



WORLD HEALTH ORGANIZATION

# EXECUTIVE BOARD

126TH SESSION

GENEVA, 18–23 JANUARY 2010

SUMMARY RECORDS

GENEVA  
2010





WORLD HEALTH ORGANIZATION

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## ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

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

## **PREFACE**

The 126th session of the Executive Board was held at WHO headquarters, Geneva, from 18 to 23 January 2010. The proceedings are issued in two volumes. The present volume contains the summary records of the Board's discussions and the list of participants and officers. The resolutions and decisions, relevant annexes and details regarding membership of committees and working groups are published in document in document EB126/2010/REC/1.

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<sup>1</sup> As adopted by the Board at its first meeting (18 January 2010).

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  - D. Rapid scaling up of health workforce production (resolution WHA59.23)
  - E. Strengthening nursing and midwifery (resolution WHA59.27)
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  - G. Multilingualism: implementation of action plan (resolution WHA61.12)
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## LIST OF DOCUMENTS

EB126/1 Rev. 1	Agenda <sup>1</sup>
EB126/1 Add.1 and EB126/1 Add.2	Proposal for supplementary agenda item
EB126/2	Report by the Director-General to the Executive Board at its 126th session
EB126/3	Report of the Programme, Budget and Administration Committee of the Executive Board
EB126/4	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits
EB126/5	Implementation of the International Health Regulations (2005)
EB126/6	Public health, innovation and intellectual property: global strategy and plan of action
EB126/6 Add.1	Public health, innovation and intellectual property: Report of the Expert Working Group on Research and Development Financing
EB126/7	Monitoring of the achievement of the health-related Millennium Development Goals
EB126/8	International recruitment of health personnel: draft global code of practice
EB126/9	Infant and young child nutrition: quadrennial progress report
EB126/10 and EB126/10 Add.1	Birth defects <sup>2</sup>
EB126/10 Add.2	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>3</sup>
EB126/11	Food safety

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

<sup>2</sup> See document EB126/2010/REC/1, Annex 1.

<sup>3</sup> See document EB126/2010/REC/1, Annex 7.

EB126/12	Prevention and control of noncommunicable diseases: implementation of the global strategy
EB126/13	Strategies to reduce the harmful use of alcohol: draft global strategy <sup>1</sup>
EB126/13 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>2</sup>
EB126/14	Tuberculosis control
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EB126/19 and EB126/19 Add.1	Availability, safety and quality of blood products
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EB126/20	Strategic Approach to International Chemicals Management
EB126/21	Guidance on the WHO review of psychoactive substances for international control: proposed revision <sup>3</sup>
EB126/22	Eleventh General Programme of Work, 2006–2015
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EB126/26	Method of work of the governing bodies <sup>4</sup>
EB126/27	Provisional agenda for the Sixty-third World Health Assembly

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<sup>1</sup> See document EB126/2010/REC/1, Annex 4.

<sup>2</sup> See document EB126/2010/REC/1, Annex 7.

<sup>3</sup> See document EB126/2010/REC/1, Annex 6.

<sup>4</sup> See document EB126/2010/REC/1, Annex 2.



## LIST OF DOCUMENTS

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EB126/28	Reports of committees of the Executive Board: Standing Committee on Nongovernmental Organizations <sup>1</sup>
EB126/28 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>2</sup>
EB126/29	Awards
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EB126/32	Appointment of the Internal Auditor
EB126/33, EB126/33 Add.1 and EB126/33 Add.1 Corr.1	Human resources: annual report
EB126/34	Statement by the representative of the WHO staff associations
EB126/35	Report of the International Civil Service Commission
EB126/36	Reports of advisory bodies: Advisory Committee on Health Research
EB126/37	Reports of expert committees and study groups
EB126/37 Add.1	Reports of advisory bodies: expert committees and study groups – expert advisory panels and committees and their membership
EB126/38 and EB126/38 Add.1	Progress reports
EB126/39	Confirmation of amendments to the Staff Regulations and Staff Rules <sup>3</sup>
EB126/39 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>2</sup>
EB126/40	Treatment and prevention of pneumonia
EB126/41	Leprosy (Hansen disease)

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<sup>1</sup> See document EB126/2010/REC/1, Annex 5.

<sup>2</sup> See document EB126/2010/REC/1, Annex 7.

<sup>3</sup> See document EB126/2010/REC/1, Annex 3.

**Information documents**

EB126/INF.DOC./1	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits
EB126/INF.DOC./2	Report of the International Civil Service Commission
EB126/INF.DOC./3	Implementation of the International Health Regulations (2005)

**Diverse documents**

EB126/DIV/1 Rev.1	List of members and other participants
EB126/DIV/2	Preliminary daily timetable
EB126/DIV/3	Decisions and list of resolutions
EB126/DIV/4	List of documents

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Dr M. BERGER  
Mr M. DEVLIN

**FDI World Dental Federation**

Dr D. ALEXANDER  
Dr R. VIANNA  
Dr J. FISHER  
Mr J. CRAIL  
Dr S.D. SHANTINAH  
Ms A. DUBRULE

**Framework Convention Alliance on Tobacco Control**

Mr L. HUBER  
Ms A. COX

**Global Forum for Health Research**

Professor A. MBEWU  
Mr J.-J. MONOT  
Mrs N. BOUDOU  
Mrs T. COLLINS  
Mrs M. FELETTTO  
Mr C. GARDNER  
Mrs S. JUPP  
Mr E. LANDRIAULT  
Mrs S. OLIFSON  
Mrs A. SIMON  
Professor S. MATLIN

**Global Health Council, Inc.**

Mr J.L. STURCHIO  
Mr M. BARUAH

**Inter-African Committee on Traditional Practices affecting the Health of Women and Children**

Dr A. ADEBAYO  
Ms M. TOLEDO  
Professor B. SCHATZMANN

**International Agency for the Prevention of Blindness**

Mr C. GARMS

**International Alliance of Patients' Organizations**

Ms J. GROVES  
Mr J. MWANGI  
Mr C. GORE

**International Alliance of Women**

Mrs M. PAL  
Mrs H. SACKSTEIN

**International Catholic Committee of Nurses and Medico-Social Assistants**

Mrs I. WILSON

**International Centre for Trade and Sustainable Development**

Mr P. ROFFE  
Mr A.A. LATIF

**International College of Surgeons**

Professor P. HAHNLOSER  
Professor C. CHEN  
Mr M. DOWNHAM

**International Council for Standardization in Haematology**

Dr R. SIMON

**International Council of Nurses**

Mr D.C. BENTON  
Dr T. GHEBREHIWET  
Mrs L. CARRIER WALKER

**International Diabetes Federation**

Ms A. KEELING  
Mr G. PATON

**International Federation of Business and Professional Women**

Ms M. GERBER  
Ms G. GONZENBACH  
Dr I. ANDRESEN

**International Federation of Gynecology and Obstetrics**

Professor G. SEROUR  
Professor H. RUSHWAN

**International Federation of Medical Students Associations**

Ms S. RUKAVINA  
Ms V. JUGOVEC  
Ms M. LJUBICIC  
Mr R. KRUTHOF

**International Federation of Pharmaceutical Manufacturers and Associations**

Mr E. PISANI  
Mr M. OTTIGLIO  
Mrs C. RAMIREZ  
Mr A. JENNER  
Mr G. CINTRA  
Dr R. KRAUSE  
Dr J. BERNAT  
Mr K. TODA  
Mr H. FUNAKOSHI  
Dr F. SANTERRE  
Ms T. MUSIC  
Mr A. AUMONIER  
Mr J. PENDER  
Ms A. ATKINSON  
Mr B. AZAIS  
Ms C. JACOBS  
Dr P. ANTONY  
Mr M. KAMIYA  
Mr F. FRANCO  
Ms S. CROWLEY  
Mr J. WALTZ

**International Federation of Surgical Colleges**

Professor S.W.A. GUNN

**International Hospital Federation**

Dr E. DE ROODENBEKE  
Miss S. ANAZONWU

**International Lactation Consultant Association**

Ms M. ARENDT

**International Organization for Standardization**

Mr T.J. HANCOX

**International Pharmaceutical Students' Federation**

Mr M. SULTAN  
Ms A. POP

**International Pharmaceutical Federation**

Mr T. HOEK  
Mr XUANHAO CHAN

**International Planned Parenthood Federation**

Dr K. ASIF

**International Society of Blood Transfusion**

Mr C. MUNK

**International Special Dietary Foods Industries**

Mr J.-C. JAVET  
Mr N. CHRISTIANSEN  
Ms G. CROZIER  
Mr THIEN LUONG VAN MY  
Mr D. HAWKINS  
Ms A. WASUNNA  
Ms T. SACHSE  
Ms W. THOMAS  
Mr T. MXAKWE  
Ms J. WITHERSPOON  
Ms R. BONA

**International Union against Cancer**

Ms C. ADAMS

Ms J. TORODE  
Mr R. ROBINSON

**Medicus Mundi Internationalis  
(International Organization for  
Cooperation in Health Care)**

Mrs A. TIJTSMA  
Mrs I. LAUSBERG

**MSF International**

Mr J. ARKINSTALL  
Ms K. ATHERSUCH  
Ms M. CHILDS  
Ms N. ERNOULT  
Dr T. VON SCHOEN-ANGERER  
Mr E. TRONC

**Rotary International**

Mr J. KÖBLER

**Soroptimist International**

Ms I.S. NORDBACK  
Ms S. STIFFLER

**Stichting Health Action International**

Mr T. REED  
Mrs S. BLOEMAN  
Ms T.-L. BESWICK

**Thalassaemia International Federation**

Dr V. BOULYJENKOV

**The International Association of Lions  
Clubs (Lions Club International)**

Mr G.E. CANFAFIO

**The Save the Children Fund**

Ms N. BRIKCI  
Mr S. WRIGHT  
Ms P. RUNDALL

**The World Medical Association, Inc.**

Mrs C. DELORME  
Dr J. SEYER  
Mrs Y. PARK  
Dr O. KLOIBER

**World Association of Societies of Pathology  
and Laboratory Medicine**

Dr R. BACCHUS  
Dr U.P. MERTEN

**World Federation of Public Health  
Associations**

Professor B. BORISCH  
Ms L. BOURQUIN

**World Heart Federation**

Ms H. ALDERSON  
Ms L. ZONCO

**World Self-Medication Industry**

Dr D.E. WEBBER

**World Vision International**

Ms R. KEITH  
Mr S. GERMAN

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## **SUMMARY RECORDS**

### **FIRST MEETING**

**Monday, 18 January 2010, at 09:40**

**Chairman:** Dr S. ZARAMBA (Uganda)

- 1. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA:** Item 1 of the provisional Agenda (Documents EB126/1, EB126/1 (annotated), and EB126/1 Add.1 and Add.2)

The CHAIRMAN declared open the 126th session of the Executive Board and welcomed participants, especially the new Board members, Ms Sujatha Rao (India), Dr Sedyaningsih (Indonesia), Dr Kabuluzi (Malawi), Dr Ould Horma (Mauritania) and Dr Al Darmaki (United Arab Emirates).

- 2. EXPRESSION OF SYMPATHY AND SOLIDARITY WITH THE PEOPLE OF HAITI SUFFERING AS A RESULT OF THE EARTHQUAKE, AND TRIBUTE TO DR QAMAR ADEN ALI**

The CHAIRMAN said that 2010 had brought with it serious challenges, in particular the recent earthquake in Haiti. The country would require considerable support in order to recover from the current tragic situation, and thanks were due to all those Member States and organizations that had already provided assistance. It was hoped that the Haitian Ambassador to the United Nations Office in Geneva would address the Board later in the session.

It was also his sad duty to inform the Board that Dr Qamar Aden Ali, Minister of Health of Somalia, had been killed in a terrorist attack in December 2009. The incident, in which a number of other people had also been killed or injured, had occurred during a ceremony to celebrate the graduation of medical students from Banadir University and was a tragic blow, especially to Somalia's medical fraternity.

**The Board stood in silence for one minute.**

- 3. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA:** Item 1 of the provisional Agenda (Documents EB126/1, EB126/1 (annotated), and EB126/1 Add.1 and Add.2) (resumed)

#### **Election of Vice-Chairmen**

The CHAIRMAN said that Dr Supari, the Board member designated by Indonesia, who had been elected as Vice-Chairman at the Board's 125th session, had been replaced by Dr Sedyaningsih. Member States in the South-East Asia Region had consulted and proposed that Dr Sedyaningsih should be elected Vice-Chairman.

**It was so agreed.**

**Adoption of the agenda**

The CHAIRMAN invited the Board to consider the provisional agenda, which had been drawn up in August 2009 after consultation with Officers of the Board and with Member States, in compliance with Rule 8 of the Rules of Procedure of the Executive Board. It had been recommended that the Board should defer the four additional proposals received from Member States to the 127th session in May 2010. Details of the consultation and recommendations were set out in document EB126/1 (annotated). As there was no proposed amendment to the Financial Regulations or Financial Rules, he suggested that item 6.2 should be deleted.

**It was so agreed.**

Dr SEDYANINGSIH (Indonesia) proposed that consideration of item 4.1, Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits, should be postponed until Wednesday, 20 January, so as to allow members more time for consultation and preparation.

The CHAIRMAN suggested that the timetable for discussions should be considered once the content of the agenda had been decided.

**It was so agreed.**

Dr GIMÉNEZ (Paraguay) said that the Board's January session remained important in the consideration of items for the Health Assembly in May. However, the current procedure excluded the possibility of reacting to the urgency of the recent earthquake in Haiti. A specific item should be included on the agenda in order to allow members to express their sympathy and solidarity with the people of Haiti, to review action and the leading roles being taken by WHO and PAHO in that health response, and to consider the mobilization of additional resources to ensure support in the short, medium and longer term.

The CHAIRMAN indicated that the Board would have the opportunity to speak on that subject immediately after the address of the Haitian Ambassador.

He drew attention to the proposals for inclusion of additional agenda items received after the deadline of 31 August 2009. Document EB126/1 Add.1 contained a proposal from the United Kingdom of Great Britain and Northern Ireland to discuss the treatment and prevention of pneumonia. Document EB126/1 Add.2 set out a proposal from Brazil for the inclusion of a supplementary agenda item on leprosy (Hansen disease). He invited comments on the proposal made by the United Kingdom.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) explained that the inclusion of an agenda item on the prevention and treatment of pneumonia was being proposed because of its immediate relevance to Millennium Development Goal 4, which targeted the reduction by two thirds, between 1990 and 2015, of the under-five mortality rate. Pneumonia accounted for the deaths of some 1.8 million children annually, and it would not be possible to attain Goal 4 unless action was taken to prevent and treat that illness. Inclusion of the item would avoid any further delay in such a vital area. The proposed item and draft resolution could be discussed informally to minimize formal discussion during the session. The United Kingdom supported due procedure in establishing the agenda and it was the first time it had requested the inclusion of a supplementary item at such a late stage.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, supported the proposal.

Professor HAQUE (Bangladesh) expressed support for the proposal and for the further development of pneumonia prevention and treatment programmes.

Dr MOHAMED (Oman) added his support to the proposal, emphasizing that the target date for achievement of the relevant Millennium Development Goal was drawing closer.

The CHAIRMAN said that, in the absence of any objection, he took it that the Board wished to include in the agenda the supplementary item set out in document EB126/1 Add.1.

**It was so agreed.**

The CHAIRMAN invited comments on the proposal made by Brazil to include in the agenda a supplementary item on leprosy (Hansen disease) (document EB126/1 Add.2).

Dr BUSS (Brazil) said that at the Global Meeting of Leprosy Control Managers on Leprosy Control Strategy held at the Regional Office for South-East Asia, New Delhi, in April 2009, 44 WHO programme managers had agreed on a global leprosy strategy for 2011–2015, which focused on reducing the number of leprosy cases. Brazil's proposal for a supplementary agenda item – the first it had ever made after the deadline referred to in Rules 8 and 10 of the Board's Rules of Procedure – was intended to enable the Board to review the global strategy and its implications for the Secretariat and to include the strategy in national leprosy control programmes.

Dr GIMÉNEZ (Paraguay) supported the proposal; leprosy was a disease of global importance. Further, he reiterated his call for inclusion of an agenda item on the response to the situation in Haiti.

Mr ROGERS (alternate to Dr Muñoz, Chile) supported the proposals to include agenda items on leprosy and the situation in Haiti.

Mr VALLEJOS (Peru) and Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, supported the proposal for the inclusion of an agenda item on leprosy.

Dr OMI (Japan) pointed out that, although leprosy was deserving of special attention, the Board's time was limited and the agenda was already full. He proposed that the Board should not add an item on leprosy to the agenda for the current session but request the Secretariat to collect and collate the available information and prepare a working document for discussion by the Board at its 127th session in May 2010.

The CHAIRMAN, noting that the Officers of the Board had extensively discussed the draft agenda in August 2009, appealed to the Board to reduce the number of agenda items as far as possible so as to ensure completion of business by the end of the session. He enquired whether the member for Brazil wished to reconsider his position.

Dr BUSS (Brazil) said that he failed to understand why the member for Japan opposed his proposal, given that a Japanese national, Mr Sasakawa, had championed efforts to eliminate leprosy. Leprosy was a matter of great importance for Latin America, Africa and Asia: new data and new issues had arisen from the New Delhi meeting. The Board's session could be extended by one or two hours, perhaps in a night meeting, to accommodate the item.

The CHAIRMAN observed that no background documentation was available on leprosy.

Dr OMI (Japan) conceded that the member for Brazil had raised a legitimate question. He was sure, however, precisely because Mr Sasakawa, as WHO Goodwill Ambassador for Leprosy Elimination, and the Nippon Foundation were so firmly committed to the elimination of leprosy, that they would wish to see sufficient time allocated to the evaluation, analysis and discussion of the issues involved.

The CHAIRMAN asked whether the Board wished to defer discussion of the proposed agenda item to its 127th session, which was only four months away.

Dr OMI (Japan) said that he would have no objection to including the item on the agenda of the Health Assembly in May, assuming the Secretariat could complete the preparatory work in the very short time available.

Dr BUSS (Brazil) said that the item should be discussed by the Board at its current session in order to prepare the Secretariat in detail for a future session. There had been no resolution on leprosy since 2001. The Board should find the one or two hours required for a subject of such cardinal importance for developing countries.

The DIRECTOR-GENERAL said that, if she had understood correctly, the member for Brazil was pressing for a discussion on leprosy in order to enable the Board to provide guidance on the content of a paper that the Secretariat would prepare for consideration by the Board at its 127th session in May. If that were the case, an informal lunchtime or evening meeting could be organized which any members of the Board able to provide such guidance could attend.

Dr BUSS (Brazil) expressed appreciation for the Director-General's proposal, but pointed out that it was not he but the member for Japan who had referred to demands on the Secretariat. He argued the necessity, in the absence of any resolution on the matter since 2001, for the Board to reconsider leprosy and highlighted the global strategy agreed at the recent meeting in New Delhi. He accepted that there was no document before the Board but nor was there one for pneumonia. Leprosy was an issue pertinent to developing countries. His proposal had been supported by the members for Chile, Peru and Paraguay, as well as Hungary on behalf of the European Union. He appealed to the member for Japan to understand those concerns and the need for a discussion at the current session.

The CHAIRMAN warmly welcomed the proposal by the Director-General for an informal meeting. He observed that leprosy could not be compared with pneumonia; discussion of the latter disease would contribute to several other items of the agenda, including monitoring of the achievement of the health-related Millennium Development Goals.

Dr GIMÉNEZ (Paraguay) pointed out that the proposal by the member for Brazil did not rule out further discussion of leprosy in the future as suggested by the member for Japan. He urged inclusion of the item on the current agenda.

The CHAIRMAN asked whether Board members wished to proceed in accordance with the proposal by the Director-General or with the proposal by the member for Brazil, or whether they preferred to vote on the matter.

Dr MOHAMED (Oman) suggested a review of the 2001 resolution on the subject in order to determine whether the epidemiological situation had changed significantly since then; he thought that unlikely.

The CHAIRMAN said that he took it that members wished to add the proposed supplementary item to the agenda. He suggested that the way in which the agenda was organized at subsequent Board sessions should be given serious consideration in view of the problems experienced in that area by the officers of the Board prior to the current session.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) pledged to keep his interventions short and to refrain from intervening purely to add to the comments of previous speakers, except on matters of exceptional importance.

The CHAIRMAN welcomed the pledge. He asked whether the member for Japan could accept the addition of an agenda item on leprosy.

Dr OMI (Japan) indicated his assent.

The CHAIRMAN drew attention to the proposal by Paraguay to add an item to the agenda on the Haiti earthquake. He suggested that the occasion of the delivery of a statement to the Board by the Ambassador of Haiti would be an appropriate time to hold a discussion and asked whether that procedure would be acceptable to Paraguay.

Dr GIMÉNEZ (Paraguay), agreed, but said that the Haiti earthquake should be included as an agenda item in its own right on account of its global significance. On the basis of the relevant report, the Ambassador's statement and no doubt a report by the Director-General, the Board would thus be able to demonstrate its support for further actions and mobilization of resources.

The CHAIRMAN, summing up, said that three items had been added to the agenda: item 4.19, Treatment and prevention of pneumonia; item 4.20, Leprosy (Hansen disease); and 4.21, Health consequences of the earthquake in Haiti.

He took it that the Board wished to adopt the agenda, as amended.

**It was so decided.**

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

#### **4. ORGANIZATION OF WORK**

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, said that, as agreed in the exchange of letters in 2000 between WHO and the European Commission on the consolidation and intensification of cooperation, and without prejudice to any future general agreement between WHO and the European Union, the European Commission attended sessions of the Board as an observer. However, under Rule 4 of the Board's Rules of Procedure, observers were not automatically invited to participate in the work of subcommittees or other subdivisions of the Board, such as drafting groups and working groups. He requested that, at the 126th session of the Board, as at previous sessions, the European Commission should be invited to participate without vote in the meetings of the Board and its committees, subcommittees or other subdivisions that addressed matters falling within the European Union's competence, in particular agenda items 4, 5, 7, 9 and 10.

The CHAIRMAN said that he took it that the Board wished to accede to the request.

**It was so agreed.**

The CHAIRMAN noted that items 8.1, "Appointment of the Regional Director for Africa" and 8.2, "Appointment of the Regional Director for Europe" would be discussed at 09:00 the following morning in an open meeting, attended by members of the Board, their alternates and advisers, Member States not represented on the Board, Associate Members and the Secretariat only. No official record would be prepared for the open meeting.

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

**5. REPORT BY THE DIRECTOR-GENERAL:** Item 2 of the Agenda (document EB126/2)

The DIRECTOR-GENERAL expressed her sadness at the death of Board member Dr Qamar Aden Ali, the Minister of Health of Somalia, in a suicide bombing. The incident had caused not only the loss of human life, but a loss of trained health personnel from a medical school supported by WHO. She also conveyed her condolences to the people of Haiti following the devastating earthquake which had struck a country already struggling to overcome serious public health problems.

With only five years to go before the deadline for achievement of the Millennium Development Goals, progress was seen to be uneven at the international level, and Africa continued to be a focus of particular concern. However, overall trends in world health were looking more positive. Aid for health development had begun to produce results. Fortunately, the global influenza pandemic had been more moderate in its impact than many had feared. Governments had shared both information and biological material rapidly and generously; public health officials had had difficult decisions to make with very little reliable information and had therefore erred on the side of caution. That was commendable, as a moderate pandemic with ample supplies of vaccine was preferable by far to the opposite scenario. The pandemic had demonstrated the value of the revised International Health Regulations (2005), which had helped to keep social and economic disruption to a minimum and provided a system of checks and balances to oversee international action.

Although in some respects the pandemic had followed a predictable course, there had also been surprises, such as public reluctance to take vaccines. The revolution in information and communication technology and the breadth of information available had undoubtedly changed public attitudes towards official medical advice and would continue to present new challenges. The pandemic had so far proved less severe than expected, but its full extent would not be known until some time after it ended. The fact that its development had been closely monitored would provide a wealth of new knowledge. She was confident that WHO's actions would withstand the inevitable scrutiny to which they would be subjected.

Despite the diversity of health problems around the world, the principal obstacles to addressing them were remarkably similar in many situations: precarious funding, chronic shortages of health-care workers, lack of laboratory capacity and widespread unsafe practices. Countries lacked critical support from regulatory and enforcement bodies. Public health services were beset by shortages, while the private sector was prohibitively expensive for many. Reports from Member States indicated that more must be done to improve the health of populations, even though progress had been made towards achieving the Millennium Development Goals. However, building capacity took time.

Recent informal consultations between the Secretariat and outside experts had examined future funding options for WHO, taking into consideration its strengths and unique role, particularly with regard to international and transnational issues, as well as areas that could be tackled by other bodies. A report would be published in due course. Views on the subject were many and varied, and reaching agreement would not be straightforward, particularly given the economic and public health considerations and competing interests involved, but she expressed the conviction that the Board was the appropriate forum to discuss the issue and move forward. The Secretariat would give its full support.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, expressed condolences to the people of Haiti.

The Board faced a challenge in addressing, in just one week, all the prominent issues with a direct impact on public health and welfare on its agenda. He expressed appreciation for the efforts and competent global leadership of WHO throughout influenza pandemic and welcomed the planned independent evaluation of the Organization's handling of the situation. He encouraged further cooperation with other stakeholders in work on those sections of the Global Influenza Preparedness Framework that had yet to be agreed.

With regard to implementation of the International Health Regulations (2005) communication between National IHR Focal Points and WHO IHR Contact Points had served effectively for information exchange and dissemination. The legal framework of the Regulations had adequately

guided the response to the pandemic (H1N1) 2009, and the IHR Emergency Committee was an important tool for the Director-General. He emphasized continued alliances with other international and intergovernmental bodies, especially those active in the transport sector.

He expressed support for WHO's leadership in monitoring the achievement of the Millennium Development Goals, particularly its involvement in the review meeting to be held in New York in September 2010. The Regional Office for Europe and the Member States of the European Region had been working towards strengthened national health systems, universal access to primary health care and financial provisions for social protection.

With regard to the international recruitment of health personnel, he emphasized the need to improve objective data gathering and processing, and the monitoring systems necessary in formulating policies. The role of the Secretariat was crucial in supporting Member States and providing a solid, voluntary code of practice, bearing in mind that the European Union comprised both source and destination countries. Formulating policies on sustainable health-care workforces would be a challenge for all Member States in the coming decades.

The European Union continued to support global food safety initiatives promoted by WHO. Such activities should cover the entire food chain and WHO should cooperate proactively with the Codex Alimentarius Commission. Stressing the importance of nutrition in combating noncommunicable diseases, he underlined the leading role of WHO in monitoring, preventing, controlling and researching noncommunicable diseases and in taking account of social determinants of health, which were of increasing relevance for developing countries. The 7th Global Conference on Health Promotion, held in Nairobi, Kenya, in October 2009, had issued a strong "Call to Action", the key recommendations of which should be implemented by WHO. He welcomed the Secretariat's report on strategies to reduce the harmful use of alcohol, contained in document EB126/13, which would help to reduce the burden of noncommunicable diseases while respecting the different contexts and traditions of Member States.

With regard to the availability, safety and quality of blood products, it was important for WHO to support the strengthening of national regulatory authorities and national control laboratories for the manufacture of plasma and blood-derived products, in accordance with international regulatory standards. He expressed support for the Secretariat's proposals with regard to international chemicals management, which were consistent with guidelines followed by the European Union. He encouraged WHO to continue highlighting the consequences of climate change for public health.

He reaffirmed the European Union's commitment to enhancing WHO's global health leadership and the strengthening of its governance and central financial management. He thus looked forward to participating in work on the Proposed programme budget 2012–2013 and to the establishment and activities of the Independent Expert Oversight Advisory Committee, a useful and efficient tool to enhance the Organization's accountability. Acknowledging WHO's contribution to United Nations reform, he encouraged the Director-General's leadership within the United Nations family in improving efficiency and effectiveness.

Dr DODDS (Canada), expressing sympathy to the people of Haiti, emphasized working together in the face of such emergencies, and the role of WHO, as a premier public health organization, in guiding that work.

The Board's agenda included several key items related to the response to the pandemic (H1N1) 2009, including the capacity of national governments and health agencies to extend surveillance, immunization and treatment regimens. While the pandemic continued, countries must remain alert for signs of human illness. In addition, the international community had a collective responsibility to improve the suboptimal distribution of vaccines.

In response to the report by the Secretariat on food safety, contained in document EB126/11, Canada had submitted a draft resolution to the Board, encouraging Member States to engage fully in international activities to assess, manage and communicate risks globally.

The work of the Board should embody the actions highlighted in the report contained in document EB126/26 on the method of work of the governing bodies. The Board had a clear obligation to discuss complex health and technical matters comprehensively. Nevertheless, she expressed the

concern that the continual addition of new items to the Board's agenda would lead to insufficient attention to those items and the deferring of others to subsequent sessions of the Board or Health Assembly. The Board should focus on supporting the Secretariat and Member States in achieving results, particularly with regard to the Millennium Development Goals, and she encouraged dialogue within the Board to resolve the problem.

Dr MOHAMED (Oman) welcomed the achievements of WHO, as outlined in the report. Echoing the need for the Organization to be prepared for future events, he expressed appreciation to the Director-General and Regional Directors for their response to the pandemic (H1N1) 2009, and support to the international community. The Director-General had referred to several issues of great importance; he singled out capacity building as needing ongoing attention by the Board and the Organization as a whole, in order to achieve the Millennium Development Goals, and, *inter alia*, to respond to the problem of emigration of health-care workers from developing countries.

Professor HAQUE (Bangladesh) said that the international community must stand by the survivors of the earthquake in Haiti. Bangladesh had contributed a skilled medical team to the international relief effort and could provide medical, nursing and technical staff in the context of any further support mobilized by WHO.

He welcomed the Director-General's forthcoming visit to Bangladesh and the visit of a high-level technical team to discuss support for influenza vaccine manufacturing. Bangladesh intended to develop a modern drug-testing laboratory and a strong combined food and drug authority. He requested Board members to give consideration to an item on cholera, a pressing public health challenge in many developing countries and which might be included in the draft provisional agenda for the Board's 127th session.

The CHAIRMAN thanked the member for Bangladesh for agreeing to defer the item on cholera to the next session.

Professor SOHN Myongsei (Republic of Korea) said that Member States must show solidarity with the people of Haiti in dealing with that country's current crisis, and subsequently continue efforts to improve public health care in Haiti. He hoped that his Government's donation of US\$ 10 million in aid would trigger additional assistance from other Member States.

He commended the Organization's rapid and timely leadership in recognizing and monitoring the pandemic (H1N1) 2009, issuing appropriate guidelines in line with the International Health Regulations (2005) and coordinating national, regional and global efforts and thus mitigating the pandemic's social impact, while avoiding unjustified interference with international trade and travel. However, in the near future Member States should evaluate the pandemic, as the international community could not be complacent, but must continue to prepare for another potential pandemic.

Dr KENYA-MUGISHA (alternate to Dr Zaramba, Uganda), speaking on behalf of the Member States of the African Region, said that the countries of Africa were deeply touched by the devastating earthquake that had caused untold suffering to the people of Haiti. He commended the quick response of the international community and encouraged continued support, in both the relief and rebuilding phases. With 2015 approaching, Haiti would require enhanced health systems if it was to fulfil its commitments to the Millennium Development Goals.

He congratulated the Director-General on having convened an informal consultative meeting on the future of financing for WHO. There was a need for WHO to define its core business more precisely and better align the priorities with the financing available. He also thanked the Director-General for her steadfastness with regard to the International Health Regulations (2005) and WHO's effective public health response to the pandemic (H1N1) 2009, avoiding unnecessary interference with international traffic and trade. He urged the Director-General to inform all Member States of the lessons learnt about implementation of the Regulations. Their core capacity requirements for



surveillance and response were still inadequate in the African Region and the Director-General was requested to mobilize increased funding to meet those minimum standards.

The financing for the response to the pandemic suggested the need to establish a trust fund for future epidemics. Additionally, considering the challenges in management of partnerships in health, the African Region proposed that the Board should adopt a decision, for consideration by the Health Assembly, on the establishment of a forum where health partners could update Member States on their priorities and activities so as to enhance synergies between the Member States and the Secretariat.

With regard to the slow pace of implementation of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, he suggested that the Director-General should convene a high-level consultation with the Directors-General of WTO and WIPO to develop jointly a framework to accelerate implementation of agreed activities that fell within the mandates of the three organizations, with progress reported to the Executive Board at its 128th session.

The poliomyelitis situation in Africa was still a concern despite the recent progress achieved and more support would be needed in order to interrupt poliovirus transmission in Africa.

Ms TOELUPE (Samoa) said that her country shared Haiti's pain, having itself been devastated by a tsunami in September 2009. She thanked WHO and the donor community for their support in the tsunami relief effort, and she commended all WHO staff, particularly those at the Regional Office for the Western Pacific, for their work in small island countries.

Professor SKVORTSOVA (alternate to Dr Starodubov, Russian Federation) expressed her country's solidarity with Haiti for its enormous loss of life in the earthquake. Russia had responded immediately with active assistance.

Noting the results from Director-General's comprehensive report, she observed that the global health-care sector, although clearly affected by the global economic crisis, should usefully pool experience and draw lessons from the crisis. The Russian Federation had maintained levels of financial provision for public health care and put into practice all of its health-care plans. Rates of mortality resulting from all major diseases had been significantly cut, including infant and maternal mortality, the birth rate had increased and the overall life expectancy extended. Thus, for the first time in several decades, the Russian Federation had been able to halt population loss.

With regard to the pandemic influenza A (H1N1) 2009 virus and largely thanks to the regular flow of information from WHO and to the introduction of the International Health Regulations (2005), Member States had been able to take the necessary anti-epidemic measures. The Russian Federation had developed four types of vaccine and had authorized them for use. Mass immunization was under way, with about 5 million people already vaccinated and a target of around 30 million vaccinations by March 2010. In 2009 the Russian Federation had transferred production technology to Thailand, and was negotiating the supply of vaccines to the members of the Commonwealth of Independent States and other interested countries.

The Russian Federation supported the Director-General in her efforts to optimize WHO's operations and to improve funding mechanisms, appreciated the timely nature of the consultation process and commended the results achieved. That process should be expanded, with participation by all interested Member States and WHO partnerships.

In the context of the Director-General's visit to Moscow in the summer of 2009, a Memorandum of Understanding had been signed between the Ministry for Health Care and Social Development of the Russian Federation and WHO, and the Russian Federation would be providing donor support to their shared programme priorities.

The First Global Ministerial Conference on Road Safety, held in Moscow in November 2009, had generated a consensus on the need to take urgent measures to prevent road traffic injuries. She expressed thanks to WHO for its major contribution to the preparation and conduct of the conference and looked forward to its continued cooperation in that work. The Russian Federation also supported the efforts of WHO in promoting the adoption of a United Nations resolution to combat noncommunicable diseases, which were the main cause of death in her country. The Russian Federation planned to host a major international conference on that issue in 2011.

Mr HOUSSIN (France) expressed his country's solidarity with the people of Haiti who had sustained grievous losses in the earthquake, and with the United Nations personnel who had paid a heavy price for their relief efforts. More than 500 French personnel were already in Haiti to provide practical assistance, and the university hospital in Fort de France, in Martinique, was fully committed to caring for the injured.

WHO, the European Union and various countries had been working for some years to enhance pandemic preparedness, and the international community's response to the pandemic (H1N1) 2009 had undoubtedly benefited. Since the spring of 2009, international cooperation had enhanced the use of the instruments available to countries to deal with the pandemic. The International Health Regulations (2005) had been a key factor in slowing the spread of the disease, as well as measures that encouraged hygiene, social distancing and early immunization. The pandemic had also shown that improvements were needed in: facilitating the supply of vaccines to the widest possible number of people; coordinating public information relating to the pandemic; and increasing the public's confidence in both the health authorities; and in the safety of health products, including vaccines.

Thus, he asked the Board to devote particular attention to the implementation of the International Health Regulations (2005); achievement of the health-related Millennium Development Goals; the draft global code of practice on the international recruitment of health personnel; and the prevention and control of noncommunicable diseases. He also intended to raise some issues in the area of multilingualism, under agenda item 10, in particular the importance of access to information in all working languages.

He commended the Director-General's initiative to improve the Organization's governance and funding arrangements, and would support reforms aimed at enhancing the focus, efficiency and credibility of the WHO of the twenty-first century.

Dr AL DARMAKI (United Arab Emirates) thanked all the organizations involved in the arrangements for United Arab Emirates Health Foundation awards.

He expressed his country's condolences to the people of Haiti in the wake of the earthquake and hoped that international coordination would enable Haitians quickly to overcome the disaster.

Information sharing was essential among all Member States and regions with regard to the pandemic influenza A (H1N1) 2009 virus, and notably also regarding the availability of safe vaccines. He emphasized communication and the role of the media in relation to pandemics and the importance of learning from past pandemics in order to prepare for such situations in the future.

Dr OMI (Japan) expressed his Government's sympathy to the people of Haiti for the damage caused by the earthquake.

Welcoming the Director-General's report, he recognized the difficult task that she and her team had undertaken in raising the pandemic alert to Phase 6. Currently, the definition of phases was based solely on the spread of the disease. He suggested that, in the future, account could also be taken of other factors such as mortality and hospitalization rates.

On the issue of funding for WHO core programmes, there had been extensive discussion on how to deal with the fact that most funding was currently allocated to specific diseases, with 20% coming from assessed contributions and 80% from extrabudgetary sources. It was the responsibility of WHO's governing bodies, particularly the Executive Board, to resolve that problem, and the donor community should establish a mechanism that allowed sufficient funds to be allocated to programmes.

Much work had been done by WHO, in conjunction with Rotary International and other stakeholders, on the issue of poliomyelitis. Although four countries still reported cases of the disease, it was time to reap the fruits of the efforts, energy, finance and resources that had been invested in eradicating poliomyelitis.

Dr DAHL-REGIS (Bahamas) thanked the Director-General for articulating clearly in her report the role of WHO in the global governance of public health, evident in its response to the disaster in Haiti. The Government of the Bahamas felt much sympathy for Haiti as 30% of its own population were Haitians; there had been many health problems on the island before the earthquake and many

more were anticipated in its aftermath. She commended the Regional Office for the Americas and PAHO for their swift response to the disaster.

Regarding innovative sources of funding, she emphasized building on previous successes in areas such as measles vaccination, which showed that there were many pathways to achieving targets under the Millennium Development Goals, particularly funding for Goal 4 and WHO's strategic objective 4. The Board should devise approaches to enhance financing of WHO and thus enable the Organization to fulfil its role.

Dr REN Minghui (China)<sup>1</sup> said that health systems in all countries, particularly developing countries, had been severely challenged by the worldwide financial crisis and the outbreak of the pandemic (H1N1) 2009. Yet the international community had coordinated a rapid response to contain the spread of the pandemic influenza A (H1N1) 2009 virus and safeguard health. The capacity of the global health system to respond to public health emergencies had also increased and China expressed thanks to WHO for its leadership in technical assistance.

His Government expressed condolences to the people of Haiti and had already sent relief workers and promised funds and resources to aid reconstruction. With international support, it was hoped that Haiti would overcome the effects of the earthquake. The swift action taken by PAHO showed the importance of an effective response to such public health emergencies.

Ms ARRINGTON AVIÑA (Mexico)<sup>1</sup> added her country's voice in expressing sympathy for the people of Haiti and said that, given its own experience of earthquakes and knowledge of the importance of aid from the international community, Mexico had sent physicians, rescue teams, medical supplies and other assistance to Haiti.

She thanked both the Director-General and the Special Adviser to the Director-General on Pandemic Influenza for their efforts to deal with the pandemic (H1N1) 2009.

Dr SEDYANINGSIH (Indonesia) expressed condolences to the people of Haiti and said that, as a disaster-prone country, Indonesia shared their grief and extended its support at that time. She sincerely thanked the Director-General for the assistance provided to Indonesia in the aftermath of its earthquake the previous year.

After welcoming the Director-General's report and her work, she noted that more was needed: to address the issue of pandemics; to find the ways and means to monitor progress towards the Millennium Development Goals and ensuring that targets were reached; and to raise public awareness and participation in addressing health issues.

The DIRECTOR-GENERAL, responding to comments, explained that Dr Mirta Roses Períago, Director of PAHO and Regional Director of the WHO Regional Office for the Americas, could not attend the current session of the Board as she had had to stay in Washington in order to coordinate work in support of Haiti. She was represented by other colleagues from the Regional Office.

All five WHO regional offices, along with headquarters, pledged a cross-regional response to the disaster in Haiti. The situation on the ground was very difficult; minimum survival was an issue even for aid workers, and many people still had nothing to eat or drink and no washing facilities. The energy and commitment of those countries that were helping was evident but the challenge was coordination. WHO was working with relief organizations and the Haitian Government to respond to the urgent health needs.

She commended the Government of Indonesia for its efforts following the tsunami that it had experienced. The country had an excellent disaster response unit and could usefully share its experiences with other countries in terms of disaster preparedness and response.

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

Many Member States had requested a review by WHO of the pandemic (H1N1) 2009 and the lessons that had been learnt. She stressed that she would listen to Member States' advice and, during later discussions, would propose a process for conducting such a review in a timely manner.

**The Board noted the report.**

**The meeting rose at 13:00.**

## **SECOND MEETING**

**Monday, 18 January 2010, at 14:35**

**Chairman:** Dr S. Zaramba (Uganda)

### **1. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD:** Item 3 of the Agenda (Document EB126/3)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, highlighted the issues in the Committee's report that were not on the agenda of the Board. Those included progress on WHO's management reforms, including the challenges that lay ahead in implementing the Global Management System and the new accounting system, the International Public Sector Accounting Standards; the Programme budget 2008–2009; the report of the Office of Internal Oversight Services; implementation of internal and external audit recommendations; and the reports of the Joint Inspection Unit. She would report the Committee's discussion of items on the Board's agenda as those items were taken up.

Dr KABULUZI (Malawi), speaking on behalf of the Member States of the African Region, welcomed the contribution of the Global Management System to enhanced budgetary controls, standardization of processes, increased transparency and improved access to information. It was not yet being widely used, and continuing efforts should be made to make it user-friendly as it was being extended to other regions, for example his own. He supported the requests for additional analysis regarding the system's costs, benefits and impact on all the Organization's work. The urgent situation regarding field staff security and the safety of headquarters premises emphasized the need for further discussion of the issue compounded with rapid action. He welcomed the thorough screening and a strict selection process for the appointment of members of the Independent Expert Oversight Advisory Committee. The African Region should be represented on the Committee, if possible.

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

**Implementation of the International Health Regulations (2005):** Item 4.2 of the Agenda (Documents EB126/5 and EB126/INF.DOC./1)

The CHAIRMAN drew attention to the report contained in document EB126/5, which described the Secretariat's activities and the procedures for convening the IHR Review Committee in early 2010. An update on the pandemic influenza A (H1N1) 2009 virus had been provided in document EB126/INF.DOC./1. In view of the close link between the International Health Regulations (2005) and the international response to the pandemic (H1N1) 2009, he suggested that the Board consider the situation concerning the pandemic under item 4.2 despite the fact that the Board had decided to postpone its consideration of item 4.1, on pandemic influenza preparedness, until later in the session. He took it that that arrangement was acceptable to the Board.

**It was so agreed.**

Dr FUKUDA (Special Adviser to the Director-General on Pandemic Influenza), giving a brief update on the current situation, recalled that pandemic influenza infections had first been reported in late April 2009. On 25 April 2009, the Director-General had declared a public health emergency of international concern, and by late May 2009, the Organization had received laboratory confirmation of infections in more than 48 countries and territories. By 11 June 2009, the infections had spread sufficiently for the Director-General to declare a pandemic, namely phase 6 under the pandemic preparedness guidance. By 1 July 2009, 120 countries and territories had reported confirmed infections; at present, that number had risen to about 208. In the northern hemisphere, virus transmission had started in May 2009, with a new surge of infections beginning in August 2009. In North America, peak activity had lasted for 10 to 15 weeks. In the southern hemisphere, virus transmission had been reported in many countries by June 2009.

The current situation in the southern hemisphere was one of sporadic infections but no large community outbreaks; in Africa, the most active transmissions were in northern countries, with data suggesting that western Africa had been largely spared; in North and South America, transmission had been declining or relatively low of late; and in Asia and Europe, transmission was still widespread but declining overall. Most infections resulted in uncomplicated influenza illness, not requiring specialized medical care. Most deaths were caused by severe viral pneumonia: unlike seasonal influenza, the pandemic virus directly attacked the lungs in severe cases. In about 25% of pneumonia cases there was a secondary bacterial infection, usually streptococcal. Among people who developed severe disease or died, up to 80% had underlying conditions, pregnancy being a major predisposing factor, although asthma, heart disease and diabetes, among others, were also implicated.

Severe cases and deaths had occurred in previously healthy young adults and children. Although young adults seemed to have been most often infected, the highest rates of admission to hospital – at least twice more than in other age groups – occurred in children under five years of age. The highest rates of death were among 50 to 60 year olds.

With regard to the impact on health-care systems, visits to outpatient clinics had increased in many countries, but it was not clear how many of the patients were merely worried or truly sick. Overall hospital admissions were generally not excessive although the rates of admission for younger people in particular were high. The most important finding, however, was that intensive-care units had been under the most pressure: about 4 to 15 times more patients than usual. Because many of the patients were young, they often spent fairly long periods in intensive care.

There was generally a good match between the vaccines being used and the viruses circulating. Viruses from people with severe as opposed to mild illness showed no consistent genetic differences. Sometimes mutation occurred and prompted speculation as to whether it was a marker for severe disease, but no such evidence had yet been borne out. One recently identified mutation had been proved to occur in a minority of viruses and it was impossible to determine whether it had a major effect on the behaviour of the viruses. Most of the viruses remained sensitive to oseltamivir and zanamivir, although about 200 cases of viruses resistant to oseltamivir had been reported. Small clusters of resistant viruses had been reported in the United Kingdom of Great Britain and Northern Ireland, the United States of America and Viet Nam, but no widespread increase in resistant viruses was so far evident.

Pandemic influenza viruses had replaced seasonal influenza viruses in nearly all countries. Meetings were to be held soon to determine the content of influenza vaccines, and a major question that scientists would be asking was what patterns of transmission could be expected for late 2010.

Pandemic infections were occurring in many countries, but decreasing overall. The highest transmission activity was in northern Africa, central and eastern Europe and southern Asia. The second wave of infection had peaked very early in some parts of the northern hemisphere. There was much speculation as to whether another wave of infection would occur in 2010 and what combination of viruses would be seen – would seasonal viruses return or be replaced by pandemic influenza viruses?

As to the availability of pandemic vaccines, by conservative estimates, more than 265 million doses had already been distributed, and about 175 million of those had been administered. Safety

monitoring had been unusually high, and coordination on reporting unusually intense. Even with especially careful scrutiny, no unusual safety issues had been reported.

Under WHO's vaccine initiative, 200 million doses had been pledged by a number of governments, foundations and manufacturers, something that the Organization greatly appreciated. Among the vaccines available worldwide, six had been prequalified by WHO and three more were under assessment. WHO and its partners were working to assist 95 countries, 86 of which had requested vaccine donations, and 32 had signed formal agreements with the Organization. Fourteen of those countries had finalized deployment and vaccination plans; vaccines had been deployed and received in two countries and used in one. It was expected that another 15 countries would receive vaccines before the end of January 2010.

The DIRECTOR-GENERAL recalled that the Sixty-first World Health Assembly in 2008 had requested the Secretariat to begin work in preparation for the first review of the functioning of the Regulations, which would be duly undertaken. Several Board members had requested the Secretariat to undertake an assessment of the current influenza pandemic. It was to be hoped that such a review would also serve to assess the performance of the Regulations. Once she had listened to comments from the Board, she would make proposals on action to be taken with respect to the reviews of both the Regulations and pandemic (H1N1) 2009.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that Member States must be neither intimidated nor driven into a situation of complacency by the recent suggestions in the media that the Organization and national health ministries had overreacted to the pandemic. It was not of practical relevance to compare mortality from the current pandemic to previous influenza pandemics and seasonal influenza outbreaks, since, for the first time in history, countermeasures including a vaccine had been available during the pandemic rather than after the peak had passed. Consequently, irrespective of the perceived severity of the pandemic, further spread could be combated and individuals around the world protected. The current strain of influenza, as with all seasonal strains, would drift and cause more serious outbreaks over time and hence the relevance of long-term protection.

Sub-Saharan Africa was particularly vulnerable to the pandemic influenza A (H1N1) 2009 virus because of three main factors: the high proportion of people under the age of 25 years, the age group shown to be most vulnerable in developed countries; the prevalence of comorbidities, given that chronic respiratory diseases, including tuberculosis, and immunosuppression due to such factors as untreated HIV infection had been shown to be risk factors of severe disease and mortality in developed countries; and the low level of income, given that studies in aboriginal populations that had been affected thus far had suggested that the least economically developed countries could potentially suffer a four-fold inflation in mortality ratios. He emphasized continued and strong precautionary action concerning the possible spread of the pandemic to vulnerable countries.

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, expressed support for the statement made by the previous speaker.

He urged the Secretariat to disseminate information on the impact and benefits of the Regulations and national public health measures. The Regulations had proved to be an adequate legal framework to manage the global response to the current pandemic; the IHR Emergency Committee had advised the Director-General appropriately; and the WHO networks had exchanged and disseminated information effectively. The network of National IHR Focal Points, however, should be consolidated further in order to become fully operational. That network and the WHO IHR Contact Points were being increasingly used for rapid communication of public health information: direct, immediate and continuous access to WHO experts had been useful in responding to public health risks and emergencies. The European Union supported the proposed procedures for convening the IHR

Review Committee in February 2010, which would provide technical advice to the Director-General and would propose ways of better implementing the Regulations. Continuous performance review of the decision instrument referred to in Annex 2 to the Regulations would also be useful.

