosis;

(11) to sustain commitments to support the eradication of poliomyelitis;

2. REQUESTS the Director-General:

(1) to continue to play a leading role in the monitoring of the achievement of the health-related Millennium Development Goals, including progress towards achieving universal coverage of services essential to these Goals;

(2) to that effect, to continue to cooperate closely with all other United Nations and international organizations involved in the process of achieving the Millennium Development Goals in the framework of the Medium term strategic plan 2008–2013 and with a strong focus on efficient use of resources based on the respective mandates and core competencies of each and avoiding duplication of efforts;

(3) to provide support to Member States in their efforts to strengthen their health systems, address the problem of the lack of health workers, reaffirm the values and principles of primary health care, and to address the social determinants of health and to strengthen their public policies aimed at fostering full access to health and social protection, including improved access to quality medicines required to support health care for, inter alia, the most vulnerable sectors of society;

- (4) to foster alignment and coordination of global interventions for health system strengthening, basing them on the primary health-care approach, in collaboration with Member States, relevant international organizations, international health initiatives, and other stakeholders in order to increase synergies between international and national priorities;
- (5) to articulate and present to the Health Assembly as part of its action plan for the renewal of primary health care, the actions that the Secretariat envisages will strengthen its support for the realization of Millennium Development Goals 4, 5 and 6;
- (6) to work with all relevant partners in order to achieve high immunization coverage rates with affordable vaccines of assured quality;
- (7) to lead the work with all relevant partners to help to ensure that action on the health-related Millennium Development Goals is one of the main themes of the High-level Plenary Meeting of the 65th session of the United Nations General Assembly [*discussion still pending in New York on format and dates*];
- (8) to continue to collect and compile scientific evidence to achieve health-related Millennium Development Goals and to distribute them as useful information to all Member States;
- (9) to continue to submit annually a report on the status of progress made, including on main obstacles and ways to overcome them, in achievement of the health-related Millennium Development Goals, through the Executive Board, to the Health Assembly.

The financial and administrative implications for the Secretariat of the draft resolution were:

1. Resolution Monitoring of the achievement of the health-related Millennium Development Goals	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected results:
2. To combat HIV/AIDS, tuberculosis and malaria.	All expected results for this strategic objective.
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.	All expected results except 4.8.
10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.	All expected results except 10.6, 10.7 and 10.9.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution is particularly relevant to strategic objective 10, which concerns both improved management and organization of health service delivery through a primary health-care approach, and enhanced monitoring and evaluation of progress. The resolution is also highly relevant to all strategic objectives concerned with the achievement of specific health outcomes, especially strategic objectives 1–4. Of the latter group, it particularly concerns strategic objective 2 and strategic objective 4. Other strategic objectives with relevance to the resolution include strategic objective 5 on emergencies and crises (expected results 5.1–5.3), strategic objective 6 on reducing risk factors for health conditions linked to unhealthy lifestyles (expected result 6.6), strategic objective 7 on tackling social and economic determinants of health and enhancing health equity (expected result 7.3), strategic objective 8 on promoting healthy environments (expected results 8.1–8.2), strategic objective 9 on nutrition and food safety and security (expected results 9.1–9.4),	

strategic objective 11 on ensuring access to medical products and technologies (expected results 11.1–11.3) and strategic objective 12 on leadership, partnerships and collaboration with countries (expected results 12.1–12.3).

3. Budgetary implications

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

The two major streams of work and associated costs relate to: (i) the production of the annual report on the health-related Millennium Development Goals; and (ii) the provision of technical support to countries for enhanced programme implementation, monitoring and evaluation. The former is primarily carried out at headquarters, the latter through the regional offices.

Total production costs for the annual report (as part of the publication, *World Health Statistics*):

Staff costs: 33% full-time equivalent, grade P6; 40% full-time equivalent, grade P5; 50% full-time equivalent, grade P4; and 50% full-time equivalent, grade P3.

Total costs for regional office inputs: US\$ 2 million.

Total costs: US\$ 4 250 000.