He emphasized that the challenges of public health alerts and emerging diseases demanded: intensified implementation of the Regulations in all States Parties; strengthened capacities for disease surveillance, and early-warning and rapid-response systems; and the sustainable integration of those into general public health surveillance strategies. The Organization should guide and support States in that endeavour in order to ensure coherence between national and worldwide measures. He stressed that such comprehensive and prompt response required WHO to strengthen relations with other international and intergovernmental organizations, especially those active in the transport sector, and expressed support for the establishment of a collaborative framework with FAO and OIE.

Mr HOUSSIN (France) said that the revised Regulations, seen functioning on a large scale in 2009, had proved satisfactory. He commended the role of WHO during the pandemic and the rapid publication of its initial recommendations, even if the scope of certain measures, such as those concerning quarantine and the use of thermal cameras in airports, had not always been adequately defined.

At least five years would be needed to build the capacities of a fully operational system. However, every effort must be made to consolidate the National IHR Focal Points; to continue building capacities, particularly with respect to laboratories and diagnosis, in which area the WHO Office in Lyon could play an essential role; to publish guidelines; and to support Member States in implementing the Regulations, notably in preparing a list of diseases necessitating disinsection, preparing minimum standards for the National IHR Focal Points and laboratories, describing procedures for issuing ship sanitation certificates and intensifying anti-vectoral activities. The IHR Review Committee must draw lessons from the pandemic but also pursue those other aspects linked to implementation of the Regulations.

Professor HAQUE (Bangladesh), anticipating the first comprehensive review of the Regulations at the Sixty-third World Health Assembly, said that the context of virus pandemics emphasized the importance of implementing the Regulations. Noting that the current pandemic had been the first human influenza pandemic since 1968, he expressed support for the statement by the member for the United Kingdom that vigilance was essential since the virus was sure to mutate: the Organization must provide guidance in that respect. The report highlighted progress in the implementation of the Regulations; its finding that many emerging diseases originated in the interaction between humans and animals demonstrated the importance of effective cooperation between the health sector and the food, agriculture, livestock and poultry sectors. Strengthening the capacities of laboratories in developing countries was also vital. The report acknowledged that points of entry into countries, particularly ground crossings, remained a serious weakness: just how public health capacities could be improved in order to address that problem required consideration. He urged the Organization to continue assisting countries such as his own in implementing the Regulations.

Dr MOHAMED (Oman) said that the pandemic had been of such proportions in the Eastern Mediterranean Region that countries had not always been able to respond on an individual basis. Nevertheless, official health measures had been introduced, not always successfully, and decisions amended as necessary. Between 6% and 7% of his country's population had access to vaccines; vaccines were in stock but had not yet been distributed. It was essential that States that did not have the capacity to tackle the pandemic, for example with respect to pulmonary or respiratory conditions, should be provided with vaccines. Although in some countries in the Region specialized medical care and admission to hospital had limited the number of deaths, the mortality rate had remained relatively high. He expressed surprise that the Secretariat had received requests for vaccines from many developing countries when other developed countries had returned unused stocks of vaccines. Vaccines and care must be provided where needed, and every effort made to avoid viral mutations, as had occurred during previous pandemics. He asked for statistics to be provided on the number of



vaccines that had been distributed and not administered, and therefore perhaps discarded, and for clarification of predictions for 2010.

Dr GIMÉNEZ (Paraguay) said that the Regulations had proved adequate for the global, regional and national response to the current pandemic; the guidelines provided by WHO, PAHO and other regional health organizations and the efforts of national health ministries, had further mitigated the impact of the pandemic. Those experiences should lead to a strengthening of systems in preparation for such events in the future. The increased public confidence in health institutions that had resulted from communication between health ministries and the general public must be preserved. Although vaccination was the main tool for preventing the spread of the pandemic, complementary measures had also had a considerable impact on health indicators in his country: a significant reduction in mortality over the winter had been attributed to communication and prevention measures through public and private institutions including the Ministry of Education. He noted that a second outbreak of the pandemic could coincide with the current dengue epidemic in the Region of the Americas and thus strain health systems. Finally, he shared the concern expressed by previous speakers regarding access to medicines, especially oseltamivir, and to vaccines.

Dr OMI (Japan) pointed out that the low mortality rate associated with pandemic influenza in Japan had been due to the provision of antiviral medicines; the high level of public awareness; and to the lengthy suspension of schools, an important factor in weakening the transmission of the virus.

Mr OTAKE (alternate to Dr Omi, Japan) expressed appreciation of WHO's leadership in the implementation of the Regulations; they had promoted global sharing of information following the outbreak of pandemic (H1N1) 2009. Member States should establish or improve national systems and ensure functioning Regulations. Noting that operational preparedness varied among States, he recommended the use of simple and effective indicators in monitoring and responding to global health emergencies. He trusted that the Secretariat would continue its efforts to improve the implementation of the Regulations.

Dr MELNIKOVA (alternate to Dr Starodubov, Russian Federation) said that the Regulations had provided for access to information, risk assessment and possible coordinated action to global threats to public health, and proven their effectiveness following the outbreak of pandemic influenza. In regard to the pandemic influenza A (H1N1) 2009 virus, she looked forward to regular updates from the Secretariat and continued technical support to Member States.

She welcomed WHO's development of global partnerships with other international and intergovernmental organizations with a view to coordinating possible emergencies and particularly in the area of transport.

Introduction of the Regulations in her country had encouraged improved epidemiological surveillance and laboratory diagnostics; strengthened response to outbreaks of disease; and enabled modernization of specialized mobile brigades. Her Government had been implementing the Regulations and was using information from WHO to prevent the spread and transmission of the virus. It was also assisting several members of the Commonwealth of Independent States in monitoring the influenza outbreak.

The Secretariat should inform States Parties of the methods, indicators and criteria that would be used to review the functioning of the Regulations, and of progress in their implementation. Its work on future implementation of the Regulations should focus on the technical issues identified in the report contained in document EB126/5.

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region with regard to pandemic influenza, said that the pandemic influenza A (H1N1) 2009 virus had taken the world by surprise. By December 2009, some 14 000 cases of the virus had been reported in the African Region and there had been 80 deaths. Since the first case in the Region, the Secretariat had provided Member States with guidance regarding management, control and surveillance, highlighting early identification

and effective communication. Public health messages on prevention and control had been circulated to all Member States, and a system established for the daily reporting of suspected and confirmed cases. The integrated regional preparedness and response plan developed for an avian influenza pandemic had been revised accordingly. By the end of July 2009, 21 Member States in the Region had finalized their preparedness and response plans. The Regional Committee for Africa had adopted a resolution urging all Member States to continue integrated disease surveillance, to apply the Regulations and to contribute to the African Public Health Emergency Fund.

African countries faced challenges in managing effectively the current influenza pandemic, including the low level of public awareness of health issues, insufficient planning and preparation, inadequate monitoring and surveillance systems, poor infection control in health facilities, and limited efforts to mobilize resources.

Intellectual property rights were at the heart of the concerns of the African Member States. Pharmaceutical companies and laboratories fixed the prices of vaccines and determined research and development priorities. Accordingly, WHO's support was essential to provide African countries with access to the technologies, medicines and vaccines necessary to respond to pandemic influenza.

Dr GOPEE (Mauritius), speaking on behalf of the Member States of the African Region on the implementation of the Regulations, said that more than one third of Member States had started to revise their national guidelines for integrated disease surveillance and response in order to incorporate the Regulations. Seventy-two laboratories in 45 countries and 13 laboratories in 12 countries were participating in external quality assurance schemes for microbiology and influenza respectively. With the technical support of WHO, health ministries were raising awareness of the Regulations and their implications. The Regional Office had helped to develop a checklist for monitoring core capacities for surveillance and response; and Cameroon and Sierra Leone had already conducted an in-depth assessment of their core capacities and developed action plans.

All countries had designated a National IHR Focal Point, and a briefing for all focal points in the African Region had been held. Almost 40% of Member States complied with the requirement to notify or otherwise reported events to WHO using the mechanism provided under the Regulations. In addition, several countries were using the IHR Event Information Site and had established communication channels with other relevant sectors. Ten of the 33 countries with sea ports had provided a list of ports authorized to issue ship sanitation certificates, and exemption certificates and extensions for ship control.

Although 36 countries had submitted annual reports to the Secretariat by February 2009, problems remained in increasing implementation of the Regulations, including delays in revising technical guidelines and tools for Integrated Disease Surveillance and Response; delays in assessing core capacities and compliance with requirements; untimely notification of events constituting a public health emergency of national or international concern; and the high turnover of National IHR Focal Points. Technical support from WHO was thus urgently required.

Ms TOELUPE (Samoa) said that WHO's response to the pandemic (H1N1) 2009 had been effective and appropriate and had demonstrated the value of the Regulations in guiding national response. Samoa looked forward to the convening of the IHR Review Committee, and trusted that the country feedback provided through National IHR Focal Points would contribute significantly to its work.

Welcoming WHO's activities to facilitate reporting by States Parties, she noted that the response rate to the 2008 and 2009 questionnaires was low, and supported WHO's promotion of global partnerships. States Parties should be kept informed of any new access to the IHR Event Information Site granted to non-national focal points, in order to assist local response and operational relationships. She commended WHO's efforts to assist States Parties in fulfilling core capacity requirements under the Regulations; developing countries should be given priority in that regard.

An excellent spirit of cooperation existed between the Secretariat and States Parties, and among States Parties themselves, in fulfilling national obligations under the Regulations, exemplified by WHO's immediate response to requests for assistance in response to the pandemic (H1N1) 2009, and

by the assistance provided to many Pacific island States by States Parties in the early sharing of information, technical advice and laboratory testing.

Ms SUJATHA RAO (India) commended the Secretariat for its efficient handling of the pandemic (H1N1) 2009, and welcomed the assistance her country had received in containing the spread of the virus. India had 1.5 million vaccine doses for the vaccination of health workers, and vaccines produced domestically were likely to be available by the end of March 2010. The closure of schools in her country had helped to interrupt transmission of the virus. Her country had had the third highest number of deaths from the virus, but reflected the trend in other countries of patients with existing conditions more likely to succumb to the virus. Oseltamivir had so far proven effective, and care was being taken to ensure that resistance to that drug did not develop.

To be listed as a country fulfilling the obligations under the Regulations, a high level of performance regarding core capacities and clear public health outcomes were required: considerable technical assistance would have to be given to enable countries to achieve those objectives within the time frame provided. India, for its part, had designated a National Centre for Disease Control as the National IHR Focal Point, and state and district level focal points were currently being designated. A new public health emergencies act would be drawn up to facilitate the implementation of the Regulations.

Dr DODDS (Canada) said that her country was committed to full compliance with the Regulations by June 2012 and to international collaboration to reduce the global impact of the pandemic influenza A (H1N1) 2009 virus. Welcoming the strong leadership shown by WHO in helping to manage the pandemic, Canada looked forward to reflecting upon the global response to the pandemic, to sharing lessons learnt in order to better prepare for, and respond to, future threats to global public health. Only two out of the 95 countries that WHO was supporting had received vaccines, emphasizing a need for further progress in pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits. Canada was prepared to draft a text to facilitate the Board's discussion of that issue.

Dr KWON Jun-wook (alternate to Professor Sohn Myongsei, Republic of Korea) highlighted the need to evaluate the implementation of the Regulations in the context of pandemic (H1N1) 2009. The high-level consultation on new influenza A (H1N1) held during the Sixty-second World Health Assembly in 2009 had provided Member States with a valuable opportunity to share experiences, and assist in their response to the situation. WHO should hold a similar meeting at the forthcoming Health Assembly to promote continued learning, collaboration and vital exchange.

Mr PEHNI DATO SUYOI (alternate to Mr Osman, Brunei Darussalam) expressed concern that, as the perceived severity of the pandemic (H1N1) 2009 decreased, populations had begun to believe that vaccination was not necessary, and he therefore welcomed suggestions on how to combat that belief. Despite support from the Organization's regional offices in the implementation of the Regulations, technical challenges included: the implementation of the broad scope of the Regulations, which required both public health surveillance and response in health and other sectors; the elaboration of plans to strengthen core public health capacities at points of entry, especially ground crossings; and dealing with events such as those caused by noncommunicable diseases or chemical and irradiation accidents.

Dr ABDESSELEM (Tunisia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the implementation of the Regulations represented a major achievement in international communication and response. The importance of transparent reporting in critical health situations had been seen particularly during the pandemic (H1N1) 2009. He urged the Organization to defend the economic interests of Member States that suffered as a result of other States' reactions to the Regulations' implementation. He asked the Organization to provide technical assistance for continued implementation of the Regulations, notably in monitoring early warning

systems, in order to complete implementation by June 2012. He emphasized the evaluation of lessons learnt from the pandemic (H1N1) 2009.

Dr VALLEJOS (Peru) said that access to influenza viruses and the subsequent vaccines had always been the subject of controversy between countries with the technological capacity to produce vaccines and those suffering the effects of a pandemic, in three main areas: the Standard Material Transfer Agreement; benefit sharing; and intellectual property rights. He therefore supported the proposals made by WHO to establish a model framework for the transfer of biological material between WHO laboratories and to define governing principles for sharing benefits with influenza vaccine manufacturers.

Dr REN Minghui (China)<sup>1</sup> noted that the pandemic (H1N1) 2009 had demonstrated the effectiveness of the Regulations for the first time. The Organization should review the lessons learnt, with particular regard to the review committee, coordination of States' control measures, and communication between WHO and States Parties, in order to further improve the implementation of the Regulations. During the pandemic, his country had strengthened its laboratory surveillance network and the capacity of the National Influenza Centre. He thanked WHO, as well as the Governments of Canada, Mexico and the United States of America, for the timely sharing of the H1N1 virus in order to enable the development and subsequent distribution of a vaccine. He requested that the Secretariat provide up-to-date information on the monitoring tool referred to in paragraph 19 of document EB126/5. Furthermore, he suggested that the differing resources and capacities of States Parties should be taken into account when developing indicators for the implementation of the Regulations.

Mr HOHMAN (United States of America)<sup>1</sup> commended the Organization's sharing of information relating to the pandemic (H1N1) 2009, and the development of evidence-based health measures and guidance in support of surveillance; clinical and pharmacological management; infection control; and individual and community measures. He further welcomed the Organization's efforts to ensure access to vaccines and antiviral medication. Further assistance would be needed in some States to develop core capacities for the full implementation of the Regulations, especially in non-health sectors, given their extensive scope. In addition, WHO should evaluate lessons learnt and any gaps in national public health capacity. He agreed with the comments made by the member for the United Kingdom on reviewing the response to the pandemic (H1N1) 2009.

Mrs ARRINGTON AVIÑA (Mexico)<sup>1</sup> said that the recent situation provided an ideal opportunity to evaluate the implementation and effectiveness of the Regulations, thereby defining gaps in capacity or areas to be strengthened. The pandemic (H1N1) 2009 had demonstrated that only measures such as the Regulations would be effective in establishing an international alert system and in ensuring global access to reliable information, allowing clear decisions to be made. Diseases previously confined to countries were having increasing international consequences and, as such, she welcomed the creation of the IHR Review Committee to further improve the measures. She reiterated her country's commitment to better preparedness, in collaboration with WHO.

Dr NAKORN PREMSRI (Thailand)<sup>1</sup> commended the continuing efforts to evaluate the implementation of the Regulations, but suggested such evaluations should not be delayed until the pandemic was over. The pandemic (H1N1) 2009 had demonstrated the importance of an accurate global reporting system, in particular the exchanges through National IHR Focal Points. Containment guidelines at points of entry should be reviewed, as had been suggested by the representative of China. He reaffirmed his country's commitment to implementing the Regulations.

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

Mr ROSALES LOZADA (Plurinational State of Bolivia)<sup>1</sup> said that his country had made significant progress in the implementation of the Regulations following recent dengue fever epidemics and the influenza pandemic. The recently created national liaison centre ensured collaboration between national, departmental and local management, as well as with the relevant international bodies, and was responsible for raising awareness of the Regulations on a national level. Capacities for the detection, verification, evaluation and notification of significant public health events were also being developed, as well as related rapid response teams. A national action plan to strengthen core capacities had been elaborated. Subsequent to that, national legislation would be reviewed to strengthen national preparedness and response.

Dr KESKİNKILIÇ (Turkey)<sup>1</sup> said that the implementation of the Regulations had been accelerated by the recent influenza pandemic, and, as a result, most countries should achieve full implementation by 2012. Only 56 experts had been included on the IHR Roster of Experts, and he urged Member States to complete that important list. Furthermore, he requested clarification with regard to the reference made in paragraph 18 of the report to measures taken by States that might interfere with international travel or trade. The Secretariat should evaluate the appropriateness of any such actions, as well as ensure their reporting, in particular during pandemic alert phase 6. He welcomed the monitoring tool being developed to evaluate the implementation of the Regulations, and looked forward to its universal application.

Dr FUKUDA (Special Adviser to the Director-General on Pandemic Influenza), responding to questions and comments, said that the pandemic influenza virus would inevitably mutate, and it was important to try to predict which influenza strains would be widespread in order to produce vaccines effectively. It was probable that further H1N1 influenza-related disease would be prevalent later in the year, in particular given that the H1N1 virus had all the characteristics of a long-term virus.

Based on current information, of the 265 million doses of vaccine that were thought to have been distributed worldwide, it was estimated that 175 million doses had actually been administered.

He welcomed the widespread recognition that the International Health Regulations (2005) had become the central mechanism for information exchange and cooperation and stressed the importance of continuing to improve them. With regard to the 2012 deadline for implementation of the Regulations, he noted that Member States could request an initial two-year extension by giving appropriate reasons for their request, and an additional two-year extension could then be granted in exceptional circumstances. Relating to the eight core capacities to be evaluated, 33 indicator variables were being field tested in 11 countries across the six regions, including India. Of those variables, it was expected that 20 would be reported to the next Health Assembly, and it had been suggested that the variables needed to be simpler overall.

The DIRECTOR-GENERAL endorsed the point made in connection with the response to pandemic (H1N1) 2009 that it was essential to guard against complacency. In doing so, however, it was also essential to strike a delicate balance with the need to avoid causing alarm. She did not subscribe to the widely held view that the pandemic influenza A (H1N1) 2009 virus caused a mild disease against which vaccination was unnecessary. On the contrary, she was concerned by that view and thus supported the many national efforts under way to promote vaccination. Communication relating to the pandemic was a key challenge for health authorities, whose efforts thus far were to be commended in the face of rapidly developing technologies that made it doubly difficult for the public to determine the reliability of the plethora of information available to it. It was therefore vital in those circumstances to identify best practices and lessons learnt in the area of communication.

She also attached great importance to zoonoses, which posed another challenge in so far as almost three quarters of the 40 diseases which had newly emerged in the past 30 years had originated

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

in the animal sector. On that score, WHO's work now largely complemented that of FAO and OIE, although there was still further room for improvement.

With regard to the suggestions that the Secretariat should conduct a review of the pandemic (H1N1) 2009 situation, such a review was not entirely within the scope of the first review of the functioning of the Regulations to be considered by the Health Assembly which would not cover such issues as vaccination availability and distribution. Her proposal for the consideration of the Board was therefore to convene the IHR Review Committee to enable the examination of the global response to the pandemic and the identification of lessons to be learnt in such areas as information-sharing that could be used to inform the functioning of the Regulations.<sup>1</sup> Given the enormous scope of the requested review, she did not envisage its completion in the four months before the Sixty-third World Health Assembly in May 2010. In addition, the pandemic was not yet over. She therefore proposed to submit an interim report on the subject to the Health Assembly, in which regard she looked forward to technical input and expert guidance from Member States.

Noting the key concerns expressed in connection with the requirements under Annex 1 to the Regulations, she agreed that the pandemic (H1N1) 2009 should be used as a fast-track exercise to provide energy and momentum in assisting developing countries to develop their core capacities for surveillance and response. She also drew attention to the method for the selection of review committee experts outlined in paragraph 3 of the report and called on States Parties to submit nominations for experts; 193 were needed, but only 56 were currently listed on the Roster.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) suggested that the proposed review would be a timely opportunity for revising the technical definition of the pandemic, which had proved to be a highly controversial issue and which was vital to maintaining credibility with the public and the media.

The DIRECTOR-GENERAL confirmed her intention to include as part of the review the question of a revised definition of the pandemic.

The CHAIRMAN said that he took it that the Board wished to accept the Director-General's proposal to conduct an interim review of the pandemic (H1N1) 2009.

**It was so agreed.**

**The Board took note of the report.**

**Public health, innovation and intellectual property: global strategy and plan of action:** Item 4.3 of the Agenda (Documents EB126/6 and EB126/6 Add.1)

Sir George ALLEYNE (Chairman of the Expert Working Group on Research and Development Financing) explained that document EB126/6 Add.1 contained an extended executive summary rather than the full report because the Expert Working Group had completed its work only on 3 December 2009, leaving no time to have the full report processed and translated from English into the other five official languages. Those versions should be available within six weeks.

He recalled the evolution and terms of reference of the Working Group, noting that the Health Assembly in resolution WHA61.21 had called for an examination of the current financing and coordination of research and development and formulating proposals for new and innovative sources of funding with which to stimulate it.

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<sup>1</sup> Subsequently issued as document EB126/INF.DOC./3.

The 24 members from 23 countries, representing a wide range of disciplines, had held a year of virtual meetings and Internet-based public hearings. It had solicited and discussed submissions from governments and the public.

A wider discussion of the reasons for financing research and development had concluded that incentives stemmed either from the existence of a market for the output, or from the absence or failure of such a market, as was the case in many developing countries. In regard to the current financing of research and development, the Working Group had examined the public records of donor agencies; the publicly available records of the world's largest pharmaceutical companies; and those of private philanthropists. It had discovered that most of the funding was going to noncommunicable diseases, especially cancer; that no reliable method existed at the global level for tracking flows of resources to research and development; and hence no global means existed for monitoring the financing. The Working Group had found no evidence of coordination of research and development at the global level, especially for the Type II and III diseases which most frequently affected developing countries. No global mechanism existed for financing health research, innovation and development to produce new diagnostics, medicines and vaccines nor one to support health policy and health systems.

Essential criteria for proposals retained included: an impact on developing countries; financial clarity; and operational efficiency. Ten proposals had been short-listed: three mechanisms to increase research and development funding; five mechanisms for allocating the resultant funding; and two efficiency proposals to cut the costs of research and development across the board.

He drew particular attention to the report's recommendations on incentives for knowledge production; the relationship between research, funding and the disease burden; supporting efforts in research tracking; and the need to create a global coordination and funding mechanism for health research and innovation. The Working Group was also keen to see WHO consider promoting the local development of policies to stimulate research and development, together with the idea of facilitating regional collaboration and funding.

Concluding in regard to any concern caused by a letter circulated to the Executive Board by one of the Working Group members, he said that a member whose opinions differed from the rest should rightfully express them within that group.

The CHAIRMAN said that that incident was regrettable and agreed that dissenting views should be dealt with internally.

Ms SUJATHA RAO (India), emphasizing the mapping of global research and development activities in order to identify gaps and priorities, appreciated the support of the Quick Start Programme to such activities and to promotion of standard-setting in the area of traditional medicine, in which India had an inherent strength. She welcomed any steps taken under the Programme to develop and strengthen regulatory capacity, including safety, efficacy, quality and ethical review.

The report of the Expert Working Group confirmed the double burden of disease borne by the poor; indicated the inadequacy of research and development to address Type II and III diseases; and further confirmed that commercial incentives provided by intellectual property rights had not sufficiently improved either public health in developing countries or access to the benefits of innovations taking place in the developed world.

However, the report contained no road map or guidance for greater access to the technologies already available for addressing the disease burdens of developing countries, which included the areas of diagnostics, classification and therapies for diseases that were expensive to treat. Indeed, high costs and encumbrances relating to intellectual property rights were responsible for greatly impeding access to medicines. WHO had a core mandate as a catalyst for facilitating delivery and should seek to obtain royalty-free licences for the benefit of developing countries in accordance with mutually agreed terms and conditions. It should also support those countries in use of the flexible options to which they were entitled under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).

An incentive structure was needed to stimulate research and development of knowledge and technologies to address the problems of developing countries. The tracking of resources was essential to understanding the distribution and coordination of the necessary financing. The creation of a

coordination and funding mechanism for global health research and innovation which targeted new drugs, vaccines, diagnostics and prioritized the health conditions of the poor was a welcome recommendation. It nevertheless fell far short of the decisive plan needed to augment research into Type II and III diseases.

She drew attention to the most recent report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, submitted to the Human Rights Council in March 2009, notably in respect to access to medicines and intellectual property rights. She suggested that the Special Rapporteur should be invited to present to the Sixty-third World Health Assembly his findings on the role of intellectual property rights in promoting public health and access to medicines. She took it that the Secretariat had noted that two privileged draft documents of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property had been published on an Internet web site.

She suggested further needs: to outline a mechanism for the funding of research and development by developed countries; to avoid unfairly placing the burden of research and development on certain developing countries; to design mechanisms to redress the limitations on access to medicines imposed by intellectual property rights; to fund and facilitate such access in the developing world; and to match resources with the technologies available for dealing with public health needs. Further dialogue on those issues could take place during the intersessional period before the Sixty-third World Health Assembly.

Mrs ESCOREL DE MORAES (Brazil) said that her Government attached great importance to the global strategy and plan of action on public health, innovation and intellectual property and to the commitments of resolution WHA61.21, to tackle health inequities. Emphasizing the duties of States to protect human rights to the highest possible standards of health, she called on the international community, led by the Member States and Secretariat to implement the global strategy. Brazil, a co-founder of UNITAID, was contributing financial resources to support the strategy.

The global strategy provided for countries with different levels of development to act in solidarity, with tools to channel resources to the health sector, thereby ensuring access to affordable medical products and fostering capacity building, technical cooperation and technology transfer. Access to medicines was critical: they must not be treated like other commercial goods. The cost of research and development must be separated from the price. The TRIPS agreement needed to be interpreted and implemented in a manner that supported the duty of States to protect public health by fully applying its flexibilities, and with the political and tactical support of WHO.

The Board must give guidance to the Secretariat on the question of ensuring access to affordable medicines, including generics; and patients had to be informed on all their options regarding medicines and treatment. Brazil would share its experiences in providing free and universal treatment to people with HIV/AIDS. Her country supported South–South cooperation programmes, especially capacity building, research and innovation in the health sector and, crucially, broader access to medicines for poor populations.

The report contained in document EB126/6 should have entered into greater detail; addressed aspects beyond research, development and innovation; provided greater focus on intellectual property and access to medicines and health products by developing countries; provided links between indicators of the plan of action and the activities undertaken; and detailed relevant regional forums, courses and seminars, such as those carried out in the Americas in 2009.

In addition, she requested more information on WHO's work with other organizations and experts regarding development of a diagnostic workbook on trade and health; current examinations of the barriers to the use of innovative technologies in resource-limited settings; the terms of the technology transfer for the production of a monoclonal antibody cocktail for the treatment of rabies; and the independent ethics committee mentioned in the report. In the context of the establishment by UNITAID of a voluntary patent pool and WHO's contribution to that process, the Board might consider suggesting to the Health Assembly that the Secretariat should become its host and manager.



In regard to the report by the Working Group, she was concerned about an apparent contradiction between the work of the Commission on Intellectual Property Rights, Innovation and Public Health and the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property regarding the impact of intellectual property rights on research and development. The Working Group appeared to have reintroduced rejected elements such as tax exemptions and its discussions had not specifically centred on poor countries, as requested in the global strategy. The report did not contain references to source documents; it did not clearly identify the criteria used to select proposals that met the needs of developing countries; and it laid the responsibility for establishing new financing mechanisms on governments and consumers without reference to the contribution of the private sector. Regarding the latter, she would have appreciated proposals for a tax on profits remitted by non-domestic pharmaceutical companies to their overseas parent companies.

In the light of the urgent need to implement the global strategy, she seconded the proposals by the member for India that the Director-General should convene intergovernmental consultations before the next Health Assembly in order to examine the recommendations of the document and that she should invite the Special Rapporteur of the Human Rights Council to address the Health Assembly.

**The meeting rose at 17:45.**

(For continuation of the discussion, see summary record of the third meeting, section 2.)

## **THIRD MEETING**

**Tuesday, 19 January 2010, at 09:20**

**Chairman:** Dr S. ZARAMBA (Uganda)

**Following an open meeting at 09:20, the meeting resumed in public session at 10:20.**

### **1. STAFFING MATTERS:** Item 8 of the Agenda.

**Appointment of the Regional Director for Africa:** Item 8.1 of the Agenda (Document EB126/30)

Dr MILOSAVLJEVIĆ (Serbia), Rapporteur, read out the following resolution adopted by the Board during the open meeting:<sup>1</sup>

The Executive Board,  
Considering the provisions of Article 52 of the Constitution of WHO;  
Considering the nomination made by the Regional Committee for Africa at its  
fifty-ninth session,<sup>2</sup>

1. REAPPOINTS Dr Luis Gomes Sambo as Regional Director for Africa as from 1 February 2010;
2. AUTHORIZES the Director-General to issue to Dr Luis Gomes Sambo a contract for a period of five years from 1 February 2010, subject to the provisions of the Staff Regulations and Staff Rules.

The CHAIRMAN congratulated Dr Sambo on his reappointment.

Dr SAMBO (Regional Director for Africa) said that he was honoured to be reappointed as Regional Director and thanked the African Union for supporting his candidacy and the Member States of the African Region for nominating him. Progress had been made towards improving the health situation in Africa, but maternal and child mortality, HIV/AIDS, malaria, tuberculosis, neglected tropical diseases, epidemics and the emerging burden of chronic disease were still hitting the Region hard, especially the poorest segments of the population. Social determinants of health and limited access to good-quality health care were critical issues, requiring more equitable management of resources at all levels. Primary health care remained fundamental.

His aim would be to work consistently within the framework of the Eleventh General Programme of Work, 2006–2015, focusing on WHO's core functions, with particular emphasis on health situation and trend analysis in order to provide evidence for policy-making, the development and enforcement of WHO's norms and standards, the promotion of health research and the provision of technical support. One strategic direction in the Region would be to support efforts to achieve the health-related Millennium Development Goals. The focus would be on monitoring of progress, advocacy for policy options; and technical support for high-priority health programmes and

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<sup>1</sup> Resolution EB126.R1.

<sup>2</sup> Resolution AFR/RC59/R1.

interventions. WHO's Country Cooperation Strategies, recently updated for all African Member States, would guide action at country level and facilitate collaboration with other international health partners, in particular within the United Nations system.

The limited budget for support to Member States in the areas of health systems management, health information systems, noncommunicable diseases, maternal health and neglected tropical diseases was a concern. More flexible and predictable funding of WHO would allow health issues to be considered in a more holistic and efficient manner through systems approaches. The current dialogue between the Secretariat, Member States and other health partners seemed promising. The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action had already helped to improve harmonization among international health partners and coordination of support to countries. The Regional Office for Africa would continue striving to be more efficient and effective in its role within international health cooperation, and he would do his best to improve WHO's performance and the impact of its work on the lives of people in Africa.

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, thanked the Board for having reappointed Dr Sambo. He wished Dr Sambo well in the performance of his duties and assured him of the Region's full support.

The DIRECTOR-GENERAL, welcoming the reappointment of Dr Sambo, said that she looked forward to continuing their close collaboration towards improving the health situation of the people in Africa, particularly women.

**Appointment of the Regional Director for Europe:** Item 8.2 of the Agenda (Document EB126/31)

Dr MILOSAVLJEVIĆ (Serbia), Rapporteur, read out the following resolution adopted by the Board during the open meeting:<sup>1</sup>

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

1. APPOINTS Ms Zsuzsanna Jakab as Regional Director for Europe as from 1 February 2010;
2. AUTHORIZES the Director-General to issue to Ms Zsuzsanna Jakab a contract for a period of five years from 1 February 2010, subject to the provisions of the Staff Regulations and Staff Rules.

The CHAIRMAN congratulated Ms Jakab on her appointment.

**At the invitation of the CHAIRMAN, Ms Jakab took the oath of office contained in Staff Regulation 1.10 and signed her contract.**

Ms JAKAB (Regional Director elect for Europe) said that she was honoured to be appointed as the Regional Director for Europe and would do everything she could to meet the expectations placed in her. The time she had spent working in the Regional Office for Europe had changed the direction of her professional life to international public health under the valuable guidance of previous Regional Directors. She was pleased to be returning to WHO after spending the previous five years with the

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<sup>1</sup> Resolution EB126.R2.

European Union as the first director of the European Centre for Disease Prevention and Control in Stockholm.

She pledged to do everything in her power to ensure that the strong public health tradition of the Regional Office was continued in order to meet the diverse needs and high expectations of Member States and that its work was fully embedded in global and interregional development. Europe's diverse health needs were the source of a unique reservoir of health policy and health system solutions that should be shared among the countries of the Region and with the rest of the world. She aimed to make the Regional Office a strong, respected and evidence-based European centre of excellence and innovation in public health; and a leader in health policy in Europe, in the forefront of developments and effectively meeting the needs of Member States.

The current economic crisis had sharpened the focus on health needs both in Europe and worldwide. The health inequities and the changing demographic and social landscape in Europe were a cause of grave concern. The combined challenges of the H1N1 pandemic, the growing epidemic of noncommunicable diseases and the health impact of climate change called for modern public health tools and new ways of responding to public health issues through intersectoral approaches. The Regional Office as a proactive leader and robust partner in joint action must adapt effectively to a changing environment, and take full advantage of the collective wisdom, experience and know-how of the Region and respond to global challenges. The health of all Europe's citizens could be improved by building partnerships for health; in particular, she aimed to make heard the voice of the most vulnerable. She extended her good wishes to the outgoing Regional Director for the next stages of his professional life.

Dr MILOSAVLJEVIĆ (Serbia), Rapporteur, read out the following resolution adopted by the Board during the open meeting:<sup>1</sup>

The Executive Board,

Desiring, on the occasion of the retirement of Dr Marc Danzon as Regional Director for Europe, to express its appreciation of his services to the World Health Organization;

Mindful of his lifelong devotion to the cause of international health, and recalling especially his ten years as Regional Director for Europe,

1. EXPRESSES its profound gratitude and appreciation to Dr Marc Danzon for his invaluable contribution to the work of WHO;
2. ADDRESSES to him on this occasion its sincere good wishes for many further years of service to humanity.

The DIRECTOR-GENERAL congratulated Ms Jakab on her appointment as Regional Director for Europe and wished her success. She expressed appreciation to the outgoing Regional Director for his achievements and wished him well in his future endeavours.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, expressed appreciation to the outgoing Regional Director for the many achievements within the Region during his tenure, such as the certification of all 52 countries in the Region as free of poliomyelitis in 2002, and welcomed the appointment of Ms Jakab.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) praised Dr Danzon's dedication and achievements as Regional Director for Europe and wished his successor well.

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<sup>1</sup> Resolution EB126.R3.

Mr HOUSSIN (France) commended the work of the outgoing Regional Director for Europe, particularly with regard to assisting countries in the south and east of the Region, and congratulated Ms Jakab on her appointment.

Dr MILOSAVLJEVIĆ (Serbia) expressed congratulations to Ms Jakab and commended the outgoing Regional Director, in particular for his leadership in dealing with lead poisoning in Roma groups in parts of former Yugoslavia.

Dr DANZON (Regional Director for Europe), thanking the Board for its good wishes, said that, during his 10 years as Regional Director, the Regional Office had striven to improve the health of populations in the Member States it served and he paid tribute to its staff, to his fellow Regional Directors and to the Director-General. He expressed particular satisfaction that the European Region had helped to highlight the importance of health systems and to make health a platform for peace in the south and east of the Region. He wished Ms Jakab every success in her new post.

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

### **Public health, innovation and intellectual property: global strategy and plan of action** (Documents EB126/6 and EB126/6 Add.1) (continued from the second meeting, section 2)

The DIRECTOR-GENERAL said that she regretted any confusion that had arisen with regard to the report of the Expert Working Group on Research and Development Financing, which concerned only element 7 of the global strategy and plan of action. As had been explained in the previous meeting, the full report would not be available in all six of the Organization's official languages for some weeks and an executive summary<sup>1</sup> had been prepared for the Board's information. The full report would be submitted to the Sixty-third World Health Assembly, together with an opinion by the Secretariat on the Expert Working Group's recommendations, which were still being evaluated. Further guidance and advice would be sought from Member States at that time. For the moment, she suggested that the Board should focus its comments on the report contained in document EB126/6, which outlined progress made with respect to all eight elements of the global strategy and plan of action.

Mr TAKAKURA (adviser to Dr Omi, Japan) said that the lack of a specific financing mechanism had presented a serious obstacle to research and development activities and in that respect the report of the Expert Working Group was an important step forward. An intellectual property rights system was an important tool for promoting research and development of pharmaceutical products. However, a range of factors, including health systems, drug regulation systems, quality assurance systems, appropriate use of medicines, and delivery systems and supply chains all affected access to medicines for diseases that disproportionately affected developing countries. In tackling those factors in a comprehensive and balanced manner, the global strategy and plan of action remained an effective tool for promoting international cooperation, and WHO should continue to exercise leadership on the issue.

Dr KENYA-MUGISHA (alternate to Dr Zaramba, Uganda), speaking on behalf of the Member States of the African Region, took note of the modest progress reported in document EB126/6. Implementation of the global strategy and plan of action was a top priority in the Region and a core function of WHO in addressing the health needs of people living in developing countries. He expressed appreciation for the work done on the Quick Start Programme and acknowledged the considerable funding difficulties hampering implementation. He therefore suggested that the Director-General, in partnership with her counterparts at WTO and WIPO, convene a high-level consultative

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<sup>1</sup> Document EB126/6 Add.1.

meeting with donors and main stakeholders in order to identify possible sources of financing for the Quick Start Programme.

Ensuring access to affordable health products and technologies and strengthening research capacity must be priorities for WHO in implementing the Quick Start Programme, and he requested further information on the Secretariat's initiative to make core health products affordable in resource-limited settings. Expressing support for the steps taken by the Secretariat to provide royalty-free licensing agreements to China, India and Thailand for vaccine-manufacturing technology, he requested that similar agreements for essential health products and technologies should be reached for the public sector in Africa and other resource-limited settings. He also requested the Secretariat to support the networks for medicines and diagnostics launched in Africa, Asia and the Americas to drive innovation, promote research and development, and build capacity. The African Network for Drugs and Diagnostics Innovation promoted African-led product research and development through the discovery, production and delivery of affordable new health products, including those based on traditional medicine.

The full report of the Expert Working Group, on which the Board was unable to have an informed discussion, should be discussed by the Sixty-third World Health Assembly. If that proved impossible, a side meeting should be held for that purpose during the Health Assembly, or the Board should have the opportunity to discuss the report before it went to the Health Assembly. He asked the Director-General to provide support for informal consultations with Member States on the full report.

Dr SAID (Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the report, notably the launching of the Quick Start Programme and the development of the monitoring and reporting framework, which should enable tracking of progress in implementing the global strategy and plan of action. Stressing the need for further funds to allow the full implementation of the plan of action, he expressed confidence that the Director-General would exercise leadership in order to find innovative funding solutions for those activities that fell within the purview of WHO. Further detail was needed on several aspects, in particular the guidelines to support technology transfer; the activities implemented in conjunction with other organizations in the United Nations system; and the form and limits of the cooperation between WHO and those bodies. WHO should play the leading role in those activities.

He supported the Regional Office's approach to cooperation with Member States through the establishment of a consultative group to oversee implementation of the global strategy and plan of action in the Region. Member States attached particular importance to the implementation of activities under element 5, which would enhance access to medicines and other health products in developing countries. The purchase of medicines represented a huge burden on the budgets of such countries, and the Organization should assist them in benefiting from the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).

Dr ALI (alternate to Professor Haque, Bangladesh) welcomed the extended executive summary but regretted that the Board had not been able to examine the full report in detail. The Board should do so, preferably before the Sixty-third World Health Assembly, and thus he supported the proposal by the member for Brazil on the convening of intersessional consultations.

He had expected bolder proposals from the Expert Working Group. Furthermore, the report of the Commission on Intellectual Property, Innovation and Public Health had provided important recommendations which had not been adequately addressed in the report of the Working Group. The scant attention given to intellectual property as a potential tool for stimulating research and development for diseases in developing countries was a glaring omission. The issues of capacity building for research and development in developing countries and strengthening of regulatory frameworks also were only sparsely addressed. Another omission related to the development of proposals for de-linking the costs of research and development from the price of health products, with the objective of concentrating on diseases that disproportionately affected the developing countries. Innovation was valuable only when its results were widely available and affordable for the beneficiaries. How would the various proposals contained in the Working Group's report enhance or

facilitate such access? Bangladesh and three other countries had submitted proposals on prize funds, but the Expert Working Group had concluded that “end” prizes were probably suitable only for the development of diagnostics. How had that conclusion been reached?

The report indicated that only one third of the total investment in health-related research and development was directed towards communicable diseases, yet those accounted for a major share of the disease burden in developing countries. Research gaps in the field of neglected diseases should be indentified through country-specific assessments and the sharing of knowledge within regions. It might be useful to map existing regional research on tropical diseases and on intellectual property regimes and barriers to the export of medicines related to trade and intellectual property issues. He supported the recommendation on the creation of a coordinating and funding mechanism for global health research and innovation and with a focus on research and development on Type II and III diseases.

He appreciated the Secretariat’s report on implementation of the global strategy and plan of action, but future reports should focus more on the Secretariat’s activities and detail the progress achieved. He supported the proposal of the member for India that the Director-General should invite the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health to address the Sixty-third World Health Assembly.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, observed that the executive summary of the report touched on many complex issues that would require further consideration. Time would be needed to study the various ideas and recommendations set forth, and it would thus be preferable if the full report were discussed at the Sixty-third World Health Assembly, as the Director-General had suggested, rather than at the present meeting.

He informed the Board that two agreements between the European Commission and WHO had been finalized in December 2009. Those related to elements 3 and 4 of the global strategy and plan of action, and would enable WHO to build capacity and support research and development on poverty-related, tropical and neglected diseases through regional networks in Africa, Asia and Latin America; and also to improve access to medicines in developing countries through transfer of pharmaceutical-related technology and local production.

Mrs ESCOREL DE MORAES (adviser to Dr Buss, Brazil) thanked the Director-General for her clarifications, and, as a complement to her suggestion, proposed that the Board adopt a procedural decision requesting the Director-General to consider convening open-ended informal consultations on the Expert Working Group’s report to be held before the Sixty-third World Health Assembly. The consultations would be an opportunity for an exchange of views on the full report and could also assist the Director-General in the preparation of her report to the Health Assembly. Recalling her earlier suggestion that WHO might host and manage the UNITAID patent pool,<sup>1</sup> she proposed that the matter should be included as an item on the provisional agenda of the Sixty-third World Health Assembly.

Dr MUÑOZ (Chile) said that he appreciated in particular the suggestions on the financing and coordination of research on diseases prevalent in the developing world. However, perhaps because the Expert Working Group’s terms of reference had been strictly limited to finance, it had failed to address the need for developing countries to strengthen their research infrastructure, especially their capacity to carry out phase III and IV clinical trials. It was important to strengthen relevant regulations and build capacity for critical analysis of the ethical aspects of research involving human subjects, and to bolster the capacity of health services in developing countries to organize clinical trials and negotiate conditions so that local populations would benefit from such research. That topic should be addressed in future iterations of the report.

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<sup>1</sup> See the summary record of the second meeting, section 2.

He supported the proposal by the member for Brazil for a consultative process before the Sixty-third World Health Assembly.

Dr DODDS (Canada) said that filling the gaps in research and development for diseases that mainly affected developing countries would require a bold international response. The global strategy and plan of action provided a balanced and comprehensive framework for international collaboration to increase access to and innovation in medicines and other health products in the developing world. She endorsed the comments made by the member for Japan, appreciated the Director-General's clarifications concerning the Working Group's full report, and looked forward to reviewing the full report.

Dr GIMÉNEZ (Paraguay) said that under his Government's health policies access to medicines and strategic health products was a fundamental human right; they emphasized strengthened capacity for research and the promotion of innovation in relation to public health priorities. The high cost of medicines represented, in practical terms, a major barrier to access, particularly for the poorest segments of the population.

He keenly awaited the Spanish version of the full report and therefore agreed with the proposal of the Director-General. He also recognized the value of informal consultations sponsored by WHO on matters of importance to the Organization and said that Paraguay would be pleased to take part in such consultations.

Mr ROSALES LOZADA (Plurinational State of Bolivia)<sup>1</sup> welcomed the Director-General's clarifications regarding the report of the Expert Working Group. However, resolution WHA61.21 called for the final report to be presented to the Sixty-third World Health Assembly through the Executive Board. Because the full report had only recently been released and was currently available only in English, he supported the proposal by the member for Brazil that informal consultations be held before the report was submitted for consideration by the Health Assembly.

It was essential to ensure transparency in order to avoid situations that might call into question the credibility of the Expert Working Group's such as the recent claims in certain specialized publications that the report had been obtained by some private bodies before it had been made available to Member States.

His Government prioritized public health and access to medicines, particularly for the poorest populations, and the country's constitution established the State's responsibility for ensuring such access. In line with that policy, Bolivia, together with Bangladesh, Barbados and Suriname, had submitted four proposals for innovative financing mechanisms to the Working Group. He asked whether consideration had been given to those proposals, which had focused on how to de-link the price of medicines from the cost of research and development, particularly for medicines used to treat Type II and Type III diseases. He looked forward to discussing several other substantive aspects of the report during the proposed informal consultations.

Dr SIRIWAT TIPTARADOL (Thailand)<sup>1</sup> expressed appreciation for the work carried out by the Expert Working Group and thanked the Director-General for her explanation of the process of documentation and consultation. He found two aspects of the process disappointing. First, the time frame for presentation and discussion of the Working Group's report had been clearly defined two years earlier, sufficient time to have ensured that the full report would be ready for consideration by the Board during the present session. Expressing concern that the Board was being called on to approve a report that had only been made available two days earlier, he strongly supported the proposal made by the member for Brazil for informal consultations in order to discuss the report before the Sixty-third World Health Assembly. Secondly, he was not confident that the issue of

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



intellectual property, which should have been an essential element of the Working Group's work, had been adequately discussed, especially in relation to de-linking the price of products from the cost of research and development.

The issue of transparency was also cause for great concern, particularly in the light of the report recently published in *The Lancet*. He asked the Director-General to initiate an investigation into the leaking of the report.

Mr HOHMAN (United States of America)<sup>1</sup> expressed thanks to the Chair of the Expert Working Group for his informative introduction of the report and aligned himself with the statements made earlier by the members for Japan and Hungary. The Director-General's proposal of a way forward seemed a sensible and productive approach to the situation created by the late release of the report. However, he expressed some ambivalence concerning the proposal for informal consultations. He recognized that those could complement the work of the Director-General in preparing a report for the Sixty-third World Health Assembly, but had concerns about the number of informal consultations on various topics that would probably be scheduled to take place before the Health Assembly.

The proposal to give WHO responsibility for hosting and managing the UNITAID patent pool caused particular concern: he questioned whether the Secretariat should be given such a responsibility. A decision on the patent pool issue should not be rushed. The governing bodies should, as suggested by the Director-General in her report to the Board,<sup>2</sup> first discuss WHO's role.

Mr BIÉLER (Switzerland)<sup>1</sup> observed that the global strategy and plan of action had been approved by consensus; therefore Member States, the Secretariat and partner institutions had a shared responsibility to ensure effective and coordinated implementation. In Switzerland, all actions to be taken by the Government and other stakeholders in order to implement the plan of action were subject to extensive evaluation.

Referring to document EB126/6, he welcomed the actions already taken by WHO and its partners. However, the report could have more clearly linked all the various initiatives to the relevant elements of the global strategy. WHO's regional offices had a key role in prioritizing implementation as they were in direct contact with health ministries in Member States.

Ms CHILDS (MSF International), speaking at the invitation of the CHAIRMAN, said that the Expert Working Group's report did not appear to build on the conclusions of the Commission on Intellectual Property Rights, Innovation and Public Health or the global strategy and plan of action, particularly in relation to the need to develop financing mechanisms to de-link the cost of research and development from the cost of products. The report of the Working Group seemed to endorse intellectual property as an incentive for research whereas the Commission's findings had shown that intellectual property failed as a tool to stimulate research and development for diseases that affected low-income populations in developing countries and hindered access to the results of innovation. The global strategy aimed to promote new thinking, but the recommendations contained in the executive summary seemed to favour organizations and companies already involved in research and development. As part of the review of the full report, the selection criteria for proposals should be re-examined. In the meantime, she urged the Organization not to delay implementation of the global strategy.

Mr MBEWU (Global Forum for Health Research), speaking at the invitation of the CHAIRMAN, said that low- and middle-income countries should become active participants in, not just beneficiaries of, research and innovation through transfer of technology. Research should address the health priorities of those countries and include the effective application of new knowledge generated.

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

<sup>2</sup> Document EB126/2.

He welcomed the Working Group's recommendations and encouraged further study on the effectiveness and sustainability of both current and future financing proposals. Conducting and commissioning such studies could be a key role for the proposed global health research and innovation coordination and funding mechanism.

Mrs BLOEMAN (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, said that innovation incentives based on protection of intellectual property had failed to meet the needs of developing countries because the neglected diseases that affected people in those countries did not represent a lucrative market and therefore did not attract adequate investment for research and development. Moreover, the current patent system did not ensure sufficient supplies of medicines to developing countries as prices remained too high.

The conclusions of the Expert Working Group fell short of expectations with regard to innovative financing mechanisms that could respond to the public health needs of developing countries. Furthermore, the report omitted real discussion of the issue of intellectual property that was central to the global strategy and plan of action. The executive summary emphasized global coordination to improve resource allocation but failed to mention the proposals for a health and biomedical research and development treaty. She supported the proposal to review the report with an eye to ensuring its consistency with the global strategy and plan of action.