(b) Estimated cost for the biennium 2010–2011 (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)

Total costs for implementation: US\$ 1.7 million (US\$ 900 000, at headquarters level and US\$ 800 000 at regional office level).

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

Yes.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Headquarters: 50% from assessed contributions, 50% from voluntary contributions.

Regional offices: 100% from voluntary contributions.

5. Administrative implications

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

Implementation activities in respect of the annual report on the health-related Millennium Development Goals will take place at headquarters. Collaboration with all regional offices to enable improved availability of up-to-date information and support to countries for data analysis, reconciliation and estimation will be organized as needed.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below

Headquarters: yes, providing that funding continues to be available.

Regional offices: no for the Regional Office for Africa and the Regional Office for South-East Asia.

(c) 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)

The Regional Office for Africa and the Regional Office for South-East Asia will need one staff member (full-time equivalent) to work with countries.

(d) Time frames (indicate broad time frames for implementation of activities)

From 2010 to 2015.

Dr KÖKÉNY (Hungary), speaking on behalf 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, Montenegro, and Serbia as well as Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with his statement. He said that monitoring showed clearly that countries were not on target to achieve the health-related Millennium Development Goals by 2015; the global economic crisis and the impact of climate change were likely to further jeopardize their achievement.

The progress made in reducing rates of child mortality and in the prevention and treatment of HIV/AIDS, tuberculosis, malaria and some neglected tropical diseases, needed to be sustained. However, maternal mortality ratios were still intolerably high and no country had achieved the 5.5% annual decline in maternal mortality that was necessary to attain Target 5.A (to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio). Free or low-cost maternal and prenatal health services were lacking, as was knowledge on sexual and reproductive health. Member States had not properly examined the failure to value adequately the lives and human rights of women, including the problems of sexual violence and forced marriages. Good health would not be possible without gender equality, education for all and environmental sustainability.

Access to safe, clean water and basic sanitation, and sufficient and nutritious food were essential and he welcomed the Declaration of the World Summit on Food Security as an important step in achieving Millennium Development Goal 1 (Eradicate extreme poverty and hunger).

The rates of HIV infection in some parts of the world remained high despite improved access to antiretroviral therapy. The strengthening of regional and technical collaboration would reduce the spread of that and other communicable diseases. The participation of middle-income countries would be crucial to achieving Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases).

Fragile health systems slowed the progress towards achieving the health-related Goals. The European Union invited WHO to make a clear road map for the strengthening of health systems, notably primary health care, showing the efforts to be undertaken at the national, regional and international levels. Similarly, national policies must enable the achievement of the Goals. The global ambition to reach Millennium Development Goal 5 should be reflected more clearly in future budgets of WHO.

The draft resolution had been proposed in order to give new impetus to monitoring the achievement of the health-related Millennium Development Goals to which end WHO's governing bodies must adopt concrete measures. Since its circulation, many additional comments on the text had been received. The Secretariat had been asked to prepare a revised draft text incorporating those comments, which would be distributed during a later meeting. In the meantime, members of the Board could discuss or propose amendments to the text currently before them; those comments could then be incorporated in the subsequent revised version.

Dr KABULUZI (Malawi), speaking on behalf of the Member States of the African Region, said that, despite some successes, huge disparities remained within and between countries in progress towards attainment of the Millennium Development Goals; many low-income countries in the African Region would not meet the targets by 2015.

In respect of Goal 1 (Eradicate extreme poverty and hunger), only eight countries were on track to attainment; in 18 countries there was some progress but in 12 there was none.

In respect of Target 4.A, to reduce the under-five mortality rate, only five countries were on track to achieve their target; 16 were making some progress; and 25 had made no progress.

In respect of Target 5.A, to reduce the maternal mortality ratio, only 13 countries had recorded a ratio below 550 deaths per 100 000 live births; 31 had a high ratio; and in 12 countries, more than 1000 deaths per 100 000 live births were recorded. In respect of Target 5.B, to achieve universal access to reproductive health, access to contraceptives among currently married women had increased 30% between 1990 and 2007.