Mrs MATSOSO (Public Health, Innovation and Intellectual Property) thanked speakers for their comments and questions and said that the Secretariat had prepared a compact disc that contained detailed information on many of the issues raised during the discussion; the information would also be made available on the WHO web site.

Clearly there was a need to ensure a coherent response from WHO and other stakeholders so that progress on realizing the four main action areas of the global strategy and plan of action – innovation, access to medicines, capacity strengthening and resource mobilization – proceeded in parallel. Document EB126/6 summarized the Secretariat's actions, which included the establishment of matrices to coordinate the activities to implement the global strategy and plan of action across the different departments at headquarters and in the regional offices. Regional consultations had been held on regional workplans for implementation. An analysis by the Regional Office for the Eastern Mediterranean had indicated that the work would comprise 50 different activities.

A monitoring and evaluation framework was being prepared. The indicators on which it was based had been adopted by the Health Assembly in May 2009 (resolution WHA62.16), and the work would include collection of data on activities undertaken by the Secretariat (49 specific activities) and in Member States (80 activities) before the review of the global strategy and plan of action in 2014. Tools were being designed for use at country level, including a grid to support Member States in identifying gaps and barriers to innovation and which would be discussed at a forthcoming meeting hosted by the Regional Office for Africa. It would be important to streamline the monitoring and evaluation process to avoid duplication of effort, for example in relation to collection of information on the indicators for the Medium-term strategic plan, 2008–2013.

Referring to specific issues raised, she noted that, as indicated in paragraph 7 of the report, WHO was engaged in a global study on pharmaceutical-related technology transfer in collaboration with UNCTAD and the International Centre of Trade and Sustainable Development, and, with the support of the European Commission, to determine the extent, directions and mechanisms of transfer, barriers to transfer, and related capacity building, regulatory and licensing issues. The activity was linked to work on regional networks, including the African Network for Drugs and Diagnostics Innovation, and network initiatives in the Region of the Americas and South-East Asia Region.

Element 1 of the global strategy and plan of action referred specifically to the mapping of research and development, and resolution WHA61.21 called for reflection of the global strategy and plan of action in the development of WHO's research strategy. Mapping work was being conducted by five WHO departments and three partners; a report on that activity was in preparation.

The initiative outlined in paragraph 15 would include activities to determine whether innovative technologies responded to the priority needs of countries. The list of proposals had been closed, and

partners to undertake the work would be selected in April 2010. Work on the transfer of technology in relation to post-exposure prophylaxis of rabies, outlined in paragraph 16, had been undertaken by six WHO collaborating centres; the relevant report would be distributed to the Board.

Action in relation to intellectual property included collaboration at the highest level between WIPO, WTO and WHO. A joint workplan had been agreed and baseline data were being collected on intellectual property matters, including the flexibilities in the TRIPS agreement.

Sir George ALLEYNE (Chairman, Expert Working Group on Research and Development Financing) said that the Working Group had interpreted its mandate to mean that it should focus on the current financing of research and development, coordination of research and development, and proposals for new and innovative sources of financing to stimulate research and development. Although he considered the question of intellectual property and its impact on access to medicines very important, the consensus of the Working Group had been that the issue fell outside its mandate. He acknowledged that some might question that interpretation, and that the Board might wish to broaden its discussion to include such matters.

He was gravely concerned at, and rejected, accusations of lack of transparency and of the existence of opportunities for the pharmaceutical industry to exert undue influence on the Working Group's conclusions, and urged those making such accusations to provide evidence. He had been surprised and disappointed that a prestigious journal should have commented on a leaked draft report that had subsequently undergone substantive amendments, and had drawn spurious conclusions about undue influences.

He looked forward to discussions on the full report, which should assist the Director-General in selecting which of the recommendations to implement. Many of the recommendations relating to sources of funding were the same as those made by the High-Level Task Force on Innovative Financing for Health Systems, about which there had been no controversy. The Working Group's suggestion was that some of the funding currently available from various sources should be allocated to research and development. Consideration of the full report should include the proposals on efficiency, coordination of research, and separation of funding for research and development on the different types of disease, as well as financing. He trusted that Member States would consider that the Working Group's recommendations were worth further discussion.

The DIRECTOR-GENERAL, expressing appreciation for the comments made, said that it was a tribute to Member States' commitment to health and their flexibility that they had been able to adopt such a complex instrument as the global strategy and plan of action. The importance she attached to it was demonstrated by the location within the Director-General's Office of the team appointed to oversee the implementation of the global strategy and plan of action, the only such initiative located in her Office. She paid tribute to the hard work undertaken by the team to date, in what was a difficult area. She also thanked the Regional Directors for their support and welcomed the appreciation expressed by Member States for the regional initiatives.

Her counterparts at WTO and WIPO had indeed agreed to meet her on a regular basis, at head-of-agency level, with a view to guiding the development of technical activities in the three organizations on the basis of a joint workplan. The Secretariat's work in the area under discussion required financial support and she therefore welcomed the important contribution from the European Union, since it was difficult to reallocate funding that had been earmarked for use elsewhere.

She reiterated her earlier explanation that the Board was not being asked to approve the full report at the current session. To date the report was available only in English and, for reasons of equity, would be disseminated to countries only when it was available in all six official languages. It was also important to allow sufficient time for Member States to review the report. For the time being, it was sufficient for the Board to note the progress made in the process of preparing the report.

She was extremely troubled by the leaking of Expert Working Group documents and had already instituted an enquiry into the matter. If the source of the leak was internal, appropriate action would be taken in accordance with Staff Regulations and the rules of due process. She attached great importance to the avoidance of conflict of interest, so it would also be necessary to determine whether

the source of the leak was external or in any way related to the Working Group's activities. She had appointed the members of the Working Group and did not believe that any of them would engage in improper conduct, but it was her duty to conduct a thorough investigation. Transparency was vital. She would not accept criticism, however, until there was clear evidence that WHO or the Working Group had been unduly influenced: she could not manage the Organization on the basis of rumour and innuendo. However, she was prepared to waive the diplomatic immunity of WHO staff members in order to ensure a proper investigation.

She requested guidance from the Board as to whether it wished to institute informal consultations on the full report in advance of her presentation of the report to the forthcoming Health Assembly.

Mrs ESCOREL DE MORAES (adviser to Dr Buss, Brazil) said that many Board members from across the regions had expressed support for informal consultations whose outcome could be taken into account by the Director-General in her presentation to the Health Assembly. The Director-General should therefore be requested to convene informal consultations before the Health Assembly in accordance with an appropriate timetable.

Dr KÖKÉNY (Hungary) suggested that the matter should be considered informally with the aim of achieving consensus on a decision at the start of the next meeting.

Dr DAHL-REGIS (Bahamas) said that Member States required time to review the full report and any additional information to be provided by the Secretariat before they could determine whether informal consultations were needed. Any decision on such consultations should be made after dissemination of the report in the six official languages.

Professor ADITAMA (alternate to Dr Sedyaningsih, Indonesia) supported the proposal to convene informal consultations.

The CHAIRMAN suggested that the Board take up the proposal made by the member for Hungary that the matter should be considered informally and that a decision should be taken at the next meeting.

**It was so agreed.**

(For continuation of the discussion, see summary record of the fourth meeting, section 2.)

**The meeting rose at 13:00.**

## **FOURTH MEETING**

**Tuesday, 19 January 2010, at 14:40**

**Chairman:** Dr S. Zaramba (Uganda)

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

**Health consequences of the earthquake in Haiti:** Item 4.19 of the Agenda

Mr PIERRE (Haiti)<sup>1</sup> said that his country's geographical location had always made it vulnerable to natural disasters. In 2008, a series of hurricanes had killed more than 800 people. The earthquake which had struck on 12 January 2010 had caused between 150 000 and 200 000 deaths. According to United Nations information, a total of three million people had been affected, of whom 300 000 were still homeless. There had been no telephone links with the outside world for several days. The presidential palace, public buildings and the offices of the United Nations Stabilization Mission in Haiti had collapsed, with the loss of dozens of lives.

The earthquake had struck just as Haiti had begun to show positive signs of growth: the security situation had eased and employment had been on the rise. The health situation, a major concern of the Haitian population even before the earthquake, was desperate. Hospitals were bursting at the seams with casualties, but lacked staff and supplies. More field hospitals were urgently needed. The potential problems included malnutrition in children and adults and epidemics of infectious disease. Supplies of clean drinking-water and access to essential medicines must be restored. Aid was urgently required not only in Port-au-Prince, but in nearby settlements.

The Government was doing its best under the circumstances. Many senior figures had been killed, others had been injured or bereaved, and it would take time to bring the response up to full strength. The Government had declared a state of emergency and a period of national mourning for one month. He thanked the international community for the assistance it had provided so quickly.

The CHAIRMAN, speaking on behalf of the Board as a whole, thanked the representative of Haiti for his moving statement and presented his deepest sympathy for the very many lives that had been lost.

Dr LAROCHE (Assistant Director-General) said that the earthquake had posed particular problems because many of the people meant to provide assistance after a natural disaster were themselves victims. Indeed, some WHO staff were still unaccounted for. United Nations headquarters had launched a flash appeal for disaster relief funding, asking for US\$ 34.3 million for the health sector, of which US\$ 10 million would be managed by WHO. The WHO response covered three areas: restoration of WHO facilities, emergency response and the key area of coordination. The United Nations Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator had designated five global clusters for immediate action: health (with WHO as lead agency); shelter; water, sanitation and hygiene; food; and logistics. Six more areas might be designated later.

The WHO response was being coordinated by the Regional Office for the Americas. A field office had been set up on the border between the Dominican Republic and Haiti, while the main decision-makers were based in Port-au-Prince. The Regional Office issued daily situation reports, and the WHO web site carried information for WHO staff and cluster partners, donors and other

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

nongovernmental organizations. Public health risks and specific priority interventions had been outlined in a document<sup>1</sup> that was intended to promote coordination between WHO and other agencies and within the Organization itself. Specific country profiles had been produced, for instance on making pregnancy safer. Two health coordination meetings had been held at global level, and meetings of the 70–100 partners in the Inter-Agency Standing Committee Health Cluster took place daily in Port-au-Prince.

The international response had been extraordinary: governments, nongovernmental organizations, the private sector and private individuals from some 64 countries had responded to the global flash appeal. Of the target of US\$ 575 million, US\$ 107 million had already been raised, along with 25% of the US\$ 33.4 million requested for health relief work. Thanks to pledges from Italy, Spain and the United States of America, the target for WHO's operations should be met in full.

Relief workers faced a chaotic and distressing situation. The immediate priority had been to rescue as many survivors as possible and to provide surgical and post-operative care, but the problems of clean water and sanitation, management of dead bodies, and supply logistics would soon become more pressing. Coordination between all parties – WHO, the United Nations, bilateral agencies, nongovernmental organizations, military personnel and the private sector – was essential. The United Nations Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator had requested that the highest possible calibre of staff should be deployed in Haiti in order to ensure the best possible coordination of relief efforts.

The international community must consider the aftermath of the relief operations, which it had failed to do after the floods in Haiti in 2007, and ensure that support continued to be provided. Planning of the relief operations must include an exit strategy.

Dr ROSES PERÍAGO (Regional Director for the Americas), speaking by video link from the Regional Office in Washington, DC, said that the devastating natural disaster in Haiti had compounded an already challenging health situation. WHO's role as lead agency of the United Nations Global Health Cluster would require massive resources. WHO staff had been working round the clock at the global, regional and country levels using all available resources; they had been overwhelmed by support from Member States and colleagues, who had offered supplies, expertise and funds. The Regional Office was working closely with the Organization of American States and the regional directors of the various United Nations agencies.

Giving an overview of WHO's current operations in Haiti, she said that no staff casualties had been reported so far. The damaged WHO office building was undergoing a safety assessment: at present, WHO staff were operating from a medical supplies warehouse near the airport at Port-au-Prince and the field office at Jimaní in the neighbouring Dominican Republic. The PAHO office in the Dominican Republic was supporting the Ministry of Health in strengthening its border health services; and other Caribbean countries, including Jamaica, Puerto Rico, Martinique and the United States of America, had taken in evacuated patients. There had been a massive internal displacement of people away from Port-au-Prince to surrounding areas and to neighbouring countries including the Dominican Republic.

Communication and transport remained extremely difficult; and food, water and fuel were scarce. The streets were blocked with rubble and dead bodies, and survivors who were living in the open, all of which made it difficult to identify clear spaces where field hospitals and temporary shelters might be erected.

The Regional Office had sent an extra 20 experts in logistics and communications in order to support the coordination of WHO's response in areas such as the management of mass casualties and dead bodies. Support had been mobilized at all levels of the Organization – countries, regional offices and headquarters. Medicines and supplies from existing WHO stocks that would treat 165 000 people for one month, and provide trauma care for a further 1000 people, were being flown in. Logistical

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<sup>1</sup> Document WHO/HSE/GAR/DCE/2010.1.

support from the country offices in Haiti and the Dominican Republic would be required to facilitate their transport, storage and distribution.

Assessment teams coordinated by staff from the Regional Office and headquarters were visiting hospitals and health-care facilities in order to determine where essential health-care services were still available and what was needed to restore those that were not. At least eight hospitals and health-care facilities had been destroyed or damaged in and around Port-au-Prince, and hospitals that were still operating had been quickly overwhelmed by large numbers of survivors needing care, particularly for trauma injuries. Between 150 and 200 babies were delivered each day. Facilities were operating with the help of nongovernmental organizations, with sometimes two or more working in the same facility, which created some tensions. Patients were being treated for injuries and other health problems at various health-care centres in the Dominican Republic along the Haitian border, while some injured patients were being evacuated from Haiti. Epidemiological reports had indicated no increase in reportable diseases to date, either within Haiti or along the border with the Dominican Republic. She recalled that Haiti and the Region were free of poliomyelitis and cholera and almost free of measles.

The Regional Office was leading the Global Health Cluster, and four daily meetings were already taking place in difficult physical conditions. She was aware of some complaints about functioning, but the situation was complex, with more than 21 partner agencies and more than 80 people participating in crowded meetings. The Regional Office was also participating in the daily cluster coordination meeting, and in the Humanitarian Forum under the leadership of the United Nations Resident Coordinator.

The PAHO Humanitarian Supply Management System had been established in Jimaní in the Dominican Republic to coordinate the arrival of humanitarian supplies. A satellite hub had been set up in Port-au-Prince airport to collate information on donations arriving and another would soon open in Santo Domingo airport, which was currently handling most of the cargo. The Global Health Cluster planned to use that information to determine gaps in supply and distribution priorities; it had assessed at least six hospitals and 15 more had been visually assessed using closed-circuit satellite imagery. In some cases the results were positive, with buildings already being reoccupied. A sub-group of the Global Health Cluster was coordinating the arrival and deployment of the multiple field hospitals and military hospitals which had been sent from Member States from many regions. The Minister of Health was leading the emergency health plan. Medical teams sent from all over the world were also on the ground. Blood and medical supplies had been received the previous day.

The emergency operations centre was coordinating the flow of information; preparing press briefings; organizing the deployment of experts to the field; updating an old database of health facilities in Haiti and compiling new entries; gathering field reports from the Global Health Cluster on damage to health facilities and assessing the operational status by means of satellite imagery. Those activities were coordinated with the Global Health Cluster and United Nations organizations. A first summit had taken place on the previous day in Santo Domingo, called by the President of the Dominican Republic and attended by the Vice-President of Spain as President of the European Union, the Prime Ministers of the Bahamas, Barbados and Dominica representing the Member States of the Caribbean Community and the Secretary-General of the Organization of American States. A preliminary donors' meeting on reconstruction would take place on 25 January 2010 in Montreal, Canada, and a world summit for Haiti was being planned, to be held in Madrid, possibly on 17–18 May 2010, which would be critical for Haiti's future. A mission of the Organization of American States was due to travel to Haiti on the following day. She would travel to the Dominican Republic two days later, and then into Haiti.

The team had accomplished much in the first six days of the response, and a large number of people had been rescued alive. However, much remained to be done and many people had been killed, including colleagues in the United Nations, civilians and military personnel. It was essential to work together as one WHO and one United Nations for the benefit of the people of Haiti, the poorest Member State in the Region, and to look towards building a robust and sustainable health system for future generations of Haitians.

The CHAIRMAN thanked the Regional Director for the update and wished the Regional Office every success in its struggle to alleviate the suffering of the people of Haiti.

Mrs ESCOREL DE MORAES (adviser to Dr Buss, Brazil) said that in Haiti 70% of the population lived on less than the equivalent of two United States dollars a day. The unprecedented magnitude of the disaster and the resulting humanitarian situation far surpassed Haiti's capacities. The disaster posed a serious setback to United Nations development endeavours in the country and solidarity in assisting Haitians was essential.

Brazil had played a prominent role in the United Nations Stabilization Mission in Haiti since 2004, alongside other Latin American countries. More than 1000 Brazilian troops were currently in Haiti working to develop the country's future. She paid tribute to the 18 soldiers and other Brazilian nationals killed in the earthquake, which sadly included the deputy chief of the Brazilian mission. The Brazilian President had pledged US\$ 15 million in humanitarian assistance, of which US\$ 5 million would be transferred to the United Nations Office for the Coordination of Humanitarian Affairs in emergency response. Brazilian airforce planes had brought in food, water, and medication; a team of 50 specialists in disaster relief; and a portable field hospital, for rapid installation and with facilities for surgery. An improvised health-care facility had been established within the Brazilian army unit.

Haiti urgently needed doctors and health professionals, facilities and supplies, however, and it was the duty of the international community to assist in that care. A massive and coordinated operation was required under the aegis of the United Nations: together, the resources could be mobilized for the long-term recovery and reconstruction of Haiti.

Dr GIMÉNEZ (Paraguay) said that, within the framework of the United Nations Stabilization Mission in Haiti and the Southern Common Market, Paraguay had provided aid and operational assistance by sending doctors, health professionals specializing in trauma cases, medicines and equipment, as well as rescue workers and disaster experts.

The humanitarian situation was critical and the health system had collapsed. Sustained coordination was key to emergency health assistance, and all aid efforts should be channelled according to priorities identified by WHO. A working group should be established to plan medium-term measures for the reconstruction of Haiti's health system and a report on the situation should be presented at the next Health Assembly or session of the Board.

Dr ALI (alternate to Professor Haque, Bangladesh), commending the coordinated action, said that, as a country that was also prone to natural disasters and the resulting human misery, Bangladesh was committed to providing resources through WHO to assist with humanitarian efforts and reconstruction in Haiti. It had already sent a military and civilian medical team; however, frustrating logistical challenges remained, preventing the aid from reaching all the areas where it was most needed.

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, recalled the ancestral and cultural links that united the African continent with Haiti. He welcomed the international solidarity shown and encouraged WHO to continue its efforts to alleviate the suffering of the Haitian people. Africa would bring all the humanitarian aid that it could to the reconstruction process. The international community should strengthen the system for coordinating international aid for natural disasters to ensure that aid reached those who needed it as quickly as possible.

Dr DODDS (Canada), noting the close ties between Canada and Haiti and the large Haitian diaspora in Canada, said that there had been an outpouring of support from the Canadian people. Her Government's assistance included matching donations by Canadian citizens, establishing a relief fund and sending medical supplies and disaster response teams. In addition, Canada would host a summit of foreign ministers on 25 January 2010 in Montreal to consider long-term plans for reconstruction. She acknowledged the demonstration of solidarity among the countries of the Americas; their timely and generous response; and the crucial role of WHO in leading and coordinating the emergency response. She pledged Canada's continuing support.



Dr KÖKÉNY (Hungary), speaking on behalf of the European Union and its Member States, said that in order to alleviate the suffering of the Haitian people the first priority had been to dispatch search and rescue teams. A timely, coordinated response was essential. The European Union welcomed the leadership shown by WHO, and supported the Haitian Ministry of Health in its emergency response and coordination.

The European Union and its Member States would provide additional assistance on the basis of the ongoing needs assessment and in response to the request from the United Nations. He announced that, following a meeting of its Foreign Affairs Council the previous day, the European Union had adopted a set of conclusions providing €122 million for urgent humanitarian assistance, €100 million for early non-humanitarian assistance, and a further €200 million as part of a longer-term response. The European Union welcomed the suggestion to launch a coordinated post-disaster needs assessment in collaboration with the United Nations and the World Bank, and stressed that reconstruction efforts must be based on national priorities, taking into account the principles of disaster risk reduction, and respecting the principles of aid effectiveness.

Dr SEDYANINGSIH (Indonesia) said that her Government had sent an early assessment team to Haiti under the coordination of the United Nations. It had also sent 85 health and medical personnel; a response unit specialized in natural disasters; and humanitarian assistance including field hospitals, tents, ambulances, systems for water purification, medicines and food.

Indonesia had long experience of natural disasters: rapid response and appropriate disaster management were essential in order to save lives, sustain morale and hasten rehabilitation. However, most developing countries lacked the capacity to provide swift and timely relief to victims as well as rehabilitation and recovery programmes; the present disaster had shown room for improvement in international cooperation on disaster management. Therefore, she called upon the international community to support developing countries in elaborating disaster preparedness plans. She welcomed the efforts led by the United Nations to coordinating the response to previous emergency humanitarian situations and stressed that continued international assistance to Haiti should enable the citizens of that country to rebuild their future.

Dr OMI (Japan) said that his country had joined the international relief efforts, and would provide about US\$ 5 million in emergency grant aid as well as emergency relief goods amounting to ¥ 30 million. A team of 24 Japanese experts, including medical personnel, had already arrived in Haiti.

Dr MUÑOZ (Chile) urged international donors to take into account Haiti's urgent needs: the recovery of survivors; treatment of victims; disease prevention; and ensuring food security for the surviving population. Aid should be coordinated through one body; he supported the establishment of a coordination centre in Haiti, and welcomed the leadership shown by WHO in tackling the most urgent health consequences. Chile would continue to provide assistance to Haiti and joined the calls for international solidarity.

Mr NEBENZIA (alternate to Dr Starodubov, Russian Federation) commended the international community's response to the tragic earthquake in Haiti. His country's contribution to the rescue operations had included a team of 175 persons; aircraft carriers and heavy aircraft; a transport plane with onboard helicopters; a search and rescue team with dog handlers and psychologists; and a field hospital with 50 beds and the capacity to treat 100 outpatients.

In many cases, patients could not be released following treatment, because they had nowhere else to go, and as a result, hospitals were unable to accept new patients. He asked what efforts were being made to prevent such bottlenecks from occurring and to ensure that more patients received hospital treatment.

Dr ALBRAIKY (alternate to Dr Al Darmaki, United Arab Emirates) welcomed the aid and rescue efforts being provided by WHO, and stressed that his Government was ready to play an active part in the international efforts to mitigate the impact of the disaster.

Dr BABB-SCHAEFER (Barbados),<sup>1</sup> speaking on behalf of the member countries of the Caribbean Community, commended WHO's efforts to coordinate health matters on the ground in Haiti. The Caribbean Community, deeply shocked at the loss of life caused in one of its member countries, intended to set up a field hospital in Haiti, and would continue to provide medical and support personnel, and medical and emergency supplies.

Mr ADAM (Israel)<sup>1</sup> said that a 280-strong team from Israel, which included medical personnel and search and rescue personnel with dog handlers, had already arrived in Port-au-Prince and was working with local authorities and organizations of the United Nations system. Within 48 hours of the earthquake, a field hospital had been set up, with a staff of 40 doctors, the capacity to treat some 500 patients a day and advanced facilities such as a children's ward, intensive care unit, operating rooms and a pharmacy. To date, the hospital had provided treatment to 267 patients, more than half of whom were under 16 years of age.

Mr HOHMAN (United States of America)<sup>1</sup> expressed gratitude to the people of Haiti who, in the midst of tragedy, had joined the rescue and relief efforts, and he thanked WHO staff for their tireless efforts to undertake health sector assessments and restore basic health services to the country. As part of the immediate assistance efforts, his President had pledged US\$ 100 million for relief, humanitarian and logistical activities. That included specialized teams for disaster assistance, search and rescue, and medical assistance. The United States appreciated the generosity of Member States and nongovernmental organizations in supporting the relief efforts. He stressed that close coordination with the Haitian Government, the United Nations and donors was critical to the success of the rescue and relief operations. The United States would support the reconstruction and sustainable recovery of Haiti.

Ms DUPUY (Uruguay)<sup>1</sup> said that her country was considering how best to channel the aid that would be provided in addition to a contingent of 1162 Uruguayans sent to Haiti to take part in security operations following the arrival of humanitarian assistance from other countries. In addition, a medical unit with 200 beds had been set up in the south of the country; rescue workers and search dogs had arrived; and two water-purification units would be sent to Haiti as soon as port logistics permitted. Her country had been requested to provide material for the fingerprinting of cadavers, and would be able to provide electricity generators upon request. Uruguay was also preparing to send orthopaedic surgeons to assist in medical procedures.

Mr FILLON (Monaco)<sup>1</sup> said that emergency financial aid and medical personnel had been sent to Haiti through the Monaco Red Cross, and that voluntary contributions not already allocated for 2010 would be directed to the relief effort through the United Nations or the International Red Cross and Red Crescent Movement. His Government was also committed to supporting reconstruction in the public health and education sectors, collaborating with nongovernmental organizations, including the Monaco Red Cross, and Haitian local authorities. Any new structures should be resistant to earthquakes and cyclones, in order to ensure sustainable recovery.

Mr PUJOLS (Dominican Republic)<sup>1</sup> said that, following the earthquake, his country had provided immediate emergency assistance, working directly with the Haitian authorities and civil society. The President of the Dominican Republic had travelled to Port-au-Prince to meet with the Haitian President and there had been a constant stream of public and private assistance since that time. Thousands of victims had been treated in his country's hospitals; food, medicines, communications equipment and electricity generators had been sent to Haiti. International humanitarian aid had also been airlifted via the Dominican Republic in order to ensure that it reached those most in need. He

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

called on the international community to work in lasting partnership and solidarity with the Government and people of Haiti.

Mr REYES RODRIGUEZ (Cuba)<sup>1</sup> said that his country had been providing aid to Haiti through an integrated health programme since 1998. About 400 Cuban health workers had been present in Haiti when the earthquake had struck and had been able to offer immediate medical assistance to the Haitian people. A further 60 experienced medical personnel had arrived and already 1987 patients had been treated and 111 surgical operations performed, in five medical posts in Port-au-Prince.

Cuba had trained 917 Haitian health professionals over a period of years and 541 Haitian students were currently studying medicine in Cuba. He reaffirmed his country's commitment to work in the saving of lives with all countries, including the United States, and welcomed the coordination of the relief effort by the United Nations, in particular by WHO. Every country had a right to receive such aid.

Mr SAMRI (Morocco)<sup>1</sup> said that his country had sent medical and pharmaceutical supplies to the value of US\$ 1 million, in addition to aid sent by the Moroccan Red Crescent. He encouraged Member States to remain committed to supporting Haiti in its future reconstruction efforts. He welcomed the leadership of WHO in coordinating the humanitarian effort, in particular in the health sector.

Dr ABDESSELEM (Tunisia), speaking on behalf of the Member States of the Eastern Mediterranean Region, informed the Board that Mr Hédi Annabi, Special Representative of the Secretary-General for Haiti and Head of Mission, a Tunisian, had died in the earthquake. The Region's countries had contributed to the humanitarian effort, but he emphasized the need to further strengthen the role of WHO in coordinating the provision of emergency aid in the event of future disasters.

Mr LORENZO (Mexico)<sup>1</sup> said that his country had joined the search and rescue effort in Haiti, as well as providing emergency aid to the population. His Government had sent two ships and six aeroplanes; and 202 specialists in medical services, search and rescue, and damage control. It had also dispatched medicines, vaccines, drinking water, food, shelters and gasoline, in addition to providing vehicles, electricity generators, satellite telephones, water purification plants, portable computers, and medical and security equipment. Furthermore, a financial contribution had already been announced by the President.

Ms PATTERSON (Australia)<sup>1</sup> said that her Government had announced an assistance package for Haiti: Aus\$ 10 million would be provided for immediate humanitarian needs and Aus\$ 5 million for longer-term rehabilitation and reconstruction. Her country would coordinate its support with the international community and with its partners in the Caribbean. Australia would be ready to consider further assistance as required.

Dr SIRIWAT TIPTARADOL (Thailand)<sup>1</sup> said that his Government had approved an initial donation for humanitarian assistance in solidarity with Haiti. Coordination of Thailand's assistance to Haiti had begun, and he thanked the Mexican Government for acting on behalf of Thailand to procure and deliver supplies in that country. Thailand was ready to provide food and medical teams to Haiti, and would be receiving donations from the public through the Thai Red Cross Society.

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

Dr KESKİNKILIÇ (Turkey),<sup>1</sup> recalling that his country had suffered from a serious earthquake 10 years previously, said that it would join the international community in providing its experience and resources and to the Haitian people.

Dr REN Minghui (China)<sup>1</sup> said that his country had dispatched rescue personnel to Haiti, established medical care centres, carried out disinfection activities and helped to organize local volunteers. China had acquired recent experience in search and rescue following an earthquake in the Province of Sichuan in 2008 and was preparing to send a second rescue team to Haiti. Supplies and emergency materials, to the value of US\$ 5 million, had already reached Haiti. The Chinese Red Cross had sent a further US\$ 1 million, and more resources would be forthcoming.

Dr BARARUNYERETSE (Organisation internationale de la Francophonie), speaking at the invitation of the CHAIRMAN and expressing his Organization's solidarity with the Haitian people, recalled that Haiti had already suffered a series of natural disasters in 2008. His Organization's Secretary General, President Abdou Diouf of Senegal, had made an urgent appeal requesting francophone states to provide emergency assistance to the people of Haiti. His organization would continue to provide humanitarian aid through French-speaking organizations.

Mr TRONC (MSF International), speaking at the invitation of the CHAIRMAN, said that his organization had responded to the major crisis in Haiti with 165 international staff and 700 local staff working in its 11 hospitals in and around Port-au-Prince; it had already treated more than 3000 patients and carried out more than 400 operations. It had thus far received in excess of €33 million in donations that would be used to support that situation. However, the persistent disorganization at Port-au-Prince airport was a cause of major concern: in the previous 72 hours, authorization to land had been denied to two cargo planes carrying medical equipment and medicines for his organization and to four other planes carrying its personnel, whereas three planes carrying high-profile public figures had been permitted to land at short notice. Such delays in the delivery of medical supplies and personnel threatened the functioning of his organization's health structures in Haiti, and he asked what priorities had been set by the United Nations agencies and coordination bodies. It was vital for all entities that claimed a coordinating role in the disaster relief efforts, including WHO, to demonstrate effective leadership and thus ensure the prompt mobilization of medical equipment and teams for the immediate benefit of the Haitian people affected by the earthquake.

Mr DOWNHAM (International College of Surgeons), speaking at the invitation of the CHAIRMAN and referring to the surgical needs resulting from the earthquake, said that well-functioning health facilities for first referral could have greatly contributed to the provision of life-saving surgical procedures in Haiti. In such situations, emergency surgical teams dispatched to the country could immediately use any existing functional infrastructure. The Haitian health system was not alone in its need for improvement, and disaster preparedness began with access to basic health care. WHO's guidelines and standards for surgical infrastructure, procedures and equipment should be applied not only for training in general but also to ensure disaster preparedness.

Dr LAROCHE (Assistant Director-General), responding to the question from the member for the Russian Federation, said that the lack of a post-operative care structure was a recognized problem that had been discussed at a cluster coordination meeting in Haiti. Work was in progress, including by nongovernmental organizations, to remedy that situation. The representative of MSF International had also raised a valid point concerning the need for closer coordination between those in charge of logistics and the Global Health Cluster. Although a certain level of disorganization was initially to be

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

expected in such a chaotic situation, the need to prioritize should be addressed to ensure a more effective, predictable and accountable response.

Dr ROSES PERÍAGO (Regional Director for the Americas) expressed appreciation for all the support received from an ever-widening variety of quarters. Concerning the problem of post-operative care facilities, efforts were being made to locate spaces in which to erect tents for the purpose of providing such care, as well as to control infection and promote early rehabilitation for amputees in particular. The level of health preparedness and mitigation in the current crisis was all the more regrettable in the light of predictions made some years earlier that a major earthquake was due to strike Haiti. Member States should therefore do their utmost in future to take forward action to mitigate the suffering and destruction caused by such events.

The DIRECTOR-GENERAL, responding to comments, acknowledged the recognition of WHO's efforts. WHO staff members present on the ground had shared the difficulties faced by Haitians in the days following the earthquake, struggling to survive in the open without adequate food, water or sanitation. Their work had been further impeded by badly damaged infrastructure and lack of transport but they were nonetheless fully committed to doing their best.

She shared the concerns regarding coordination problems: WHO would follow up to find out why they had occurred and would work to improve both logistics at the airport and the delivery of medical supplies. Nevertheless, she also appreciated that high-profile public figures had a role to play in such crises by raising morale, obtaining first-hand information and rallying support from development partners. The outpouring of international support was indeed commendable, but it was important to learn lessons from previous disasters and to avoid "aid tourism" by ensuring that assistance did not seep away once the immediate crisis was over. The United Nations Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator would always lead the humanitarian work and WHO would do its utmost to fulfil its lead role in the Health Cluster, coordinating and working closely with its partners and with the authorities in Haiti. Efforts would also be made to ensure that the WHO team was enlarged in order to allow periodic respite for its members. She expressed gratitude for the useful input received and for the invaluable work of Dr Roses Periago and her team on the ground. Updates on the situation would be provided regularly on the WHO web site and through other mechanisms.

Mr ST-VIL (Haiti), speaking on behalf of the Haitian Ambassador to the United Nations in Geneva and other International Organizations in Switzerland, thanked participants for their expressions of solidarity with the Haitian people as they confronted the worst disaster in their history. The situation was extremely difficult and there was an urgent need for medical equipment, field hospitals, water-purification systems, and food. In the longer term, reconstruction and other activities would pose another challenge. He believed, however, that Haiti could count on the international solidarity expressed, including that of the Director-General in her opening address, to assist in its recovery from the disaster.

**Public health, innovation and intellectual property: global strategy and plan of action:** Item 4.3 of the Agenda (Documents EB126/6 and EB126/6 Add.1) (continued from the third meeting, section 2)

The CHAIRMAN asked the member for Hungary to report on the outcome of informal discussions on whether the Board should adopt a decision requesting the Director-General to convene informal consultations on the report of the Expert Working Group on Research and Development Financing.

Dr KÖKÉNY (Hungary), setting out the position of the Member States of the European Union, supported the earlier comments by the member for the Bahamas. He stressed careful examination of the full report, once it had been translated from English into the other official languages, before engaging in a wider process. The European Union could agree to a one-day consultation on the report,

if necessary, but it must have clear objectives and terms of reference determined by the Secretariat; and must take place within the context of the Health Assembly, which was the proper forum for discussing implementation of the global strategy and plan of action.

Ms SUJATHA RAO (India) welcomed the support for her request for a meeting. Everybody should have the chance to study the report and the Director-General's comments needed to be made available. Hence, the meeting should not take place on the eve of the Health Assembly but in April, providing Board members with time to return to their countries, brief their Governments and prepare for the Health Assembly.

Mrs ESCOREL DE MORAES (adviser to Dr Buss, Brazil) endorsed the proposal by the European Union and the comments by the member for India.

Dr OMI (Japan) said that consultation, whether formal or informal, was always important. One of the strengths of WHO was that Member States had come together to resolve many difficult issues over the years through a frank exchange of views. Yet views on the item at hand remained divergent, despite the succession of 10 formal and more than 50 informal meetings in which Japan had taken part since 2003. In some cases the divergence had even increased. The Director-General had pointed to the need to find some middle ground, a theme echoed in the report on influenza preparedness.<sup>1</sup> Member States and the Secretariat had worked hard to find some middle ground. Their failure to do so thus far was due not necessarily to a lack of consultations but to insufficient determination on all sides. Japan was willing to take part in another set of informal consultations, but he urged Member States to seek ways of being a little more flexible in advance. Otherwise the result might be another recommendation to hold further consultations.

The CHAIRMAN agreed about the need to find the middle ground.

Ms ROCHE (New Zealand) acknowledged the important points made by the member for Japan, but recalled that not all Member States had the means to send representatives back to Geneva for one day between the current session of the Board and the next Health Assembly. Alternatively, the consultation could take place via the web or in conjunction with another scheduled meeting. Either way, such consultations must remain the exception and not become normal practice.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, supported the proposal to hold the consultations during, although not necessarily as part of, the proceedings of the Health Assembly. However, they should last no longer than one day and should focus strictly on the full report of the Expert Working Group and not on its implementation.

Ms ARTHUR (alternate to Mr Houssin, France) expressed support for comments made, including those by the member for Japan. Analysis of the full report of the Working Group was needed before decisions on further consultations could be taken. That seemed the wisest option at present, especially since it related to improving governance. Furthermore, given the current debate on governance at WHO and in the international health arena, it seemed premature to include an item on patent pools in the agenda for the next Health Assembly before UNITAID had completed its deliberations on the subject.

Mrs ESCOREL DE MORAES (adviser to Dr Buss, Brazil) recalled that the Board was trying to comply with the decision by the Health Assembly in resolution WHA61.21 to request the Director-General to submit the report of the Working Group to the Sixty-third World Health Assembly, through

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<sup>1</sup> Document EB126/4.

the Executive Board. The Board might not be in a position to approve the report at present, but it should be given the opportunity to do so once it had been issued. She was glad that the member for Japan was not against consultations, as those were the only way to achieve middle ground between incompatible positions.

Regarding the comment by the member for New Zealand on long-distance travel to Geneva, a member of the national mission could represent the country instead. In the meantime, she was in favour of holding an additional consultation before the April meeting proposed by the member for India. Either way, the aim would be not to negotiate but to exchange views on the report, which already existed in English, in order to make it possible for the Director-General to present it to the Health Assembly, and for members to be well-prepared. The various proposals put forward were not mutually exclusive.

Ms SUJATHA RAO (India) supported the previous speaker's comment that the full report should be presented to the Health Assembly through the Executive Board. However, it was unfair to expect the Board to continue working on, and to approve, an executive summary which did not provide sufficient information to do justice to the full report. She could not see why it had even been included in the agenda of the current session. It was essential to hold a one-day consultation to reflect on the report before Government ministers were asked to comment on it.

The DIRECTOR-GENERAL asked whether the member for Brazil was proposing that two consultations should be held before the Health Assembly. Meanwhile, the member for India had perhaps come up with a solution. Resolution WHA61.21 stated that the final report to the Health Assembly should be submitted by the Director-General through the Executive Board, but since the Board was already assembled it could decide that the report should be submitted straight to the Health Assembly. She sought the views of the Legal Counsel on that point. There appeared to be general acceptance of the proposal to hold consultations; it was simply a matter of agreeing when they would be held.

Dr MOHAMED (Oman) said that, since the Health Assembly had requested the Director-General to submit the report through the Board, he doubted that the Board could decide to bypass the process. The Board could decide either to hold a meeting one or two days before the Health Assembly or to hold a web-based meeting, as proposed by the member for New Zealand. In any event, it might be wise to delay the whole process for another year because the matter needed more thorough examination.

Dr DAHL-REGIS (Bahamas) acknowledged the importance of bringing the matter to a close. Past deliberations – on avian influenza, for instance – had shown, however, that it was equally important to take the time to do things properly. Missions should engage in dialogue, but that must be based on an analysis of the full report in all six official languages. If that analysis produced further clarification and moved everybody toward the middle ground, it could advance the process. But the burden on both Member States and the Secretariat, which was being asked to take on an ever-increasing workload in a short period of time, called for sensitivity to the time constraints and respect for the competing priorities within the Organization.

Dr OMI (Japan) said that, for practical reasons, the meeting should take place as part of the Health Assembly. Members were more or less aware of others' positions on the subject, which were deeply entrenched, and individual members or delegations could not reverse those positions and join a consensus unless there was agreement within their governments. It would be more important for members to spend time discussing the matter with their governments in order to come up with a flexible approach which they could take to a future meeting.

Dr DODDS (Canada) said that all agreed on the need to see the full report in all WHO's official languages and to see an analysis of the report. They also agreed, that if consultations were held, the

report could be submitted through the Board to the Health Assembly in May 2010. Canada supported that view on condition that scheduling and travel problems were resolved. It would be up to individual States to decide whether to be represented by their missions or to send delegations to the consultations.

The DIRECTOR-GENERAL said that members agreed on the importance of holding consultations, but she would need to receive clear instructions on their timing in order to plan the Secretariat's support. To assist the Board in its deliberations, she drew attention to some factual information: the Health Assembly was scheduled for 17 to 22 May 2010; in the meantime, the report could be made available in all official languages by late February 2010, when it would be transmitted to countries and uploaded on the WHO web site. If the consultations were held during the weekend preceding the Health Assembly, they might disrupt the many regional meetings that were usually scheduled at that time.

Mrs ESCOREL DE MORAES (adviser to Dr Buss, Brazil) proposed, in the interests of reaching consensus, that, in April 2010, open-ended, information consultations be held with the participation of national missions or delegations from capitals. The day before the Health Assembly, a formal meeting of the Board could be held for the purpose of discussing the subject and transmitting the report to the Health Assembly.

Mr BURCI (Legal Counsel) said that any action taken by the Board should be seen in the light of its primary functions under the Constitution, which were to prepare for and advise the Health Assembly. In the past, in similar situations, the Board had complied with the Health Assembly's requests for action on a given subject in several ways. Taking the Board's practice into account, one option would be to request the Director-General to convene consultations, either open-ended or among members of the Board; those discussions would either enable the Director-General to hear the views of Member States in order to prepare a substantive report for the Health Assembly, or would allow Member States to hold an exchange of views, thus permitting a more informed discussion at the Health Assembly. The purpose of the consultations would determine the timing.

It would not be necessary to hold a Board meeting before the Health Assembly: based on available precedents and the flexibility available to the Board, it could ask the Director-General to convene consultations that would provide feedback for the Director-General or that would serve as an exchange of views preparatory to the Health Assembly.

Dr KÖKÉNY (Hungary), supported by Dr OMI (Japan), said that the European Union was not in favour of consultations being held in April 2010; they should be held nearer to the time of the Health Assembly.

Dr DODDS (Canada) said that the request from the Health Assembly in 2009 had been for the Board to comment on a report by an expert committee, not to approve it, something that would be inappropriate. It was not for the Board to modify a report by an independent body; the credibility of expert committees must be maintained. On the other hand, the Board needed to see the full report and the Secretariat's analysis thereof and it needed to hold consultations on the implications of the report. She repeated her proposal for informal consultations and suggested that they be held in the week starting 20 or 27 April 2010, which would allow ample time for full consideration of the report before the Health Assembly. She was not in favour of holding another session of the Board immediately before the Health Assembly.

Ms SUJATHA RAO (India) supported that proposal.

In response to a query by the DIRECTOR-GENERAL, Dr DAHL-REGIS (Bahamas) said that holding consultations would put small countries like her own at a disadvantage, but she would not oppose a consensus in favour of such a course of action.



Dr MOHAMED (Oman) suggested that the consultations should be held on the Thursday or Friday in the week preceding the Health Assembly as the proposal to hold them in April 2010 would obviously cause problems for developing countries and small nations.

The DIRECTOR-GENERAL pointed out that there was a meeting of the Programme, Budget and Administration Committee on the Friday of that week.

The CHAIRMAN suggested that the consultations be held on the Thursday preceding the opening of the Health Assembly in May.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union and its Member States, endorsed that proposal.

Dr MUÑOZ (Chile) expressed support for the holding of consultations and suggested that the Secretariat should hold an Internet consultation to enable countries that could not attend to make their views known.

The DIRECTOR-GENERAL said that there was a consensus on the way forward: the full report would be circulated in late February 2010, and a web-based consultation would be held, followed by consultations with Member States the day before the meeting of the Programme, Budget and Administration Committee in May 2010.

**It was so agreed.**

**The meeting rose at 17:43.**

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

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

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

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;

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<sup>1</sup> 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 health<sup>1</sup> 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

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<sup>1</sup> *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:

<b>1. Resolution</b> Monitoring of the achievement of the health-related Millennium Development Goals	
<b>2. Linkage to programme budget</b>	
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.
<b>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</b>	
<p>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),</p>	

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,<sup>1</sup> 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

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<sup>1</sup> 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.**

## **SIXTH MEETING**

**Wednesday, 20 January 2010, at 14:40**

**Chairman:** Dr S. ZARAMBA (Uganda)

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

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

The DIRECTOR-GENERAL reported that, following discussions, it had proved unnecessary to convene a working group to consolidate the draft resolution on the Millennium Development Goals, and she thanked Member States for their flexibility in that respect.

Dr DAHL-REGIS (Bahamas), speaking on behalf of the member countries of the Caribbean Community, said that the Secretariat should provide guidance on the WHO definitions of fetal death and neonatal death as those were not being consistently applied across the region. Noting that childhood pneumonia accounted for 60% of child mortality, she stressed the issue of access to and affordability of pneumococcal vaccines. Recalling the region's initiative to prevent mother-to-child transmission of HIV and to eliminate congenital syphilis, she echoed calls for more equitable distribution of funds. The current model for reporting data on maternal mortality should be revised: it disadvantaged countries with small populations where the mortality rate might amount to only one or two deaths per year but was no less of a problem.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), welcoming the achievement of a reduction in child mortality, agreed that support for effective health strategies and strong health systems must be consolidated. Progress towards the Millennium Development Goal on maternal health was disappointing: one woman died every minute as a result of complications during pregnancy and childbirth. Emphasizing the removal of barriers to health services, he strongly welcomed the Consensus on Maternal, Newborn and Child Health (2009), which supported countries that removed user fees levied at the point of delivery as a means to encourage universal coverage.

Dr GIMÉNEZ (Paraguay) said that it was vital to protect health spending, improve the way in which funds were spent through results-based management, monitoring and evaluation. Paraguay had almost doubled its health budget over the previous decade, yet rates of maternal and child mortality had not decreased: clearly, the health system needed a change in focus. Health policies must be integral to social policies with prioritized funding. Following an international seminar hosted by Paraguay in June 2009, health ministers of the countries of the Southern Cone Common Market had agreed to promote health equity by focusing on the social determinants of health; he expressed support for the proposal to hold a global forum on that subject in 2011. He emphasized strengthened health systems through social participation, effective monitoring, information networks, developing human resources, and access to essential medicines and, more immediately, vaccines.

Dr VALLEJOS (Peru), noting varied progress towards achieving the health-related Millennium Development Goals, said that 90% of malnourished children or those suffering from stunted growth were concentrated in 36 countries, including Peru; and around half a million women died each year as a result of complications during pregnancy and birth. The achievement of Goal 5 (Improve maternal

health) required measures aimed at decreasing rates of malnutrition, reducing maternal mortality ratios, ensuring access to medical care during and following pregnancy; and fostering contraceptive use.

Those efforts would have a great impact on the other Goals and must involve all areas of government in a multisectoral, multidisciplinary approach, strategies that had been implemented in Peru with the aim of breaking the vicious circle of poverty and improving general health and well-being. With imagination, hard work and solidarity, solutions would surely be found in order to attain the Millennium Development Goals by 2015.

Mr OSMAN (Brunei Darussalam), welcoming the report's linking of noncommunicable diseases to the Millennium Development Goals, said that progress towards achievement of the Goals would be hampered by the financial crisis, emerging diseases and natural disasters. Susceptible areas included maternal health and access to family planning methods; sanitation and access to clean drinking-water; and access to essential medicines, which included rational use and affordability. The Secretariat should therefore provide technical support to Member States, especially developing countries, in strengthening national health systems to achieve the Millennium Development Goals.

Dr MOHAMED (Oman) said that some countries in the Eastern Mediterranean Region would have difficulty achieving the Millennium Development Goals unless they received assistance. The economic crisis had adversely affected budgets for health services and sufficient funding must be ensured. As the Goals were interlinked, he emphasized that issues should not be considered in isolation.

Dr BIRINTANYA (Burundi) expressed support for the essential amendments to the draft resolution proposed by the member for Malawi.

Mrs ESCOREL DE MORAES (alternate to Dr Buss, Brazil) said that Brazil was committed to the Global Campaign for the Health Millennium Development Goals. In relation to Goal 6 (Combat HIV/AIDS, malaria and other diseases) it was essential for the Secretariat to define a strategy and prepare a programme of work for the period 2011–2015. She also requested a report on progress made with initiatives on universal access.

She welcomed the draft resolution, but Brazil was not in a position to sponsor it. Recalling the commitment under the Monterrey Consensus on Financing for Development (2002) of coordinated support to development, the international community must join forces to preserve financial stability and sustain economic growth, essential to attaining the Goals. Developed countries must fulfil their pledge to allocate 0.7% of their gross national product as official development assistance, and promote reform of global governance.

Mr SATPATHY (alternate to Ms Sujatha Rao, India) said that India had some concerns about the draft resolution and wished to see it amended. Health equity was not only a national requirement but also an international prerequisite for the achievement of the Goals. Therefore the text should also take account of the need for international cooperation and global solidarity in that regard, in order to guarantee a flow of resources and technology, access to knowledge and the availability of medicines.

Social protection related to health but also covered areas such as education, sanitation and habitation. Accordingly, some countries would have difficulty in implementing social protection and require assistance through technical cooperation, resources and efficient budgeting. The concerns expressed in other United Nations bodies regarding social protection should also be taken into account. It was to be hoped that the high-level meeting to review progress on the Millennium Development Goals, to be held during the forthcoming session of the General Assembly, would focus on all the Goals, given their interconnection.