In respect of Goal 6 (Combat HIV/AIDS, malaria and other diseases), progress was indicated. HIV prevalence in pregnant women aged 15–24 years had dropped or stabilized in 13 countries, but had increased in two countries. The most recent prevalence estimates ranged from 1.7% to 27.1%. Coverage of antiretroviral therapy had risen from 17% in 2005 to 42% in 2007. Malaria morbidity and mortality rates had been reduced through wider use of insecticide-treated nets and indoor residual spraying. Regarding the target for tuberculosis, five countries were on track, eight had made insufficient progress and 33 had made no progress; prevalence was high in 14 countries and had increased in 27 countries owing to coinfection with HIV. Drug-resistant tuberculosis was further complicating the situation.

In respect of Target 7.C, to halve, by 2015, the proportion of people living without sustainable access to safe drinking-water and basic sanitation, only nine countries were on track; six had made some progress but 19 had made none.

The challenges facing African countries included lack of resources and inadequate international support; lack of political commitment to prioritize health; health inequities; inadequate access to proven interventions; weak health systems and health information systems; and inadequate capacity.

He proposed three amendments to the draft resolution. A new fifth preambular paragraph should be inserted with wording taken from resolution WHA61.18: “Concerned by the fact that achievement of Millennium Development Goals varies from country to country and from Goal to Goal”. The words “including inappropriate infant and young child feeding practices” should be added at the end of paragraph 1(5), in order to emphasize the importance of that aspect for child mortality and morbidity. A new operative paragraph should be inserted to read “URGES the international community to invite concerned organizations of the United Nations system, international development partners and agencies, international financial institutions, nongovernmental organizations and private-sector entities to continue their support and consider further support to countries, particularly in sub-Saharan Africa, for the development and implementation of health policies and national development plans consistent with the Millennium Development Goals and other internationally agreed health goals”.

Ms ROCHE (New Zealand) expressed support for the comments made by the member for Hungary, notably those regarding family planning and sexual health, and concern at the pace of progress towards the attainment of the health-related Millennium Development Goals. Progress varied between and within countries and some countries in the Western Pacific Region were at risk of not attaining the Goals by the target date. New Zealand supported an increased focus on primary health care and strengthening of health systems; and improved access to both health care and to sexual and reproductive health services. Those points should be reflected in the draft resolution, with the aim of reducing rates of maternal and infant mortality. The collection of reliable data was important in order to monitor progress towards the Goals; however, constraints to good data collection needed to be weighed against limited capacities to deliver health improvements. She endorsed the call to harmonize international initiatives on the Millennium Development Goals and to further collaboration between organizations. She supported the draft resolution and stood ready to contribute to refinement of the text.

Professor HAQUE (Bangladesh) said that Bangladesh had made good progress towards attaining Goal 4 (Reduce child mortality), thanks to a combination of approaches, including sustained immunization coverage, integrated management of childhood illnesses, programmes to control communicable disease, breast-feeding and nutrition programmes, and improved supplies of medicine. Child malnutrition was declining. Progress in reducing neonatal mortality remained slow although neonatal tetanus had been eliminated in Bangladesh.

In respect of attainment of Goal 5 (Improve maternal health) and, in particular Target 5.A, to reduce the maternal mortality ratio, the report was gloomy. Bangladesh was currently surveying maternal mortality, but large, representative sampling was costly. A new demographic and health registry for citizens should enable online monitoring of progress. Bangladesh was committed to improving maternal health; it was expanding its network of community clinics, revitalizing primary health care and in some areas had attained the 2015 target for maternal health. Its Vision 2021

programme set out a comprehensive approach to attaining targets for improvements in the health and socioeconomic conditions of the population.

He supported the draft resolution but wished to see greater emphasis on the need for development partners to fulfil their commitments to support for action in attaining the Millennium Development Goals. He therefore supported the proposal put forward by the member for Malawi for a new operative paragraph.

Mrs ESCOREL DE MORAES (adviser to Dr Buss, Brazil), speaking on behalf of the Group of Latin American and Caribbean countries, said that the report broadly emphasized the elusive progress, accentuated by the financial crisis, towards the attainment of the health-related Millennium Development Goals. An integrated approach to all the Goals was required to attain the health-related Goals and, without high-level political leadership and without coordinated and sustained financial support from development partners, attainment of the targets by 2015 was unlikely.

Maternal mortality was of particular concern: around half a million women died annually as a result of preventable complications of pregnancy. Yet pregnancy was not a disease; the tools and knowledge to prevent complications existed, and must be made available to all and quickly. Actions must match words to ensure universal access to reproductive health. As stated in the preamble to WHO's Constitution, governments had a responsibility for the health of their peoples: and therefore in the provision of adequate health and social measures. That provision should include information on family planning and early monitoring of pregnancy; support responsible decisions on pregnancy and motherhood; and provide clinical and hospital care by qualified health professionals. A rights-based approach to women's health would free women to seek and receive information and support. Despite progress in her Region, if current trends persisted, few countries would attain the targets to reduce the rates of maternal mortality by 2015. The Secretariat should set standards and place greater emphasis on maternal health within primary health care services.

The Secretariat should also support activities relating to the social determinants of health: improving the conditions in which people lived and worked, reducing inequalities, hunger and extreme poverty, were all essential to improving health-related indicators.

The attainment of Goal 6 (Combat HIV/AIDS, malaria and other diseases) would require the strengthening of targeted prevention, universal access to antiretroviral treatment, respect for human rights, equality between the sexes, and reduced stigmatization and discrimination.

The adoption of the Millennium Development Goals in 2000 had represented a victory for ethical values and human solidarity over neglect of inequities and poverty. With only five years to the target date, the international community must renew its determination towards open trade, technical cooperation, South-South cooperation, technology transfer and improved access to affordable medicines, and commitment to existing aid.

Speaking as the member for Brazil, she said that her Government offered to host the global event on social determinants of health in July 2011, probably in Rio de Janeiro, in line with paragraph 4(11) of resolution WHA62.14, which requested the Director-General to convene such an event before the Sixty-fifth World Health Assembly. An item on that subject might be included in the provisional agenda of the Sixty-third World Health Assembly.

The CHAIRMAN thanked Brazil for its kind offer. The provisional agenda for the Health Assembly would be discussed at a later meeting,¹ but he recalled earlier comments on heavy agendas of governing body meetings.

Mr PETERU (alternate to Ms Toelupe, Samoa) said that he was encouraged by progress towards the attainment of some health-related Millennium Development Goals, in particular in the

¹ See summary record of the twelfth meeting, section 7.

area of child health, and urged the Secretariat to sustain current gains through technical and financial support. Welcoming WHO's renewed commitment to the strengthening of health systems through primary health care, he emphasized health as an outcome of policy across all sectors, universal access and response to people's needs. Greater attention should be given, *inter alia*, to equity, solidarity and gender balance, and to improved monitoring and systems for health information.

Noncommunicable diseases were a significant burden for the small Pacific island States and for fragile economies; control programmes should receive greater budget allocations. WHO should support the inclusion of an item on noncommunicable disease indicators under Goal 6 in the agenda of the forthcoming United Nations high-level meeting on the Millennium Development Goals, scheduled to be held in New York, 20–22 September 2010. WHO should also seek to ensure that noncommunicable diseases were included in any successors to the Millennium Development Goals.

Dr MUÑOZ (Chile) said that Chile was pleased to sponsor the draft resolution as increased efforts were needed to attain the health-related Millennium Development Goals by 2015, with attention given to improving maternal and child health care. Current rates for maternal deaths from avoidable causes, even in countries with a high proportion of hospital births, were unacceptable. Protection of pregnancy was a responsibility of society at large. The social determinants of health must also be addressed. Family planning programmes were essential to fundamental reproductive rights and reduced the probability of complications at birth, but necessitated facilities for primary health care that were adequately resourced, provided with guidelines and options for referrals to hospitals. Childbirth should take place in the safest conditions with trained, qualified staff. He supported the draft resolution in its current wording, the product of open consultations and especially important in the year that progress towards attainment of the Millennium Development Goals would be reviewed.