Dr LIU Peilong (China)<sup>1</sup> welcomed the information on noncommunicable diseases and injuries contained in the report; it was to be hoped that they would rapidly be included among the Millennium Development Goals. The draft resolution should make reference to noncommunicable diseases in both its preamble and operational paragraphs.

Mrs NYAGURA (Zimbabwe)<sup>1</sup> said that the report should include both graphic and written information on progress made in individual regions. Her country, like others in sub-Saharan Africa, remained constrained by inadequate financial resources, weak health systems, lack of access to proven interventions and an acute shortage of health workers. Limited progress had been made in achieving the Millennium Development Goals in general, and in some cases, such as Goals 4 and 5, the gains made had been eroded. If further advances were to be made, funding would be needed in maternal and child health and for noncommunicable diseases. She trusted that the Director-General would continue to draw attention to that issue.

Achieving the target of universal access to reproductive health by 2015 was essential to improving maternal health in general. The countries of the African Region required sustained support in order to strengthen family planning programmes; to address all causes of maternal mortality; and to further integrate HIV interventions within reproductive health services. She called on all Member States and development partners to match commitments with concrete and coordinated action.

Ms MNISI (South Africa)<sup>1</sup> said that the report and the draft resolution should include reference to regional disparities. The Regional Committee for Africa at its fifty-ninth session had concluded that most countries in the African Region had made insufficient progress towards achieving the health-related Millennium Development Goals. Only five countries were on track to achieve Goal 4 (Reduce child mortality) and estimates indicated that no progress had been made in the Region towards achieving Goal 5 (Improve maternal health). Only one third of the population with advanced HIV infection had had access to antiretroviral treatment in 2007.

The capacity of health information systems had to be strengthened, in particular for data management, by means of sufficient and trained human resources, adequate financing and logistical support.

She thanked WHO, UNAIDS, UNICEF and UNFPA for their support in assessment of the integration of HIV interventions within reproductive health services. With five years remaining until 2015, countries needed to recommit to all the Millennium Development Goals, which were interrelated, and in particular Goals 4, 5 and 6. She called on development partners to continue their support in the African Region.

Professor KULZHANOV (Kazakhstan)<sup>1</sup> thanked the Director-General for her efforts to promote the achievement of the health-related Millennium Development Goals. Kazakhstan had placed a focus on primary health care as essential for strengthening health systems. A sharp decline in maternal and child mortality rates was due in part to initiatives to promote breastfeeding and maternal health. However, questions remained concerning Kazakhstan's ability to achieve other Goals, owing to the spread of HIV. Difficulties included the identification of risk groups, and the availability of antiretroviral medicines, but Kazakhstan was cooperating closely with the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS, other international organizations and civil society in order to prevent the further spread of the virus in the country. He trusted in support from WHO and other United Nations agencies in that regard.

The report should further emphasize learning from the positive experiences of other countries, including those in central Asia. Kazakhstan would be pleased to share its experience with others.

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

Mr FEYDER (Luxembourg)<sup>1</sup> trusted that WHO would make an important contribution to the high-level meeting on the Millennium Development Goals that was to be held in September 2010 under the auspices of the United Nations. That meeting should highlight the interdependent nature of the Goals, and the importance of establishing health systems. He welcomed the almost four-fold increase in spending on health between 1997 and 2007; health ministries should be given the resources they needed to build health systems from both national budgets and official development assistance. He drew attention to the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008), and to the need for innovative national and international financial mechanisms. To overcome the remaining obstacles to achievement of the Goals, the essential work of international organizations needed to be complemented by concrete action at country level implemented by national ministries of health.

Dr KESKİNKILIÇ (Turkey)<sup>1</sup> said that countries should develop mechanisms to provide free access to primary health care services, in particular for the most vulnerable groups of society. He emphasized the importance of the health workforce for the achievement of the Millennium Development Goals, and welcomed WHO's efforts regarding the establishment of ethical codes. He suggested, in view of the limited time before 2015, the establishment of an action plan covering priority areas for the reallocation and provision of new resources.

Turkey had become the sixth most successful country in reducing child mortality according to UNICEF's 2009 report on the *State of the World's Children*, and provided proof that child mortality could be decreased.

Mr FILLON (Monaco)<sup>1</sup> said that Monaco had committed 0.7% of its gross national income to official development assistance. He supported the draft resolution, which had been the subject of lengthy informal discussions among the parties concerned, and took account of important issues such as equity, solidarity and gender specificity.

Dr SIRIWAT TIPTARADOL (Thailand)<sup>1</sup> said that Thailand was on track to achieve many of the Millennium Development Goals and the country's "MDG-plus" targets by 2015. Following the extension of rural health services to all subdistricts and districts, several of the Goals' indicator targets had been achieved. Those included 98% antenatal care coverage, which had facilitated the scaling up of the national programme on mother-to-child transmission of HIV; and 98% immunization coverage against tetanus, diphtheria and pertussis. Moreover, the antiretroviral treatment programme had been expanded in 2009, with more than 200 000 patients currently enrolled.

Continued support from WHO and donor countries was still vital to enable South-East Asian countries to achieve Goal 4 (Reduce child mortality) and to improve in the areas of neglected diseases and noncommunicable diseases. Technical support for improving health information systems and strengthening public-private partnerships was also critical to the achievement of the Goals.

Ms ARMITAGE (United Nations Population Fund), speaking at the invitation of the CHAIRMAN, commended the Director-General's unwavering commitment to women's health and her recognition of its importance for the achievement of all the health-related Millennium Development Goals. Recent research suggested that, if countries doubled investment in family planning and pregnancy-related care, maternal deaths in developing countries could be cut by 70%, and neonatal deaths by nearly half. Goal 5 (Improve maternal health) should be placed at the centre of global health, health systems strengthening and national funding. Strong health systems delivering services for family planning; maternal, child and newborn care; and the prevention and treatment of HIV/AIDS, tuberculosis and malaria.

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



Her organization, working in collaboration with WHO, UNICEF and the World Bank, was convinced that the health-related Millennium Development Goals could be achieved through broad-based coalitions and mutually supportive action.

Mr BARARUNYERETSE (Organisation Internationale de la Francophonie), speaking at the invitation of the CHAIRMAN, said that, with only five years remaining until 2015, the work needed on maternal and child health should be closely monitored, resources mobilized, and appropriate policies developed before it was too late. His Organization supported the draft resolution.

Mgr TOMASI (Holy See), speaking at the invitation of the CHAIRMAN, welcomed the draft resolution and said that ongoing commitment and effective action would be required to achieve the Millennium Development Goals. The application of measures in that regard, despite the difficult global financial situation, would produce important benefits for the development of nations in need of assistance, and for the peace and well-being of all countries. Referring to steps being taken to reduce maternal and child mortality and morbidity, he reaffirmed the Holy See's position that the terms "sexual health" and "reproductive health" referred to a holistic concept of health and sexual maturity within moral norms, and abortion was not considered to be included in those terms.

Ms KEITH (World Vision International), speaking at the invitation of the CHAIRMAN, recalling the 8.8 million childhood deaths due to preventable diseases every year, said that her Organization's first global campaign "Child Health Now" had been launched in November 2009. Strengthened political commitment was needed to meet the Millennium Development Goals, as seen by the progress made in Liberia as a result of increased financing, better human resources, support of the national health plan, and the decision to ensure free access to health care. Expressing support for the Paris Declaration on Aid Effectiveness (2005), she said that all discussions on innovative financing for health systems should be more transparent and inclusive of civil society.

With regard to the draft resolution, she agreed with the comments made by the members for Malawi, Brazil and Indonesia, and was encouraged by the statement made by the representative of Turkey. Paragraph 1(4) should include a reference to the need to assist States in removing health charges at the point of access and increase resources for social protection mechanisms. Many of the issues being discussed had been agreed previously by the adoption of resolution WHA58.31 in 2005. She asked that health governance and accountability also be included in paragraph 2(4) of the draft resolution.

Ms CHILDS (MSF International), speaking at the invitation of the CHAIRMAN, said that, while 4 million people had access to HIV treatment, 10 million people still did not. The many shortfalls in child and maternal health services included emergency obstetric services. The target related to tuberculosis would not be met without improved diagnostics and medicines. Effective global nutrition programmes to combat child malnutrition would need an estimated US\$ 12 500 million. Ensuring universal access to HIV treatment needed renewed political commitments in the global financial crisis.

The draft resolution should include a reference to the global strategy and plan of action on public health, innovation and intellectual property; ensuring access to health technologies was needed to achieve the Millennium Development Goals. WHO should play a leading role in reporting on health programmes that were at risk from the global financial crisis, in estimating gaps in funding, and discussions on innovative financial mechanisms, such as financial transaction taxes. The 2009 Millennium Development Goals Gap Task Force Report had noted that action was required to improve access to and affordability of essential medicines, such as the patent pool for HIV medicines being set up by UNITAID.

Ms BARUAH (Global Health Council), speaking at the invitation of the CHAIRMAN, welcomed the report and the draft resolution, and noted the progress made. She drew attention to the contribution of the noncommunicable disease network in efforts to combat noncommunicable

diseases. Immunizations were an important child health intervention, and continued funding was needed for new vaccine research, in particular for AIDS, malaria and tuberculosis, and for neglected tropical diseases. There was a need to strengthen health systems; to provide greater human resources; and to focus on leadership, especially at the community level. Member States needed to make key policy changes to enable the Millennium Development Goals to be met, in particular in areas such as gender-based violence and drug use.

Mr WRIGHT (Save The Children Fund), speaking at the invitation of the CHAIRMAN, called for a reference to the Global Consensus on Maternal, Newborn and Child Health to be included in the draft resolution. The Global Consensus encouraged an integrated approach to maternal, neonatal and child health; it supported free access to health-care services, as had already been endorsed by resolutions WHA58.31 and WHA58.33; and it highlighted the strengthening of health systems with the provision of responsive, resourced emergency care. Emphasizing renewed commitment in the short time left to achieve Goals 4, 5 and 6, his organization had launched a global campaign for child survival, called Every One.

Dr EVANS (Assistant Director-General) identified the common elements of the discussion, including: rights and equity, affordable and accessible services, health systems with appropriate and adequate workforces, and a whole-society approach to health care. There would be opportunities for progress in the short-term, such as the high-level meeting of the United Nations General Assembly due to be held in September 2010. In the longer term further developments would be required after the 2015 deadline. He had taken note of specific calls for enhancing standardization in maternal and neonatal health. Good progress had been made in increasing capacity for monitoring and measurement, with more real-time information being used than models and estimates, in particular in small populations and during rare events. In response to the request for a regional breakdown of information, he said that more detailed regional information would be provided in the World health statistics report to be published in time for the next Health Assembly in May.

The DIRECTOR-GENERAL welcomed the consensus on the urgent need to achieve the Millennium Development Goals before 2015, but recalled that 2015 would not be the end of efforts. She affirmed the importance of an integrated approach to meeting the health-related Goals, and the inclusion therein of programmes relating to noncommunicable diseases. In addition, equitable access to primary health care was essential. Important regional and national meetings to assess progress on attainment of the Goals would be held in 2010, and she expressed the hope that related events would also take place during the next session of the Health Assembly. She thanked the member for Brazil for the offer to host a global forum on social determinants in health in 2011. With regard to the importance of an Organization-wide strategy, she said that such a strategy was already being developed, having begun with the need for an integrated approach to HIV/AIDS. She encouraged members to adopt the draft resolution by consensus.

(For adoption of the resolution, see summary record of the seventh meeting, section 2.)

**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) (continued from the fifth meeting)

Dr SEDYANINGSIH (Indonesia), reporting on the outcome of the informal consultations, said that participants had agreed that negotiations between the Member States should be conducted by an open-ended working group, using as a basis the report by the Director-General on the outcome of the

resumed Intergovernmental Meeting on Pandemic Influenza Preparedness.<sup>1</sup> The proposal was that, in order to optimize the use of WHO's resources, the group should convene on 10, 11 and 12 May 2010. The group would aim to reach agreement on remaining elements under the pandemic influenza preparedness framework and to report on the outcome to the Sixty-third World Health Assembly. The Director-General was requested to facilitate that process.

Dr OMI (Japan) expressed support for the proposal but emphasized the need to avoid repetitive discussions and to resolve problems. He therefore urged Member States, in the interests of consensus, to consider and prepare concessions in advance of the proposed meeting.

Dr DODDS (Canada) echoed that support. She suggested that the working group could also refer to the Director-General's consultation with Member States on proposals to finalize remaining elements under the framework.<sup>2</sup>

The CHAIRPERSON said that he took it that the Executive Board wished to agree to the proposal outlined by the member for Indonesia.

**It was so decided.**

The DIRECTOR-GENERAL said that she would do her best to facilitate the agreed process but that it might be necessary to approach Member States for the additional funding that would undoubtedly be required, notwithstanding the cost-effectiveness of convening the meeting in the days preceding the Health Assembly. Concerning the Board's earlier request for a review of the pandemic (H1N1) 2009 and the functioning of the International Health Regulations (2005), she would appreciate further guidance. To that end, she would prepare a summary of the review mechanism that she had suggested at the time, including information on the intended components and scope of the review.<sup>3</sup>

Dr DAHL-REGIS (Bahamas) appealed for every effort to be made to finalize the remaining elements under the pandemic influenza preparedness framework at the meeting to be held in May 2010, thereby ending a process that had been time-consuming, labour-intensive and costly.

**The Board noted the report.**

**International recruitment of health personnel: draft global code of practice:** Item 4.5 of the Agenda (Document EB126/8)

Mr DE CAMPOS (alternate to Dr Buss, Brazil) welcomed the fact that the matter had been debated among the six regional committees and that the outcomes of those discussions had been incorporated into a revised draft code of practice. Those advances having been achieved, it was time to move ahead.

Human resources being the key to building a strong health system, Brazil had a national secretariat for dealing with the education and working conditions of its health workforce. It had also participated in international meetings aimed at highlighting those resources. His country was not yet directly affected by the migration of health-care personnel; however, such movement was likely to increase in today's globalized world. He therefore supported the immediate adoption of the draft code

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<sup>1</sup> Document A72/5 Add.1.

<sup>2</sup> Document HSE/GIP/PIP/2009.1.

<sup>3</sup> See document EB126/INF.DOC./3.

as a first step towards bringing the issue to the fore, and looked forward to its wide implementation by Member States.

Dr OULD HORMA (Mauritania), speaking on behalf of the Member States of the African Region, said that the increasing migration of health professionals to the richer countries weakened the fragile health systems in the Region and threatened the achievement of the health-related Millennium Development Goals. The current version of the draft code gave rise to concerns, including: the need for a sizeable return on investment to enable the training of health personnel in developing countries; the non-binding character of the draft code, and the lack of any clear mechanisms for dispute resolution; reciprocal benefits and the failure to recognize the detrimental effect of recruitment on countries with poor health systems; protection of the rights of health workers; and the legal implications of restrictions on the free movement of such workers.

A database on human resources for health in African countries was available, established with the aim of aiding decision-making. Policies for retention of the health workforce in rural and remote areas had also been documented in two African countries in order to assist WHO in its task of developing guidelines and recommendations on the subject. As was the case in Mauritania, such retention was encouraged through, *inter alia*, improved planning and management of human resources for health, salary reviews, incentive measures, and enhanced working conditions. The challenge was to mobilize sufficient resources to implement such measures, including any code of practice on international recruitment of health personnel.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, the candidate countries Croatia, Turkey and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro, Serbia, as well as Ukraine, the Republic of Moldova and Armenia, said that the draft code, for which the European Union and the European Region had expressed support, was more accurate and structured in its preamble, and its content should have a positive impact on health systems in developing countries and countries with economies in transition. Its multisectoral approach to tackling structural problems was also a proven key to addressing weak health systems. He welcomed the call for national policies and measures for a sustainable workforce, workforce planning and retention. Data availability and resource constraints should also be taken into account, as the formulation of evidence-based policies demanded systems for reliable data collection and monitoring of the migration of health personnel. He also proposed that national measures, and the role of decentralized authorities, should be mentioned in the preambular paragraphs and definitions of key concepts provided in an annex.

While understanding the need for compromise, the European Union had difficulty with articles 4.2, 7 and 8. It was essential to avoid the impression that individuals were to be held responsible for development in their country of origin or that their right to leave was to be restricted. Policies that could lead to discrimination in the immigration process on grounds of nationality or profession were similarly to be avoided. The financial and administrative implications of the revised draft code should also be specified, particularly in the context of articles 7 and 8, which were potentially demanding. In the area of data-gathering, WHO would do well to cooperate with OECD in order to avoid overlap and ensure high quality data. The voluntary financial mechanisms mentioned in articles 3.3 and 11.3 also required clarification, as did the applicability of article 5.4. He called on the Secretariat to arrange consultations on the draft code, which should be submitted to the Sixty-third World Health Assembly for consideration.

Dr DODDS (Canada) fully supported the overall intent of the draft code. On its basis her Government had developed a unified approach to the recruitment of health personnel that reflected the challenges of the Canadian federation and its multiple jurisdictions. The current draft of the code posed challenges to Canada in so far as the primary responsibility in matters of health personnel resided at the subnational level. The meaning and intent of articles 4 and 5 required clarification. In view of those concerns, she proposed that Member States should exchange comments and suggestions

on the text through the Internet, with a view to finalizing the draft. A revised version of the draft code, taking into account the views expressed, could then be produced for consideration by the Health Assembly.

Mr PETERU (alternate to Ms Toelupe, Samoa) said that the consultations held by the regional committees on the draft code had addressed many of the concerns regarding the specific needs of source countries such as Samoa. He therefore supported the draft code.

Dr ABABII (Republic of Moldova) said that in his country, in addition to international migration of health personnel, internal migration had a dire effect on the population's access to health care: from the health-care system to other branches; from the public to the private sector, including pharmaceutical companies; and from rural to urban areas. In response, the Government was providing financial incentives to physicians practising in rural areas and had legislated to improve the career prospects of newer members in the medical professions.

The impact of losing large numbers of health-care professionals to foreign countries had not been solely negative. Working abroad, health personnel had improved their living conditions, acquired valuable experience in using the latest technology, and mastered foreign languages. However, the difficulty was in keeping track of the rapid pace of that brain drain; hence the need to develop an international monitoring mechanism, as the draft code envisaged.

The ethical principles set out in the draft code, designed to achieve a balance between the rights and obligations of source and destination countries, were in line with contemporary needs. Significantly, the draft code applied to health personnel in both the public and private sectors. Equally important, destination countries should provide technical and financial assistance to source countries aimed at strengthening their health systems. The draft code should also delineate mechanisms for, if not international, at least regional accreditation for schools of medicine and the licensing of physicians, over which WHO must have authority. It took nine to eleven years to train a physician, and a mechanism must be envisaged under which destination countries could compensate source countries public funds spent on such training. The same principle should be applied domestically when health personnel migrated to the private sector.

He requested support in strengthening health-care systems and in training health personnel in countries like his own with economies in transition.

Dr STARODUBOV (Russian Federation), supporting the revisions made to the draft code, considered that clearer wording would facilitate its practical application. The adoption and subsequent application of the draft code by Member States should promote an equitable balance of interests among source and destination countries.

In line with current international practice regarding non-binding instruments, the draft code was intended to facilitate voluntary compliance at the national and international levels, through bilateral agreements, and voluntary mechanisms for the exchange of information and monitoring. In developing the draft code, the regional offices had already begun working on regional coordination and exchange of information, yet no coordinating role was envisaged for them under the draft code.

The migration of health personnel occurred in all countries, including his own, which acted as both a source country and a destination country. Like most Member States, it already applied the principles set out in the draft code and provided educational opportunities for health personnel from other countries, which included reference to bilateral agreements. In future, the use of distance learning for physicians from foreign countries would be expanded. The Russian Federation's existing system for monitoring the lawful migration of workforces did not yet take account of the specificities of health workforce migration. It would like to gain from the experience of WHO and OECD in creating special national and regional databases on the migration of health personnel and was prepared to exchange information with interested countries. The Russian Federation would support further efforts to achieve agreement on the draft code.

Ms ROCHE (New Zealand) said that, as work to refine the draft code continued, it must be recognized that individuals made personal choices about whether to live and work in a different country; that governments needed to manage migration; and that health-service provision must operate within a global health workforce. Recognizing the progress made, New Zealand sought greater clarity with regard to the rationale for global employers of health workers to adopt and implement the draft code; further elaboration of WHO's role in supporting implementation; and better reflection of the global nature of the issue. It supported the suggestion by the Health Worker Migration Global Policy Advisory Council that in the title of article 6, the word "national" be deleted so that it read "Health workforce sustainability and retention".

New Zealand sought recognition of the challenges faced by small island States that often struggled to meet the needs of their widely dispersed populations. Specific objectives and indicators that took account of Member States' capacities would need to be agreed on and used for reporting on eventual implementation of the code. She supported the suggestion by the member for Canada of a web-based consultation because it would enable small countries to participate fully. She suggested that, as had been done for the Commonwealth Code of Practice for the International Recruitment of Health Workers, the WHO draft code, once adopted, should be submitted to relevant stakeholders.

Mr PRASAD (adviser to Ms Sujatha Rao, India), emphasizing the threat posed to already fragile health systems in developing countries by health-worker migration, suggested some further amendments to the draft code. Article 2 should be strengthened to ensure that the draft code applied to all types of health workers, and that should be described in an accompanying glossary. Clear guidelines should be introduced: in article 3.5 to ensure fairness and transparency in recruitment; and in article 9 for implementation of the code by Member States, with particular reference to the private sector. Under article 4.2, migrant health workers should be required to declare legal obligations in their source country to recruiters in the destination country, and under article 4.3 they should have access to detailed job descriptions. Under article 5 or 6, Member States should be required to support migrants wanting to return to source countries; and should be provided with guidelines for systems to redress grievances arising during recruitment and employment. India would welcome a draft global code of practice that responded to the needs of countries that were investing in their health workforce only to lose a good share of it to migration. However, he suggested further examination of the draft code's compatibility with ILO's existing provisions, notably on migration, human rights and freedom of movement: a code specific to the health sector might have discriminatory repercussions in other sectors.

Professor HAQUE (Bangladesh) said that his country suffered from a shortage of health workers but did not oppose their migration to other countries, out of a respect for individual human rights; for the opportunities to gain experience from other work settings in other countries; to promote technology transfer; and to foster flows of remittances back to Bangladesh. The draft code could protect migrants from ill-treatment in destination countries, and the provisions on mutuality of benefits in article 5 were especially noteworthy. A meeting of stakeholders in Bangladesh in 2009, while endorsing most of the draft code, had observed that the costs of training skilled health workers called for a mechanism for destination countries to compensate source countries for their investment, either in monetary terms or through support for the development of their health systems and personnel. They had also emphasized equal treatment of migrant health workers, irrespective of race, religion, age or gender; had suggested that authority for implementation of the draft global code at the national level should lie with ministries of health; and had advocated that source and destination countries should examine ways to prevent migration flows from being influenced by a sudden surge in "push-and-pull" factors.

Dr GIMÉNEZ (Paraguay) said that the situation of the health workforce in his country perhaps epitomised J.T. Hart's "inverse care law", with the fewest workers available where they were most needed. Migration had reduced the size of the workforce to less than half the minimum recommended by WHO, and regional and national statistics showed a deep rural-urban divide. In response, the Government had developed a strategy for human resources based on the Toronto Call to Action

(2005). The draft code might be short on ambition or too general in parts, but it represented a huge step in the right direction and, once adopted, would be of great importance to countries like Paraguay. Expressing particular satisfaction with the provisions under article 5.2, which set out specific measures for ensuring mutuality of benefits, he endorsed the draft code.

Ms ARTHUR (alternate to Mr Houssin, France) acknowledged the efforts to prevent the migration of qualified health workers from further weakening the fragile health systems of developing countries. Adoption of the draft code would be a step towards strengthening those systems, with further work needed after that, for example in regard to good recruitment practices. The revised draft code represented a significant improvement: the preamble clarified the challenges; the principles of ethical recruitment and equality of treatment implied a reference to duties as well as rights; there was improved balance between respect for the freedom of movement of health workers in search of better opportunities, and the impact on health systems in source countries; and article 6 underscored the importance for all countries to formulate management policies for their health workforce. Data-gathering would be essential for implementation of the code, and she commended the joint approach of WHO and OECD to improving the availability and comparability of data, including plans to hold a workshop in June 2010 to identify useful data sources and the types and scope of data required. The consultation process should continue and France would work with other partners to finalize the draft code for adoption at the next Health Assembly.

Dr DAHL-REGIS (Bahamas), noting that the principles contained in the draft code were clearly in line with the Commonwealth Code of Practice, which had been endorsed by every country in the Caribbean region, welcomed the suggestion of the member for New Zealand. Yet clarifications were still required. The ground had shifted in her region: the Bahamas, once chiefly a source country, had become both a source and a destination country after having had to restore its health system. She supported the proposal to hold a web-based consultation to examine the language of the draft code: additional consultations of some kind were in order before a finalized document could be submitted to the Sixty-third World Health Assembly.

Dr OMI (Japan) supported the revised draft global code of practice. It was comprehensive and reflected the need, repeatedly emphasized by his delegation, to stress the voluntary nature of the code.

Dr MOHAMED (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the review process had identified the strengths and weaknesses of the draft code, enabling submission of the draft code to the forthcoming Health Assembly with a view to its subsequent implementation. As already pointed out, the migration of health personnel had its positive aspects; remittances sent to source countries, for example, could be used to great advantage, both in their health sectors and elsewhere.

For its part, the Regional Office for the Eastern Mediterranean worked in close coordination with the Member States of the Region in order to build their health capacities. Through its focus on poorer countries, it had lent support for education facilities and training activities in such countries as Djibouti, Somalia and the Sudan. Changing work conditions were, however, creating difficulties in connection with the recruitment of health personnel. Wages in source countries, for instance, were starting to compete with those paid in destination countries. He expressed support for the draft global code of practice and looked forward to its implementation, on which basis it could then be further revised and amended, as necessary.

Ms DLADLA (South Africa)<sup>1</sup> expressed appreciation for the principles and objectives of the draft code and its potential to protect the interests of developing countries. However, she agreed with the member for the Bahamas on the need for clarifications and some form of consultation. One key point was whether the draft code could, in its present form, ensure a fair return on the investment made in the training of health workers by developing countries, including those in some of the neediest parts of the world. Another was mutuality of benefits, which had been articulated well in the Commonwealth Code of Practice. On the matter of gains and losses of health personnel migration, she asked the Secretariat to clarify exactly what those gains were and, further, to explain why the draft code attributed a statement concerning the balance of gains and losses to the African Region when no mention of the subject had appeared in either the report or the resolutions of the Regional Committee for Africa at its fifty-ninth session.

Ms NYAGURA (Zimbabwe), supporting the comments made by the representative of South Africa, said that hers was one of the countries hardest hit by continuing migration of health workers, weakening the country's health system and had hindering its progress in achieving the health-related Millennium Development Goals. The draft code must redress the inherent inequalities between source and destination countries. The rights of the individual must be upheld, but individuals had to cooperate fully with the State to ensure that all people enjoyed the highest attainable standard of health. That concept of cooperation should be incorporated into the guiding principles of the draft code to bring it into line with the WHO Constitution. The draft code had been sufficiently developed in the course of regional consultations to provide a basis for negotiation at the next Health Assembly. She could agree to the proposal by the member for Canada to conduct web-based consultations as long as the outcomes were not incorporated into the final document; and it was fully prepared to participate constructively in the negotiations to finalize the draft code at the Health Assembly.

Dr NEIKNAM (Islamic Republic of Iran)<sup>1</sup> welcomed the revised text of the draft code, which incorporated specific changes requested by the regional committees. The international migration of health workers was a global health challenge that called for multidimensional solutions. While health workers had a human right to migrate to countries that agreed to admit and employ them, large-scale migration could have a devastating impact on the health systems of source countries. The draft code should accordingly include a recommendation that Member States limit international recruitment from countries with critical shortages to their health workforce. It should also promote the formulation and implementation of bilateral and multilateral agreements based on the principle of mutuality of benefits. Nationalization of medical education, and matching education with local health needs were safeguards against the migration of health workers from developing countries to destination countries and should be promoted by the Secretariat and Member States.

Mr BIÉLER (Switzerland)<sup>1</sup> said that more than one third of health workers in Switzerland came from foreign countries, mostly neighbouring countries. Yet Switzerland was fully aware of the damage done by unauthorized recruitment of physicians and nursing staff from countries where the health systems were most vulnerable. The time had come to strengthen those health systems, in order to address the root of the problem.

The formulation of an effective draft code of practice had immediately appealed to his Government, which had been studying the phenomenon of migration and brain drain. In order for such a draft code to make an impact on national policy, however, it must define more precisely the measures proposed, the partners involved, and the States that would be adopting its recommendations. Regional consultations had suggested that a clearer distinction should be drawn between recommendations to States and to other health care partners; that the wide variations in national legislation on recruitment must be taken into account; and that the concepts of self-sustainability and

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



of compensation should be elaborated. Taking such concepts into account would ensure that the most important elements of the draft code were in line with the legislative capacities of States for practicable implementation. The limited capacities of States with decentralized decision-making powers should not be overlooked. Holding a meeting to finalize the draft code before the Health Assembly was preferable to a web-based consultation.

Mr HOHMAN (United States of America)<sup>1</sup> said that he was aware of the responsibility shared by all to help to alleviate the international shortage of health workers. Working together, countries could begin to find sustainable alternatives that benefited everyone. The draft code had been considerably improved by the views expressed during the regional committee meetings, yet serious concerns remained.

The document should be structured more as a set of guiding principles and less like a legislative act. It should not link provision of development assistance to recruiting practices. It should address the situation in federal States. All countries had legitimate needs and interests, but the document should not attempt to balance rights, which might imply that the rights of one group were more important than those of another. Most importantly, nothing in the draft code should undermine the human rights of health workers who were in the process of migrating.

He supported requests for an opportunity for Member States to contribute further to the draft, perhaps initially through a web-based consultation.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)<sup>1</sup> said that the revised draft code was more balanced, but he agreed with the representative of the United States that further improvement was needed. There were far too many square brackets; a clean text should be sent to the Health Assembly. He suggested that in the fourteenth preambular paragraph, the words “and social obligations” should be inserted between “the rights” and “of health personnel”, in order to ensure a proper balance. Article 3.4 would then have to be amended accordingly. The sixteenth preambular paragraph was unclear and its relevance was questionable. He agreed with the wording suggested by the member for India for article 4.2. The title of article 7 should read “Evidence basis for policy decisions”. He would welcome any opportunity to fine-tune the text in advance of the Health Assembly.

The CHAIRMAN asked the representative of Thailand to submit his suggestions in writing.

Dr OULD ABDI SALEM (adviser to Dr Ould Horma, Mauritania), speaking on behalf of the Member States of the African Region, said that he was open to any practical suggestion that would take into account the Region’s specificities. The draft code had been the subject of lengthy consultations with all regional committees and was a good basis for negotiation, which could take place at the next Health Assembly. He had reservations, however, about the proposal to use a web-based consultation as a tool for revising the current text.

Ms TIJTSMA (Medicus Mundi Internationalis – International Organization for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, welcomed the revised version of the draft code, with its emphasis on the roles and responsibilities of destination countries. Monitoring of the code should be a transparent process inclusive of all relevant stakeholders. Article 3 of the draft code should stress the obligation of countries both to strengthen their own health systems and to provide international cooperation and assistance; and it should call for more coherent domestic and international policies. The concept of shared responsibility should be added to article 5. Her organization urged countries that were reliant on foreign health workers to share the responsibility of supporting human resources for health in source countries.

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

The title of the draft code should be amended to include the word “ethical”. The preamble should highlight the fact that development measures for the domestic workforce and incentives offered by destination countries actually increased the international movement of health workers. The draft code should be submitted to the next Health Assembly.

Mr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN and on behalf of the International Pharmaceutical Federation, the World Dental Federation and the World Medical Association, which together formed the World Health Professional Alliance, said that balance was needed between the rights of individual health workers and the right to health of the populations of source countries. The draft code should apply to both the public and the private sector and to both permanent and temporary staff. His organization welcomed the provisions of article 4 on responsibilities, rights and recruitment practices and article 6 on national health workforce sustainability and retention. However, the term “active recruitment”, which appeared in article 5.3, was not defined, and therefore it was not clear how the proposed ban on it would be implemented.

He welcomed the provision in paragraph 9.5 that encouraged Member States to maintain a record of and monitor authorized recruiters, and the proposed system of reporting by Member States to the Secretariat (paragraph 10.1), which would allow WHO to monitor the status of migration of health workers and its impact on health systems throughout the world. He supported the revised draft, which should be submitted to the Health Assembly in May.

Mr PRASAD (adviser to Ms Sujatha Rao, India) supported the amendments proposed by the representative of Thailand.

Dr ETIENNE (Assistant Director-General) thanked participants for their valuable comments and their suggested amendments, which the Secretariat would endeavour to reflect in the draft, as it had done with the views expressed during the discussions by the regional committees.

The DIRECTOR-GENERAL asked how the Board wished to proceed. A small number of members appeared to be prepared to adopt the current draft straight away. The majority wanted more negotiations, either in a face-to-face meeting or via a web-based consultation, while a third group felt that the current draft should be submitted to the Health Assembly for negotiation and adoption by all Member States. Some had said that they would not accept any amendments proposed in the course of web-based consultations, and the latter would consequently be of limited value.

Mr DE CAMPOS (alternate to Dr Buss, Brazil) said that, if the Board sent the draft round for yet more consultations, it would be no nearer finalization than the previous year. The issue was urgent, and the draft code should be adopted as soon as possible.

The CHAIRMAN noted the remark in paragraph 10.5 of the draft that the draft code should be considered a dynamic text which would be updated as required.

Mrs NYAGURA (Zimbabwe)<sup>1</sup> said that a web-based procedure could be used to clarify the positions of the various parties, but the draft should not be changed.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)<sup>1</sup> recalled that, in the previous web-based consultations held in September and October 2008, responses from professional organizations that dealt with migrant workers had far outnumbered those from the developing countries which were most affected. Views obtained via the Internet would inevitably constitute a biased sample.

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

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, said that there had already been ample opportunity for consultations and that he was not, therefore, in favour of a web-based consultation. They had a number of comments and amendments to suggest, and other parties had made suggestions during the current meeting: all of them must be reflected. It was essential that the draft code be adopted by the next Health Assembly, without further delay.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that the Board had already spent a great deal of time at the current session discussing procedural matters. It should take a decision so that it could move on to the rest of its agenda.

Dr GIMÉNEZ (Paraguay) said that his country had endorsed the draft code as it stood. The Secretariat had the tools, leadership skills and institutional authority to produce a final text that could be adopted by the Health Assembly.

Dr OMI (Japan) said that there had already been enough consultation on the text, which was not as controversial as some others. He agreed with the points raised by the representative of Thailand. The suggestions made at the current meeting should be incorporated into the draft and it should be transmitted to the Health Assembly for consideration.

Dr MOHAMED (Oman) said that the text should be checked for any errors but should otherwise be considered ready for adoption.

The DIRECTOR-GENERAL said that she would submit the draft text without any amendments to the Health Assembly.

Mr HOHMAN (United States of America)<sup>1</sup> said that his delegation, for one, had more substantive amendments to suggest. Comments and proposed amendments from all Member States could certainly be collected together and submitted to the Health Assembly, but would they be incorporated into the current draft, or would that go forward unchanged?

The CHAIRMAN said that the general principles behind the text appeared to be agreed. Delegations should submit their comments and amendments; they would be incorporated into the text in brackets, if that could be done easily, or submitted separately to the Health Assembly.

Dr OMI (Japan) suggested that interested delegations should discuss their proposed amendments with the Secretariat, so that consolidated agreed text could be incorporated before the document was transmitted to the Health Assembly.

Dr SADRIZADEH (Islamic Republic of Iran)<sup>1</sup> said that sufficient discussion had been held. The Secretariat should prepare a final revised draft for review by the Health Assembly, taking into account the points raised at the current meeting.

The DIRECTOR-GENERAL suggested that the current draft should not be changed, since it reflected the views of the regional discussions. Comments or amendments submitted by Member States would be forwarded separately to the Health Assembly for consideration.

**It was so agreed.**

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

Replying to a question from Dr OULD ABDI SALEM (alternate to Dr Ould Horma, Mauritania), speaking on behalf of the Member States of the African Region, the DIRECTOR-GENERAL said that the comments and amendments would be summarized in a separate document, for the information of Member States.

**The meeting rose at 18:10.**

## **SEVENTH MEETING**

**Thursday, 21 January 2010, at 09:10**

**Chairman:** Dr S. ZARAMBA (Uganda)

### **1. ORGANIZATION OF WORK**

Dr KÖKÉNY (Hungary) said that the European Union and the group of Latin American and Caribbean countries had held an informal discussion the previous day on agenda item 4.10 on strategies to reduce the harmful use of alcohol. Both regional groups were keen to adopt the strategy, but recognized the need for further textual adjustments in a few areas. He invited representatives from all interested regions to hold further informal discussions with the European Union that morning in order to map any areas of major concern.

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

**Monitoring of the achievement of the health-related Millennium Development Goals:** Item 4.4 of the Agenda (continued from the sixth meeting)

The CHAIRMAN drew attention to a revised version of the draft resolution on monitoring of the achievement of the health-related Millennium Development Goals proposed by Albania, Argentina, Armenia, Australia, Austria, Belgium, Bulgaria, Canada, Chile, Colombia, Congo, Croatia, 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, Uruguay and Zimbabwe, which read:

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

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

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<sup>1</sup> Document EB126/7.

particular ~~the Monterrey Consensus of 2002, [Brazil]~~ 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;

**Concerned by the fact that achievement of MDGs varies from country to country and from goal to goal; [AFRO]**

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, **inter alia through capacity building, transfer of technology, sharing of best practices and lessons learned, South-South cooperation, as well as predictable resources;**

**Recalling the agreement reached at the United Nations International Conference on Financing for Development, held in Monterrey in March 2002, to "urge developed countries that have not done so, to make concrete efforts towards the target of 0.7% of the gross national product as official development assistance"; [Brazil]**

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;~~

Welcoming **increasing efforts to improve the quality of official development assistance and to increase its development impact, such as the Development Cooperation Forum of the Economic and Social Council, the commitments by many countries [Brazil]** in the Paris Declaration and the Accra Agenda for Action, **and the experience of the IHP and others, to strengthen** ~~to~~ national ownership, alignment, harmonization and managing for results, ~~and the experience of the International Health Partnership and others; [USA]~~

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 health<sup>1</sup> 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, **and recalling the importance of preventing infectious diseases that still represent a heavy burden, particularly in developing countries**, 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 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, **infectious and noncommunicable [China]** 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

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

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, **in particular inappropriate infant and young child feeding practices [AFRO];**

(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)~~(7) to maximize synergies between the HIV/AIDS response and strengthening of health systems and social support;

~~(9)~~(8) to enhance policies to address the challenges of malaria including monitoring of drug resistance in artemisinin-based combination therapy;

~~(10)~~(9) 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)~~(10) to sustain commitments to support the eradication of poliomyelitis;

**(11) to include in bilateral and multilateral initiatives addressed to the achievement of the Millennium Development Goals, in particular in South-South cooperation initiatives, best practices in strengthening health services;**

**(12) to support developing countries in their national endeavours to achieve the Millennium Development Goals, in particular the health-related MDGs, inter alia through capacity building, transfer of technology, sharing of lessons learned and best practices, South-South cooperation, as well as predictable resources;**

**(13) to fulfil their commitments regarding official development assistance by 2015;**

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 **and fragmentation of aid, as well as promoting the coordination of work among international agencies;**

(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-;

**3. INVITES concerned organizations of the United Nations system, international development partners and agencies, international financial institutions, nongovernmental organizations and private sector entities:—(1) 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 health development plans, consistent with internationally agreed health goals, including the Millennium Development Goals. [AFRO]**

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, drew attention to some further revisions that are to be made following informal consultations; the ninth preambular paragraph should read: “Recalling the Monterrey Consensus of March 2002 ‘to urge developed countries that have not done so, to make concrete efforts towards the target of 0.7% of gross national product as official development assistance’ and ‘encourage developing countries to build on progress achieved in ensuring that ODA is used effectively to help achieve development goals and targets’;” thereby reflecting the wording of paragraph 42 of the Monterrey Consensus.

The eleventh preambular paragraph should read: “Welcoming increasing efforts to improve the quality of official development assistance and to increase its development impact, such as the Development Cooperation Forum of the Economic and Social Council, the principles contained in the Paris Declaration, the Accra Agenda for Action and the experience of the International Health Partnership and others to strengthen national ownership, alignment, harmonization and managing for results;”.

Referring to proposals from other delegations concerning paragraphs 1(4) and 1(5), he observed that the pre-existing paragraphs used United Nations texts that contained agreed language, namely resolution WHA62.14 for paragraph 1(4); and paragraphs 15 and 16 of the Ministerial Declaration of the United Nations Economic and Social Council for paragraph 1(5). In the case of paragraph 1(4), the growing burden of noncommunicable diseases was referred to in the last preambular paragraph, and it seemed redundant to add another reference to them in an operative paragraph, particularly as that might prejudice ongoing discussions at the United Nations on a possible new Millennium Development Goal target.

As the issue of nutrition would be covered in a separate item on the agenda, the proposal made on feeding practices could be deleted from paragraph 1(5).

Dr LIU Peilong (China),<sup>1</sup> agreeing that noncommunicable diseases were not explicitly part of the Millennium Development Goals, stressed their relevance to achievement of the targets; the reference to them should be retained. The international community had expended huge efforts in the past 10 years to control the three communicable diseases: malaria, tuberculosis and HIV/AIDS; however, Member States should also be urged to take action to reduce the great burden of noncommunicable diseases, in both developing and developed countries.

Ms TOELUPE (Samoa) said that her small country had a considerable problem of noncommunicable diseases and therefore supported the position of the representative of China.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, said that it was sufficient to mention noncommunicable diseases in the preamble as they would be considered under a separate agenda item.

Dr MOHAMED (Oman) suggested that the addition of the phrase “poverty-related” would enable a link to be made between noncommunicable diseases and the Millennium Development Goals.

Mr KABULUZI (Malawi), speaking on behalf of the Member States of the African Region, explained that the reference to feeding practices had been included because the subject of the draft resolution was the Millennium Development Goals and especially Goal 4, and the importance of feeding in reducing child mortality was well known. The intent of adding a call to redress inappropriate feeding practices was to promote, by implication, the type of appropriate feeding recommended by WHO. However, he would be flexible and agree to the omission of the reference to feeding practices.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, thanked the member for Malawi for his flexibility and agreed to the retention of the reference to noncommunicable diseases in paragraph 1(4).

Mr ALBUQUERQUE E SILVA (adviser to Dr Buss, Brazil) expressed his country’s appreciation for the recognition of its concerns about official development assistance.

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

**Infant and young child nutrition: quadrennial progress report:** Item 4.6 of the Agenda (Document EB126/9)

The CHAIRMAN drew attention to the draft resolution proposed by Peru and the associated financial and administrative implications, which read:

The Executive Board,  
Having considered the quadrennial progress report on infant and young child nutrition,<sup>3</sup>

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

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

<sup>2</sup> Resolution EB126.R4.

<sup>3</sup> Document EB126/9.

The Sixty-third World Health Assembly,  
Having considered the quadrennial progress report on infant and young child nutrition;

Recalling resolutions WHA35.26, WHA37.30, WHA39.28, WHA41.11, WHA43.3, WHA45.34, WHA46.7, WHA47.5, WHA49.15 and WHA54.2 on infant and young child nutrition and WHA59.11 on nutrition and HIV/AIDS;

Conscious that achieving the Millennium Development Goals will require the reduction of maternal and child malnutrition;

Aware that worldwide malnutrition accounts for 11% of the global burden of disease, leading to long-term poor health and disability and poor educational and developmental outcomes; that worldwide 178 million children are underweight and 20 million suffer from the most deadly form of severe acute malnutrition each year; and that nutritional risk factors, including underweight, suboptimal breastfeeding and vitamin and mineral deficiencies, particularly of vitamin A, iron and zinc, are responsible for 3.9 million deaths (35% of total deaths) and 144 million disability-adjusted life years (33% of total disability-adjusted life years) in children less than five years old;

Aware that countries are faced with increasing public health problems posed by the double burden of malnutrition (both undernutrition and overweight), with its negative later-life consequences;

Acknowledging that 90% of stunted children live in 36 countries and that children under two years of age are most affected by undernutrition;

Mindful of the challenges posed by the HIV/AIDS pandemic and the difficulties posed for formulating appropriate policies for infant and young child feeding, and concerned that food assistance does not meet the nutritional needs of young children infected by HIV;

Aware that inappropriate feeding practices and their consequences are major obstacles to attaining sustainable socioeconomic development and poverty reduction;

Concerned about the vast numbers of infants and young children who are still inappropriately fed and whose nutritional status, growth and development, health and very survival are thereby compromised;

Mindful of the fact that full implementation of the Global Strategy for Infant and Young Child Feeding and its operational targets requires strong political commitment and a comprehensive approach, including strengthening of health systems and communities and careful monitoring of the effectiveness of the interventions used;

Recognizing that the improvement of breastfeeding practices could save annually the lives of about one million children under five years of age and that each year the deaths of more than half a million such children could be prevented by adequate and timely complementary feeding;

Aware that, for successful scaling up of evidence-based safe and effective nutrition interventions, multisectoral food and nutrition policies are needed;

Recognizing the need for comprehensive national policies on infant and young child feeding that are well integrated within national strategies for nutrition and child survival;

Convinced that it is time for governments, civil society and the international community to renew their commitment to promoting the optimal feeding of infants and young children and to work together closely for this purpose;

Convinced that strengthening of national nutrition surveillance is crucial in implementing effective nutrition policies and scaling up interventions,

1. URGES Member States:

- (1) to increase political commitment to reducing malnutrition in all its forms;

- (2) to strengthen and expedite the implementation of the Global Strategy for Infant and Young Child Feeding with emphasis on giving effect to the International Code of Marketing of Breast-milk Substitutes, adopted in resolution WHA34.22, and also implementing subsequent related Health Assembly resolutions;
- (3) to develop or review current policy frameworks addressing the double burden of malnutrition and allocate adequate human and financial resources to ensure its implementation;
- (4) to scale up interventions to improve infant and young child nutrition, including the protection and promotion of breastfeeding and complementary feeding; the implementation of complementary and therapeutic feeding interventions for severe malnutrition; and the control of vitamin and mineral deficiencies;
- (5) to strengthen the nutrition surveillance system and adopt appropriate indicators for assessing progress towards achieving the Millennium Development Goals;
- (6) to implement the WHO Child Growth Standards by their full integration into child health programmes;

2. REQUESTS the Director-General:

- (1) to strengthen the evidence base on effective and safe nutrition actions to counteract the public health effects of the double burden of malnutrition and describe good practices for successful implementation;
- (2) to mainstream nutrition in all WHO's health policies and strategies and confirm the presence of essential nutrition actions in the context of the reform of primary health care;
- (3) to continue and strengthen collaboration with other United Nations agencies and international organizations involved in the process of ensuring improved nutrition;
- (4) to support Member States, on request, in expanding nutritional interventions related to the double burden of malnutrition, monitoring and evaluating impact, strengthening or establishing effective nutrition surveillance systems, and implementing the WHO Child Growth Standards;
- (5) to develop a comprehensive implementation plan on infant and young child nutrition for discussion at the Sixty-fifth World Health Assembly, through the Executive Board and after broad consultation with Member States.

**1. Resolution** Infant and young child nutrition: quadrennial progress report

**2. Linkage to programme budget**

Strategic objective:

2. To combat HIV/AIDS, tuberculosis and malaria

Organization-wide expected result:

2.1 Guidelines, policy, strategy and other tools developed for prevention of, and treatment and care for patients with, HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, and hard-to-reach and vulnerable populations.

2.2 Policy and technical support provided to countries towards expanded gender-sensitive delivery of prevention, treatment and care interventions for HIV/AIDS, tuberculosis and malaria, including integrated training and service delivery; wider service-provider networks; and strengthened laboratory capacities and better linkages with other health services, such as those for sexual and reproductive health, maternal, newborn and child health, sexually

	transmitted infections, nutrition, drug-dependence treatment services, respiratory care, neglected diseases and environmental health.
	2.4 Global, regional and national systems for surveillance, evaluation and monitoring strengthened and expanded to keep track of progress towards targets and allocation of resources for HIV/AIDS, tuberculosis and malaria control and to determine the impact of control efforts and the evolution of drug resistance.
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.	4.4 Guidelines, approaches and tools for improving neonatal survival and health applied at country level, with technical support provided to Member States for intensified action towards universal coverage, effective interventions and monitoring of progress.
	4.5 Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.	7.2 Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels to address social and economic determinants of health, including understanding and acting upon the public health implications of trade and trade agreements, and to encourage poverty reduction and sustainable development.
9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development.	9.1 Partnerships and alliances formed, leadership built and coordination and networking developed with all stakeholders at country, regional and global levels, in order to promote advocacy and communication, stimulate intersectoral actions, increase investment in nutrition, food-safety and food-security interventions, and develop and support a research agenda.
	9.2 Norms, including references, requirements, research priorities, guidelines, training manuals and standards, produced and disseminated to Member States in order to increase their capacity to assess and respond to all forms of malnutrition, and zoonotic and non-zoonotic foodborne diseases, and to promote healthy dietary practices.
	9.3 Monitoring and surveillance of needs and assessment and evaluation of responses in the area of nutrition and diet-related chronic diseases strengthened, and ability to identify best policy options improved, in stable and emergency situations.
	9.4 Capacity built and support provided to target Member States for the development, strengthening and implementation of nutrition plans, policies and programmes aimed at improving nutrition throughout the life-course, in stable and emergency situations.

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

- Guidelines on nutrition interventions to be reviewed and developed, scaling up from 10 to 40 guidelines.
- Monitoring child growth, infant and young child feeding practices, micronutrient status and implementation of nutrition interventions performed, scaling up from 50 to 70 countries implementing growth standards; 5 micronutrient surveys implemented; and implementation data collected in 150 countries.
- Interagency collaborative initiatives developed at global and country levels in order to scale up nutrition programmes: 5 initiatives.
- Technical support for scaling up nutrition interventions provided to 20 countries and capacity building provided to an additional 15 countries.
- Technical support provided to Member States in strengthening and implementing national nutrition policies and strategies to scale up action in tackling the double burden of malnutrition: an additional 15 countries provided with support.
- Technical guidance provided on priority nutrition actions aimed at the prevention of tuberculosis and support against HIV: an additional 15 countries provided with support.

**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)**

US\$ 12 million (staff: US\$ 5 million, activities: US\$ 7 million) for three years.

**(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)**

US\$ 8.5 million (staff: US\$ 4 million, activities: US\$ 4.5 million; breakdown across the Organization: headquarters – US\$ 2.5 million, regions – US\$ 6 million).

**(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)?**

A global resource mobilization plan is being prepared to approach potential donors. Partial funding has been provided by Italy, Japan, Luxembourg, Spain, United States of America and philanthropic bodies.

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

Although the normative work (including guidelines development and scientific reviews) will be carried out at headquarters, the majority of activities will be undertaken at country and regional levels. Priority will be given to the 36 countries identified by WHO upon which malnutrition places the highest burden of mortality and morbidity.

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

As already recommended in the review conducted of WHO's nutrition work, staffing needs to be strengthened. This is particularly the case at country level and in some of the regional offices.

**(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)**

Staffing needs to be strengthened in all regions, particularly in African, South-East Asia and Eastern Mediterranean Regions. There is a particular need for technical nutrition staff at the P.2 and P.3 levels.

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

Implementation of some activities under this resolution has already started in the current biennium. Most activities will be implemented by the first quarter of 2011.

Professor HAQUE (Bangladesh) said that in Bangladesh 200 children under the age of five years died of malnutrition every day, many from sepsis in the first 28 days of life because they had not benefited from the protective effects of breast milk given within one hour of birth or exclusive breastfeeding for six months. On a positive note, 92% of Bangladeshi mothers were still breastfeeding 20–23 months after giving birth. The country had baby-friendly hospitals and an ambitious national nutrition programme that covered about one third of the population, and which would be improved before being expanded nationwide.

The suggestion might be made to the United Nations Millennium Development Goals Gap Task Force to include early and exclusive breastfeeding for the first six months of life in the list of key indicators of child survival. Additionally, funding might be sought to intensify support to Member States for implementation of the International Code of Marketing of Breast-Milk Substitutes.

He commended the Secretariat's preparation of the WHO Child Growth Standards and recommended the strengthening of relevant programmes so that growth charts would be widely used to monitor the nutritional status of young children. Anaemia, which was a barrier to child development and prevalent in many developing countries, could be countered through exclusive breastfeeding for the first six months of life, followed by nutrient-dense complementary feeding and continued breastfeeding for the first two years of life.

Dr GOPEE (Mauritius), speaking on behalf of the Member States of the African Region, reported that a draft manual on implementing community activities on infant and young child feeding, prepared by the Regional Office for Africa, had been field-tested in Kenya. The Regional Office had also collaborated with IAEA on a five-year project to assess nutrition levels in the Region using isotope techniques.

Consensus had been reached on a framework to integrate nutrition into HIV/AIDS control programmes and five Member States had begun national training programmes for trainers in counselling and support for infant and young child feeding. Some countries in the Region had formulated national strategies on infant and young child feeding, plans of action for the Baby-friendly Hospital Initiative in the context of HIV/AIDS, or both.

National capacity building for the application of WHO Child Growth Standards was being pursued through direct technical support. Draft guidelines on the integration of nutrition into integrated disease surveillance and response had been drawn up.

Despite achievements in the Region, challenges remained; action should be taken to ensure technical support to countries in implementing policies, to build capacity to tackle malnutrition, to strengthen partnerships for resource mobilization, and to promote breastfeeding as the most effective way to improve the survival and health of children.

Dr SAID (Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, reported noticeable progress in infant and young child nutrition. Nevertheless,

the overall percentage of underweight children in the Region had increased from 14% in 1990 to 17% in 2004, owing to circumstances in certain countries such as Iraq, Sudan and Yemen; that situation had deteriorated since the beginning of the global food crisis.

A high rate of undernutrition and stunted growth among children was a result of inadequate practices at the health-care level, disease transmission, poor-quality foods and unsatisfactory dietary habits, particularly among poorer populations.

The implementation of the WHO Child Growth Standards was part of an overall effort to improve surveillance of child nutrition, and training was being given in their use. The Global strategy for infant and young child feeding had been incorporated into national programmes but information on the impact of implementation activities on young children was so far limited.

Breastfeeding was essential for protecting children's health, but was undermined by intense advertising campaigns for breast-milk substitutes. Exclusive breastfeeding must be promoted, even in situations of crisis, and Member States should ensure proper surveillance and assistance in health emergencies. Mothers should be given adequate information on the nutritional value of breast milk compared with substitutes while proper environmental assistance should be given, such as the provision of safe water.

He encouraged the implementation of the International Code of Marketing of Breast-Milk Substitutes by all countries and called on the Secretariat to provide assistance to that end. It should provide a list of indicators to facilitate monitoring infant and young child nutrition in lower-income countries and coordination should be established among interregional and international partners to ensure the provision of adequate resources.

Dr TAKEI (adviser to Dr Omi, Japan) emphasized the value of exclusive breastfeeding in improving infant nutrition. The progress made in putting the Global strategy for infant and young child feeding into practice at the national level was welcomed. In countries with high infant mortality rates in particular, action plans for implementation should be developed. Further, the Baby-friendly Hospital Initiative should be suitably promoted in accordance with health-care systems in individual countries.

An effective global outreach approach should be applied to the Partnership for Mother, Newborn and Child Health. Exclusive breastfeeding should be promoted not only on the basis of economic or scientific evidence, but also in the light of its importance for natural mother and child interaction.

Dr VALLEJOS (Peru) regretted that efforts to reduce malnutrition and improve feeding practices were irregular and inadequate. Greater commitment was needed from governments, civil society and the international community in order to counter malnutrition effectively and avoid the deaths of millions of people. That was the background for the proposal of the draft resolution. The text sought to increase the political commitment of Member States to reducing malnutrition in all its forms, to strengthen the Global strategy for infant and young child feeding and to secure sufficient human and financial resources to ensure its implementation, to incorporate the issue of nutrition into all WHO's policies, and to enhance a secure and effective nutritional database.

Informal consultations with other members of the Board had taken place since the drafting of the text and, in order to reflect the comments that had been made, he proposed the following amendments. In the fourth preambular paragraph, the word "iodine" should be inserted after "iron". In the tenth preambular paragraph, the word "full" should be deleted. In paragraph 1(2), the words "and also implementing subsequent related Health Assembly resolutions" should be deleted. In paragraph 1(4), the words "timely, safe and appropriate" should be inserted before the first mention of "complementary", while, at the second mention, "complementary" should be replaced by "supplementary". A new paragraph 1(5) should be inserted to read "to include these strategies in comprehensive maternal and child health services and supporting to the aim of universal coverage and principles of primary health care, including strengthening health systems as outlined in resolution WHA62.12". Paragraph 1(5), which would become paragraph 1(6), should be amended to read "to strengthen nutrition surveillance systems and improve use and reporting of agreed Millennium



Development Goal indicators to monitor progress". The words "including clear identification of leadership, division of labour and outcomes" should be inserted at the end of paragraph 2(3). Paragraph 2(5) should be amended by replacing "for discussion at the Sixty-fifth World Health Assembly" with "as a critical component of a global multisectoral nutrition framework for preliminary discussion at the Sixty-fourth World Health Assembly and for final delivery at the Sixty-fifth World Health Assembly".

Dr GIMÉNEZ (Paraguay), expressing support for the draft resolution and the amendments proposed by the member for Peru, nevertheless voiced concern that in many workplaces women were not provided with a room in which they could breastfeed. The right to breastfeed must be encouraged in both the public and private sectors: in the interests of gender equality and women's and children's rights, health institutions should set an example in that regard.

Remarking on the need to strengthen surveillance institutions, especially in view of the weak surveillance of marketing, advertising and consumption of breast milk substitutes, he drew attention to the importance of the renewal of primary health care and the improved results it would achieve.

Ms TOELUPE (Samoa) confirmed progress in infant and young child nutrition in her country as a result of the Baby-friendly Hospital Initiative. Significant challenges had been experienced in ensuring sustainability; strengthening community partnerships; widening the nutritional knowledge base; and making healthy eating more appealing within the home. She emphasized the need for adequate funding during the period 2010–2011 for national action on the International Code of Marketing of Breast-milk Substitutes in the Western Pacific Region. Even though exclusive breastfeeding was undoubtedly valuable in socioeconomic terms, Samoa planned to conduct an assessment of complementary feeding, severe, moderate and micronutrient malnutrition and childhood obesity.

She looked forward to the publication of the revised version of the Operational Guidance on Infant and Young Child Feeding in Emergencies; such guidance had been particularly needed during the pandemic (H1N1) 2009 and in the aftermath of the recent tsunami, when breastfeeding counselling and promotion among women had been a priority. WHO should strengthen technical assistance to small Pacific island States, where there were only a limited number of qualified nutritionists, in order to achieve progress on the issues referred to in the report.

Ms ARTHUR (alternate to Mr Houssin, France) underscored the importance of quality and safety in complementary feeding practices. Food safety for infants and young children depended on the hygienic practices of mothers and access to clean drinking water. Powdered formula distributed in times of crisis or to those living in extreme poverty could lead to infant deaths given that the water available was often contaminated.

She welcomed and supported the draft resolution.

Dr BUSS (Brazil) reported that programmes to encourage breastfeeding, particularly in the context of primary health care, had received much support in Brazil, where a broad family health programme gave coverage to six million people. The national strategy promoted breastfeeding beyond two years and, for that reason, he wished to propose an amendment to the draft resolution which otherwise he supported: the words "along with continued breastfeeding for up to two years or beyond" should be added at the end of the eleventh preambular paragraph.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) also welcomed and supported the proposed draft resolution. Undernutrition must be tackled as a matter of urgency by governments and international agencies, particularly if Millennium Development Goals 1, 4 and 5 were to be achieved by the deadline of 2015. A new strategy to counter undernutrition would be launched imminently by the Department for International Development in his country.

Dr LIU Peilong (China)<sup>1</sup> endorsed the report and expressed continued support for the joint WHO and UNICEF *Planning guide for national implementation of the global strategy for infant and young child feeding* issued in 2007. WHO should objectively assess implementation of the International Code of Marketing of Breast-milk Substitutes and propose recommendations for its improvement. WHO should link the issue of improving quality of service in maternal and paediatric health departments with that of management of baby-friendly hospitals to facilitate the selection of core indicators.

Dr MOHAMED (Oman) welcomed the proposed draft resolution, but asked for clarification of the reference made to breastfeeding beyond two years. Was there any scientific report on that?

Ms DLADLA (South Africa)<sup>1</sup> expressed support for the implementation of the International Code of Marketing of Breast-milk Substitutes. She called for increased advocacy on breastfeeding and infant and young child feeding, including beyond the health sector, though with particular focus on the Baby-friendly Hospital Initiative. Member States and other development partners should strengthen and provide adequate funding for community involvement and participation, as it was the critical element in ensuring breastfeeding,

Dr ALBRAIKY (alternate to Dr Al Darmaki, United Arab Emirates) expressed support for the draft resolution but recommended that it include reference to monitoring the content of breast-milk substitutes that were distributed at times of crisis or in natural disasters when it was difficult to breastfeed. Such monitoring should occur in order to assess whether it was appropriate, in terms of food security for infants, to offer those breast-milk substitutes.

Dr DAHL-REGIS (Bahamas) welcomed the draft resolution and endorsed the amendments and other comments put forward by other members of the Board. She supported the call to investigate the impact on women of breastfeeding beyond two years, as many women showed signs of significant health concerns as a result of prolonged breastfeeding.

Ms BLACKWOOD (United States of America)<sup>1</sup> expressed concern that the report did not give adequate emphasis to the role of nutrition in the integrated management of childhood illness, an area in which WHO would be the most appropriate agency to take a lead role. She would welcome an analysis by WHO of the scientific and programmatic evidence of the impact of the International Code of Marketing of Breast-milk Substitutes on infant and young child nutrition in those countries that had incorporated the Code into national legislation.

Noting WHO's coverage of intrauterine growth retardation as a cause of malnutrition, she considered the Organization to be suitably positioned to make maternal nutrition a priority in malnutrition prevention programmes and therefore to have a positive impact on both child survival and maternal health.

The report would be strengthened by the provision of further detail on country-level implementation, for both the Global strategy and International Code, and would have benefited from referencing a report on the International Code by the Bill & Melinda Gates Foundation which had found that interpretation of the Code at country-level was ambiguous and that some countries had prohibited the marketing of any fortified food product.

The Secretariat's report should also have contained more details on WHO's overall strategy to improve infant and young child nutrition and to reduce malnutrition rather than a more limited focus on the rehabilitation of malnourished children at the country level. Given the significant recent developments in the management of severe acute malnutrition more information on WHO's work in that area would have been helpful. The report could also have made the case for additional resources

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

to be allocated to reducing malnutrition and, in particular, stunting, given that they were a major cause of child mortality and contributed to reduced productivity and gross domestic product.

She welcomed the draft resolution.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)<sup>1</sup> asked the Secretariat to provide the Board with the latest information on progress in implementing the International Code and the prevalence of violations of the Code by the food industry. Articles in the scientific literature indicated that violations were prevalent in middle-income countries and where the Code was implemented on a voluntary basis. He suggested that the Board amend the draft resolution by inserting a new operative paragraph that would call upon the food industry to observe the Code and enhance its corporate social responsibility.

Ms ARENDT (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, said that, although the revised materials had stimulated progress in developing the Baby-friendly Hospital Initiative, Member States would need to make considerable efforts in order to make all maternity facilities baby-friendly. She welcomed WHO's work on developing norms and standards for use in emergency nutrition responses which should include responses to emergencies brought on by climate change. Her Association was a cosponsor of the Operational Guidance on Infant and Young Child Feeding in Emergencies and had recently called for breast-feeding support as a vital part of current relief efforts in Haiti.

She welcomed the recommendation for wider application of the principles of the International Code. Lactation consultants had confirmed that commercial products were being promoted with claims of superior health and nutrition benefits that might undermine mothers' confidence in the benefits of breast milk. The Association had therefore decided to monitor such marketing practices and submit information on violations to the International Baby Food Action Network. Referring to the comment about funding in the report, she called on Member States to ensure that budget allocations were sufficient to permit intensification of WHO's support for implementation of the International Code.

She called on WHO and UNICEF to develop specific recommendations on the marketing of complementary foods. Without regulations, heavily-promoted commercial complementary foods would go on displacing continued breast-feeding and fresh home-made foods. Regulation was also needed to ensure that ready-to-use therapeutic foods were used exclusively for the treatment of severe malnutrition and only in infants aged more than six months. They should not be given as complementary foods, which would be detrimental to sustainable nutrition strategies and would risk contributing to overweight and obesity problems. Breast-feeding remained the single most effective preventive intervention for improving the survival and health of children. She called on the Board to adopt an appropriate resolution for consideration by the Health Assembly.

Mr JAVET (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, said that the members of his organization, which included the International Association of Infant Food Manufacturers, made extensive efforts to produce food products for special dietary use that were of the highest possible quality and contributed to proper nutrition, thereby improving the health and well-being of infants and young children. Industry-sponsored research had made significant contributions to current knowledge about the nutritional needs of infants and young children, and the quality and benefits of breast-feeding. He strongly supported government action to implement the International Code as appropriate to their social and legislative frameworks, including the adoption of national legislation and regulations.

The draft resolution should help to promote comprehensive and balanced health policies. He endorsed the call for monitoring progress towards the Millennium Development Goals and urged Member States to ensure availability and access to goods and services essential to health and well-being. Multisectoral approaches to improving nutrition would provide a welcome opportunity for

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

the industry to participate in the development of a comprehensive WHO implementation plan on infant and young child nutrition that should include: the protection and promotion of breastfeeding; the proper use of breast-milk substitutes when they were necessary; the appropriate use of nutrient-dense complementary feeding; the implementation of therapeutic feeding interventions; the reduction of micronutrient deficiency; and relevant educational programmes. The draft resolution would also provide the industry with the opportunity to participate in technical groups and the establishment of an electronic library of effective interventions, and to share its research findings and expertise. The industry reaffirmed its commitment to collaborate with WHO in combating child malnutrition, improving infant and young child survival, and attaining the Millennium Development Goals.

Ms LHOTSKA (Consumers International), speaking at the invitation of the CHAIRMAN, said that infants and young children were particularly vulnerable during emergencies and, at a time when emergency teams were rushing to assist Haiti, she urged the Board to adopt a strong resolution that would facilitate the work of such teams and increase the priority given by Member States to emergency preparedness for optimal infant and young child feeding. The clear operational guidance on infant feeding in emergencies provided by the international community had been incorporated in the work of the United Nations Inter-Agency Standing Committee Global Nutrition Cluster. An increasing number of international organizations agreed on the need to minimize the risks of artificial feeding and avoid donations of breast-milk substitutes and feeding bottles in such situations. They advocated a proper needs assessment, support for breast-feeding for most infants, and procurement of breast-milk substitutes through normal channels for those that required them. That guidance had been highlighted in the recent call by WHO, UNICEF and WFP for support for appropriate infant and young children feeding in Haiti. Full implementation by Member States of the Global strategy on infant and young child nutrition would protect all their infants in emergencies. Consumers International and the International Baby Food Action Network urged Member States to scale up action to implement the Global strategy in order to improve feeding practices for infants and young children. Coordination was the key in emergency situations and development programmes. In 2009, the global Breastfeeding Initiative for Child Survival had been launched, with a call on governments, the health profession and academics to join forces with civil society groups to intensify efforts to attain the health-related Millennium Development Goals.

Mr WRIGHT (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that his organization was concerned that everything possible should be done to support Haiti during the current emergency. It was easy to lose focus, however, and assume that donations were the correct way forward. National and international response plans must continue to follow guidance, which aimed to minimize the risks of artificial feeding, support optimal breast-feeding wherever possible, and ensure that any breast-milk substitutes used were purchased through normal procurement channels and distributed and used according to strict criteria and only for those who needed them. Donations from companies seeking to enhance their corporate social responsibility image should be avoided.

The Save the Children Fund UK was involved in the provision of ready-to-use therapeutic foods for the treatment of severe acute malnutrition in infants and children aged more than six months. Such products should be of high quality and not be used for general prevention of malnutrition or as an opportunity for commercial exploitation of poor people or to undermine continued breastfeeding. In all settings, mothers should be supported in improving complementary feeding with safe and appropriate locally-available ingredients, alongside breastfeeding, which was far more sustainable than dependence on imported processed foods. While fortified foods could play a role, the market was being fuelled by irresponsible health and nutrition claims that distorted parents' understanding of good nutrition, affected children's palates and were leading to an increase in the double burden of under- and over-nutrition. He reviewed the benefits of breastfeeding and welcomed the draft resolution.

Dr ALWAN (Assistant Director-General) affirmed that there had been no real improvement in the nutrition of infants and young children, especially in sub-Saharan Africa. Across the world some 112 million children were underweight, 180 million under the age of five years were stunted and

43 million were overweight. He therefore welcomed the proposals made by the member for Peru and others. WHO was scaling up its work in the area and introducing nutrition into work across the Organization.

In response to specific queries, he indicated that the WHO Child Growth Standards had been adopted in 106 countries and were under consideration in 69 others. The Secretariat shared the concern expressed regarding the donation of breast-milk substitutes and feeding bottles in emergency situations and its potential to promote artificial feeding. It was taking action to ensure that, in such situations, procurement was only through the appropriate institutional channels in the appropriate circumstances, and that promotion of breastfeeding was strengthened. It had developed a tool for supervising the implementation of nutrition programmes and was completing a global review in that area. It was also assessing nutrition indicators in countries affected by emergencies.

He welcomed the commitment given by Member States and civil society organizations to extend action to implement the global strategy, including the revitalization of the Baby-friendly Hospital Initiative and greater support for implementation of the International Code. In relation to the marketing of complementary foods, WHO and UNICEF were collaborating to develop guiding principles for adequate provision of safe and nutritious complementary foods in all settings, and for ensuring that commercial products did not displace healthy feeding practices. WHO was also cooperating with other United Nations organizations to draw up guidelines for the treatment of severe and moderate malnutrition, including appropriate nutrition standards for nutritional products and recommended circumstances for use. The current WHO recommendation was to breastfeed exclusively for six months, and thereafter to introduce complementary feeding while continuing breastfeeding for up to two years or beyond. There was some evidence that prolonged breastfeeding provided continued protection from diarrhoeal diseases, including shigellosis. WHO was convening a consultation in February 2010 on programme guidance in relation to moderate malnutrition and stunting. He welcomed the attention drawn to nutrition during the management of childhood illnesses.

The Secretariat had created a monitoring framework for implementation of the International Code and was supporting countries in strengthening monitoring capacity. In relation to the analysis of the impact of implementation on nutrition, data had so far been obtained from some 60 countries and it was hoped that the report could be completed in the next two to three months.

The DIRECTOR-GENERAL welcomed the consensus on the importance of nutrition, especially in the first two years of life which were so crucial to development (including that of cognitive function). The double burden of undernutrition and overnutrition in infants and young children could be solved through interventions to promote breastfeeding and appropriate introduction of complementary foods that would not require large allocations of resources. It was vital to continue to emphasize the importance of breastfeeding.

Dr YOUNES (Office of Governing Bodies) read out the amendments proposed to the draft resolution. In the fourth preambular paragraph of the resolution contained in the draft resolution, the word "iodine" should be inserted after "iron". In the tenth preambular paragraph, the word "full" should be deleted. The words "along with continued breastfeeding for up to two years or beyond" should be added at the end of the eleventh preambular paragraph. In paragraph 1(2), the words "and also implementing subsequent related Health Assembly resolutions" should be deleted. In paragraph 1(4), "timely, safe and appropriate" should be inserted before the first mention of "complementary", while, at the second mention, "complementary" should be replaced by "supplementary". A new paragraph 1(5) should be inserted to read "to include these strategies in comprehensive maternal and child health services and supporting to the aim of universal coverage and principles of primary health care including strengthening health systems as outlined in resolution WHA62.12". Paragraph 1(5), which would become 1(6), should be amended to read "to strengthen nutrition surveillance systems and improve use and reporting of agreed MDG indicators to monitor progress". The words "including clear identification of leadership, division of labour and outcomes" should be inserted at the end of paragraph 2(3). Paragraph 2(5) should be amended by replacing "for discussion at the Sixty-fifth World Health Assembly" with "as a critical component of a

global multisectoral nutrition framework for preliminary discussion at the Sixty-fourth World Health Assembly and for final delivery at the Sixty-fifth World Health Assembly”.

Dr VIROJ TANGCHAROENSATHIEN (Thailand),<sup>1</sup> supported by Mr CHAUDHRY (alternate to Ms Sujatha Rao, India) and Ms ABBAS (alternate to Dr Said, Syrian Arab Republic), proposed the addition of a new paragraph 2, reading: “calls upon food industries to observe the International Code of Marketing of Breast-milk Substitutes and enhance their corporate social responsibility;”.

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

**Birth defects:** Item 4.7 of the Agenda (Documents EB126/10, EB126/10 Add.1 and EB126/10 Add.2)

The CHAIRMAN drew attention to the report contained in document EB126/10, and to document EB126/10 Add.1, which contained a draft resolution considered by the Executive Board at its 125th session and modified in the light of comments and proposals made by Member States. The financial and administrative implications of that draft resolution, were it to be adopted, were contained in document EB126/10 Add.2.

Dr REITENBACH (alternate to Dr Seeba, Germany), welcoming the report, said that many of the estimated 260 000 infant deaths worldwide each year could be avoided if women had free access to effective prenatal care. Reducing birth defects and congenital disorders was important to the attainment of Millennium Development Goal 4. Prenatal preventive care, including prenatal diagnostics and comprehensive medical and psychosocial counselling, was beneficial to the health of mothers and their unborn children and must be a part of any functioning health care system. Prenatal diagnostics should not, however, be abused. The subject was ethical, not just medical. Germany’s position was clear: modern technologies should not be used to prevent unwanted life from being born. The role of medical and psychosocial counselling was crucial.

The draft resolution should refer to awareness-raising and the importance of prevention, for example through greater knowledge of the risks posed by medicines, alcohol and environmental toxins. Subparagraphs 1(2) and 1(6) were misleading in that respect; the main focus should be on prevention.

Reference should also be made to the United Nations Convention on the Rights of Persons with Disabilities, to which Germany was strongly committed. It was imperative to do everything possible to ensure that children with disabilities could enjoy all human rights and fundamental freedoms on an equal basis with other children.

She proposed the following amendments: in subparagraph 1(2), insert “that include comprehensive guidance, information and awareness raising” after “interventions”, and insert “birth defects” after “to prevent”; amend subparagraph 1(6) to read: “to develop the expertise and to build capacity on the prevention of birth defects and care of children with birth defects”; and insert a new subparagraph 1(8) to read: “to take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children and give priority to the child’s well-being and support and facilitate families in their child-care and child-raising efforts;”.

Professor ADITAMA (alternate to Dr Sedyaningsih, Indonesia), commending the report, said that mortality due to congenital anomalies was moderate in Indonesia. Several prevention programmes had been implemented encompassing community education, early detection of certain congenital anomalies during pregnancy within antenatal care programmes, distribution of iodine and folic acid,

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

<sup>2</sup> Resolution EB126.R5.

and prevention and monitoring of sexually transmitted diseases. Screening of newborn infants for congenital hypothyroidism had been conducted in eight provinces since 2006, with prenatal screening for thalassaemia in certain areas. However, preventive activities such as vaccination against rubella and early detection of congenital anomalies were still not included in national programmes because of the country's limited capacity, facilities and resources.

Considering the significant contribution made by birth defects to neonatal and infant deaths, he supported the draft resolution. The issue must be taken seriously by the Secretariat and Member States. The Secretariat should continue to provide technical support to Member States, particularly developing countries, especially in building prevention capacities, including marriage counselling and birth planning, early detection, treatment, raising awareness of the bioethical aspects and drawing up relevant legislation. Support was also needed in developing national and international networks for the sharing of information among appropriate medical specialists such as geneticists, obstetricians and paediatricians. Prevention and care should be integrated into primary care, with special emphasis on maternal and child health.

Dr DOS RAMOS (Sao Tome and Principe), speaking on behalf of the Member States of the African Region, welcomed the draft resolution. In the African Region, neonatal mortality represented one quarter of infant deaths among the under-fives, of which about 6% were due to congenital malformations. More than 50% of deaths occurred in the 24 hours after birth. It had been estimated that about 1.5% of all deaths among the under-fives in Africa were attributable to congenital malformations or birth anomalies. A considerable proportion of congenital anomalies were at least partially genetic in origin. Certain serious congenital anomalies occurred before conception, for example as a result of the mother's exposure to environmental agents, diseases such as syphilis and rubella, and iodine deficiency.

At its fifty-fourth session, the Regional Committee for Africa had adopted, in resolution AFR/RC54/R9, a Road Map for accelerating the attainment of the Millennium Development Goals relating to maternal and neonatal health in Africa, and, at its fifty-sixth session, resolution AFR/RC56/R2 on Child Survival: a Strategy for the African Region. Early diagnosis, care and treatment of congenital anomalies were challenges that the African Region still had to tackle. Others included the weakness of the health systems in most countries of the Region; the lack of diagnostic capacity and poor filing systems; the lack of surveillance of congenital disorders and dependence on hospital data; poor programme coordination for congenital anomalies; and the difficulty of sustaining salt iodization programmes.

Dr SAID (Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that mother and child health in the Region had improved considerably since 1990, but maternal mortality was still a cause for concern. Early detection of birth anomalies should be improved and could help in attaining the Millennium Development Goals. Public information and education were required, for instance to raise awareness of the risks associated with consanguinity, underline the importance of maternal health care, reduce risks in the prenatal and postnatal periods and help women to avoid sexually transmitted infections. Some countries had conducted successful programmes to raise awareness about congenital problems and emphasize the importance of appropriate nutrition during pregnancy, and some had national networks for the care of pregnant women. His Government had introduced pre-marital check-ups for women. Further work was needed to discourage the inappropriate use of alcohol and tobacco. A proper assessment of the problems required a country-by-country analysis of statistics. Care must be extended to families facing the consequences of birth defects. There was also a need for specialist clinics and hospitals. The ethical aspects of the matter, which were sensitive, also had to be addressed. He paid tribute to the work of WHO and other organizations in the area and encouraged them to provide the resources needed to strengthen national efforts in the Region.

Dr GIMÉNEZ (Paraguay) said that evidence was accumulating that exposure to environmental pollutants during fetal development could cause disease in later life. Little was understood as yet about

the health consequences of exposure to small doses of chemicals. The draft resolution, of which his country was a cosponsor, was important for drawing attention to the role of environmental factors in birth defects, especially chemical substances including pesticides, to which pregnant women in urban and rural areas alike were exposed daily. The Secretariat's support was needed in order to strengthen the capacity of health ministries to tackle the problems, including dealing with chemical substances, especially those used in agriculture. Thus, the relevance of the draft resolution extended beyond birth defects to environmental protection. There were powerful interests involved, and the tools to counter them remained very weak.

Referring to the report, Professor HAQUE (Bangladesh) proposed that disruption sequences and dysplasia sequences should be included in the definition of birth defects, and subaponeurotic haemorrhage, intraventricular haemorrhage, clavicular fracture, brachial plexus injury and spinal injury as causes of birth defects. The role of emergency obstetric care in reducing the number of birth defects under the revitalization of primary health care should also be mentioned.

Dr RAHMAH (alternate to Mr Osman, Brunei Darussalam) pointed out that some birth defects were difficult and costly to diagnose and treat, and many countries, particularly those with small populations, like Brunei Darussalam, might not have the necessary facilities. She welcomed the basic components of a prevention and care programme outlined in the report and called upon the Secretariat to work towards filling the gaps in capacity for diagnostics and treatment and redressing the repercussions of those inadequacies on the quality of surveillance. Since existing genetic services tended to be located within the secondary health-care sector, links to the primary health care sector should be made in order to support continuity of care and implementation of prevention programmes. The definition of congenital anomalies in the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision should be reviewed, with a view to better supporting surveillance of birth defects.

Mr CHAUDHRY (alternate to Ms Sujatha Rao, India) said that India had no data on the prevalence of birth defects, but several maternal and child health initiatives had been undertaken to reduce birth defects. Some of the interventions put forward in the report relating to pre-conception, pregnancy, and newborn, infant and child care would not be feasible in India for sociocultural reasons, the need to focus on other pressing causes of maternal and child mortality and the current state of the health system. Advanced diagnostic tests were available in a limited number of tertiary settings, but it would not be feasible, physically or financially, to include them in routine programmes for maternal and child health. Nor was routine prenatal diagnostic screening feasible in India, as the preference for the male child still prevailed in several parts of the country and might lead to a higher rate of female feticide in spite of the stringent laws in place to prevent it. Furthermore, the health system in the public sector was still not ready to take on the physical and financial burden of such interventions.

Dr PUNIVALU (adviser to Ms Toelupe, Samoa), welcoming the draft resolution, said that her country had made much progress in enhancing and strengthening primary health care, including maternal and child health-care services, increased accessibility to which had significantly reduced infant and child mortality rates over the past three decades. She supported efforts to achieve the Millennium Development Goal of reducing child mortality, including reducing morbidity and mortality resulting from birth defects, which were perceived to be on the increase in Samoa and neighbouring countries. National data collection on birth defects must be improved in order to assess accurately the extent of the problem and identify measures that could be easily implemented. She requested the Secretariat's assistance to that end.

Factors affecting health, including those that contributed to birth defects, were no longer just local or regional. The issue of birth defects was an emerging global health priority, both in terms of child mortality and in view of the need for Member States to have ethical and legal guidelines in place to ensure that the special needs of such children were properly addressed. Samoa looked forward to the Secretariat's support in developing its capacity to take preventive measures and provide for the



needs of children, families and communities affected by birth defects. Collaborative research projects on issues related to birth defects should be encouraged and supported.

Dr MUÑOZ (Chile) expressed strong support for the revised draft resolution, which appropriately reflected observations made by the Board at its previous session. Encouraging early detection programmes with a greater emphasis on prevention, through a variety of measures such as avoiding environmental toxins, vaccinating against rubella and providing folic acid supplements, could reduce causes of death and permanent disability, thereby contributing to achieving the Millennium Development Goals.

Ms ARTHUR (alternate to Mr Houssin, France) requested clarification of the phrase “minimally invasive screening methods” in paragraph 11 of the report. She supported the draft resolution as amended by the members for Paraguay, the Bahamas, Canada, Chile and New Zealand.

Dr DODDS (Canada), welcoming the revised draft resolution, emphasized the need to increase access by women and their families to adequate care and reproductive health services before conception as an effective measure to prevent birth defects worldwide. In order to reflect the statement in paragraph 12 of the report that screening of newborn infants for congenital disorders facilitated early detection, treatment and care, she proposed the addition of a new subparagraph at the end of paragraph 1, to read: “to raise awareness among all relevant stakeholders, including government officials, health professionals, civil society and the public, about the importance of newborn screening programmes and their role in identifying infants born with birth defects.” She also suggested that, in paragraph 1(5), the word “integrate” be altered to “record”.

Dr WATT (alternate to Sir Liam Donaldson, United Kingdom of Great Britain and Northern Ireland), expressing support for the draft resolution as amended by the member for Canada, suggested that the word “into” in paragraph 1(5) be changed to “as part of”.

Dr TAKEI (adviser to Dr Omi, Japan) said that, although the draft resolution emphasized prevention, preventable causes of birth defects were limited, and attention should also be given to provision of health care and social welfare for people affected by such conditions. He therefore proposed that the words “and social welfare” should be inserted after “child health services” in paragraph 1(2), and that the words “such as for measles and rubella” should be added after “vaccination coverage” in paragraph 2(3).

Dr DAHL-REGIS (Bahamas), expressing support for the amendments proposed by the member for Canada, requested that reference to diagnosis at the earliest possible time be added to the new subparagraph that member had proposed. The standard formula by which the Board recommended resolutions for adoption by the Health Assembly had been omitted from the current version of the text and should be added.

Ms ROCHE (New Zealand) called for alcohol consumption during pregnancy, a major cause of birth defects, along with tobacco and drug consumption, to be given more prominence in the draft resolution. She also proposed the addition of a new subparagraph at the end of paragraph 1, to read: “to support families who have children with birth defects and associated disabilities, and ensure that appropriate habilitation and support is provided to children with disabilities”.

Dr MOHAMED (Oman) proposed the addition of a reference to food fortification strategies in paragraph 2(3), given the success of interventions with micronutrients such as folic acid.

Mr GWIAZDA (Poland)<sup>1</sup> expressed full support for the international community's efforts to prevent and treat birth defects. However, any intervention to prevent or treat birth defects should be carried out within national legal frameworks.

Dr LIU Peilong (China),<sup>1</sup> expressing support for the draft resolution, outlined measures being taken in his country to reduce birth defects, such as improving management of and access to public health services, providing free folic acid supplements, and establishing programmes on congenital conditions such as phenylketonuria and hypothyroidism. China was ready to enhance cooperation with international organizations and relevant governments.

Mgr TOMASI (Holy See), speaking at the invitation of the CHAIRMAN, said that protection of the rights, dignity and worth of persons with disabilities remained a major concern for the Holy See, which had consistently called for disabled individuals to be completely and compassionately integrated into society, convinced that they possessed full and inalienable human rights. He therefore expressed concern at the inclusion in the report of the phrase "selective termination of pregnancy" in relation to the prevention of birth defects during pregnancy. Affirming that life began at the moment of conception, and firmly rejecting abortion and any policy that favoured it, he drew attention to the protection of the right of conscience of health workers conferred by, inter alia, Article 18 of the United Nations Universal Declaration of Human Rights.

At a recent conference focusing on the needs of deaf people, Pope Benedict XVI had appealed to political and civil authorities and international organizations to act to promote proper respect for the dignity and rights of disabled persons. The Catholic Church would continue to support pastoral and social initiatives for their benefit. Referring to Article 10 of the United Nations Convention on the Rights of Persons with Disabilities and a call by the United Nations Secretary-General in December 2009 to focus on persons with disabilities and their communities as a means of advancing the development agenda, he expressed the strong view that offering abortion as a means of preventing birth defects would constitute an unethical practice, since it entailed the destruction of human life.

Dr BOULYJENKOV (Thalassaemia International Federation), speaking at the invitation of the CHAIRMAN, outlined the work of his Federation, in collaboration with WHO, to prevent congenital haemoglobinopathies, provide care for patients, and educate health workers and the public. Resolutions EB118.R1 and WHA59.20 urged Member States to develop, implement and reinforce comprehensive national programmes for the prevention and management of haemoglobin disorders, to develop and strengthen medical genetics services, and to promote community education and training. He supported the draft resolution, which continued WHO's efforts in the area of genetics and congenital disorders and supported the Federation's work at national level. WHO should promote further debate on the issue.

Ms MAFUBELU (Assistant Director-General) expressed appreciation for the guidance received from Member States and took note of the progress made at national level, the challenges faced, and the requests made for assistance from the Secretariat. Some Member States had limited capacity to implement WHO's recommendations, and the Secretariat would provide support in that regard and the guidance requested on technical matters. She drew attention to the opportunity provided by the eleventh revision of the International Statistical Classification of Diseases and Related Health Problems to review current definitions.

In reply to the member for France, she clarified that "minimally invasive screening methods" was understood to mean taking blood and performing the diagnostic tests currently available through screening of maternal serum.

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

Dr YOUNES (Office of Governing Bodies) summarized the amendments proposed to the draft resolution. The following text should be inserted between “The Executive Board” and the first paragraph of the existing preamble:

“Having considered the report on birth defects,

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

The Sixty-third World Health Assembly,”

In the eighth paragraph of the ensuing preamble, “, tobacco” should be inserted after “consumption of alcohol”. Paragraph 1(2) should be amended to read: “to set priorities, commit resources, and develop plans and activities for integrating effective interventions that include comprehensive guidance, information and awareness raising to prevent birth defects, and care for children with birth defects into existing maternal, reproductive and child health services and social welfare for all individuals who need them”; paragraph 1(5) should read: “to record surveillance data on birth defects as part of national health information systems”. In paragraph 1(6), the words “prevention and management of children with birth defects” should be altered to “prevention of birth defects and care of children with birth defects”. Three new subparagraphs should be added at the end of paragraph 1, as follows: “to take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children and give priority to the child’s well-being and support and facilitate families in their childcare and child-raising efforts”; “to raise awareness among all relevant stakeholders, including government officials, health professionals, civil society and the public, about the importance of newborn screening programmes and their role in identifying infants born with birth defects”; and “to support families who have children with birth defects and associated disabilities, and ensure that appropriate habilitation and support is provided to children with disabilities”. Finally, in paragraph 2(3), the words “such as for measles and rubella, and food fortification strategies” should be inserted after “vaccination coverage”.

The CHAIRMAN took it that the Board agreed to adopt the revised draft resolution, as amended.

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

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

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<sup>1</sup> Resolution EB126.R6.

## **EIGHTH MEETING**

**Thursday, 21 January 2009, at 14:40**

**Chairman:** Dr S. ZARAMBA (Uganda)

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

**Food safety:** Item 4.8 of the Agenda (Document EB126/11)

The CHAIRMAN drew attention to a draft resolution on advancing food safety initiatives proposed by Canada, which read:

The Executive Board,  
Having considered the report on food safety,<sup>1</sup>

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

The Sixty-third World Health Assembly,

Recalling resolution WHA53.15 on food safety, which requested the Director-General to put in place a global strategy for the surveillance of foodborne diseases and for the efficient gathering and exchange of information in and between countries;

Recalling resolution WHA55.16 on the global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health, which noted that such agents can be disseminated through food- and water-supply chains;

Noting the endorsement by the Executive Board in 2002 of WHO's global strategy for food safety,<sup>2</sup> which had as its aim the reduction of the health and social burden of foodborne disease;

Noting also, that other food safety-related activities identified in resolutions WHA53.15 and WHA55.16 have been undertaken, including: the revision of the International Health Regulations in 2005; the establishment of the International Food Safety Authorities Network in 2005; the establishment of WHO's Foodborne Disease Burden Epidemiology Reference Group in 2006; and increased participation, particularly by developing countries, in the elaboration of international food safety standards by the Codex Alimentarius Commission;

Recognizing that the Codex Alimentarius Commission presents a unique opportunity for all countries to join the international community in formulating and harmonizing food standards and ensuring their global implementation;

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<sup>1</sup> Document EB126/11.

<sup>2</sup> Document EB109/2002/REC/2, summary record of the fourth meeting.

Further recognizing the important roles of WHO and FAO in support of the Codex Alimentarius Commission as the international reference point for developments associated with food standards;

Confirming that foodborne disease continues to represent a serious threat to the health of millions of people in the world, particularly those in developing countries with poor nutritional status;

Mindful of the inextricable links between food safety, nutrition and food security and acknowledging the instrumental role of food safety in eradicating hunger and malnutrition, in particularly in low-income and food-deficit countries;

Aware of increasing evidence that many communicable diseases, including emerging zoonotic diseases, are transmitted through food, and that exposure to chemicals and pathogens in the food supply is associated with acute and chronic diseases;

Acknowledging that climate change will increase rates of some foodborne diseases, including those of zoonotic origin, owing to the more rapid growth of microorganisms in food and water with higher temperatures, resulting in the emergence of toxins in new geographical areas and in possible higher levels of toxins or pathogens in food;

Recognizing that the global trade in food is increasing every year, contributing to the risk of spread of pathogens and contaminants across national borders, thereby creating new challenges for food authorities and necessitating more efficient global sharing of food safety information;

Acknowledging the continuing need for closer collaboration between the health sector and the agriculture sector, and increased action on food safety at the international and national levels, across the full food production chain, in order to reduce significantly the incidence of foodborne disease;

Noting the continuing need for updated and comprehensive risk assessments and scientific advice to support measures and interventions to improve the safety and nutritional quality of food;

Recognizing the importance of international agreement on global management of food safety, the application of scientific principles in finding solutions, the efficient exchange of monitoring and surveillance data, and practical experience,

1. URGES Member States:<sup>1</sup>

- (1) to continue to establish and maintain the activities and measures elaborated in resolutions WHA53.15 on food safety and WHA55.16 on the global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health;
- (2) to further develop and implement the core capacities as defined in Annex 1 of the International Health Regulations (2005), specifically for food-safety events, including the development of systems for: surveillance for foodborne disease and food contamination; risk assessment, risk management and risk communication; food safety emergency response; and product tracing and recall;
- (3) to participate fully as a member of International Food Safety Authorities Network in its activities, including supporting the timely transmission of data, information and knowledge about food-safety emergencies through the network;

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<sup>1</sup> And, where applicable, regional economic integration organizations.

- (4) to enhance the integration of food-safety considerations into food aid, food security and nutrition interventions in order to reduce the occurrence of foodborne diseases and improve the health outcomes of vulnerable populations;
- (5) to improve the evidence base for food safety through systematic efforts on disease burden estimation and surveillance, and through comprehensive risk and risk-benefit assessment, and to provide support for international activities in these areas, in particular, WHO's initiative to estimate the global burden of foodborne diseases from all major causes (microbiological, parasitic and chemical);
- (6) to contribute to the timely conduct of international risk assessments through the provision of relevant data and expertise in order to tackle more efficiently and consistently foodborne diseases and food-safety issues that threaten global public health security;
- (7) to continue to develop and maintain sustainable preventive measures, including food safety-education programmes, aimed at reducing the burden of foodborne diseases through a systems approach encompassing the complete food-production chain from farm to consumption;
- (8) to promote dialogue and collaboration among human health, veterinary and food-related disciplines, focused on an integrated effort of foodborne risk reduction along the whole food-production chain, including consideration of zoonotic risks;
- (9) to participate actively in the Codex Alimentarius Commission's standard-setting process and to adopt Codex standards whenever appropriate;

2. REQUESTS the Director-General:

- (1) to develop the International Food Safety Authorities Network further through the implementation of a strategic plan in collaboration with partners and Member States; to encourage communication and technical exchange of risk assessments and best practices among members of the Network; and to facilitate Member States' involvement in the Network's operation and development;
- (2) to strengthen the emergency function of the International Food Safety Authorities Network as a critical component of WHO's preventive and emergency operations relative to food safety, and linkages to other relevant international organizations and networks in this area;
- (3) to continue to provide global leadership in providing technical assistance and tools that meet the needs of Member States and the Secretariat for scientific estimations on foodborne risks and foodborne disease burden from all causes;
- (4) to promote the inclusion of food safety into the international debate on food crises and hunger emergencies, and provide technical support to Member States and international agencies for considering food safety, nutrition and food security issues in a comprehensive, integrated manner;
- (5) to monitor regularly and report to Member States on the global burden of foodborne and zoonotic diseases from the country, regional and international perspectives;
- (6) to promote research, including investigation of the association of foodborne hazards with acute and chronic diseases, in order to support evidence-based strategies for the control and prevention of foodborne and zoonotic diseases;
- (7) to provide support to Member States in building relevant capacity to improve cross-sectoral collaboration and action at international and national levels along the whole food-production chain, including the assessment, management and communication of foodborne and zoonotic risks;
- (8) to develop guidance on the public health aspects arising from zoonotic diseases that originate at the human-animal interface, in particular prevention, detection and response;

- (9) to provide adequate and sustainable support for the joint expert bodies of FAO and WHO, the Codex Alimentarius Commission and the International Food Safety Authorities Network in order to advance the international development, provision, utilization, and sharing of scientific risk assessments and advice; to support the development of international food standards that protect the health and nutritional well-being of consumers; and address and communicate more effectively on food safety issues at the national and international levels;
- (10) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on progress in implementing this resolution.

The financial and administrative implications for the Secretariat were:

<b>1. Resolution</b> Advancing food safety initiatives	
<b>2. Linkage to programme budget</b>	
Strategic objective:	Organization-wide expected result:
1. To reduce the health, social and economic burden of communicable diseases.	1.3. Effective coordination and support provided to Member States in order to provide access for all populations to interventions for the prevention, control, elimination and eradication of neglected tropical diseases, including zoonotic diseases.
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.	5.5. Support provided to Member States for strengthening national preparedness and for establishing alert and response mechanisms for food-safety and environmental health emergencies.
9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development.	9.1. Partnerships and alliances formed, leadership built and coordination and networking developed with all stakeholders at country, regional and global levels, in order to promote advocacy and communication, stimulate intersectoral actions, increase investment in nutrition, food-safety and food-security interventions, and develop and support a research agenda.
	9.2. Norms, including references, requirements, research priorities, guidelines, training manuals and standards, produced and disseminated to Member States in order to increase their capacity to assess and respond to all forms of malnutrition, and zoonotic and non-zoonotic foodborne diseases, and to promote healthy dietary practices.
	9.5. Systems for surveillance, prevention and control of zoonotic and non-zoonotic foodborne diseases strengthened; food-hazard monitoring and evaluation programmes established and integrated into existing national surveillance systems, and results disseminated to all key players.
	9.6. Capacity built and support provided to Member States, including their participation in international standard-setting in order to increase their ability to assess risk in the areas of zoonotic and non-zoonotic foodborne diseases and food safety, and to develop and implement national food-control systems, with links to international emergency systems.

<p align="center"><b>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</b></p> <p>The resolution will provide an updated framework for WHO's normative work on food safety within the existing expected results, with an additional emphasis on strengthening scientific advice, the estimation of the health burden imposed by foodborne disease, support for the International Food Safety Authorities Network (INFOSAN) and cross-sectoral prevention of zoonotic diseases.</p>
<p><b>3. Budgetary implications</b></p> <p><b>(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):</b></p> <p>US\$ 29.1 million over the coming six-year period (staff: US\$ 16.5 million, activities: US\$ 12.6 million).</p> <p><b>(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):</b></p> <p>US\$ 9.7 million at headquarters.</p> <p><b>(c) Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010–2011?</b></p> <p>US\$ 8 million are included in the Programme budget.</p>
<p><b>4. Financial implications</b></p> <p><b>How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?</b></p> <p>Through the extrabudgetary funds of interested Member States and relevant nongovernmental organizations.</p>
<p><b>5. Administrative implications</b></p> <p><b>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)</b></p> <p>Implementation will be organized at headquarters, in coordination with all six regional offices and selected countries of each region.</p> <p><b>(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below</b></p> <p>No.</p> <p><b>(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)</b></p> <p>Two staff members in the professional category at headquarters.</p> <p><b>(d) Time frames (indicate broad time frames for implementation of activities)</b></p> <p>Food safety initiatives are continuing activities. The next progress report will be made to the Sixty-fifth World Health Assembly; thus the major new initiatives should be evaluated by the end of the period 2010–2011.</p>

Dr DODDS (Canada), introducing the draft resolution, said that the following Member States wished to cosponsor it: Israel, Kazakhstan, Oman, Paraguay, Republic of Korea and South Africa. She recalled WHO's global leadership over the past decade in the promotion of food safety as an essential part of public health policy, but recent developments such as the increasingly global reach of foodborne diseases, the rising incidence of chronic diseases, emerging zoonoses and global warming meant that the time had come for WHO to consider a new resolution to advance food safety initiatives. The draft resolution encouraged Member States to engage fully in international activities and forums,



including the International Food Safety Authorities Network, to assess, manage and communicate risks globally. It also highlighted the link between human health, animal health and the environment, given their implications for food safety.