Dr ABDI (Somalia), speaking on behalf of the Member States of the Eastern Mediterranean Region, identified common factors that inhibited the developing countries in the Region from achieving the Millennium Development Goals: severe poverty; complex emergencies; inefficient health systems; lack of financial and human resources; low literacy rates; and a lack of reliable data and monitoring. In respect of Goal 4 (Reduce child mortality), the rate of under-five mortality had dropped in the Region by 26% between 1990 and the end of 2007. However, those figures were compromised by insufficient progress in six countries: the difference in mortality rates between the poorest and richest quintiles was related to inequity in health. Vaccine-preventable diseases accounted for about 25% of under-five mortality. Reduction in rates of measles mortality in the Region had reached the target set for 2010. In 2008, an estimated 58 300 women and 510 000 neonates had died in the Region due to complications in pregnancy and childbirth. Half of all newborn babies were still delivered away from health-care facilities, and 40% of those deliveries were not attended by skilled health personnel.

Achievement of Goal 6 (Combat HIV/AIDS, malaria and other diseases) was essential since tuberculosis, malaria and AIDS killed around 264 000 people annually in the Region. He recalled that data from the 1918 influenza pandemic had shown a correlation between mortality and household income: disparities in access to health care could be a factor in large-scale morbidity and mortality from an influenza pandemic. Malaria had been eliminated in most countries in the Region, but remained endemic in nine; achieving Goal 6 as a whole therefore depended on progress in those nine countries. The Region was on track to halve prevalence of tuberculosis by 2015, control of which remained a most important challenge for public health in the Region.

He emphasized reforms in financing and commended the renewed commitment to primary health care; specific barriers to service access should be eliminated, and effective local solutions found. Global health security depended on tackling the preventable environmental causes of diseases that were responsible for 13 million deaths annually. Without more financial and technical support from WHO and the international community, the poorest countries, such as Somalia, would not be able to achieve the Millennium Development Goals.

Ms SUJATHA RAO (India) commended the report. Notwithstanding impressive achievements globally, much remained to be done. In India, which was a significant contributor to the global capacity to achieve the Millennium Development Goals, the picture was mixed. Certain indicators relating to maternal mortality, HIV/AIDS and tuberculosis were likely to be achieved; but infant mortality, which was associated with development, and malaria, remained a challenge, despite a five-fold increase in public health investment. The issues of maternal and childhood nutrition, the availability of and access to skilled human resources, and of affordable technologies were currently being addressed.

Building capacity for universal access to institutional delivery was the focus of maternal health. The Secretariat's support would be welcome in clarifying and standardizing aspects of institutional care, skilled birth attendance and home delivery, and management of high-risk pregnancies in order to make quality standards comparable. In the case of neonatal care, too, there was confusion in the strategies proposed by different donors. WHO's guidance on supplementary nutrition and micronutrient requirements to reduce infant mortality due to diarrhoea, facilitating training of health-care workers, and cross-border linkages for malaria control would be welcome.

She called on the Secretariat to provide support to the developing countries in order to improve tuberculosis detection and cure rates under the DOTS strategy; obtain access to the diagnostic technologies available in developed countries; and promote generic medicines as a strategy for rational use of medicines. Only WHO had the global leadership to withstand the persuasive power of the manufacturers of branded and patented medicines. She urged all Member States to promote access to medicines and not to confuse counterfeit medicines with safe and effective generic medicines.

While still struggling with communicable diseases, India was facing the emergence of noncommunicable diseases. Programmes being drawn up included primary screening of diabetes and hypertension, and preventive health measures for tobacco cessation and healthy lifestyles. She commended WHO's initiative to identify core indicators and standardized methods of data collection of risk factors and determinants, which would enable strengthened surveillance under India's national programme for the control of chronic diseases.

She supported the draft resolution, but had some amendments to propose. She could do so either immediately or in a drafting group, as suggested by previous speakers.

The CHAIRMAN indicated that the proposed drafting group was the preferred option.