She proposed amendments, resulting from consultations with interested Member States, which strengthened the content and aligned the wording with previously agreed international texts. The phrase “and in particular the participation of developing countries in this regard should be encouraged” should be added at the end of the fifth preambular paragraph. The first line of the tenth preambular paragraph should be amended to read: “Acknowledging that climate change could be a factor in the increasing rates of some foodborne diseases”. The phrase “taking into account that protection of food safety cannot lead to discrimination or a disguised restriction on international trade” should be added at the end of the eleventh preambular paragraph. The first part of the twelfth preambular paragraph should be amended to read: “Acknowledging the continuing need for closer collaboration among the health sector and other sectors”; and the words “internationally agreed standards and agreements for” should be added after “updated and comprehensive” in the thirteenth preambular paragraph. In subparagraph 1(2), the words “as applicable and those required for participation in INFOSAN” should be added after “International Health Regulations (2005)” and “traceability” should be inserted after “risk assessment”. The word “regional” should be inserted after “international” in subparagraph 2(7), and a new subparagraph 2(10) should be added, reading: “to establish with the International Food Safety Authorities Network an international initiative for the collaboration of laboratory partners in support of surveillance for foodborne disease, identification of food contamination and emergency response, including outbreak investigation and linking product to illness to support recall; to also include the establishment of mechanisms for data sharing”. The existing subparagraph 2(10) would be renumbered accordingly.

She suggested that the Secretariat organize a technical briefing on food safety, concerning in particular diseases at the human–animal interface, during the forthcoming Health Assembly in May 2010.

Professor HAQUE (Bangladesh) said that his Government’s Ministry of Health and the Secretariat were implementing a collaborative programme on food safety that sought to strengthen laboratory training for human resources; provide food safety information for community leaders, food handlers and others; and promote quality control in the food industry. In addition, FAO, with the collaboration of WHO, was implementing a three-year project on improving food safety and quality control in Bangladesh, which was aimed at improving consumer health and reducing foodborne diseases.

Speaking on behalf of the Member States of the South-East Asia Region, he welcomed the draft resolution but proposed several amendments. The words “and strengthen laboratory capacity” should be added at the end of subparagraph 1(2), and “in a transparent manner” should be added at the end of subparagraph 1(3). The last part of subparagraph 1(4), should be amended to read: “improve the health outcomes of populations, in particular the vulnerable groups”. At the beginning of subparagraph 1(5), the words “establish or” should be inserted before “improve”. For the purposes of clarity, the words “within and among Member States” should be inserted after “related disciplines” in subparagraph 1(8). In subparagraph 2(1), “implementation of a strategic plan” should be replaced by “implementation of the WHO Global Strategy for Food Safety”, and the words “and to encourage additional membership into the International Food Safety Authorities Network” should be added at the end of the paragraph.

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. The European Union continued to support the global food safety initiatives promoted by WHO. Concerted efforts by all WHO’s Member States were necessary to overcome the global threats from foodborne diseases through targeted actions that covered the entire food chain, including the animal feed sector. The use of safe feed for animals destined for food production was a key element in ensuring the highest levels of food safety. Animal feed production

should therefore be included within the remit of the International Food Safety Authorities Network, which should work in cooperation with the European Union's Rapid Alert System for Food and Feed, so that European Union Member States did not have the burden of reporting to both. The European Union was willing to work with WHO on that matter.

Sustainable funding for the joint FAO/WHO expert bodies and the Codex Alimentarius Commission must be ensured. WHO currently provided 14.5% of the budget for the Codex Alimentarius Commission; the remainder came from FAO. That funding imbalance should be rectified, particularly as many Codex activities had a direct bearing on WHO's priorities. Such action would reflect the importance that WHO attached to food safety and ensure that the setting of food safety standards did not shift from the Codex to non-transparent private bodies.

Dr SEDYANINGSIH (Indonesia) commented that climate change and emerging zoonoses had increased the global burden of foodborne diseases. The spread of pathogens and contaminants across borders, for example through trade in food, could pose risks to public health. In developing countries, food safety issues were highly complex: steps should be taken to prevent food dumping, in particular in disaster areas, and to recognize other sensitive issues associated with food, such as halal food.

An unhealthy environment, poor animal-breeding conditions, and the use of unsafe chemicals on crops could also put safety at risk. A sound policy framework providing for appropriate monitoring and evaluation using existing tools should be implemented.

As an addition to the draft resolution, which she supported, she proposed that the words "the safety and quality of traditional foods, and" be inserted after "to promote research, including" in subparagraph 2(6).

Dr OULD HORMA (Mauritania), speaking on behalf of the Member States of the African Region, said that food safety was a major concern for all the countries of the Region, where up to five episodes of foodborne and waterborne diarrhoeal disease were recorded per child every year. In Africa, numerous epidemics of foodborne disease (including typhoid and botulism) had been recorded, cholera remained endemic in many countries, and recently there had been an unprecedented number of emergency hospital admissions due to the ingestion of contaminants through food, including toxic waste, pesticides and bromide. Climate change was likely to increase the incidence of foodborne disease owing to the faster growth of microorganisms at higher temperatures.

Training in laboratory research had been provided, through the Global Foodborne Infections Network, for more than 50 epidemiologists and microbiologists from 25 countries, organized in Cameroon, Kenya and Madagascar, and applied to food safety, foodborne diseases and epidemics caused by contaminated water and food.

With regard to the chemical contamination of foodstuffs, Cameroon and Ghana had received support to organize training workshops in October 2006. Melamine-contaminated milk had been detected in Burkina Faso, Burundi, Ghana, Seychelles and South Africa. National authorities had been informed of detection methods by the International Food Safety Authorities Network.

Guidelines and manuals for evaluations of quality control systems and monitoring of foodborne diseases in the African Region had been elaborated at the regional level.

Workshops on strengthening food safety in food businesses using the Hazard Analysis and Critical Control Point system had been held in several countries and further workshops on that system had also received funding. A regional training seminar on the Codex Alimentarius, attended by 40 delegates from seven countries, had been organized in Cameroon by WHO, FAO and other partners. A similar workshop had been organized during the 17th session of the Codex Coordinating Committee for Africa. National Codex Committees had been strengthened in several countries; and 21 countries had evaluated their food safety programmes and drawn up policies, legislation and plans of action. Twenty countries had also strengthened their information, education and communication systems on the basis of WHO's Five Keys to Safer Food.

Food safety programmes in African countries remained underfunded and in most countries responsibilities were dispersed among different ministries and institutions.

Dr ABDESSELEM (Tunisia), speaking on behalf of the Member States of the Eastern Mediterranean Region, drew attention to the devastating health and economic consequences of outbreaks of foodborne diseases. A strategy should be developed to reduce the incidence of foodborne diseases, including emerging zoonoses; to contribute to reducing morbidity levels; and to promote policies on food safety. All Member States should be encouraged to participate in the International Food Safety Authorities Network. Support for capacity building should be provided for developing countries to collect and transmit data on the emergence of foodborne diseases. In addition, research should continue on food production and safety, and the developing countries in particular should be encouraged to strengthen their legislation on food safety.

Mrs CHISTYAKOVA (adviser to Dr Starodubov, Russian Federation) said that her country prioritized food safety and had legislation that was consistent, as far as possible, with international guidelines and requirements, including those of FAO and WHO. Research on contaminants and pollutants in food and food products had led recently to new indicators for permissible concentrations of several chemical and biological contaminants. She concurred with the need to improve legislation concerning risk assessment and food standards.

Welcoming WHO's new strategic directions concerning zoonoses, which focused on human health aspects and strengthened epidemiological surveillance, the Russian Federation was ready to participate in international work in that area. Increasing international trade in food products required international exchange of information on the safety of food products. The experience gained in the exchange of information concerning the pandemic (H1N1) 2009 could be applied to the food safety issue.

Dr GIMÉNEZ (Paraguay), noting the regional impact of foodborne diseases, including zoonoses and poisoning due to agricultural chemicals, and their public health priority, welcomed the focus on strengthening zoonosis surveillance; forecasting and alert and response mechanisms; and providing tools for the assessment, management and communication of zoonotic risks. Expressing support for the draft resolution, he emphasized the implementation of sustainable integrated surveillance and alert systems for human and animal health and food quality, and providing support to Member States in building capacity along the whole chain of food production, particularly in the communication of foodborne and zoonotic risks. Member States were urged to participate actively in the Codex process of standard-setting, and the Director-General was requested to provide sustained support in that regard. Those actions could determine the future exposure of populations to biological and chemical pollutants in food. Effective policies for the protection of consumer health could only be established on the basis of scientific risk assessment.

Dr MOHAMED (Oman) said that reference to the Hazard Analysis and Critical Control Point system would have strengthened both the report and the draft resolution. He proposed that such a reference be included in paragraph 13 of the report and in the draft resolution.

Dr LEE Young-chan (alternate to Professor Sohn Myongsei, Republic of Korea) welcomed the Secretariat's continued provision of scientific advice to Member States, in particular concerning food safety assessment and decision-making from farm to table. The decrease in financing for food safety cause him concern; he encouraged the Secretariat to continue working with Member States and organizations such as FAO to reverse the trend, and, importantly, to develop scientific risk assessments and food standards. He urged adoption of the draft resolution, which would provide WHO with a key role in guaranteeing global food safety.

Dr ALBRAIKY (alternate to Dr Al Darmaki, United Arab Emirates) emphasized the link between food safety and the need for adequate scientific assessment of the quality of locally-produced and imported foods in laboratories.

Dr MUÑOZ (Chile) supported the draft resolution. Food safety was most important for public and environmental health, and for the food trade, which generated substantial revenue for developing countries and for agricultural workers. The draft resolution provided for the protection of food safety without raising arbitrary barriers to exports. He welcomed in particular the call for funding of the Codex Alimentarius Commission, an initiative that had led to positive changes to his country's food regulations and thus to increased exports of safe and healthy food products. Chile would continue to support WHO's food safety strategy.

Ms TOELUPE (Samoa) said that her country was working to improve food safety and strengthen the link between food safety and Millennium Development Goal 1 (Eradicate extreme poverty and hunger) and Goal 4 (Reduce child mortality). A food hygiene standard had been drafted, and national food safety legislation was being updated. The Codex Alimentarius Commission was an ideal forum for all States to harmonize food standards and ensure their international implementation; Samoa was preparing its first Codex standard. Small island States would need to balance food safety standards with the survival of food industries, while complying with WTO requirements. She requested the Director-General to strengthen the International Food Safety Authorities Network. Pacific island nations would require significant technical assistance to meet the standards outlined in the report. She supported the draft resolution, as amended.

Dr OSPANOV (Kazakhstan)<sup>1</sup> said that in the past, in his country, poor food quality had been responsible for disease, low birth rates, increased mortality and reduced life expectancy. Specific measures taken had educated the population about healthy eating and had improved access to quality food products and overall food safety. Vitamins and minerals were added to flour to combat iron-deficiency anaemia, and iodized salt was available to all the population. He supported WHO's food safety strategy as a priority. He welcomed the draft resolution and had asked for Kazakhstan to be added to the list of sponsors.

Dr REN Minghui (China)<sup>1</sup> said that the report should have reproduced points contained in the 2007 Beijing Declaration on Food Safety, including those relating to food safety awareness, regulatory regimes, policies, education and international communication. Food safety was a complex issue: food producers should bear the primary responsibility but intergovernmental coordination was also important. His Government had legislated in June 2009 to reinforce the risk monitoring of food safety along the whole food-production chain; that would be extended progressively to cover rural food pollutants and foodborne diseases. He supported the draft resolution and said that China would continue to work with the International Food Safety Authorities Network, sharing information and data with the Secretariat and other Member States. China would require further technical support from the Secretariat on risk evaluation management.

Mr ADAM (Israel)<sup>1</sup> recalled that foodborne and waterborne diarrhoeal diseases were major causes of childhood deaths, along with other preventable diseases such as pneumonia. He supported WHO's food safety strategy, and commended the organization by the Secretariat of a seminar on bridging the research policy gap in food safety in October 2009. Israel's Centre for International Cooperation was among research centres that were sharing knowledge and technology to prevent foodborne diseases, and to improve water management and treatment, in developing countries. Israel was a sponsor of the draft resolution.

Dr AHMAD (Food and Agriculture Organization) expressed satisfaction with the synergies achieved in the collaboration between WHO and his Organization. FAO's new emergency prevention system for food safety complemented the International Food Safety Authorities Network, and together

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

they covered all sectors of food safety from primary production to consumption. FAO's food-chain approach was well positioned to counter possible threats at different stages of the supply chain. Collaboration between the health and agriculture sectors should further enhance the effectiveness of food-control systems and improve consumer protection. The WHO Foodborne Disease Burden Epidemiology Reference Group provided essential information to support policy decisions. International coordination on scientific advice was encouraging, notably the Codex Alimentarius Commission. The technical scope of that advice should be expanded so that all decisions on food safety could be taken on the basis of scientific evidence. Recent efforts to establish a trust fund for scientific advice initiatives required greater donor support. The joint FAO/OIE/WHO Global Early Warning and Response System for Major Animal Diseases had proven essential, for example during the recent influenza emergencies. He supported the draft resolution, and emphasized the need to sustain funding for joint FAO/WHO normative work on food safety.

Dr SCHLUNDT (Food Safety and Zoonoses) recognized that food safety was an international problem, as had been emphasized in the 2007 Beijing Declaration. WHO would continue to work closely with FAO to encourage a strategic integrated approach to human and animal health, including animal feed, especially in relation to zoonotic diseases. With regard to scientific advice, he agreed with Member States on the importance of common international food safety standards. Care must be taken to ensure adequate funding for all relevant programmes, including Codex standards and other scientific advice initiatives. The International Food Safety Authorities Network could be used to improve emergency response capabilities in both developing and developed countries. The inclusion of a laboratory component would strengthen food safety capacity as a whole.

The DIRECTOR-GENERAL stressed the importance of efficiencies in dealing with a complex, cross-cutting issue such as food safety. She acknowledged progress in multisectoral collaboration, covering the entire food chain from farm to table, clarity in government policies, and cooperation between United Nations agencies. It was also important to take into account the globalization of food. There was a need to continue promoting and supporting health and prevention initiatives in national health ministries. She welcomed the draft resolution, which encouraged WHO in its continued collaboration with FAO and OIE. She exhorted all States to work together, as WHO could not be the sole provider of funding for every programme, for example, for capacity building to develop Codex standards in developing countries.

The CHAIRMAN encouraged developing countries to provide more input to the Codex system, which would mean budgeting for participation in Codex meetings instead of relying on outside support.

Dr YOUNES (Office of Governing Bodies) read out the proposed amendments to the draft resolution proposed by Canada on advancing food safety initiatives. A phrase should be added at the end of the fifth preambular paragraph, reading: "and in particular the participation of developing countries in this regard should be encouraged". The first part of the tenth preambular paragraph should read: "Acknowledging that climate change could be a factor in the increasing rates of some foodborne diseases,". Preceded by a comma, the phrase "taking into account that protection of food safety cannot lead to discrimination or a disguised restriction on international trade" should be added at the end of the eleventh preambular paragraph; and the first part of the twelfth preambular paragraph should read: "Acknowledging the continuing need for closer collaboration among the health sector and other sectors,".

In paragraph 1, subparagraph (2) should be amended to read: "to further develop and implement the core capacities as defined in Annex 1 of the International Health Regulations (2005), as applicable, and those required for participation in the International Food Safety Authorities Network (INFOSAN), specifically for food-safety events, including the development of systems for surveillance for foodborne disease and food contamination; risk assessment, traceability, risk management, including Hazard Analysis and Critical Control Points (HACCP) and risk communication; food safety

emergency response; and product tracing and recall, and strengthen laboratory capacity;”. Preceded by a comma, the phrase “in a transparent manner” should be added to the end of subparagraph (3). The last part of subparagraph (4) should read: “... and improve the health outcomes of populations, in particular the vulnerable groups;”. The first part of subparagraph (5) should read: “to establish or improve the evidence base ...”; and the first part of subparagraph (8) should read: “to promote dialogue and collaboration among human health, veterinary and food-related disciplines, within and among Member States, focused on ...”.

In paragraph 2, subparagraph (1) should read: “to develop the International Food Safety Authorities Network further through the implementation of the WHO global strategy for food safety; to encourage communication and technical exchange of risk assessments and best practices among members of the Network; to facilitate Member States’ involvement in the Network’s operation and development; and to encourage additional membership into the International Food Safety Authorities Network;”; and subparagraph 6 should read: “to promote research, including the safety and quality of traditional foods and investigation of the association of foodborne hazards with acute and chronic diseases, in order to support evidence-based strategies for the control and prevention of foodborne and zoonotic diseases, such as the hazard analysis and critical control points;”. A new subparagraph (10) should be added, reading: “to establish with the International Food Safety Authorities Network an international initiative for the collaboration of laboratory partners in support of surveillance for foodborne disease, identification of food contamination and emergency response, including outbreak investigation and linking product to illness to support recall, to also include the establishment of mechanisms for data sharing;”. The current subparagraph (10) would then be renumbered as subparagraph (11).

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

**Prevention and control of noncommunicable diseases: implementation of the global strategy:**  
Item 4.9 of the Agenda (Document EB126/12)

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that, as extensive debates had produced little significant change, the marketing of food and non-alcoholic beverages to children should be more strongly considered in the set of recommendations annexed to the report. Furthermore, those recommendations should be limited neither to children under 12 years of age, nor to such traditional forms of marketing as television advertising; they should also cover new and less obvious forms of marketing, including the use of non-licensed cartoon characters designed to appeal to children in advertising unhealthy foods. Regarding the coverage of promotions, he pointed out that not all food companies had signed voluntary pledges to avoid marketing to children and some had different policies for different markets. The definitions of less healthy foods needed greater consistency in order to ensure that voluntary restrictions were evenly applied. A reference to energy should be made in several of the recommendations in order to include high-calorie foods within their scope. He said that further emphasis, and regular progress reports, on implementation of the Framework Convention on Tobacco Control would be welcome.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, said that the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Ukraine, the Republic of Moldova and Armenia, aligned themselves with his statement. The prevention and control of noncommunicable diseases merited the priority assigned to it by the Director-General; the dramatic increase in preventable noncommunicable diseases required concerted action at all levels. Political focus on the control of risk

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<sup>1</sup> Resolution EB126.R7.

factors, including the consumption of tobacco, salt, fat and alcohol, was also required, together with improved living and working conditions, effective health systems and preventive measures.

The action plan for the global strategy for the prevention and control of noncommunicable diseases provided a first step towards combating the alarming trends. Prevention of such diseases should be further integrated into global development work. He welcomed the set of recommendations against the irresponsible marketing of foods and non-alcoholic beverages to children. The European Union had produced its own list of unfair marketing practices in that context and supported all such actions, their monitoring and evaluation. Parents and schools were vital to promoting nutrition and health education at an early age.

All major elements of the global strategy to tackle noncommunicable diseases, including health determinants and social factors, must be integrated into a joint approach to implementation; that could not be achieved by the health sector alone. Furthermore, the promotion of health and the prevention of noncommunicable diseases should be integral to all health-care services.

Inclusive leadership, universal coverage, fair financing and primary health care centred on the patient were all principles on which to develop and sustain strong health systems. Large population groups suffering from, or at risk of, noncommunicable diseases needed more effective organization of systems. Capacity building for Member States to meet the challenges posed by noncommunicable diseases would be crucial to the future work of WHO and supported by the European Union, as would intersectoral efforts to implement measures set forth in the action plan. Future resource allocations must therefore be commensurate with the share of noncommunicable diseases in the global disease burden.

Dr SEDYANINGSIH (Indonesia) said that the perceptive report reflected the urgent need for prevention and control of noncommunicable diseases. The prevalence of those diseases in ageing populations was growing as a result of higher life expectancy, and their nature had implications for social and public health spending. Cardiovascular diseases, cancer, chronic respiratory diseases and diabetes were responsible for more than half all deaths globally. In Indonesia, there had been an epidemiological shift in the causes of mortality from communicable to noncommunicable diseases, a pattern that paralleled the demographic transition of patient age from the younger to older populations. Most noncommunicable diseases, however, were preventable through the elimination of shared risk factors such as tobacco use, unhealthy diet and physical inactivity.

The implementation of prevention strategies was crucial in developing countries; the management of noncommunicable diseases and their risks was an additional financial burden. Indonesia wished to participate in the monitoring and evaluation of the Global Strategy on Diet, Physical Activity and Health. It had recently legislated on tobacco control and was taking steps to ratify the WHO Framework Convention on Tobacco Control. She urged continued technical support, particularly for developing countries needing to increase capacity building, epidemiological profiling and risk-factor surveillance.

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, said that the fragile health systems in African countries were being further weakened by the rise in noncommunicable diseases, to which insufficient attention had been devoted. Cardiovascular diseases, strokes and diabetes mellitus could be largely avoided through the elimination of such risk factors as tobacco use, unbalanced diet and a sedentary lifestyle.

The WHO STEPwise approach to chronic disease risk factor surveillance had been implemented in 23 African countries and had provided data for awareness-raising activities on noncommunicable diseases. Other activities had included holding capacity-building workshops, elaborating national plans and establishing a cancer register. WHO had also been active in prevention, early screening and primary care. Training and health-promotion activities had included community-based action to encourage healthier diets and active lifestyles among schoolchildren. Implementation of the WHO Framework Convention on Tobacco Control was under way and several countries had enacted anti-tobacco laws and conducted sensitization campaigns on the harmful effects of alcohol. All Member States in the Region had participated in the International Conference on Diabetes and Associated Diseases (Mauritius, 12–14 November 2009), a meeting supported by WHO.

Strengthened systems for monitoring noncommunicable diseases in the Region were needed, by defining base indicators and using standardized data-collection methods, together with innovative financing, especially in poor countries with no social security systems in place. The availability of resources for the implementation of action plans for the prevention and control of noncommunicable diseases seriously challenged a continent already facing a multitude of priority demands.

Ms TOELUPE (Samoa) said that the Western Pacific Regional Action Plan for Noncommunicable Diseases<sup>1</sup> was aligned with the global strategy for the prevention and control of those diseases, which were regarded as a pandemic in Pacific island States such as Samoa, with substantial negative impacts on their health systems and economies. The inclusion of noncommunicable diseases in the resolution on monitoring achievement of the health-related Millennium Development Goals was heartening.

Samoa would require significant assistance to implement the recommendations contained in the report on prevention and control of noncommunicable diseases. It had held the Samoa Food Summit in August 2009 and its health plan advocated a whole-society approach as part of the Healthy Islands concept.

WHO's Global Noncommunicable Disease Network, recognizing the clear linkages between specific noncommunicable diseases and risk factors, aimed to harmonize disjointed efforts in those areas. WHO should follow suit with a more integrated approach to tackling noncommunicable diseases. She requested technical support in linking and balancing the competing demands of public health promotion and of policies driven by economic considerations.

Dr DAHL-REGIS (Bahamas) endorsed the statement made by the member for Hungary. The profile of noncommunicable diseases had been raised and the support of non-health sectors was vital in the fight against them. The risk factors had been widely identified and she shared the concern about the marketing of unhealthy foods to children, among whom there was an epidemic of obesity in the Caribbean region. International collaboration, as well as regional and subregional support, was needed to tackle the problem of such diseases. She expressed the hope that the Board would support the proposal first made at a summit of Caribbean Heads of State in 2007 for the convening of a United Nations summit on noncommunicable diseases.

Mr CHAUDHRY (adviser to Ms Sujatha Rao, India) said that developed countries had a higher prevalence of noncommunicable diseases than developing countries such as India, where they were nevertheless afforded priority attention because of their growing incidence among the poor. As a result, India was launching a programme to prevent tobacco use.

A global strategy must embrace equitable access to treatment, the greatest barrier to which was the high cost of diagnostics and medicines. WHO should develop a strategy on both of those fronts without delay, and thus avoid a repetition of the sad experience of HIV/AIDS. WHO should also develop treatment protocols on the basis of rational use of technology and the principles of cost effectiveness, which would steer care providers away from commercial considerations; that approach would yield dividends in the case of noncommunicable diseases.

Dr MUÑOZ (Chile), commending the report, said that obesity in children was a problem of epidemic proportions that would negatively affect the future prevalence of chronic noncommunicable diseases. Alongside the WHO Framework Convention on Tobacco Control and, if approved, the global strategy to reduce the harmful use of alcohol, the global strategy for the prevention and control of noncommunicable diseases should provide for a set of coherent measures in the areas covered. He welcomed the report's emphasis on the need for regulatory mechanisms, consistent with the realities of individual countries, which would provide for raising consumer awareness about *trans*-fatty acids,

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<sup>1</sup> Endorsed by the Regional Committee for the Western Pacific in resolution WPR/RC59.R5.



free sugars and salt in food. However, some of the wording was too cautious, especially on the aggressive advertising of junk foods. Public policies should seek to curb television advertising during children's viewing hours, as well as offers of free gifts and prizes with unhealthy goods, and other subliminal means of stimulating consumption. He looked forward to the next progress report.

Ms ARTHUR (alternate to Mr Houssin, France) recalled that, according to many participants at the Annual Ministerial Review of the United Nations Economic and Social Council in July 2009, combating the global proliferation in noncommunicable diseases should be considered a development goal. WHO had a crucial role to play, and the global strategy for the prevention and control of noncommunicable diseases must take account of how behavioural risk factors affected quality of life. Many of those behaviours could be changed. Emphasis should be placed on research, primary prevention and action to promote reduced tobacco and alcohol consumption, a balanced diet and regular physical exercise. Action on the social and environmental determinants of health, especially exposure to toxic substances such as pesticides, fertilizers and carcinogenic substances, was essential; WHO's work in that field should be better coordinated with, and even integrated into, the global strategy. The recommendations on the marketing of foods and non-alcoholic beverages to children appeared far-reaching but underestimated conflicts of interest between the food processing industry and the advertising sector. Reduced advertising of foods high in fat, sugar and salt intended for consumption by children should be emphasized. In that connection, recommendation 2 should be more detailed.

Dr REITENBACH (adviser to Dr Seeba, Germany), welcoming in particular the recommendations contained in the report on the marketing of foods and non-alcoholic beverages to children, said that her Government was working with industry, in a multisectoral and multistakeholder framework, on a plan of action focusing on nutrition, children's eating habits and physical activity, and on a voluntary, self-regulatory code of conduct that sought to reduce the impact of such marketing, especially in schools. She proposed that the word "and" in the phrase "stepwise and comprehensive" in recommendation 3 should be replaced by "or"; that "Settings where children gather" at the beginning of recommendation 5 should be replaced by "Schools, child-care and other educational settings"; and that in the penultimate line of recommendation 6 the words "including self-regulatory initiatives" should be inserted between "other stakeholders" and "while protecting the public interest".

Dr MOHAMED (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that noncommunicable diseases accounted for half the morbidity in the Region; no expense should be spared to implement the global strategy for their prevention and control. Most were caused by modifiable behavioural risk factors and civil society could help to contain their spread. The requisite primary health-care protocols and a programme should be introduced for early detection and treatment, especially among adults aged 40 years or older, with a review of screening techniques for conditions such as kidney disease, hypertension and diabetes. Countries in the Region had implemented, in addition to the global strategy, a regional strategy for cancer prevention and control. They had fostered cooperation between governments and nongovernmental organizations; developed partnerships and networks; established the Eastern Mediterranean Approach to Noncommunicable Diseases Network; and endorsed the Doha Declaration on Noncommunicable Diseases and Injuries. Noncommunicable diseases should be included in the Millennium Development Goals.

Dr ABDESSELEM (Tunisia) supported the action plan presented in the report. WHO must provide the financial and human resources needed to implement it because more forceful efforts to combat noncommunicable diseases and their dramatic social and economic consequences were crucial for sustainable global development and growth. He welcomed the recommendations on the marketing of food and non-alcoholic beverages to children and wanted to see a progress report in two years on their implementation. Meanwhile, a new paragraph should be inserted in resolution EB126.R4 requesting that the impact of noncommunicable diseases and tobacco use on the Millennium

Development Goals be included in the agenda for the United Nations Millennium Development Goals Summit scheduled for September 2010.

Dr GOPEE (Mauritius) described the extent to which his country's population had been affected by the high prevalence of diabetes and associated diseases, mental health problems and cardiovascular diseases owing to alcohol consumption and tobacco use by adults and, increasingly, young people. More was spent on those two commodities than the combined budgets of the ministries of health and education. Concern about the situation had been reflected locally in an international conference on diabetes and associated diseases organized with the support of WHO headquarters and regional offices in November 2009. Nevertheless, his Government was carrying out an aggressive prevention and control campaign; regulations had been put in place to control tobacco use; and the consumption of alcoholic beverages in public places, as well as sales to minors and advertising, promotion and sponsorship, had all been prohibited. Meanwhile, in spite of strong opposition, the Government had recently banned the sale in school canteens of foods high in fat, sugar and salt, recommending other, healthier, foods. It was also campaigning, with media support, to encourage physical activity, including yoga, through both schools and community outreach programmes.

Mrs BUGROVA (adviser to Dr Starodubov, Russian Federation) said that methodological and technical assistance by WHO would be important in the formulation and application of national plans to combat noncommunicable diseases, the training of health personnel, the introduction of modern diagnostic methods and the treatment of patients. Her Government's recent efforts in the prevention and treatment of noncommunicable diseases with a significant social impact had already visibly affected health indicators: since 2006, first time registration of disability cases had declined and mortality had dropped by 5.6%. Since 2009, a programme had been in progress to promote healthy lifestyles; to counter alcohol and tobacco use; and to uncover risk factors for noncommunicable diseases in ostensibly healthy individuals. Future efforts would see introduction of new pedagogical standards, the promotion of popular sports and information campaigns. The Russian Federation would like to see its own institutions and specialists participate in WHO programmes and projects on noncommunicable diseases and renewed its offer to convene, in cooperation with WHO, an international ministerial conference on noncommunicable diseases in 2011.

Ms ROCHE (New Zealand) welcomed the suggestion by members to strengthen the emphasis on tobacco control. Regarding the set of recommendations in the report, she noted that recommendation 6 stated that governments should be the key stakeholders in developing policy and providing leadership. However, they must also be urged to work with relevant food and advertising industries and other agencies to maximize the implementation of policies. In her country, for example, a self-regulatory system administered by the relevant authority was in effect. Recommendation 8 required mention of an appropriate time frame so that all countries and multinational corporations worked towards the same goals at the same time. In general, it should be recognized that approaches to implementation and the extent to which the recommendations were given effect should be worked through with stakeholder groups. At the national level, long-term commitment to an agreed approach, closely linked to obesity prevention policies, was needed.

Ms BILLINGS (alternate to Dr Dodds, Canada) said that her country remained committed to the implementation of the global strategy for the prevention and control of noncommunicable diseases. Despite wide agreement on the serious nature of the problem, global efforts were needed to reduce the number of unnecessary and premature deaths caused by such diseases, primarily through a focus on prevention. Her Government was very concerned about levels of childhood obesity; there was increasing evidence linking marketing to the eating preferences and behaviour of children and young people. There should be further discussions at the Health Assembly on the implementation of the global strategy and on strengthening and clarifying the recommendations on the marketing of food and beverages to children.

Dr ALBRAIKY (alternate to Dr Al Darmaki, United Arab Emirates) said that, when the global strategy had been adopted in 2008, Member States had been urged to develop national strategies to reduce the incidence of noncommunicable diseases, analyse causative factors and improve public services to those affected by such diseases. Her Government had set up administrative units to devise national and local strategies for the prevention of noncommunicable diseases: it already had a strategy to combat cancer and was about to institute others to combat respiratory and cardiovascular diseases, in accordance with WHO's recommendations. It had been applying the global strategies against cancer, diabetes, cardiovascular diseases and chronic respiratory diseases and had taken steps to combat tobacco use. It would work with other governments and the Secretariat in implementing regional plans in those areas.

Mr D'AVINO (Italy)<sup>1</sup> drew attention to the wide consensus on the growing threat to global public health represented by noncommunicable diseases. A priority area under the action plan on such diseases concerned the responsible marketing of food and non-alcoholic beverages to children. In that area, his Government was cooperating closely with the various stakeholders, nutrition experts, industries, nongovernmental organizations and academia. Italy emphasized cooperation with the food industry, on the basis of scientific evidence, in campaigns to change product composition in favour of a healthier diet; enhance the clarity of available information; promote healthier lifestyles through physical activity; and encourage greater responsibility in advertising directed at children. It was also important to examine the kind of cooperation that might be established with the private sector.

Mrs NYAGURA (Zimbabwe)<sup>1</sup> said that, while noncommunicable diseases accounted for more than half of global mortality, there was a glaring disparity in the funding to combat such diseases. Hypertension, for example, was more prevalent than HIV/AIDS in the African Region. Noncommunicable diseases caused a huge drain on individual households and on national economies, further straining health systems. She called for a realignment of resources; an integrated approach to redressing the situation; technical support by the Secretariat for the implementation of policies; the establishment of viable health information systems; and effective strategies for health promotion. Donors should consider supporting the provision of essential medicines to people living with noncommunicable diseases in developing countries.

Ms QUACOE (Côte d'Ivoire)<sup>1</sup> encouraged the Secretariat to support Member States in strengthening their systems for monitoring noncommunicable diseases through the identification of core indicators and the collection of data on risk factors. Consideration should be given to devising innovative means of financing treatment of noncommunicable diseases, especially in developing countries, in view of their weak social welfare systems, the heavy burden of morbidity caused by such diseases and the cost of treatment.

Dr REN Minghui (China)<sup>1</sup> said that his Government agreed with WHO's analysis of the global situation with regard to noncommunicable diseases and the estimates of trends in their development. He welcomed the Organization's prioritization of prevention and control of such diseases and supported the efforts of the Secretariat and Member States to make combating noncommunicable diseases an important part of the Millennium Development Goals. China had a high disease burden from noncommunicable diseases, and a mortality rate of about 75% from cardiovascular diseases, cancer, chronic respiratory diseases and heart disease. In 2005, the economic burden of noncommunicable diseases had been equivalent to about 12% of gross domestic product. In response, his Government planned to formulate and strengthen prevention and control policies and plans, promote multisectoral collaboration, and implement the WHO Framework Convention for Tobacco Control. It was striving to involve the whole population in the prevention and control of

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

noncommunicable diseases; to promote healthy lifestyles; to introduce appropriate technology at grassroots level; and to integrate prevention and control of cardiovascular diseases, diabetes and cancers into community health and primary health care. China was ready to work with the Secretariat to strengthen its internal coordination in order to better manage its budgets and resources.

Mr HOHMAN (United States of America)<sup>1</sup> said that the recommendations on the marketing of food and non-alcoholic beverages to children could significantly help Member States to promote healthier patterns of eating. Reducing the growing epidemic of childhood obesity was a priority for his Government, and especially for the First Lady, who had raised awareness of the importance of healthy eating habits. He was pleased to see that the stakeholder consultations carried out by the Secretariat had resulted in considerable improvements in the recommendations and he welcomed the range of implementation mechanisms mentioned. There was a shared responsibility for tackling the growing obesity epidemic. Governments, industry, nongovernmental actors and individuals all had roles to play, and no stakeholder should be left out.

Mr ADAM (Israel)<sup>1</sup> said that WHO's work on prevention and control of noncommunicable diseases had resulted in important global and national action. Israel was committed to implementing tobacco control measures in line with the WHO Framework Convention on Tobacco Control, and had devised an interministerial action plan on diet, physical activity and the prevention of chronic diseases, in line with the global strategy. More collection of data by the Secretariat on the effectiveness of interventions to reduce obesity could be useful for work at country level. His country was currently developing an approach to the issue of marketing to children and valued the recommendations contained in the annex to the report.

Ms DE MORA (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, noted the strong links between poverty and noncommunicable diseases. Growing health inequities must be resolved if global health promotion was to be achieved. Low-income communities must be empowered to conduct their own health promotion activities in order to curtail the spread of noncommunicable diseases. Through coordinated approaches to tackling contemporary health problems, her organization would continue its partnership with WHO at national and international levels. National societies were already assisting governments to build community capacity in order to find sustainable solutions to address the social determinants of poor health.

Mr CHAN Xuanhao (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and also on behalf of the International Council of Nurses, said that front-line health professionals in hospitals and particularly in communities were in a position to facilitate action to counteract chronic disease, identify unhealthy lifestyles and provide corrective health promotion services such as smoking cessation support. However, a sustainable health workforce to deliver such services was needed. WHO estimated the minimum number of health workers needed to deliver basic care at 2.3 per 1000 population; crisis countries had less than 1 health worker for every 1000 population. Only through sustained and urgent funding, directed to health systems and the training of health professionals, could the challenge of prevention and control of noncommunicable diseases be met. Regarding objectives 4 to 6 on promoting sustainable research and partnerships such as the proposed Global Noncommunicable Disease Network and the global tracking of progress, WHO should strengthen the role of health professionals in health promotion, surveillance, prevention and management of chronic noncommunicable diseases at both national and regional levels.

Ms ALDERSON (World Heart Federation), speaking at the invitation of the CHAIRMAN and also on behalf of the International Diabetes Federation and the International Union against Cancer,

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

said that the Board should take the following specific actions: support the resolution being put forward at the United Nations General Assembly requesting the holding of a special session on noncommunicable diseases; support the inclusion of indicators on noncommunicable diseases in Millennium Development Goal 6 at the United Nations Millennium Development Goals Summit in September 2010; ensure that noncommunicable diseases were included in discussions on the successor goals of the Millennium Development Goals; and address the availability and affordability of essential medicines for noncommunicable diseases in developing countries. Member States should address the main obstacles to implementing the global strategy cited in the Secretariat's report without further delay.

Mr FAIRCLOTH (Corporate Accountability International), speaking at the invitation of the CHAIRMAN, said that the recommendations contained in the report upheld important principles including a rationale for Member States to take action to reduce the impact of food marketing on children; they also restated the importance of governments in setting policy, most important considering the food industry's promotion of ineffective self-regulatory and voluntary approaches. Nonetheless, the recommendations should be strengthened. Statutory regulation, rather than voluntary corporate agreement, was the best approach for reversing the impact of the food industry's direct marketing of unhealthy food to children. Effective action to address cross-border marketing must be identified. The WHO definition of unhealthy foods lacked specificity: the food industry would continue to bend it and market junk food directly to children. Technical support should be developed by WHO for the nutrient profiling of foods. WHO must monitor the marketing of foods and beverages to children and develop preventive measures to guard against industry conflicts of interest. Article 5.3 of the WHO Framework Convention on Tobacco Control provided precedent and guidance on how industries with potential conflicts of interest should interact with public health policy.

Ms NORTON (Consumers International), speaking at the invitation of the CHAIRMAN, said that the recommendations took an important step towards protecting children but they could be strengthened. The current definition of the foods to be covered excluded those high in vegetable oil. It should be amended to include all energy-dense foods that were poor in nutrients and high in fat, sugar and salts. She urged for more specific recommendations to define broadcast marketing, non-broadcast marketing, the age of children and the nutrient profile of the foods covered. That would clarify guidance to governments as to what effective regulation should include and increase the likelihood of the recommendations achieving the stated aims. Specific definitions developed by a European network on the marketing of food to children could be included in the WHO recommendations. The Secretariat should be mandated to develop technical support for the nutrient profiling of foods and for monitoring the marketing of foods to children; that would ensure public health criteria, free from conflicts of interest. It should be given a mandate also to devise mechanisms to meet concerns raised about the cross-border marketing of foods and to facilitate uniform implementation of the recommendations.

Dr ADEBAYO (Inter-African Committee on Traditional Practices affecting the Health of Women and Children), speaking at the invitation of the CHAIRMAN, drew attention to the Nairobi Call to Action adopted at the 7th Global Conference on Health Promotion (Nairobi, 26–30 October 2009). Member States should mandate the Director-General to develop a global health promotion strategy and action plan, with regional follow-up; assist Member States in developing sustainably funded structures; set up reporting mechanisms; and gather and disseminate evidence on the social, economic, health and other benefits of health promotion. Civil society would provide a vital link in spanning the health equity gap. By working directly in local communities at the grassroots level and in partnership with their governments, their responsibilities would promote the health and well-being of all citizens, build the capacities of communities, and find sustainable solutions for tackling the social determinants of poor health.

Professor MBEWU (Global Forum for Health Research), speaking at the invitation of the CHAIRMAN, welcomed the report's recommendations for more research towards the prevention and

control of noncommunicable diseases, particularly in resource-poor settings. His organization estimated that five major governments had invested US\$ 12 200 million in research on the five noncommunicable diseases with the highest burden in 2008; and that 68.4% of research and development expenditure by pharmaceutical companies was devoted to noncommunicable diseases. However, it remained unknown how much of that research was relevant to low- and middle-income countries. Therefore, research and development expenditure on noncommunicable diseases should be accurately tracked at both national and global levels; that would assist the setting of priorities and the monitoring of progress on prevention and control.

Dr ALWAN (Assistant Director-General) thanked speakers for their important contributions. The set of recommendations in the report had been developed in accordance with a mandate given to the Secretariat by the Health Assembly in resolution WHA60.23, which specifically referred to reducing the impact of foods high in saturated fats, *trans*-fatty acids, free sugars or salt. However, under the recommendations, Member States could determine which foods were to be covered by their national plans to reduce marketing; high-energy foods and foods high in vegetable oil could be included. The recommendations did not include a specific age limit; Member States were free to establish their own. Paragraph 19, on implementation by Member States, stated that important definitions included the age group for which restrictions should apply. Marketing communication channels that appealed to children were addressed in paragraphs 8 and 19. The amendment proposed by the member for Germany to recommendation 3 was acceptable, but the amendment to recommendation 5 would narrow the intent and might create many loopholes. The amendment to recommendation 6 might be seen as creating a bias towards industry-led self-regulation, which went against the spirit of allowing each Member State to choose the course it considered best. He thanked the member for New Zealand for support in implementing the global strategy and the development of the recommendations. Referring to her comment on recommendation 6, he said that the recommendation already referred to a multistakeholder platform, which could include the private sector if individual governments so wished.

The DIRECTOR-GENERAL, responding to the call from the member for Hungary and others for more resources to be allocated to prevention of noncommunicable diseases, said that the help of Member States would be needed. The Programme budget and contributions from Member States provided lamentably few resources for noncommunicable diseases. In 2008 and 2009, despite the very limited flexibility she had been given, she had maximized the budgetary allocation to that area. Although much was said about the importance of noncommunicable disease prevention, progress was insufficient. She endorsed the remark by the representative of the United States that every stakeholder must play a role. The Secretariat would certainly play its part, but its best contribution would be to improving health system capacity to deal with noncommunicable diseases through an integrated approach. Several Board members had spoken of ensuring that essential medicines were affordable and accessible, and she would look into making additional efforts in that area.

**The Board noted the report.**

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

## **NINTH MEETING**

**Thursday, 21 January 2010, at 18:15**

**Chairman:** Dr E. SEDYANINGSIH (Indonesia)

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

**Tuberculosis control:** Item 4.11 of the Agenda (Document EB126/14)

- **Progress and long-term planning**
- **Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis**

Mr PRASAD (adviser to Ms Sujatha Rao, India) said that an estimated 131 000 cases of multidrug-resistant tuberculosis had emerged in his country in 2007 alone. India accounted for almost one fifth of the annual global incidence of tuberculosis: the need to expand diagnostic and treatment services under the DOTS Plus strategy was urgent. His Government aimed to introduce treatment for patients who were still sputum-positive after supervised re-treatment (category IV patients) across the country by 2010, and provide access to laboratories for quality-assured diagnosis of multidrug-resistant pulmonary tuberculosis by 2012. By that time, the country should have the capacity to diagnose and treat 32 000 cases of multidrug-resistant tuberculosis per year.

The Revised National Tuberculosis Programme was consistently meeting the international targets for global tuberculosis control and cooperated with the national HIV programme in areas with high rates of coinfection. The Government was revising upwards the targets for case detection and treatment success; it aimed for universal access to prevention, diagnostic and treatment services. It was in contact with health-care providers in the private and corporate sectors as well as nongovernmental organizations, faith-based organizations and the Indian Medical Association through public-private mixed schemes and other mechanisms. It was promoting the rational use of first-line and second-line tuberculosis medicines, and had imposed severe penalties for the sale of such medicines without a valid prescription. Pharmaceutical manufacturers were encouraged to participate in quality assurance through the Green Light Committee. The national programme procured tuberculosis medicines from suppliers holding the WHO certification for good manufacturing practices. The pre-dispatch testing of medicines was mandatory, and independent laboratories had been recruited for post-dispatch testing. He called upon WHO to strengthen the prequalification mechanism.

The Government planned to expand capacity by creating 43 laboratories accredited for the diagnosis and monitoring of multidrug-resistant tuberculosis, and equipped with advanced technologies. Laboratories currently using culture systems and undertaking drug susceptibility testing, in both the public and the private sectors, would be accredited in order to increase capacity.

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region, said that the HIV/AIDS pandemic had exacerbated the epidemic of tuberculosis, already a serious public health problem in the Region. The Region had been notified of 9000 cases of multidrug-resistant tuberculosis from more than 30 countries between 2007 and 2008; and seven countries had already notified cases of extensively drug-resistant tuberculosis. The cure rate of only 75% could be attributed to shortcomings in the implementation of the DOTS strategy, with many patients failing to complete treatment or being lost to follow-up.

The Region lacked diagnostic capacity: 36 countries could diagnose drug-resistant tuberculosis, but only two had the facilities for diagnosis of extensively drug-resistant tuberculosis and 12 countries had no facilities for diagnosing multidrug-resistant tuberculosis. There were shortages of second-line medicines in some countries. The Regional Office had set up a surveillance system to monitor drug resistance; organized regional and national courses on multidrug-resistant tuberculosis; and provided support for some laboratories. Rapid surveys of multidrug-resistant and extensively drug-resistant tuberculosis had been conducted, and 10 countries had obtained second-line medicines at reduced prices. At its last session, the Regional Committee for Africa, in resolution AFR/RC59/R2, called upon Member States to strengthen their public health laboratories and adopt measures against infectious diseases, especially multidrug-resistant and extensively drug-resistant tuberculosis.

Developing countries, especially in Africa, needed more technical and financial support to combat tuberculosis and coinfection with HIV, whose increased incidence had been recorded. They needed to strengthen their technical and human capacity for the diagnosis of multidrug-resistant and extensively drug-resistant tuberculosis. Second-line medicines should be supplied free of charge. Follow-up activities and drug-resistance monitoring should be incorporated in national programmes, and awareness-raising activities should be conducted in communities.

Dr ABDI (Somalia) said that the Beijing Call for Action on Tuberculosis Control and Patient Care and the Health Assembly, in resolution WHA62.15, demanded urgent action. Only eight countries in the Eastern Mediterranean Region had conducted drug-resistance surveys. According to WHO's fourth global report on drug resistance,<sup>1</sup> the prevalence of multidrug resistance in the Region was 2% in new tuberculosis cases and 35.3% in re-treated cases. There were an estimated 25 475 multidrug-resistant cases in the Region every year.

At its fifty-sixth session in October 2009, the Regional Committee for the Eastern Mediterranean, in resolution EM/RC56/R.10, called for the implementation of national strategic plans for the management and care of multidrug-resistant and extensively drug-resistant tuberculosis; mandatory notification of such cases under the International Health Regulations (2005); the sale of tuberculosis medicines by accredited public and private providers only; and the strengthening of national drug regulatory authorities to ensure that national pharmaceutical manufacturers produced tuberculosis medicines of assured quality. A five-year regional strategic plan was currently being devised to provide universal access to diagnosis and treatment for multidrug-resistant and extensively drug-resistant tuberculosis by 2015.

Mrs BUGROVA (adviser to Dr Starodubov, Russian Federation) observed that the collective response was beginning to yield results. Indicators of global tuberculosis incidence were beginning to fall, and the global cure rate of 87% exceeded the target figure.

As the report indicated, most of the funding for tuberculosis programmes in the European Region went to the Russian Federation. The Government had strengthened the State's tuberculosis monitoring system: almost all laboratories throughout the country had modern equipment and facilities for rapid diagnosis. Testing of smear-positive cases for drug resistance had reached a coverage rate of 82%, and an average reduction of 4% in the prevalence of multidrug-resistant tuberculosis had been achieved in pilot areas of the country. Russian experts, in collaboration with WHO, had developed a reliable and effective mechanism for the implementation of antituberculosis measures. The Government had succeeded in monitoring the tuberculosis situation effectively, and was willing to share its experience with others.

Her Government was increasing the funding of tuberculosis programmes, and planned to allocate 10 000 million roubles for the purchase of second-line medicines in the period to 2015. She commended the coordinating role of the Secretariat, which had provided technical assistance in monitoring the tuberculosis situation and drafted international standards.

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<sup>1</sup> Document WHO/HTM/TB/2008.394.



Dr TAKEI (adviser to Dr Omi, Japan) commended the Secretariat's work on tuberculosis globally, but expressed concern about the slow progress being made in the African and European regions. Japan was willing to share its experience; actions had included financial support for a network of tuberculosis laboratories and technical support for the development of human resources in the Western Pacific Region. Between 2000 and 2007, the prevalence of tuberculosis in that Region had decreased by 4.5% annually and mortality by 3.7% annually.

In both the public and private sectors, maintenance of high standards of therapy under the DOTS strategy by all providers was the mainstay of the fight against tuberculosis, including multidrug-resistant and extensively drug-resistant forms. Research and development were also needed, with in particular better laboratory workforces, training, and monitoring and evaluation, as well as affordable tools for diagnosis and treatment for use in developing countries.

Tuberculosis control programmes should contribute to the strengthening of health systems. Without a robust financing system or appropriate human resources, achieving the Millennium Development Goals and other health targets would be difficult. The Director-General and the Regional Directors had provided powerful leadership for the strengthening of health systems. The Secretariat should continue to operate vertical prevention programmes, such as the tuberculosis programme, alongside horizontal measures to strengthen health systems. He emphasized surveillance of tuberculosis in priority countries.

Dr REN Minghui (China)<sup>1</sup> commended the Secretariat's work on tuberculosis prevention and treatment. His Government's tuberculosis policy was guided by the Global Plan to Stop TB 2006–2015. By the end of 2005, China had achieved 100% DOTS coverage, and currently had a cure rate of more than 85% and a case detection rate of 79%. The Government was particularly interested in the quality and effectiveness of DOTS treatment and in research and development for new diagnostic tools, vaccines and medicines, particularly for developing countries. More attention should be paid to prevention and treatment of tuberculosis, especially among migrants and people with HIV. The international community should provide funding to support countries with a high burden of tuberculosis. WHO should increase its collaboration in that area with other partners, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Ms VAN WOERSEM (Netherlands)<sup>1</sup> welcomed the report and commended the global leadership of the Stop TB Partnership, including WHO, in the fight against tuberculosis. She shared the concerns described in the report: in particular, Member States should not rely solely on the Stop TB Partnership or the Global Fund to help them to reach their targets under the Global Plan to Stop TB 2006–2015. Lack of funding and technical challenges were not the only problems. Member States would need to develop their infrastructure, emphasize community interventions, strengthen links with other programmes, particularly those on HIV/AIDS, and target groups that were hard to reach.

She expressed support in particular for the Regional Office for Europe. The Millennium Development Goals were achievable in the European Region only if countries reassessed their approaches and cooperated in strengthening national and cross-border tuberculosis programmes. She commended the Secretariat's work on impact measurement: the principle "know your epidemic" was relevant not only for HIV/AIDS, but for all programmes that targeted specific diseases.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that his organization was active in several areas of tuberculosis control, including case detection; implementing WHO's new policy on tuberculosis control in health-care facilities, congregate settings and households;<sup>2</sup> improving integrated care for patients coinfecting with tuberculosis and HIV; and supporting universal access to diagnosis, treatment and care. In

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

<sup>2</sup> Document WHO/HTM/TB/2009.419.

collaboration with partners, his organization had been building global nursing capacity in the area of tuberculosis. In its “training of trainers” approach, nurses experienced in tuberculosis and HIV care were trained to pass on their knowledge to colleagues in local health facilities. Since 2005, his organization had trained 752 nurses in 14 countries with a high burden of tuberculosis in Africa, Asia and eastern Europe: those nurses had then trained more than 16 000 others. The programme would be extended and its broad stakeholder approach could make a substantial difference.

Dr NAKATANI (Assistant Director-General) said that he was greatly encouraged by the commitment expressed by speakers. Progress was being made towards the achievement of Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases), and the incidence of tuberculosis had been in decline since 2004, albeit slowly. Those gains would be lost without successful responses to multidrug-resistant and extensively drug-resistant tuberculosis and coinfection with HIV. The Global Plan to Stop TB 2006–2015 covered six main areas, particularly HIV coinfection and multidrug-resistant tuberculosis, but it would not be easy to find effective medicines and organize procurement and laboratory services. It would be essential to strengthen health systems by involving all health-care providers, empowering communities and people with tuberculosis, and promoting research. The most vital priority of all was to achieve high-quality DOTS treatment.

**The Board noted the report.**

**Viral hepatitis:** Item 4.12 of the Agenda (Document EB126/15)

The CHAIRMAN, introducing the item, drew attention to the draft resolution proposed by Brazil, which read:

The Executive Board,  
Having considered the report on viral hepatitis,<sup>1</sup>

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 viral hepatitis and the proposal therein for the establishment of a world day for the struggle against 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 responsible for most of the severe cases of hepatitis, and that in about 80% of those cases the infection becomes chronic;

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;

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;

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<sup>1</sup> Document EB126/15.

Reaffirming resolution WHA45.17 on immunization and vaccine quality which urged Member States to include hepatitis B vaccines in national immunization programmes;

Considering the proposal of WHO to reduce the liver cancer mortality rates and that viral hepatitis are responsible for 5% to 10% of cases of liver cancer;

Recognizing the need for actions to be taken to reduce the incidence of and to control viral hepatitis, to improve diagnostics and to institute treatment in all regions,

1. RESOLVES that 19 May shall be designated as the World Day for the Struggle against Viral Hepatitis 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 apply integrated methods for the prevention and control of viral hepatitis through multisectoral collaboration among health and educational institutions and associated participation of nongovernmental organizations and civil society;
- (2) 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;
- (3) to institute or strengthen national programmes for the prevention and control of viral hepatitis which have as their main elements health promotion, diagnosis, surveillance and the follow-up and treatment of people affected by viral hepatitis;
- (4) to assign national and international resources, either human or financial, for technical support in order to provide local populations with the most advanced and suitable means to meet the needs of local epidemiological situations;
- (5) to establish, as necessary, national legislative mechanisms for the use of the flexibilities stated in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to promote access to specific pharmaceutical products;<sup>1</sup>
- (6) to use all necessary administrative and legal means in order to promote access to preventive, diagnostic and treatment technologies;
- (7) to elaborate monitoring and evaluation tools of public policies on viral hepatitis in order to check the efficacy of preventive, diagnostic and treatment actions;
- (8) to implement and/or improve epidemiological surveillance systems in order to generate reliable information for guiding prevention and control measures;
- (9) to promote the celebration of 19 May each year as the World Day for the Struggle against Viral Hepatitis;

3. REQUESTS international organizations and financial institutions:

- (1) to provide support for building capacity in developing countries for increasing the use of reliable diagnostic and treatment methods suitable to local epidemiological situations;

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<sup>1</sup> 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.’

- (2) to assign resources for the prevention and control of viral hepatitis, providing support to countries in a equitable manner to provide technical assistance in the most efficient and suitable manner;
4. REQUESTS the Director-General:
- (1) to establish the necessary guidelines needed by Member States to establish the policies, 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 adopt measures for more precisely estimating the prevalence of viral hepatitis in the world;
  - (4) to support Member States in conducting events to celebrate the World Day for the Struggle against Viral Hepatitis;
  - (5) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on the implementation of this resolution.

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

<b>1. Resolution</b> Proposal for the establishment of a world day for the struggle against viral hepatitis	
<b>2. Linkage to programme budget</b>	
Strategic objective:	Organization-wide expected result:
1. To reduce the health, social and economic burden of communicable diseases.	<p>1.1 Policy and technical support provided to Member States in order to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies, and to integrate other essential child-health interventions with immunization.</p> <p>1.4 Policy and technical support provided to Member States in order to enhance their capacity to carry out surveillance and monitoring of all communicable diseases of public health importance.</p> <p>1.5 New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, with scientists from developing countries increasingly taking the lead in this research.</p>
<b>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</b>	
The resolution is consistent with the expected result. Indicators specific to prevention of viral hepatitis will be designed as needed.	
<b>3. Budgetary implications</b>	
<b>(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)</b>	
US\$ 30 million are needed for the next five years. Of this amount, one third (US\$ 10 million) is needed at headquarters for global planning and coordination between stakeholders, global policy guidance, and the provision of support to regional and country offices; two thirds (US\$ 20 million) are needed for support activities at regional and country levels.	

<p><b>(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)</b></p> <p>Total costs are estimated at US\$ 6 million per year.</p> <p><b>(c) Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010–2011?</b></p> <p>The Organization's hepatitis prevention activities involve a number of technical units. It is difficult to know the true amount of resources available for these activities as they may not be directly identified in the Programme budget and may, for example, be covered under references to blood safety, injection safety, food safety, cancer prevention, child immunization or treatment of opportunistic infections in HIV/AIDS.</p>
<p><b>4. Financial implications</b></p> <p><b>How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?</b></p> <p>Additional funding from voluntary contributions is expected through active resource mobilization.</p>
<p><b>5. Administrative implications</b></p> <p><b>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)</b></p> <p>Currently, most activities are performed at headquarters (policy and technical guidance, global advocacy and stakeholder coordination, and fund-raising) and in two WHO regions (Eastern Mediterranean and Western Pacific).</p> <p><b>(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below</b></p> <p>No.</p> <p><b>(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)</b></p> <p>At headquarters, at least two additional staff (full-time equivalents) will be required in the professional category, together with one staff member (full-time equivalent) in the general service category. During the biennium 2010–2011, one additional staff member (full-time equivalent) will be needed in the professional category in each of three regional offices (plus administrative support); during the biennium 2012–2013, three more staff (full-time equivalents) will be needed for the other regional offices (plus administrative support). A total of eight staff (full-time equivalents) will therefore be required in the professional category, together with three or four staff (full-time equivalents) in the general service category. In at least 10 countries, a dedicated national programme officer will be needed.</p> <p><b>(d) Time frames (indicate broad time frames for implementation of activities)</b></p> <p>The global programme will be expanded into the African, European, and Eastern Mediterranean regions in 2010, and into all regions during the biennium 2010–2011.</p>

Mr DE ALMEIDA CARDOSO (adviser to Dr Buss, Brazil) recalled that 2000 million people were infected with hepatitis B virus, despite an effective vaccine being available, and hepatitis C virus, against which there was no vaccine. Infection with hepatitis viruses was associated with complex cultural, socioeconomic and environmental factors. Prevention and control measures therefore required considerable commitment from governmental and nongovernmental organizations, health professionals, communities and other partners. The designation of a world day for the struggle against viral hepatitis would give impetus to national programmes and campaigns.

The draft resolution provided guidelines for research and development to improve access to technology for the prevention and control of viral hepatitis, particularly in developing countries and

vulnerable populations. As several amendments had been proposed in informal discussions, he suggested that its consideration be postponed until a revised text was available.

Dr GOPEE (Mauritius), speaking on behalf of the Member States of the African Region, said that the Region was home to 50 million carriers of hepatitis B virus. Hepatitis B and C viruses were even more prevalent and more infectious than HIV, leading to high morbidity (liver cirrhosis and liver cancer) and high mortality. In millions of cases every year they were transmitted through unsafe injection practices. Furthermore, the probability of transmission through the transfusion of unscreened or poorly screened blood was high; and contamination of medicine vials was a more serious cause of nosocomial infection than had previously been believed.

Vaccination with a safe and effective vaccine against hepatitis B had been integrated into the national immunization programmes of 45 of the 46 countries in the African Region. The Secretariat should collect the necessary evidence and develop policies for the screening and treatment of hepatitis B and C in the African Region, taking into account the constrained resources. Surveillance of trends in incidence and risk factors was also needed. WHO should appeal to pharmaceutical manufacturers to reduce the prices of medicines for the treatment of hepatitis, as they had done for HIV/AIDS. At present, the cost of treatment was prohibitive for many African countries.

Participants from some 20 sub-Saharan African countries at the second “Hepatitis B and C - the African Experience Exchange Conference” (Mauritius, 2–4 April 2009) adopted a declaration urging African States to scale up the diagnosis, prevention, treatment and care of hepatitis B and C and to strengthen health systems in order to promote universal access to treatment and care.

The CHAIRMAN suggested that consideration of the draft resolution be postponed until the next morning, when a revised text incorporating the proposed amendments would be available.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) recommended that, in the interests of time and efficiency and bearing in mind the Board’s heavy workload, every effort should be made to finish work on the item at the current meeting.

Mr DE ALMEIDA CARDOSO (adviser to Dr Buss, Brazil) explained that his proposal would enable the Board to work more quickly and efficiently with a clean text containing all the proposed amendments.

The DIRECTOR-GENERAL suggested that the debate on the agenda item should continue while a revised text containing all the proposed amendments was being prepared.

**It was so agreed.**

Dr AWAD (adviser to Dr Abdi, Somalia), speaking on behalf of the Member States of the Eastern Mediterranean Region, noted that viral hepatitis, although a growing concern for public health, had long remained on the margins of other competing health priorities. His Region was facing a silent epidemic of viral hepatitis, especially hepatitis B and C. Hepatitis A and E were also endemic in some countries. The financial cost of treating patients and the opportunity cost to health services were staggering. Current global efforts to implement prevention and control measures remained fragmented; and a comprehensive and coordinated strategy must be adopted in order to protect future generations from infection. Viral hepatitis posed a serious problem in developing countries but, in an era of global migration, the burden was shared by all nations. Clear leadership and strategic direction were needed with a timeline and framework in which countries could work towards specific goals. The Regional Committee for the Eastern Mediterranean had adopted resolution EM/RC56/R.5 at its fifty-sixth session (Cairo, 3–6 October 2009); that set a regional target for reduction in prevalence of chronic hepatitis B virus infection to less than 1% among children below five years of age by 2015. He called on the Secretariat to continue providing technical and strategic guidance to Member States for the prevention and control of viral hepatitis.

Dr MELNIKOVA (adviser to Dr Starodubov, Russian Federation), confirming the serious and growing burden of viral hepatitis, said that her country had taken many steps in accordance with WHO's guidelines. As part of a national strategy on prevention and treatment, more than 50 million children, teenagers and adults up to the age of 55 years had been vaccinated in a mass immunization programme over several years. As a result, the prevalence of acute cases of hepatitis B had been reduced to sporadic levels in most areas of the country. In order to prevent transmission through contaminated blood products, programmes were in place to screen donors and record the information obtained in a database. Her country was well aware of its need to improve treatment of patients chronically infected with hepatitis B and C viruses, and had increased its purchases of antiviral medicines. Programmes to educate the public on prevention of infection with hepatitis B and C viruses and HIV were targeting people with high-risk behaviour in particular, resulting in a fall in the morbidity rate for viral hepatitis. However, despite widespread vaccination, mutant and drug-resistant forms of the viruses were emerging, and an international monitoring system and comprehensive global strategy were needed. She commended the Secretariat's technical support to Member States, especially for expanding immunization programmes, and requested regular updates on results achieved. She supported the draft resolution, but proposed that wording should be added to subparagraph 3(2) to in order emphasize that immunization and public information campaigns were the most effective forms of prevention.

Dr ABDESSELEM (Tunisia) requested the addition of a paragraph to the draft resolution emphasizing the importance of the use of safe, disposable syringes for vaccination, as a way of preventing infection with hepatitis B and C viruses.

Professor ADITAMA (alternate to Dr Sedyaningsih, Indonesia) commented that most carriers of hepatitis B virus lived in developing countries, mainly in South-East Asia and the Far East. Indonesia's carrier rate was about 10%. The disease must be recognized urgently as a public health priority in order to reduce morbidity and mortality rates, to save on related public health expenditures, and raise the awareness of health officials about the need for prevention programmes. Hepatitis B vaccination must be made more accessible and affordable in regions endemic for the disease and universal access to affordable treatment of hepatitis B and C must be ensured. Improved surveillance should be prioritized, along with systems for detecting hepatitis, including blood screening. Support should be strengthened for research aimed at preventing and managing the disease. The Secretariat should provide Member States with technical support for defining national prevention and control strategies with clear goals and timelines, and to ensure surveillance, immunization and treatment. Indonesia wished to cosponsor the draft resolution, which should lay foundations for solid global cooperation.

Dr GIMÉNEZ (Paraguay), noting the report's acknowledgement of support from the GAVI Alliance in the introduction of the hepatitis B vaccine, wished to acknowledge also the fundamental role of PAHO's Revolving Fund for Vaccine Procurement in the Region of the Americas. He supported the draft resolution, but requested the addition of wording that would emphasize the vaccination of health professionals and better institutional safety measures.

Dr TAKEI (adviser to Dr Omi, Japan), noting that the new Japanese Government was giving higher priority to viral hepatitis, expressed support for the proposal to establish a world day for the struggle against viral hepatitis and thus strengthen prevention and control through multisectoral collaboration. The draft resolution covered several potentially controversial issues relating to intellectual property, and, in the interests of avoiding protracted discussions in that respect, he proposed the deletion of subparagraphs 5 and 6 of paragraph 2.

Dr MUÑOZ (Chile) expressed support for the draft resolution, noting that he would have liked to see a final version before commenting on it. Parenteral transmission of hepatitis viruses was a serious problem in developing countries, which had not only to ensure safe blood transfusions but also

the ethical duty to treat patients who had contracted hepatitis C through transfusion of unscreened blood. Given the current cost of treatment to prevent cirrhosis following infection, a paragraph should be added on the possible use of the flexibilities provided for by international intellectual property treaties in order to facilitate access to medicines.

Dr DODDS (Canada) welcomed the draft resolution, which would contribute to raising awareness of the global challenges posed by viral hepatitis. She supported the proposal to designate 19 May as World Hepatitis Day. Canada was working with Brazil and other Member States to consolidate the draft resolution. A comprehensive approach to prevention, management and research was essential, with a particular focus on hepatitis B and C.

Dr SADRIZADEH (Islamic Republic of Iran),<sup>1</sup> noting that hepatitis B virus infection early in life was associated with the highest risk of chronic infection and therefore premature death from liver cancer, said that most Member States had introduced hepatitis B vaccine into their immunization programmes. In his country, hepatitis B vaccination had been fully integrated into primary health-care services since 1993, and 98% of infants were fully vaccinated by their first birthday. Persons at risk were routinely vaccinated, and adolescents born between 1989 and 1992 had been the target of a catch-up immunization strategy.

Dr REN Minghui (China),<sup>1</sup> noting that the prevalence of viral hepatitis was high in China, expressed support for the draft resolution but wanted to propose several amendments. Greater emphasis should be placed on hepatitis B vaccination as a prevention measure and on ensuring access to vaccination for neonates, children and people at high risk. Strengthened health promotion should contribute to controlling the spread of hepatitis C and E viruses. Public health measures to control viral hepatitis should be integrated with those to deal with other viruses, such as HIV, in order to make best use of resources. The Secretariat should set global targets for viral hepatitis control, assist in identifying specific national targets and encourage Member States to boost funding in that respect. It should also lead in the elaboration of guidelines for the management of viral hepatitis. He suggested that it should be left to individual Member States to decide the date on which they wished to mark world hepatitis day: 19 May was not an appropriate date in China as it was currently the national day for persons with disabilities.

Ms BLACKWOOD (United States of America)<sup>1</sup> pointed out that the report did not contain a proposal for the establishment of a world day for the struggle against viral hepatitis, as was erroneously stated in the preamble to the draft resolution; that reference should be corrected. She supported the proposal by the member for Japan to delete subparagraphs 2(5) and 2(6).

Mr GORE (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN and noting that the Alliance represented the interests of some 365 million patients in 200 member groups, said that, as president of the World Hepatitis Alliance and a hepatitis patient himself, he was speaking for the 500 million people infected with hepatitis B and C viruses (one twelfth of the world's population) and the many millions more at risk of infection and disease. Hepatitis B and C were often described as silent diseases as they could remain undiagnosed for many years, allowing carriers unknowingly to infect others. Too often, silence also characterized the response to the diseases. Many of the one million or so deaths each year linked to chronic viral hepatitis were preventable. Viral hepatitis had been overlooked and, despite the many excellent examples of national hepatitis programmes, infectious diseases as prevalent as hepatitis B and C required a global response. He urged the Board to adopt a resolution on viral hepatitis that would recognize the need for action;

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



ensure that WHO provided leadership and technical assistance, and identified a global strategy; and call on Member States to adopt targets and take specific action to prevent and control hepatitis B and C.

Mr COMMAR (Australia),<sup>1</sup> noting that hepatitis B and C viruses could be transmitted through blood and plasma supplies, said that the Organization should focus on the safety and quality objectives of national drug systems. Education on prevention for high-risk groups and improvements to ensure safe blood supplies in countries that currently did not undertake screening activities were crucial to reducing the spread of viral hepatitis. He proposed two amendments to the draft resolution: the insertion at the end of subparagraph 2(2) of the phrase “including strengthening adverse events reporting systems that capture transfusion transmitted infections”; and the insertion at the end of subparagraph 4(1) of the phrase “including national policies for strengthening regulation and enhancing safety and quality of blood and plasma”.

Dr FUKUDA (Assistant Director-General) agreed that viral hepatitis was a major public health problem that entailed a long list of challenges relating to, among other things, behavioural change, blood supply, the use of safe needles and access to vaccines. As such, several clusters in the Secretariat dealt with the matter. The draft resolution would encourage the adoption of an integrated approach, and every effort would be made to respond to the calls for leadership, coordination and provision of technical support to Member States.

The DIRECTOR-GENERAL noted that the proposed amendments were being incorporated into a consolidated text which, when ready, would be distributed for the Board’s consideration. She suggested that, at that point, those members who had suggested further amendments during the current discussion should propose them again for incorporation. Consideration of the item should therefore be resumed when the consolidated text became available.

The CHAIRMAN said that he took it that the Board agreed with the approach suggested by the Director-General.

**It was so agreed.**

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

#### **Leishmaniasis control: Item 4.12 of the Agenda (Document EB126/16)**

Mr PRASAD (India) acknowledged WHO’s efforts in achieving a substantial reduction in the price of five medicines for the treatment of leishmaniasis, and stressed that those medicines should be included in national control programmes at the reduced price. He called for more information on the state of progress of research into vaccines, diagnostics and new, less toxic medicines. According to a recent report,<sup>2</sup> in 2008 total funding for leishmaniasis had amounted to US\$ 57.74 million, including US\$ 18.96 million for antiprotozoal agents and research, US\$ 5.23 million for vaccine research, and US\$ 5.76 million for diagnostics. However, there had been limited funding for the development of vector-control products. He urged more countries to support research on leishmaniasis.

Dr DOS RAMOS (Sao Tome and Principe), speaking on behalf of the Member States of the African Region, said that cutaneous leishmaniasis had been detected in at least 26 countries in the Region, although the actual extent of areas endemic for the disease was unknown. Strategies adopted

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

<sup>2</sup> Moran M et al. *Neglected disease research & development: new times, new trends*. G-FINDER report. Sydney, Australia, The George Institute for International Health, 2009.

to reduce the incidence of leishmaniasis following the adoption of resolution WHA60.13 included early diagnosis and rapid treatment; use of insecticide-treated bednets; and programmes to educate the public about the clinical signs of the disease and related treatment.

The African Region was planning a consultative meeting that would cover strategies and national control programmes, the mapping of epidemiological data, and information on outbreaks, morbidity burden, and availability of medicines.

She urged the Secretariat and Member States to continue their efforts to reduce morbidity rates related to leishmaniasis.

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, since the adoption of resolution WHA60.13, progress had been made to raise awareness about the regional burden of leishmaniasis. In 2008 some 100 000 cases of cutaneous leishmaniasis and 5000 of visceral leishmaniasis in the Region were reported, nearly two thirds from Afghanistan, Morocco, Saudia Arabia and the Syrian Arab Republic. A regional meeting (Sharm-el-Sheikh, Egypt, 27–29 October 2009) had further reviewed control strategies of cutaneous leishmaniasis in the Region.

Interventions to build regional capacity had included: the training of health personnel from Afghanistan, Iraq and in other countries endemic for the disease; further training to cope with the outbreak in southern Sudan; the establishment of a harmonized regional system for surveillance, data collection and analysis; and the creation of the Leishmaniasis Mediterranean and Middle East Network, a platform for sharing knowledge online.

Long-term efforts were essential for reducing the burden of the disease. The Region's control strategy was based on active surveillance, prompt treatment and measures to prevent transmission, such as use of insecticide-treated bednets and rodent control. The strategy incorporated the recommendations arising from assessments made in the four most affected countries in 2009.

Dr GIMÉNEZ (Paraguay) welcomed the report, as leishmaniasis was one of the most neglected tropical diseases. In 2009, more than half the people affected by the disease in Paraguay had been children under the age of five years. It was vital that the medicines available to treat leishmaniasis were included in the national list of medicines and that access to treatment was expanded.

Dr SADRIZADEH (Islamic Republic of Iran)<sup>1</sup> also observed that leishmaniasis was one of the most neglected tropical diseases with few control tools available and no agreed strategy. Globally the trend of coinfection with the *Leishmania* parasites that caused visceral leishmaniasis and HIV was increasing ominously; that was changing the epidemiology and bringing visceral leishmaniasis to new geographical areas. Research was urgently needed, under the stewardship of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, into alternative and cheaper medicines and rapid and more reliable diagnostics. Mapping of the disease distribution and at-risk populations should be a priority at local levels, and integrated vector control had the potential to strengthen a multidisciplinary approach to prevention and control. His country would be pleased to share its experience in this regard with interested Member States.

Mrs FERNANDEZ DE LA HOZ (Spain),<sup>1</sup> also speaking on behalf of France and Italy, noted that leishmaniasis was present in more than 25 countries in the European Region, in some of which national control programmes were inadequate or non-existent and access to medicines was limited. Furthermore, coinfection with HIV was increasing. The Governments of France, Italy and Spain were providing political and financial support to the development of programmes in accordance with resolution WHA60.13; that included research in collaboration with developing countries into innovative treatment methods, improvement of existing networks, and activities in the veterinary

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

sphere related to transmission from animals to humans. She emphasized their readiness to continue working with the Secretariat in order to strengthen interregional collaboration networks, particularly in the Mediterranean region, Europe and central Asia; and to promote capacity building, research into innovative diagnostic tests, new medicines and vaccines for both canine and human leishmaniasis, and the establishment of national surveillance systems.

She urged governments and nongovernmental organizations to collaborate in order to help developing countries affected by the disease and to encourage pharmaceutical companies to continue to manufacture existing medicines and sell them at reduced prices.

Ms BLACKWOOD (United States of America)<sup>1</sup> said that her Government was committed to reducing the burden of neglected tropical diseases such as leishmaniasis. It was continuing to provide support for research on the topic, including, for instance, complications related to coinfection with HIV, the mechanisms of disease transmission, the development of safe and effective treatments and vaccines, and ecological and integrated vector management. She confirmed the previously mentioned and essential elements of a safe and effective control strategy for leishmaniasis.

Dr NAKATANI (Assistant Director-General) thanked speakers for their contributions. In response to the member for India, he said that no new combination of medicines or single-dose regimens had been developed, although results of trials of combinations of existing medicines were promising. He congratulated India and the Islamic Republic of Iran on their contributions to research in that area.

Monitoring was also an important aspect of the control of leishmaniasis, in particular in relation to coinfection with HIV. The next meeting of the Expert Committee on Leishmaniasis, scheduled for March 2010, would consider all of the aspects covered in the discussion.

**The Board noted the report.**

**Global eradication of measles: Item 4.14 of the Agenda (Document EB126/17)**

Dr DAHL-REGIS (Bahamas) commended the contribution of all parties to the significant progress towards the goal of the global eradication of measles. The reported reductions in mortality would be paralleled with decreases in morbidity. Further efforts should be devoted to the Western Pacific Region and she asked for an update on progress in the South-East Asia Region. She also asked whether an interim report on the independent analysis of cost-effectiveness mentioned in the report was available, and whether the lack of cost-effectiveness data had affected regional efforts. The report clearly demonstrated WHO's leadership role as a global public health authority.

Mr PRASAD (adviser to Ms Sujatha Rao, India) said that, in India, about 70% of children had been vaccinated against measles. The Government recognized the need to increase coverage and was seriously considering undertaking an additional catch-up round of immunization. The previous lack of catch-up vaccination had been the price that had to be paid for the global campaign to eradicate poliomyelitis, which had severely affected India's capacity to deliver routine immunization programmes. He encouraged the Secretariat to consider India's situation and provide support for developing a sustainable strategy for all routine immunizations.

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, said that the Region had achieved the target of a 90% reduction in measles mortality rates three years before the target date, based on estimates for the period 2000–2006, mainly thanks to the combined efforts of Member States in implementing measures that had proved successful in the Region of the Americas.

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

As the report indicated, the goal of 2020 for elimination had been adopted by the Regional Committee for Africa; the Region was setting pre-elimination targets for 2012, and emphasizing improved coverage rates of first-dose measles vaccine. Measures that had been implemented included increased coverage rates of routine immunization, supplementary vaccination activities and the implementation of a monitoring system that included laboratory confirmation. However, challenges remained, including large-scale outbreaks in some countries, the lack of political commitment, and the limitations in health service accessibility and capacity for follow-up.

Dr MOHAMED (Oman), speaking on behalf of the Member States in the Eastern Mediterranean Region, said that significant progress had been made: the number of cases had decreased from 101 000 in 1977 to 7000 in 2008. However, certain countries, notably Afghanistan, Somalia and Sudan, continued to face a heavy burden of measles. In some countries, first-dose vaccination coverage in 2008 had reached 83%; however, problems affecting health systems, such as security, meant that, in 2009, there had been outbreaks of measles in Afghanistan, Iraq, the Libyan Arab Jamahiriya and Somalia. In some countries, government commitment had been lacking, foreign funding for vaccination programmes had been insufficient, and renewed financing was required.

Global eradication of measles was indeed possible. The countries of the Region that would not achieve the goal of eradicating measles by 2010 had taken steps, such as immunization campaigns and monitoring, towards that objective. Achieving the objective was a step-by-step process, and it was important that the objectives be reviewed every year.

Dr GIMÉNEZ (Paraguay) commended the report. Regarding the achievements of the Region of the Americas, he noted the two prerequisites for eradication of measles: the commitment of political and programme leaders at national level, and of the leadership of PAHO, to strengthen immunization programmes, together with the significant impact of the Region's Revolving Fund for Vaccine Procurement, which ensured equitable access to vaccines at fixed, affordable prices. Ensuring vaccination activities in border areas remained challenging: difficulties with surveillance, information-sharing and logistics had to be overcome. The latter point could add a strategic dimension to the Secretariat's report to the next Health Assembly.

Dr MELNIKOVA (adviser to Dr Starodubov, Russian Federation) expressed her country's support for WHO's strategy for the eradication of measles, which was a priority for her Government. Country-wide immunization of children and adults had reduced the morbidity rate to one reported case per million population – in line with WHO's goal for measles elimination. That experience reflected the importance of surveillance, public information and assessment of virus circulation. A molecular epidemiological approach with genotyping of strains of measles virus allowed monitoring of eradication of the disease; already, one previously endemic genotype was no longer circulating in the country. Although measles prevalence rates were low in the Russian Federation, the threat from imported strains and genotypes was recognized. She emphasized technical support for preventive measures in order to reduce morbidity and mortality to the level of the indicators given in the report.

Dr FENG Yong (China),<sup>1</sup> noting the many difficulties that remained, said that the Secretariat should increase both support and funding for the eradication effort. He also expressed the hope that other international organizations and foundations could make additional funding and technical support available to developing countries. His Government had already developed a national action plan for the period 2006–2012 and begun a vaccination programme in the provinces. As a result, for the period from January to November 2009 reported incidence had fallen nationally by 58.5% year on year. The plan being developed for the period 2010–2012 included an intensified programme of vaccination with the first dose of measles-containing vaccine, to be conducted nationally in 2010.

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

Dr NAKORN PREMSRI (Thailand)<sup>1</sup> commended the report. His country aligned itself with the goal of Member States in the South-East Asia Region, to eliminate measles by 2020; and fully supported the global eradication effort which contributed significantly to the achievement of Millennium Development Goal 4 (Reduce child mortality). However, he was concerned that efforts to eradicate measles globally constrained health systems in developing countries, particularly in resource-limited settings, and competed with work on other priority diseases such as influenza, malaria, dengue and poliomyelitis. He further emphasized that other factors could exacerbate outbreaks in the adult population, such as armed conflict, the movement of migrant workers and the location of populations that were hard to reach.

Strong political commitment, financial support and the continued support of global funding agencies would be crucial in view of the following: the current low rate, in countries in the South-East Asia Region, of coverage with the first dose of measles-containing vaccine (averaging 25% instead of the target of more than 90%); the information provided on the incremental cost of the vaccination strategy for measles eradication in Latin American and Caribbean countries (US\$ 244 million from 1994 to 2002); the estimated additional costs of vaccination in countries in the South-East Asia Region; and the heavy financing and manpower needed for measles surveillance. Measles mortality was rising, despite the availability of effective vaccines, and a global effort was needed with strong commitment from all partnerships and parties.

Ms DLADLA (South Africa)<sup>1</sup> welcomed the report and commended the leadership and support provided by the Secretariat, including the recommendations of WHO's technical support mission that had considered the outbreak of measles in her country in October 2009. She noted the challenges posed by inadequate access to, and low quality of, immunization services; poor quality of data on immunization coverage; and inadequate resources. A concerted effort would thus be needed if the African Region were to reach the target of measles elimination. She supported the global measles targets for 2015 together with the regional elimination target. Her Government was encouraged by the efforts of the African Region and committed itself to further collaboration in order to achieve the pre-elimination targets for 2012.

Ms BLACKWOOD (United States of America)<sup>1</sup> thanked the Secretariat for its report and said that she would respond to that document's request for strategic direction concerning the establishment of the next global measles goal.

The Centers for Disease Control and Prevention strongly supported the stepwise process proposed by the Secretariat, setting global measles targets for 2015 as milestones towards eradication. They appeared reasonable and achievable. However, numerous challenges underscored the need to conduct a thorough technical assessment and to establish realistic targets for sustaining current gains before setting future goals. As the member for Paraguay had said, the accomplishments of the Region of the Americas indicated that measles eradication was feasible; however, the fight against poliomyelitis had shown that regional successes were not necessarily easy to replicate. Although vaccine supply and logistics should be manageable with sufficient lead time and planning, there were concerns over financing, competing priorities and the platform of support for the next global eradication goal. Cost-effectiveness studies were under way. An essential lesson learnt from the poliomyelitis eradication programme was that realistic estimates of long-term costs were needed to ensure that donors had a more comprehensive understanding of their obligations.

Ms ATHERSUCH (Médecins Sans Frontières (MSF) International), speaking at the invitation of the CHAIRMAN, said that, despite the progress made, control of measles remained a major challenge in many countries. She therefore welcomed the call for new, ambitious targets for 2015. In 2008, her organization had vaccinated more than 1.9 million children and had treated 32 000 cases

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of measles in response to outbreaks. Additional investment and strong political will would be needed if the 2015 targets were to be attained.

Member States could take practical steps: programme monitoring and disease surveillance were crucial for assessing progress and validating elimination. Independent surveys were needed in order to evaluate immunization coverage, guide adjustments to immunization programmes, and determine the risks to specific populations; and assessments were needed to enable appropriate adjustments of age-group criteria and timing between campaigns.

The enlargement of the target group for measles immunization to five years of age, in accordance with the WHO/UNICEF Global Immunization Vision and Strategy, would be important, especially where there were cases or outbreaks of the disease. Further, supplementary activities would be needed where routine rates of coverage remained below 90% for the first dose. It was never too late to use vaccination in measles outbreaks. At times of high risk of outbreaks, the target group should be extended; and during outbreaks, measles treatment should be offered free of charge to encourage the seeking of care. Outbreak responses also provided an opportunity to provide the second dose to some and to use additional antigens, thereby increasing overall coverage under the Expanded Programme on Immunization. Member States should provide funds to enable the Secretariat to allocate additional support during responses to measles outbreaks. The introduction of new systems for vaccine delivery should be accelerated, for the benefit in particular of those populations that were hard to reach.

Ms MAFUBELU (Assistant Director-General) expressed appreciation for the comments made by Board members. She commended Member States' efforts to control measles. Eradication was achievable, but major challenges remained. It was crucial to protect all children against the disease, to maintain vigilance in the border areas of countries that had eliminated the disease and to share information, as outbreaks would continue for the time being. Effective routine immunization with high coverage and strong health systems were essential.

In answer to specific questions, she replied that there would be no interim report on the independent analysis of the cost and cost-effectiveness, whose results were expected in June 2010. The lack of cost-effectiveness data was not affecting regional efforts. The main problem faced by Member States was the lack of resources and the estimated shortfall in funding was around US\$ 60 million in 2010. WHO was working in partnership with and acknowledged the support being received from the Measles Initiative in securing additional resources. In the South-East Asia Region, with the exception of India whose situation had been described, all Member States were on track to attain their current measles targets of reduction in measles mortality.

#### **The Board noted the report.**

**Smallpox eradication: destruction of variola virus stocks:** Item 4.15 of the Agenda (Document EB126/18)

Dr AWAD (adviser to Dr Abdi, Somalia), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the fact that the world had remained free from smallpox ever since the announcement by WHO in 1980 that it had been eradicated. The Eastern Mediterranean Region welcomed the progress made in health research involving variola virus. All essential research requiring live variola virus stocks for the purpose of sequencing and development of diagnostic tests and vaccines had been completed. Further sequencing was perhaps not justified from a public health perspective: accordingly, live variola virus stocks should no longer be retained for those purposes. The Secretariat kept an emergency stockpile of smallpox vaccines in case of need. For all those reasons, the Member States of the Eastern Mediterranean Region strongly recommended that a date for the destruction of variola virus should be set as soon as possible.

Dr KABULUZI (Malawi), speaking on behalf of the Member States of the African Region, recounted the history of WHO's work on smallpox eradication, as reflected in Health Assembly resolutions WHA52.10, WHA55.15, WHA55.16 and WHA60.1. He noted that the virus that caused

smallpox was believed to exist in places other than WHO-authorized repositories and that it could potentially be released deliberately to cause harm. Following the global eradication of smallpox, health workers had almost lost skills in smallpox diagnosis and treatment, including surveillance and case definition. Updated training was therefore needed. At least one member of the Advisory Committee on Variola Virus Research should be a representative of the African Region. With those comments, he endorsed the report on smallpox eradication.

Mr PRASAD (adviser to Ms Sujatha Rao, India) said that the retention of variola virus stocks with no definite time frame for their total destruction was a matter of concern, and Member States should reach a consensus on a proposed date for their destruction. The report was silent on whether all 10 Member States that had declared virus stocks in 1977 had provided further information on the legal status of ownership of stocks. He noted that an emergency stockpile of smallpox vaccine was safely stored, and supported the steps being taken to develop the vaccine reserve so that timely and adequate supplies could be made available to an affected country if the need arose. It was a matter of concern that advances in synthetic biology made it possible to synthesize a full-length variola virus genome. For that reason, he recommended that existing guidelines on work with live variola virus and with variola virus DNA should be evaluated.

Ms ARTHUR (alternate to Mr Houssin, France) requested clarification on the proposed laboratory network referred to in resolution WHA60.1; it seemed to be a step backwards as more than two centres would then hold stocks of variola virus, even if they were only samples. She expressed some concern about strains being stored in different laboratories, particularly as there was no mention of geographical distribution.

Priority should be given to reliable testing but there was also concern about long-term experimentation. The report had referred to sequencing activity within the two repositories but such work was not useful, particularly as the report stated that there was no justification for it from a public health perspective. Further transparency was needed in the report on what research was being conducted in that area.

Dr HOSSEIN NIEKNAM (Islamic Republic of Iran),<sup>1</sup> recalling resolution WHA59.10 and the recommendation contained therein to destroy the remaining stocks of variola virus, noted that the issue had been discussed annually for many years but no date had been set for their destruction. He therefore called for a fixed date to be set either by the Executive Board at its current session or by the Sixty-third World Health Assembly.

Dr NAKORN PREMSRI (Thailand)<sup>1</sup> welcomed the report's focus on research, in particular regarding the third-generation smallpox vaccine. The continuous global research effort on smallpox vaccine was welcome; however, the WHO smallpox vaccine stockpile of 32.6 million doses, together with the 27 million pledged doses, fell far short of the 200 million doses recommended by the Ad Hoc Committee on Orthopoxvirus Infections in 2004. He echoed concerns expressed by the Advisory Committee regarding the advances in technology for virus synthesis and synthetic biology, which could lead to illegal variola virus synthesis. Control procedures should be established for all repositories of variola virus and genome-sequencing laboratories. He reiterated the comments of earlier speakers concerning the threat of the existence of live variola virus. The only solution was the total destruction of the variola virus.

Dr RYAN (Global Alert and Response) thanked Member States for their continued support to the important regulatory process, despite the additional workload created by the pandemic H1N1 (2009). The establishment of the Advisory Committee on Variola Virus Research had led to oversight of

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

research projects involving live variola virus, establishment of a vaccine stockpile, and standard operating procedures for use of that vaccine. The Advisory Committee had also evaluated new and promising antiviral agents and diagnostic tools. Regular inspections had been made of the two WHO collaborating centres, with the testing of a new protocol for standardized inspections. The Advisory Committee was also responsible for regulating the use of segments of variola virus DNA, and had developed an operational framework to handle an outbreak of smallpox. The current archives relating to the variola virus and the eradication of smallpox had been digitally recorded. A report of all actions would be presented at the Health Assembly in 2011.

The Advisory Committee had continued to act in the spirit of resolution WHA52.10, which stated that all research should be outcome-focused, health-oriented and time-limited, and had followed up on all activities requested in resolutions WHA49.10, WHA52.10 and WHA55.15. With regard to the request for a new date for destruction to be set, a full scientific review of all published and unpublished data, currently being drafted by the Advisory Committee, would be presented to the Health Assembly in 2011, following additional scrutiny by independent experts to be appointed by the Director-General. At the request of the Health Assembly, geographical representation on the Advisory Committee had been improved, including the invitation of experts from four African Member States, and the broadening of its public health expertise. He thanked the Governments of Canada and the United Kingdom of Great Britain and Northern Ireland, which had provided significant funds to purchase the vaccines being stockpiled by WHO, and the Governments of France, Germany, New Zealand and the United States of America, which had made pledges to provide 27 million doses. The number of doses did fall short of the recommended 200 million, but the existing 60 million doses would be adequate to respond to an emergency at the point of origin. He recognized the contribution of the Government of Switzerland, which had provided facilities for the safe stockpiling of the vaccines, and the Secretariat had worked with all parties to determine operational procedures for the release of those vaccines if required.

The development of technology had led to advances in genome sequencing, and the capacity to synthesize viruses was growing. While guidelines existed, they would require constant review as well as the independent oversight of all research. The Committee had worked, at the request of the Health Assembly, on increasing access to reliable diagnostics, and a review of capacity had been under way since November 2009. It would subsequently be for the Sixty-fourth World Health Assembly in 2011 to decide on future actions. In answer to the concern expressed by the member for France, he said that the proposed network of laboratories was intended solely to improve diagnostic capacity, and there was no intention to distribute variola virus.

**The Board noted the report.**

**The meeting rose at 21:10.**



## **TENTH MEETING**

**Friday, 22 January 2010, at 09:15**

**Chairman:** Dr S. ZARAMBA (Uganda)

### **1. PROGRAMME AND BUDGET MATTERS:** Item 5 of the Agenda

**Eleventh General Programme of Work, 2006–2015:** Item 5.1 of the Agenda (Documents EB126/3 and EB126/22)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, reported briefly on the Committee's discussion of the subitem as set forth in paragraphs 7 to 10 of document EB126/3. The Committee had suggested a further review of the indicators for use in monitoring and assessing implementation of the Eleventh General Programme of Work, 2006–2015, with the addition of new indicators where necessary, and had asked the Secretariat to provide details on how Member States would be involved in the assessment. The Committee had recommended that the Board should note the report contained in document EB126/22.

Mr TSESHKOVSKIY (adviser to Dr Starodubov, Russian Federation) requested clarification of paragraph 14 of the report.

In response, Dr JAMA (Assistant Director-General) explained that paragraph 14 reflected the conclusion reached, after review and internal discussion, that the Eleventh General Programme of Work remained relevant to the work of the Organization and, therefore, to the Medium-term strategic plan 2008–2013 and the Programme budget 2010–2011.

**The Board took note of the report.**

### **2. FINANCIAL MATTERS:** Item 6 of the Agenda

**Scale of assessments:** Item 6.1 of the Agenda (Documents EB126/3 and EB126/23)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as the Chairman of the Programme, Budget and Administration Committee, summarized the Committee's discussion of the subitem as set forth in paragraphs 18 and 19 of document EB126/3. The Committee had recommended that the Board should propose that the Sixty-third World Health Assembly adopt the proposed scale of assessments as contained in document EB126/23.

Ms RUIZ VARGAS (Mexico)<sup>1</sup> voiced concern over the increase in her country's assessed contribution under the proposed new scale. She emphasized that her Government was not opposed to supporting international organizations financially, but noted that the global financial crisis and the influenza pandemic had had a severe impact on the national economy. Recovery had been slow and

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

capacity to cover the country's contributions to all organizations had been severely compromised. Mexico would have considerable difficulties in contributing a greater amount to WHO, particularly as its assessed contribution to PAHO had also recently increased. She requested that countries whose assessed contributions were due to increase should be offered an adjusted payment schedule, as had been done in the past, that would mitigate the effect of those increases.

The DIRECTOR-GENERAL, noting comments made by some Committee members on the late distribution of the new scale of assessments, explained that WHO had not received notification of the adoption of the new scale in time to send the report to countries before the current session of the Board. However, the Secretariat would provide, as soon as possible, a comparison for individual countries between what they were paying currently in assessed contributions and what they would be paying under the new scale to be applied in 2011.

She recognized that some countries would be paying more than before and, inevitably, difficulties would arise in adhering to the proposed new scale. Although the scale itself could not be changed, the Secretariat was willing to discuss payment schedules with any Member State for which such problems arose, with a view to enabling all countries both to fulfil their obligations to the Organization and to maintain their voting rights. She appealed to those Member States due to contribute less under the proposed scale to continue paying, if possible, the same amount as before through a combination of assessed and voluntary contributions. Ideally, the latter would be in the form of core voluntary contributions.

The CHAIRMAN took it that the Board wished to recommend to the Sixty-third World Health Assembly that it should adopt the proposed scale of assessments as set out in document EB126/23.

**It was so decided.**

### **3. MANAGEMENT MATTERS:** Item 7 of the Agenda

**Safety and security of staff and premises and the Capital Master Plan:** Item 7.1 of the Agenda (Documents EB126/3 and EB126/24)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as the Chairman of the Programme, Budget and Administration Committee, reported briefly on the Committee's discussion of the item as set forth in paragraphs 20 to 23 of document EB126/3, noting that the Committee had requested further elaboration on financing options for capital expenditure and recurrent costs, including detailed assessments of possible mechanisms and their implications. There had been particular interest in the integration of the proposed mechanisms into the programme budget and the consequent impact on technical programme delivery. The Secretariat had agreed to provide those details in time for their consideration by the Sixty-third World Health Assembly.

Ms ROCHE (New Zealand) said that ensuring stable funding for staff safety and security improvements and for the Capital Master Plan should be a priority and be better reflected in future planning and budgeting. A financing mechanism should be developed that would give WHO the flexibility both to respond to urgent needs and to fund longer-term improvements.

Dr KÖKÉNY (Hungary), voicing concern at the deterioration of staff safety and security conditions in recent years, expressed strong support for the Director-General's proposal to establish a centralized trust fund, as described in document EB126/24.

Mr BRUCHEZ (Switzerland)<sup>1</sup> expressed support for the proposal to establish a specific fund to finance building maintenance and renovation, but stressed that such a fund must be sustainable and ensure regular, long-term provision of funds. He suggested that, for example, WHO should set aside, particularly for its headquarters, an annual allocation amounting to 1% of the fire insurance value of the building. Establishing a centralized trust fund and a sustainable financing mechanism would not, however, solve the problem of finding funding for urgent capital works. The Secretariat should estimate the amount needed for such works and seek an ad hoc funding solution.

Sir LIAM DONALDSON (United Kingdom of Great Britain and Northern Ireland) pointed out that WHO was the only United Nations organization that did not have a programme budget allocation for safety and security. He noted the proposal for the establishment of a centralized trust fund to provide more sustainable funding but maintained that there should be discussion of other options before the matter was taken up by the Health Assembly. In particular, the possibility of providing funding directly from the regular budget rather than through a separately managed trust fund should be explored.

Ms BLACKWOOD (United States of America)<sup>1</sup> agreed that the regular budget should include allocations for safety and security expenditures, but stressed that such expenditures should be distributed evenly across all sources of funding. She looked forward to reviewing additional financing options at the Health Assembly.

Dr MOHAMED (Oman) acknowledged that the safety and security of the staff was extremely important but pointed out that the resources available through the regular budget were limited and that allocations to safety and security would reduce the funds available for technical cooperation programmes. He asked whether it would be possible to use some of the US\$ 1600 million carried forward from previous financial periods, mentioned in paragraph 14 of document EB126/3.

Mr ALLO (adviser to Mr Houssin, France) agreed on the importance of the item and endorsed the comments made by the representative of Switzerland on the maintenance of WHO's buildings. The Secretariat should be requested to prepare a report for the Health Assembly outlining various possible options for mobilizing the necessary funding in the short and long term from both the regular budget and extrabudgetary resources. Consideration might also be given to amending the Financial Regulations to allow the Director-General more flexibility to take appropriate action in relation to safety and security expenditures.

Ms BILLINGS (alternate to Dr Dodds, Canada), voicing support for the Director-General's proposal to set up a centralized trust fund, said that that approach would not resolve all the immediate security concerns; however, there was an urgent need to begin the initial "catch-up" work, using a phased approach, and to set the stage for eventually dealing with such expenditures through the regular budgeting process. The Secretariat should continue to provide detailed information about the situation, and, as soon as possible, prepare estimates of the amounts that would be required from assessed and voluntary contributions.

Dr JAMA (Assistant Director-General) acknowledged the concern that WHO was not fully compliant with the United Nations Minimum Operational Security Standards, and that WHO staff members had lost their lives in the field as the security situation had deteriorated. There was clearly a need to enhance the protection of staff and premises. He confirmed that there was no regular budget allocation for security and safety, and detailed cost estimates had not yet been provided. The Secretariat was currently working on the estimates and they would be included, together with

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

additional options for sustainable security and safety financing mechanisms, in the report to the Health Assembly. The regular budget represented only around 20% of WHO's total budget, and there was therefore a need to look at the distribution of costs between the regular budget and voluntary resources, as had been noted. However, earmarking of many voluntary contributions reduced flexibility. The report to the Health Assembly would also include detailed information on the Capital Master Plan as a whole, including expenditures required for WHO's buildings in Geneva and the regions. He thanked the Government of Switzerland for its continued support as the host country for WHO headquarters and for the resources it had approved for perimeter protection.