Dr STARODUBOV (Russian Federation) welcomed the progress made globally towards the Millennium Development Goals. Progress in his country was mixed: antiretroviral medicines had helped in the treatment of HIV and AIDS, but mother-to-child transmission of HIV remained a challenge. Maternal and child health had become a national priority: over the previous five years, the birth rate had increased by 16.3% to 12.1 per 1000 population. Unfortunately, the overall rate of maternal mortality had also increased, by 11.5% over the same period. However, rates of infant mortality had dropped by 44% between 2000 and 2008. The under-five mortality rate, a good measure of a country's demographic potential, had declined by 40% between 2000 and 2008.

His Government had significantly increased the level of funding allocated to achievement of the Millennium Development Goals. He commended the report and supported the draft resolution.

Dr ABABII (Republic of Moldova) affirmed that achievement of the health-related Millennium Development Goals should remain a priority for all countries. In 2007 his Government had adopted a national health policy that provided for sustained pressure to improve intersectoral cooperation. Achievement of the Millennium Development Goals had, however, been impeded by the emergence of the pandemic (H1N1) 2009 and the global economic crisis.

With regard to child mortality and morbidity, the country had already achieved the indicators for 2010; the under-five mortality rate had remained stable over the previous five years. Progress on Goal 5 (Improve maternal health) had not met expectations. In respect of indicators for rates of HIV/AIDS morbidity and mortality, there was concern that the lack of progress would have

repercussions for the tuberculosis indicators. That in turn made it more difficult to achieve Goal 3 (Promote gender equality and empower women). Environmental conditions in parts of the country, for instance with respect to drinking-water, prevented achievement of some Goals.

Countries with economies in transition were all suffering from a lack of resources and low income levels. His country's modest advances might be lost if sustained technical support for implementing its national health strategy and achieving the Millennium Development Goals was not forthcoming from WHO and international partners. He supported the draft resolution.

Dr SEDYANINGSIH (Indonesia), commending the progress made by some Member States towards achieving the Millennium Development Goals, acknowledged that factors such as political instability, lack of resources, and economic and humanitarian crises constituted major impediments. Achievement of the health-related Goals correlated positively with socioeconomic development and therefore required a joint effort by all related sectors. Reinvigorating the global partnership for development, vital to achieving the Goals, required greater political commitment and cooperation.

Her Government, with the support of WHO and international donors, had conducted health programmes of relevance to Goals 4 and 5. Over more than two decades, the general status of the population's health had improved considerably, and maternal and infant mortality rates had declined. Nevertheless, further efforts were needed and national strategies were being reassessed.

In respect of Goal 6 (Combat HIV/AIDS, malaria and other diseases), the number of cases of HIV/AIDS in Indonesia had increased, although HIV prevalence was still low, at around 0.2%. In order that Indonesia could produce and use its own antiretroviral medicines, WHO's support would be sought in the prequalification process. Programmes for malaria control had been improved, but the problems of drug-resistant parasites and insecticide-resistant mosquitoes remained. The prevalence of tuberculosis in Indonesia had decreased by almost 42% nationally since 1990, but the emergence of multidrug-resistant cases and cases of coinfection with HIV indicated that much remained to be done. The treatment of other neglected tropical diseases remained a challenge.

Adverse geographical conditions, lack of health personnel capacity, insufficient health facilities, particularly in remote areas, limited health funding and a lack of community empowerment were among the obstacles to achieving the health-related Goals by 2015. She emphasized revitalized primary health care, integrated policies, and equal access to health-care facilities.

The CHAIRMAN, observing that there were still 22 speakers on his list, proposed that the meeting rise to allow time for informal discussions during the lunch break.

Dr KÖKÉNY (Hungary) suggested that, in order to save time, the Secretariat prepare a revised text of the draft resolution containing the comments and amendments proposed thus far for distribution at the beginning of the next meeting.

The DIRECTOR-GENERAL said that, for logistical reasons, only an English version could be prepared during the lunch break. The Board's rules required that all six language versions should be made available to members; that could be done by the end of the day, provided that any further proposed amendments were submitted by 13:00.

The CHAIRMAN said that he took it that the Director-General's proposal was acceptable.

It was so agreed.

The meeting rose at 12:40.