The DIRECTOR-GENERAL, adding her thanks to the Swiss Government, noted that WHO was operating in about 150 countries, in some of which the exposure of staff members to risk was high. WHO was providing essential humanitarian assistance in critical situations, however, and she intended to maintain WHO's presence at country level, as she believed that to be the wish of Member States. Nevertheless, in her view, Member States must balance that wish with their duty, as the employers of WHO staff, to protect staff adequately and to cover the cost of that protection, bearing in mind that relocation or evacuation of staff in emergencies also entailed significant expense. There was an immediate shortfall in funding, which included a US\$ 6 million increase in contributions to the United Nations Security Management System and in addition the costs of serious maintenance needed in WHO buildings. The Secretariat would continue to examine different options for establishing longer-term, sustainable and transparent financing mechanisms, and for separating capital costs from those for security and safety, and would report to the Health Assembly. The regular budget was limited and, if additional calls were made on it, there would have to be reductions in allocations to other activities.

The CHAIRMAN invited the Board to take note of the request by the Programme, Budget and Administration Committee that financing options for capital expenditure and recurrent costs should be further elaborated, to include detailed assessments of possible mechanisms and their respective implications, and that the information should be submitted to the Sixty-third World Health Assembly for consideration.

**It was so decided.**

**Appointment of members of the Independent Expert Oversight Advisory Committee:** Item 7.2 of the Agenda (Documents EB126/3 and EB126/25)

The CHAIRMAN recalled that, in resolution EB125.R1, the Board had requested the Director-General to propose candidates for membership of the new Independent Expert Oversight Advisory Committee. The Secretariat's report on that action was contained in document EB126/25.

Dr DAHL-REGIS (Bahamas), speaking in her capacity as the Chairman of the Programme, Budget and Administration Committee, said that the Committee had noted that the screening process had been thorough and that the selection had been strict. It had also noted an observation in respect of consideration of the geographical balance in that selection. The Committee had endorsed the Director-General's proposal to the Board for the selection of the five members of the new Committee.

The DIRECTOR-GENERAL, expressing appreciation for the guidance on the item provided previously by Member States, recalled the terms of reference adopted for the new Committee (annexed to the report). The criteria for the composition of the Committee included, first and foremost, proven professional experience and competence, balanced representation of public- and private-sector experience, geographical and gender balance to the extent possible, and provision of services without payment. Of the 150 applicants received by the Secretariat, 140 responded to advertisements and 10 had been proposed by Member States; 17% were women and 21% were from developing countries. In the future, it was to be hoped that more women and candidates in developing countries would apply.

Candidates had been assessed internally in a robust and transparent process, which had been verified by an external independent company, since WHO did not have the requisite expertise to assess all aspects of the candidates' financial and risk management experience. That exercise had produced a list of 40 suitable candidates. It had proved a considerable challenge to select just five from the list. A relatively even gender balance had been achieved: two of the five proposed members were women. Every effort had been made also to achieve geographical balance, but it had been impossible to ensure representation of all six WHO regions because there were only five Committee positions. The Board might wish to consider increasing that number in the future with a view to achieving representation of all regions. Membership of the Committee would rotate and there would thus be a chance for candidates from currently under-represented countries and regions to be considered. She sought the Board's endorsement of the proposal, subject to which she would convene the first meeting of the Committee as soon as possible so that its work could begin before the forthcoming Health Assembly. The Committee would elect a chairman from among the five members.

Dr LUKITO (adviser to Dr Sedyaningsih, Indonesia) welcomed the proposal of a candidate from Thailand, a Member State of the South-East Asia Region, but expressed remaining concern about equitable geographical representation, as no candidate from the African or Eastern Mediterranean regions had been proposed. He understood the difficulties faced in making the selection but asked whether it was possible to include a member from at least one of those regions.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) recognized the concerns regarding geographical balance, but favoured accepting the membership proposed, as the selection process described by the Director-General appeared to have been exhaustive, fair and strongly based on merit. With a view to achieving better geographical representation for the Committee in future, and indeed for other committees, it might be appropriate to identify, and endeavour to increase, the number of submissions of candidatures from under-represented regions.

The CHAIRMAN observed that the Board had approved a five-member composition of the Committee,<sup>1</sup> well aware that WHO had six regions. The intention had been that membership should be based not on political representation, but on competence.

Dr MOHAMED (Oman) said it was not clear to him whether the number of Committee members was to be increased in the next round or whether the figure of five was immutable. He observed that the proportion of candidates from developing countries equated to one in five members of the Committee.

The DIRECTOR-GENERAL encouraged the Board to agree to the five candidates proposed so that the Committee could begin its important work of ensuring that the Organization was run properly. As the process evolved, it would be up to Member States, in the light of operational experience, to provide the Secretariat with further instructions. In the meantime, the Secretariat had done its best to work within the boundaries established by the current terms of reference.

Dr DAHL-REGIS (Bahamas), speaking in her capacity as the Chairman of the Programme, Budget and Administration Committee, said that the membership of five could not currently be changed. The Committee's mandate was clear: to be an independent body to review and oversee the work of the Organization. The Programme, Budget and Administration Committee had discussed the matter at length, and a member speaking on behalf of the African Region had indicated that he was satisfied that the candidate selection process had been transparent.

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<sup>1</sup> Resolution EB125.R1.

Dr REN Minghui (China)<sup>1</sup> acknowledged that the Secretariat had done its best to maintain a regional balance and that the candidates had been selected on the basis of their independence and personal competence. Nevertheless he expressed concern about the outcome of the selection process. It was to be hoped that in the future a better regional balance and developing country representation would be assured. He expressed his support for the current five candidates.

The CHAIRMAN said that in the absence of further comments he took it that the Board wished to appoint the candidates proposed by the Director-General as members of the Independent Expert Oversight Advisory Committee.

**It was so decided.<sup>2</sup>**

**Method of work of the governing bodies:** Item 7.3 of the Agenda (Documents EB126/3 and EB126/26)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as the Chairman of the Programme, Budget and Administration Committee, summarized the Committee's discussion of the item as set forth in paragraphs 27 and 28 of document EB126/3. The Committee had recommended that the Board should provide guidance on the proposals contained in the report, and that it should adopt the draft resolution contained in document EB126/26.

Dr KÖKÉNY (Hungary) said that the effectiveness of the work of the governing bodies needed to be improved urgently. He agreed with the proposals of the Committee, but wished to make some more radical suggestions. Since it had proved difficult and at times counterproductive to include on the provisional agenda of the Health Assembly items that had not been examined by the Executive Board, a rule should be introduced allowing the inclusion of such items only if they were of the utmost urgency. Further, he questioned whether it was really necessary to re-examine at the Health Assembly topics that had been fully discussed and accepted by the Executive Board. Better use could perhaps be made of time and resources by selecting a few important and topical issues each year for full discussion by the Health Assembly, leaving the others for the Board to decide. The proposal was sensitive, but might be considered for the medium term.

Ms BILLINGS (alternate to Dr Dodds, Canada) supported the Secretariat's efforts to foster more efficient and effective governance processes within WHO. Harmonization of the Board's Rules of Procedure with those of the Health Assembly and adherence to the good governance practices highlighted in the report would help to achieve that objective. The meeting of the Programme, Budget and Administration Committee the previous week had exemplified good chairmanship and effective and efficient management of the agenda. The inclusion of more strategic items on the provisional agenda of future meetings of that Committee might help to improve the effectiveness of Board meetings.

Dr MUÑOZ (Chile) supported the recommendations in the report but argued that they could be more strict. For example, the Organization might adopt the practice of the Human Rights Council and other organizations of not only closing the list of speakers on the first day but also of not allowing any more statements than could be accommodated within a pre-established period of time. It was simply not acceptable to delay the work of a body because there were still speakers left on the list after the time scheduled for discussion of an item had elapsed, particularly as the so-called "discussion" was often just an opportunity for heads of delegation to read out a prepared statement and have their photograph taken. Time should be limited even if that meant that some speakers could not take the

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

<sup>2</sup> Decision EB126(1).

floor. Another option would be to limit the number of delegates who could speak on behalf of country groups in any given year, for example, by allocating to each region a certain number of speaking slots according to the number of members for countries in that region on the Executive Board, it being understood that the designated countries would be obliged to speak not just on their own behalf, but on behalf of the group.

Dr WATT (alternate to Sir Liam Donaldson, United Kingdom of Great Britain and Northern Ireland) welcomed the report as an important starting point towards enhancing the efficiency of the work of the governing bodies and endorsed the suggestion made by the member for Canada.

Mr CHAUDHRY (adviser to Ms Sujatha Rao, India), supported by Dr TAKEI (adviser to Dr Omi, Japan), endorsed the statements by the members for Canada, Chile and the United Kingdom. More attention must be given to time management. The item under discussion repeatedly came up for debate, yet members failed to exercise the necessary self-discipline. A time cap should be considered for all agenda items. Member States should identify the priority items on which they wished to comment and refrain from making a statement on every item. If there was insufficient time for a Member State to speak on an item, it could ask another country to express its views. Ceremonial business such as the ratification of the appointment of Regional Directors should be considered to be carried by acclamation and not allowed to take up an entire half-day of meeting time as in the current session of the Board.

Ms ROCHE (New Zealand) endorsed the suggestion made by the member for Canada. As an outgoing member of the Board, she offered to share her views on ways of improving the methods of work of the governing bodies.

Mr SAMRI (Morocco)<sup>1</sup> cautioned against the introduction of speakers' lists with a requirement that Member States sign up in advance, a practice that had caused problems in other organizations. Moreover, the time allowed for a statement in most international organizations was five minutes. He said that he could not accept that a delegate could deliver a worthwhile statement in three minutes. Limiting the number of agenda items would be a more effective means of streamlining the governing bodies' work than limiting the speaking time and number of speakers.

Dr YOUNES (Office of Governing Bodies) said that it was clear that Board members wished to streamline the work of the governing bodies. Success in that endeavour would depend largely on Member States themselves, however. The Secretariat could not limit the number of agenda items or change the periodicity of reporting because reporting requirements were set by resolutions and generally extended over long periods. Hence agendas tended to become ever longer. The Board could assist the Secretariat by not adding supplementary agenda items except in cases of real urgency. The proposal that certain topics should be decided by the Board and not forwarded for consideration by the Assembly would certainly serve to enhance efficiency but was not a straightforward matter. The proposal relating to the list of speakers would apply to the general debate in plenary. Different rules clearly had to apply to the discussion of technical items in the committees. Noting the calls for further reflection and discussion, he said that the Secretariat would consult with Board members and others, also taking into account the experience of other agencies, before preparing a new report for consideration by the forthcoming Health Assembly.

Mr BURCI (Legal Counsel) said that he took comments made by members of the Board as endorsement of the proposals contained in the report. As had been observed, self-discipline was an important factor in agenda management. The debate on the methods of work of the governing bodies

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

recurred cyclically because of the dichotomy between Member States' wish to pursue their own policy aims through the governing bodies and the need to work as economically and efficiently as possible. The draft resolution contained in document EB126/26 offered the Board an opportunity to take concrete action right away, pending discussion of the topic at the forthcoming Health Assembly on the basis of a revised report that would take into account comments by Board members.

The CHAIRMAN stressed the need for self-discipline in discussing items on the Board's agenda. Speakers must make every effort to respect time limits and to make their arguments clearly and concisely, and he welcomed the approach taken by some regional groups to designate one member to speak on their behalf. The Board should be a forum for discussing and deciding on technical and policy issues, rather than for political debate.

The DIRECTOR-GENERAL emphasized that the role of the Secretariat was to implement the decisions and follow the guidance of Member States. The Secretariat could share with Member States its own experience and that of other organizations within the United Nations system in trying to establish efficient and effective methods of work for the Organization's governing bodies, but it fell to Member States to act on that information in order to render the Board's working methods more efficient. However, changes in the membership of the Board and political changes within Member States meant that decisions taken by members at one session might be reversed at a future session, thus restarting the cycle of rising frustration with the functioning of the governing bodies.

The CHAIRMAN suggested that orientation should be provided for all new Board members, so that they clearly understood how the Board's business was to be conducted. He invited the Board to consider the draft resolution contained in paragraph 24 of document EB126/26.

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

#### **4. STAFFING MATTERS: Item 8 of the Agenda (continued)**

##### **Appointment of the Internal Auditor: Item 8.3 of the Agenda (Document EB126/32)**

The CHAIRMAN drew attention to the report, which contained an update on progress in appointing a new Director of the Office of Internal Oversight Services in the Secretariat. A copy of the curriculum vitae of the selected candidate had been provided to each Board member. Paragraph 112.2 of Rule XII (Internal Audit) of the Financial Rules required the Director-General to consult with the Board before appointing of the head of the Office and that he or she be technically qualified.

There being no comment, he took it that the Board wished to take note of the report and the appointment.

**It was so agreed.**

**Human resources: annual report: Item 8.4 of the Agenda (Documents EB126/3, EB126/33, EB126/33 Add.1 and EB126/33 Add.1 Corr.1)**

Dr DAHL-REGIS (Bahamas), speaking in her capacity as the Chairman of the Programme, Budget and Administration Committee, reported briefly on the Committee's discussion of the subitem as set forth in paragraph 29 of document EB126/3, noting that the Committee had emphasized the need for harmonization with developments in the United Nations common system and had endorsed

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<sup>1</sup> Resolution EB126.R8.



efforts to identify talent and implement sustained performance management strategies. The Committee had recommended that the Board take note of the reports of the Secretariat contained in documents EB126/33 and EB126/33 Add.1.

Dr REITENBACH (adviser to Dr Seeba, Germany), commending the progress made in human resources management, said that a good, efficient and adaptable staff mobility scheme not only served the Organization's interests but was also important for career advancement and staff motivation. He welcomed the streamlining of recruitment, noting that the efficiency of any organization depended greatly on its ability to fill staffing gaps quickly. She also highlighted the importance of balanced geographical representation in all professional and, in particular, higher category posts across the Organization and expressed satisfaction at the steady narrowing of the gender gap.

Dr WATT (alternate to Sir Liam Donaldson, United Kingdom of Great Britain and Northern Ireland) expressed appreciation of the work of the new Director of the Department of Human Resources Management and encouraged the Secretariat to finalize work on a full human resources strategy. Endorsing the comments of the member for Germany, she drew particular attention to the issue of equal opportunity, in both recruitment and talent management, and the need for a robust performance management system.

The CHAIRMAN, praising the work of the new Director, Department of Human Resources Management, invited the Board to take note of the reports.

**The Board took note of the report.**

**Confirmation of amendments to the Staff Regulations and Staff Rules:** Item 8.5 of the Agenda (Documents EB126/3, EB126/39 and EB126/39 Add.1)

The CHAIRMAN invited the Board to consider the two draft resolutions set out in paragraph 10 of document EB126/39. The Programme, Budget and Administration Committee had recommended that the Board should adopt the two draft resolutions.<sup>1</sup>

**The resolutions were adopted.<sup>2</sup>**

**Statement by the representative of the WHO staff associations:** Item 8.6 of the Agenda (Document EB126/34)

Mr BAILEY (representative of the WHO staff associations), highlighting key issues from the statement contained in document EB126/34, drew attention to the need for maximum attention to staff safety and security, both at headquarters and in the field; the need for transparency and accountability; the possibility of a leave of absence for staff members running for elected office within the Organization in order to avoid potential conflicts of interest; the staff associations' wish for a third-party evaluation of the Global Management System; and the effect of the global financial crisis on WHO's work, with particular reference to the need for flexibility in managing human and financial resources, including staff mobility and rotation. He welcomed the constructive relationship between staff and managers within the Organization and reaffirmed the dedication of WHO staff members to working in and with Member States to improve the health of their populations.

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<sup>1</sup> See document EB126/3.

<sup>2</sup> Resolutions EB126.R9 and EB126.R10.

The DIRECTOR-GENERAL, affirming that WHO's staff were its foremost asset, agreed that the constructive relationship between staff and managers was conducive to progress on staff matters and to the solution of difficult problems, such as the issue of staff security and safety. On the issue of staff rotation and mobility, it was necessary to strike an appropriate balance that took account of the specific nature of different posts; some simply did not lend themselves to rotation. She encouraged staff members to join the associations and thanked the representative for his support.

Mr SAMRI (Morocco)<sup>1</sup> commended the work of the Organization's staff and the sacrifices they made, particularly in emergency situations such as the aftermath of the recent earthquake in Haiti. Welcoming the generally positive relations between staff and management, he underscored the need to take the staff's safety and security concerns seriously.

**The Board took note of the statement by the representative of the WHO staff associations.**

**Report of the International Civil Service Commission:** Item 8.7 of the Agenda (Documents EB126/3, EB126/35 and EB126/INF.DOC./2)

**The Board took note of the report.**

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

**Availability, safety and quality of blood products:** Item 4.16 of the Agenda (Documents EB126/19, EB126/19 Add. 1 and EB126/19 Add.2)

The CHAIRMAN drew attention to the report contained in document EB126/19, to a draft resolution (which had been considered by the Board at its 125th session<sup>2</sup>) and its associated financial and administrative implications, contained in documents EB126/19 Add.1 and EB126/19 Add.2 respectively, and to an amended version of the draft resolution submitted by the member for Hungary on behalf of the European Union, which read:

The Sixty-third World Health Assembly,

Recalling resolution WHA58.13 on blood safety: proposal to establish World Blood Donor Day and preceding related resolutions since resolution WHA28.72 on utilization and supply of human blood and blood products, which urged Member States to promote the full implementation of well-organized, nationally coordinated and sustainable blood programmes with appropriate regulatory systems and to enact effective legislation governing the operation of blood services;

**Recognizing that sufficiency in the supply of safe blood components based on voluntary, non-remunerated blood donation, and the security of that supply based on voluntary, non-remunerated blood donation, are important national goals to prevent blood shortages and meet the transfusion requirements of the patient population; [based on comments by Bangladesh, Japan, Nigeria, New Zealand and Republic of Moldova<sup>2</sup>]**

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

<sup>2</sup> See document EB125/2009/REC/1, summary record of the first meeting, section 5.

Conscious that plasma-derived medicinal products for the treatment of haemophilia and immune diseases are included in the WHO Model List of Essential Medicines<sup>1</sup> and of the need to facilitate access to these products by developing countries;

Concerned by the unequal access globally to blood products, including particularly plasma-derived medicinal products, leaving many patients in need of transfusion and with severe congenital and acquired disorders without adequate treatment;

Aware that a major factor limiting the global availability of plasma-derived medicinal products is an inadequate supply of plasma meeting internationally recognized standards for fractionation;

Bearing in mind that treatment using labile blood components is gradually being included in medical practice in developing countries and that thereby increased quantities of recovered plasma should become available for fractionation into plasma-derived medicinal products **to meet their needs**;

Concerned that in developing countries, blood components separation technology and fractionation capacity are lacking, and because of insufficient regulatory controls and failure to implement appropriate practices in blood establishments, plasma from developing countries is often unacceptable for contract fractionation, with considerable wastage of plasma as a result;

Convinced that assuring the suitability of plasma for fractionation requires the establishment of a nationally coordinated and sustainable plasma programme within a properly organized, legally established and regulated national blood programme;

**Recognizing that the capacity to collect plasma is limited and would not suffice to produce enough essential medicines to cover global needs, it is essential that all countries have local capacity to collect plasma of acceptable quality and safety from voluntary and unpaid donations in order to meet their needs**;

**Convinced that fractionation should be set up as close to the source as possible, and that, where national plasma fractionation capacities are lacking, there should be an option for supply of fractionation capacity in other countries, it should be ensured that the supply of plasma derived medicinal products can be made available to meet local needs in the country of the plasma supplier**;

Recognizing that access to information about strategies to ensure supplies of blood products sufficient to meet demand, effective mechanisms of regulatory oversight, and technologies to ensure the quality and safety of blood products, guidelines on the appropriate clinical use of blood products and the risks of transfusion have become more and more necessary;

Bearing in mind that voluntary and non-remunerated blood donations can contribute to high safety standards for blood and blood components and being aware that the safety of blood products depends on testing of all donated blood for transfusion-transmissible infections, and correct labelling, storage and transportation of ~~blood and~~ blood products;

Bearing in mind that patient blood management means that before surgery every reasonable measure should be taken to optimize the patient's own blood volume, to minimize the patient's blood loss and to harness and optimize the patient-specific physiological tolerance of anaemia following the WHO's guide for optimal clinical use (three pillars of patient blood management);

**Recognizing that excessive and unnecessary use of transfusions, and plasma derived medicinal products, unsafe transfusion practices and errors (particularly at the patient's**

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<sup>1</sup> The WHO Model List of Essential Medicines identifies individual medicines that together could provide safe and effective treatment for most communicable and noncommunicable diseases. This List includes plasma-derived medicinal products, namely immunoglobulins and coagulation factors, which are needed to prevent and treat a variety of serious conditions that occur worldwide (<http://www.who.int/medicines/publications/essentialmedicines/en/index.html>).

bedside) seriously compromise patient safety; [based on comments by Bangladesh, Chile, Republic of Moldova and United Kingdom of Great Britain and Northern Ireland<sup>1</sup> ]

Concerned that unsafe and/or poor-quality blood products can render patients vulnerable to avoidable risk if the blood programmes are not subject to the level of control now exercised by experienced national or regional regulatory authorities;

Alarmed that patients in developing countries continue to be exposed to the risk of preventable transfusion-transmitted infections by blood-borne pathogens such as hepatitis B virus, hepatitis C virus and HIV;

~~Concerned~~ **Observing** [Nigeria<sup>1</sup>] that the increasing mobility of populations is contributing to increased risk of transmission of infectious diseases worldwide; ~~[deletion proposed by Brazil and Paraguay<sup>1</sup>] [deletion supported by EU]~~

Noting the increasing movement across boundaries of blood products and blood safety related in vitro diagnostic devices, together with their rapid development and introduction into health-care systems of both developed and developing countries;

Recognizing the value of international biological reference materials (WHO International Standards) for the quality control of blood products and related in vitro diagnostic devices for detection of known and emerging blood-borne pathogens;

Convinced that traceability of all stages of the preparation of blood products, from the donor to the recipient and vice versa, is essential to identify risks, particularly the transmission of pathogens and transfusion reactions, and to monitor the efficacy of corrective measures aiming to minimize such risks;

Convinced that ~~the whole chain of processes in the production of plasma derived medicinal products, i.e.~~ **good practices need to be implemented for** recruiting voluntary, non-remunerated healthy blood and plasma donors from low-risk donor populations; **and** testing of all donated blood for transfusion-transmissible pathogens, **and that the whole chain of processes in the production of blood products, i.e.** correct processing, labelling, storage and transportation ~~of blood components and plasma derived medicinal products~~ needs to be covered by **relevant**, reliable quality assurance procedures, ~~compliant with good manufacturing practices;~~

Recognizing that stringent regulatory control is vital in assuring the quality and safety of blood products, as well as of related in vitro diagnostic devices, and that special effort is needed to strengthen globally the technical capacity of regulatory authorities to assure the appropriate control worldwide;

Recalling previous resolutions of the Health Assembly mentioning the vital need to strengthen blood establishments and ensure the quality, safety and efficacy of blood products.

1. URGES Member States:<sup>2</sup>

(1) to take all the necessary steps to establish, implement and support nationally coordinated, efficiently managed and sustainable blood and plasma programmes **according to the availability of resources;**

(2) to take all the necessary steps to update their national legislation on the collection, testing, processing, storage, transportation and use of blood products and operation of regulatory authorities to ensure that regulatory control in the area of quality and safety of blood products meets internationally recognized standards;

(3) to establish quality systems, **for the processing of whole blood and blood components**, good manufacturing practices **for the production of plasma-derived medicinal products** and appropriate regulatory control; ~~for the production of blood components and plasma derived medicinal products.~~

<sup>1</sup> See document EB125/2009/REC/1, summary record of the first meeting, section 5.

<sup>2</sup> And regional economic integration organizations, where applicable.

- (4) to build human resource capacity through the provision of initial and continuing training of staff to ensure quality of blood services and blood products; [based on comments by India and Republic of Moldova<sup>1</sup>]
- (5) to enhance the quality of evaluation and regulatory actions in the area of blood products and associated medical devices, including in vitro diagnostic devices;
- (6) to establish or strengthen systems for the safe and rational use of blood products and to provide training for all staff involved in clinical transfusion, to implement potential solutions in order to minimize transfusion errors and promote patient safety, and to promote the use of autologous transfusion and patient blood management; [based on comments by Bangladesh, China, Republic of Moldova and United Kingdom of Great Britain and Northern Ireland<sup>1</sup>]
- (7) to ensure the reliability of mechanisms for reporting serious or unexpected adverse reactions to blood and plasma donation and to the receipt of blood components and plasma-derived medicinal products, including transmissions of pathogens.

2. REQUESTS the Director-General:

- (1) to guide Member States to meet internationally recognized standards in updating their **legislation, national standards** [based on comments by Chile and New Zealand<sup>1</sup>] and regulations for effective control of the quality and safety of blood products and associated medical devices, including in vitro diagnostics;
- (2) to advise and build capacity in Member States on leadership and management of blood supply systems in order to strengthen national coordinated and sustainable blood and plasma programmes; [based on comments by Chile and New Zealand<sup>1</sup>]
- (3) to extend the support offered to Member States for developing and strengthening their national regulatory authorities and control laboratories so as to increase their competence in the control of blood products and associated medical devices, including in vitro diagnostic devices, and fostering the creation of regional collaborative and regulatory networks where necessary and appropriate;
- (4) to ensure sustainable development and provision of international biological reference materials (WHO International Standards) for use in the quality control and regulation of blood products and related in vitro diagnostic devices;
- (5) to improve access by developing countries to international biological reference materials and to the scientific information obtained in their validation in order to assure the appropriate use of these materials;
- (6) to develop, provide and disseminate guidance and technical support to strengthen national **coordinated** blood and plasma programmes and **introduction of blood component separation and plasma fractionation technology, to meet local needs**, [based on comments by Bangladesh<sup>1</sup>] and promote effective regulatory oversight of blood services and implementation of good manufacturing practices in plasma-fractionation programmes, under the responsibility of regulatory authorities;
- (7) to provide guidance, training and support to Member States on safe and rational use of blood products, and to support the introduction of autologous transfusion, and safe transfusion practices and patient blood management; [based on comments by Bangladesh, China, Republic of Moldova and United Kingdom of Great Britain and Northern Ireland<sup>1</sup>]
- (8) to encourage research into new technologies for producing safe and effective blood substitutes; [based on comments by Republic of Moldova and United Kingdom of Great Britain and Northern Ireland<sup>1</sup>]

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<sup>1</sup> See document EB125/2009/REC/1, summary record of the first meeting, section 5.

- (9) to inform regularly, at least every four years, the Health Assembly, through the Executive Board, on actions taken by Member States and other partners.

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 also aligned themselves with his statement. He recalled that in the 1980s the European Union had had to learn hard lessons from massive transmission of serious viral diseases through blood. Since then, amendments to legislation, enhanced regulatory controls and development of scientific guidance and good practices had yielded high levels of quality and safety in blood products. Similar measures should be adopted by all countries. In particular, it was essential for developing countries to have local capacity to collect sufficient plasma of acceptable quality and safety from voluntary donors.

The aim of the amended draft resolution proposed by the European Union was two-fold: to emphasize continuing support for existing or emerging national blood systems with regard to supply, testing, processing, rational clinical use and patient blood management, and to advocate strongly local plasma collection and, when possible, local fractionation capacity. To those ends, the resolution encouraged Member States to amend their relevant legislation, strengthen regulatory oversight and enhance the capacity of their control authorities, and called on the Secretariat to support Member States by providing technical cooperation to enable them to meet international quality and safety standards for blood products and to strengthen their national regulatory authorities and control laboratories.

Dr AL HAJ HUSSEIN (alternate to Dr Said, Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, observed that many of those countries suffered from a lack of blood supplies and blood products and from difficulties with blood safety. The Millennium Development Goals relating to reduction of child and maternal mortality and to control of HIV/AIDS and malaria could not be attained without improving the availability, safety and quality of blood products. That would require adoption of sound policies and appropriate strategies and the creation of the necessary framework within which they could be applied. A workshop had been held in Tehran during 2008 to seek ways of achieving those objectives. The workshop had focused on the establishment of new regulatory authorities, or the enhancement of existing ones, to take responsibility for monitoring the safety and quality of blood products. The countries of the Region looked forward to receiving support from the Secretariat in their efforts to improve their blood systems.

Mr PRASAD (alternate to Ms Sujatha Rao, India) said that amendments to legislation, enhanced regulatory control and scientific guidance, personnel training and technology transfer were needed in order to build capacity to produce sufficient supplies of safe blood products. WHO should take steps to ensure efficient use of plasma and should issue guidelines on proper synergy among the stages of blood collection, component separation, plasma preparation and production of therapeutic blood products. It should also give consideration to coordinating and facilitating technology transfer, training in and implementation of good manufacturing practices, and support for the establishment of plasma fractionation centres in developing countries. The Organization might also issue uniform guidelines on testing of plasma for bloodborne viruses and set harmonized safety and potency standards. It should establish a network of collaborating centres to facilitate and strengthen research and development activities and ensure availability of rare blood group antigens and antisera, and should promote cooperation between regulatory authorities with regard to compliance with good manufacturing practices and encourage the establishment of haemovigilance systems.

Dr DOS RAMOS (Sao Tomé and Príncipe), speaking on behalf of the Member States of the African Region, said that the challenges facing them with respect to availability, quality and safety of blood products included weak implementation of national transfusion policies, lack of human and financial resources, high demand for blood, high prevalence of bloodborne infections and heavy

reliance on paid family donors. With WHO's guidance, 45 countries of the Region had drawn up national blood transfusion policies and several had established a legal framework to support such policies. However, support was needed to speed up their implementation, which remained slow.

Through innovative strategies, such as the formation of clubs of young blood donors, voluntary unpaid donation had increased, but only 20 countries had reached the target of obtaining at least 80% of blood from voluntary unpaid donors. Screening of donated blood had improved significantly over the years, and currently 98% of transfused blood was tested for HIV, 96% for markers of hepatitis B virus infection and 84% for hepatitis C markers. Nevertheless, the risk of infection through blood transfusion remained higher in Africa than elsewhere. Forty-one countries had drawn up guidelines on the appropriate clinical use of blood, but countries needed support in order to provide training on their application. The countries of the Region also needed support in strengthening the infrastructure of their blood transfusion services and in implementing good manufacturing practices.

Dr LUKITO (adviser to Dr Sedyaningsih, Indonesia) expressed support for WHO's strategy for blood safety, which promoted the establishment of nationally coordinated blood transfusion services and emphasized collection of blood only from voluntary unpaid donors and high-quality screening and processing of blood and its rational use. The Indonesian National Blood Transfusion Council was working to implement WHO's strategy and to ensure that ethical principles were respected, both for donors and for recipients. The Secretariat should continue to support Member States in policy and programme development and capacity-building in order to improve the availability, safety and quality of blood products. He strongly supported the draft resolution.

Dr TAKAI (adviser to Dr Omi, Japan) commended the Organization's efforts and achievements in blood safety and expressed support for the resolution. He proposed two amendments: the word "sufficiency" in the second preambular paragraph should be replaced by "achieving self-sufficiency", and the phrase "with the aim of achieving self-sufficiency" should be added after "according to the availability of resources" at the end of paragraph 1(1). He encouraged the Secretariat to provide further technical support to Member States to strengthen their national blood and plasma programmes.

Ms ROCHE (New Zealand) proposed four amendments. At the end of the twenty-first preambular paragraph, which began "Convinced that good practices need to be implemented", the phrase "reliable quality systems based on the principles of good manufacturing practice" should be added. Secondly, the term "donor management" might be included in that paragraph, as a broad concept to include selection and counselling processes. In paragraph 1(2), she proposed the wording "to take all necessary steps to update their national legislation on donor assessment and deferral, collection, processing, storage, transportation and use of blood products, and operation of regulatory authorities to ensure that regulatory control in the area of quality and safety of blood products across the entire transfusion chain meets internationally recognized standards". In paragraph 1(6), she proposed that "the use of autologous transfusion" should be replaced by "availability of transfusion alternatives including, where appropriate, autologous transfusion". If that change were accepted, a similar one would also need to be made to paragraph 1(7).

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

## **ELEVENTH MEETING**

**Friday, 22 January 2010, at 14:35**

**Chairman:** Dr S. ZARAMBA (Uganda)

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

**Availability, safety and quality of blood products:** Item 4.16 of the Agenda (Document EB126/19) (continued)

Dr MUÑOZ (Chile) welcomed the revised draft resolution, in particular the reference in paragraph 2(2) on the need to advise countries on management of blood supply systems. To ensure greater clarity, he proposed insertion of the phrase “by sharing best practices about the best organizational structures for blood supply systems in order to increase efficiency and minimize error” at the end of paragraph 2(2).

Professor HAQUE (Bangladesh) was encouraged by the reference in the draft resolution to autologous blood transfusion, and encouraged the Director-General to continue promoting that as a transfusion alternative, particularly for elective surgeries.

Ms TOELUPE (Samoa) said that in her country the Samoa Red Cross Society and the national laboratory played a leading part in mobilizing donors and securing the blood supply, especially significant following recent natural disasters. Given the increased prevalence of blood-borne diseases such as dengue, more research into strategies for prevention and control was required. Like other small island States, Samoa required technical assistance in areas relating to the entire blood chain, and in particular the testing of systems for processing blood donations and plasma; strengthening of regulatory and quality assurance systems; and blood safety programmes and information systems. She supported the draft resolution, as amended.

Ms ARRINGTON AVIÑA (Mexico),<sup>1</sup> supporting the statement made by the member for Hungary, underlined several difficulties: internationally, blood donation was not a priority; management of blood programmes was weak; and in many cases funding to strengthen the availability, safety and quality of blood products was not sustainable. With regard to paragraph 1(2) of the draft resolution, Mexico had been working to raise awareness of blood donation, safety and availability, and domestic legislation was being prepared with a view to using surplus plasma to obtain blood products through industrial fractionation.

Mr MUNK (International Society of Blood Transfusion), speaking at the invitation of the CHAIRMAN, said that the draft resolution echoed the Society’s view that a safe and effective supply of blood should be based on voluntary and nonremunerated donation and implemented through efficient national services. He emphasized the application of good manufacturing practice; regulations to blood collection and the production of blood products; and international collaboration to guarantee sufficient plasma worldwide for fractionation. The Society would contribute to the implementation of the resolution, once adopted, through training programmes in the area of blood transfusion. Safe blood and plasma, and their derivatives, could be obtained only from committed, safe and healthy blood

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



donors within a safe environment for public health. The resolution therefore had a wider impact than just blood safety.

Dr BOULYJENKOV (Thalassaemia International Federation), speaking at the invitation of the CHAIRMAN, said that blood transfusion was the primary course of treatment for patients with thalassaemia; in Europe 500 000 units of blood were needed each year for that purpose. The promotion of safety, quality and adequacy of blood was of the utmost importance and WHO's Blood Transfusion Safety Programme provided valuable information for patients and health professionals.

Dr ETIENNE (Assistant Director-General) recognized that, although advances had been made in many developing countries, blood quality and safety was not optimal, availability of plasma-derived products was limited, and capacity for the production of plasma-derived medicinal products was low. In many cases, plasma did not meet quality standards; 6% of donated blood was wasted globally, a figure that increased to 13% in some areas. WHO's comprehensive blood safety programme, developed in collaboration with stakeholders, provided norms and standards, and assisted in national policy development, programme planning and implementation and capacity building. The Secretariat had enhanced the support it provided to States, for example through comprehensive guidelines for blood donation, collection, screening and use, and the development of guidelines for haemovigilance and blood product manufacturing; the latter would be considered by the Expert Committee on Biological Standardization in October 2010. The Secretariat was committed to the continued strengthening of all aspects of the blood transfusion chain, including the transfer of technology.

Dr YOUNES (Office of Governing Bodies), referring to the proposed amendments, said that the beginning of the second preambular paragraph should be amended to read "Recognizing that achieving self-sufficiency in the supply of safe blood components"; and the end of the twenty-first preambular paragraph should be amended to read "needs to be covered by relevant, reliable quality systems based on the principles of good manufacturing practices". In paragraph 1(1), the phrase "with the aim of achieving self-sufficiency" should be added after "according to the availability of resources". Paragraph 1(2) should be amended to read "to take all the necessary steps to update their national legislation on donor assessment and deferral, collection, processing, storage, transportation and use of blood products and operation of regulatory authorities to ensure that regulatory control in the area of quality and safety of blood products across the entire transfusion chain meets internationally recognized standards;". The end of paragraph 1(6), following the words "promote patient safety", should be amended to read "and to promote availability of transfusion alternatives including, where appropriate, of autologous transfusion and patient blood management". The words "by sharing best practices about the best organizational structures for blood supply systems in order to increase efficiency and minimize error" should be added at the end of paragraph 2(2). Paragraph 2(7) should be amended to read "to provide guidance, training and support to Member States on safe and rational use of blood products to support the introduction of transfusion alternatives including, where appropriate, autologous transfusion and safe transfusion practices and patient blood management".

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that, given the problem in his country of variant Creutzfeldt-Jakob disease, many blood products had to be imported. Although that situation might change in the future, the insertion of references to self-sufficiency in the second preambular paragraph, as suggested by the member for Japan, would be problematic for the moment. He requested a suspension of the meeting so that an alternative text could be sought.

Dr KÖKÉNY (Hungary) requested that a clean English version of the draft resolution be produced before the Board was asked to endorse it.

Dr GIMÉNEZ (Paraguay) asked the Secretariat to ensure that the preambular paragraph referring to population mobility be deleted.

Dr MUÑOZ (Chile), concurring with the member for the United Kingdom, said that the reference to self-sufficiency was problematic.

Ms ROCHE (New Zealand) suggested amending the phrase to read “to aim for sufficiency”.

Dr TAKEI (adviser to Dr Omi, Japan) asked for more time to consider the amendment.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) suggested adding the phrase “unless special circumstances preclude it” after the reference to self-sufficiency.

Dr TAKEI (adviser to Dr Omi, Japan) agreed with that proposal.

The DIRECTOR-GENERAL said that a revised draft resolution would be produced.

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

**Strategies to reduce the harmful use of alcohol:** Item 4.10 of the Agenda (Documents EB126/13 and EB126/13 Add.1)

Ms BILLINGS (alternate to Dr Dodds, Canada), introducing the revised global strategy to reduce the harmful use of alcohol, acknowledged the Secretariat’s valuable consultations over the past year and reported that informal discussions held during the Board’s session so far had made good progress towards consensus. As a result, she proposed the following amendments to the draft resolution contained in document EB126/13. A new operative paragraph should be added after paragraph 1 to read: “2. AFFIRMS that the global strategy aims to give guidance for action at all levels; to set priority areas for global action; and that it is a portfolio of policy options and measures that could be considered for implementation and adjusted as appropriate at the national level, taking into account national circumstances, such as religious and cultural contexts, national public health priorities, as well as resources, capacities and capabilities;”. Paragraphs 3(2) and 3(3) should be combined to read: “to collaborate with and provide support to Member States as appropriate, in implementing the global strategy to reduce the harmful use of alcohol and strengthening national responses to public health problems caused by the harmful use of alcohol”.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, said that the candidate countries Croatia, Turkey and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro, Serbia, as well as Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with his statement. He supported the statement by the member for Canada.

Given that harmful use of alcohol was the third leading risk factor worldwide for premature deaths and disabilities, the European Union supported the draft global strategy’s aims, objectives, guiding principles and policy options. The draft strategy provided the flexibility for countries to determine national actions on the basis of their own situations, guided by public health considerations.

The presentation of strong evidence alongside policy options made an explicit link between evidence and proposed actions. Entities in the alcohol beverage chain should be encouraged to enforce regulatory measures in order to ensure the responsible production, distribution and marketing of their products.

He welcomed the focus placed on the impact of harmful use of alcohol on social equity, and the inclusion of those broader effects, such as violence against women and children. The policy options presented largely corresponded to the priorities and practices identified in the strategy to reduce alcohol-related harm adopted by the European Union. In its Conclusions on Alcohol and Health, adopted in December 2009, the Council of the European Union underlined the need to protect adolescents and children, and to consider reduction of the risk factors in terms of national contexts.

Policies and actions to reduce the harmful use of alcohol must be considered from a wide public health, social and economic perspective: they were important in combating noncommunicable diseases, injuries and even infectious diseases and must also tackle the broader social determinants of health, including access to education and employment. A global strategy offered concrete guidance for national development of a strategic mix of complementary actions that would increase the legitimacy of sound public health policies on alcohol at all levels. Monitoring, follow-up and comparative studies were also vital to measuring progress. The Secretariat's support for implementation of the strategy was crucial, particularly in the case of low- and middle-income countries where harmful use of alcohol could hamper social development.

He noted that a previously agreed footnote had been omitted from paragraph 2 of the draft resolution, which should read "And regional economic integration organizations, where applicable".

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region, said that in the Region such phenomena as noncommunicable diseases, traffic accidents and congenital disease were linked to alcohol abuse. Adulterated alcohol posed another public health risk. Advertising, some of it specifically targeted at young people, encouraged excessive alcohol consumption; and the disruption of personal finances could also result. However, the production and sale of alcohol could generate substantial income for both countries and individuals.

The Regional Committee for Africa had adopted in 2008 measures to reduce the harmful effects of alcohol: the strengthening of political commitment; partnership and community action; the introduction of alcohol information and monitoring systems; drink-driving legislation; and higher alcohol taxation.<sup>1</sup> In March 2009, the Regional Office had convened a technical regional consultation on strategies and interventions aimed at reducing the harmful use of alcohol.

A strengthening of measures was needed to ensure effective regional implementation of actions adopted at the international level, including public awareness-raising and regulations geared to the local context; vulnerable groups, including young people, pregnant women and drivers, must be clearly identified. Any encouragement of the harmful use of alcohol deserved condemnation; and actions to the contrary should be commended. He supported the draft strategy and the proposed amendments.

Mr TSESHKOVSKIY (adviser to Dr Starodubov, Russian Federation) said that an integrated approach was vital to tackling the acute problem of harmful use of alcohol. In her country, active measures had been put in place in the 1980s for combating alcohol abuse, with stringent penalties attached. Regrettably those measures had not been maintained, despite their success. The draft strategy was a vital tool supported by the Russian Federation, which was again seeking to implement policies to discourage the consumption of alcohol and its detrimental effects to society through measures such as pricing increases, and by punishing excesses.

Dr MUÑOZ (Chile) said that the draft strategy was an extremely important step in the fight against mental illness, liver cirrhosis, violence and other traumas associated with the excessive consumption of alcohol. In Chile, a recent survey had shown significantly increased prevalence in cases of alcohol-related death and disability, particularly among young people. The recommendations of the draft strategy concerning the marketing of alcohol, while inevitably giving rise to controversy, were necessary as access to alcohol was related to price. It would be difficult, however, for the countries producing alcohol to increase domestic prices, which were set on the basis of commercial agreements; the upshot of that was that paradoxically prices of those beverages were cheaper in countries that imported them. One solution would be to fix a minimum price for alcoholic drinks to ensure that they were not cheaper than soft drinks. Chile intended to develop a national strategy to control the harmful use of alcohol by applying those of the policy options and interventions set forth in

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<sup>1</sup> Documents AFR/RC58/3 and AFR/RC58/20 (Final report).

the draft strategy that were relevant to its circumstances. He encouraged submission of the draft strategy to the Health Assembly.

Dr AL HAJ HUSSEIN (alternate to Dr Said, Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, observed that the ill effects of the harmful use of alcohol had implications for families, friends and society as a whole. Alcohol abuse was linked to a variety of health problems, including mental disorder, communicable and noncommunicable diseases, cancer and cardiovascular disease. It also led to such social problems as drink-driving, violence and low productivity in the workplace. A global public health response was vital to reducing all such ill effects.

In the Middle East, the percentage of teetotallers among both men and women was extremely high in a comparative global context. However, the production of illegal alcohol, for marginalized and vulnerable groups in particular, was a problem in some countries of the Region. All States in the Region shared a religious, cultural and social heritage that promoted abstinence, which accounted for the low alcohol consumption. That culture could also deny the existence of alcohol-related problems which were thus afforded little attention and health systems in turn were ill-equipped to cope.

After recalling the resolution on public health problems of alcohol consumption in the Eastern Mediterranean Region, adopted at the fifty-third session of the Regional Committee for the Eastern Mediterranean,<sup>1</sup> he commended the Secretariat's wide consultations and evidence-based methodology in preparing the draft strategy. A "one-size-fits-all" strategy was not feasible in view of differences in national, religious and cultural contexts, public health priorities, available resources, constitutional principles and international legal obligations. As it stood, however, the draft strategy would prepare the way for coordinated measures that would sustain combat against the health risks of the harmful use of alcohol. It offered an array of policy options that member states could adapt to their own circumstances. Any measures adopted, however, should err towards the stringent rather than the lenient. Marketing and pricing policies merited careful consideration, particularly in his Region, where they were not widely applied. The draft strategy would promote adoption of measures in the Region in the other areas covered under the proposed policy options and interventions; and it would bring support to all related international efforts.

Dr ABABII (Republic of Moldova) said that his country had adopted national programmes to encourage healthy living, including a reduction in alcohol consumption. All alcohol advertising, as well as the use of alcohol by persons under the age of 18 years, was prohibited; and taxes were being raised on spirits and low-alcohol beverages. Coordinated action and partnerships promoted information about the consequences of the harmful use of alcohol, an approach that should be followed at the international level. The draft strategy should include a reference to the need for a special tax on alcohol. Systems of law enforcement should also be established with a view to covering some of the costs resulting from the harmful use of alcohol.

Dr KABULUZI (Malawi) welcome the draft strategy, which would help to contain the harmful use of alcohol by guiding measures to establish regulations, raise public awareness, and document the consequences of harmful use.

Ms TOELUPE (Samoa) said that the draft strategy was a reminder that many health concerns were best addressed outside the traditional health sector. A global strategy would strengthen synergies with the Western Pacific Regional Strategy to Reduce Alcohol-related Harm<sup>2</sup> and produce positive outcomes at national and local levels. Samoa would require technical assistance with the economic aspects of an alcohol policy, notably in connection with trade issues being considered by WTO.

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<sup>1</sup> Resolution EM/RC53/R.5.

<sup>2</sup> Adopted by the Regional Committee for the Western Pacific in resolution WPR/RC57.R5.

Mr REYES RODRIGUEZ (Cuba)<sup>1</sup> said that the manifestations of the harmful use of alcohol and related policies differed according to the health situation in each country. The implementation of inclusive education policies on responsible alcohol consumption together with relevant national policies should be emphasized. The voluntary and flexible nature of the draft strategy enabled countries to choose from the various policy options included therein.

Having participated in all stages of the development of the draft strategy, Cuba had joined with Sweden to facilitate the negotiations of a consensus version that could be recommended for submission to the Health Assembly. He expressed gratitude for the flexibility and compromise shown in those negotiations and for the vital support provided by the Director-General.

Dr KESKİNKILIÇ (Turkey)<sup>1</sup> said that actions should not be restricted to simply controlling the harmful use of alcohol as harm prevention efforts were also needed. The role and commitments of the alcoholic beverages sector had to be considered given the difficult conflict of interests existing in many countries. No country could tolerate losing so many young people and members of the workforce through alcohol-related traffic injuries, in addition to the health-related problems caused by the harmful use of alcohol. Timely and concrete steps must be taken to limit harmful use of alcohol, and he expressed the hope that the draft strategy would serve its intended purpose.

Dr REN Minghui (China)<sup>1</sup> supported the draft strategy. China had been actively involved in the consultations. He agreed in principle with the strategy's policy options and interventions, and welcomed the allowances made for different country situations and the provision of technical assistance to low- and middle-income countries. His Government was in favour of stronger measures of law enforcement to reduce drink-driving. It supported the control or prohibition of marketing of alcohol to children and young people; and efforts to halt illicit alcohol production and introduce appropriate pricing policies for alcohol, all of which would help to reduce its harmful use. China had introduced domestic regulations on the marketing and distribution of alcohol.

Mr ADAM (Israel)<sup>1</sup> said that the harmful use of alcohol had a serious effect on public health and on young people in particular. WHO's work was timely for countries such as his own where alcohol use was increasing. The draft strategy would serve as a beacon for ministries, agencies and civil society in Israel. He was satisfied with its concept and with the recommendations, policies and measures that it proposed: it started a process of awareness-raising and action and all countries could learn from and assist one another. Regional and national mechanisms should therefore be established to facilitate coordination among Member States and stakeholders.

Ms ARRINGTON AVIÑA (Mexico)<sup>1</sup> welcomed the agreement reached on the draft strategy, which would lay the groundwork for countries to carry out public policies to reduce the harmful use of alcohol and its adverse effects on health. The strategy's five objectives were useful guidelines for governmental action. She endorsed the request made in the draft resolution for the Director-General to give priority to the issue. It would be important for the Secretariat to provide support to Member States in implementing the strategy and appropriate follow-up. All Member States should, to the best of their ability, carry out the recommendations in the strategy and provide information relevant to other members of the international community.

Mr MARTINEZ (Dominican Republic)<sup>1</sup> strongly supported the draft strategy and commended the technical support of the Secretariat in facilitating the successful outcome to consultations on the draft resolution.

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

Mr LEAL MARTINS DA CUNHA (adviser to Dr Buss, Brazil), commending the Secretariat, said that the draft strategy and its range of policy options provided for flexible national responses to the harmful use of alcohol. Mutual understanding among countries was essential for dealing with wider health problems like alcohol that needed the cooperation of Member States, civil society and economic operators in the implementation of the strategy. Brazil had hosted the regional technical consultation in May 2009 in São Paulo; it was committed to furthering the discussion within WHO and to implementing the strategy.

His country had developed intersectoral and multistakeholder programmes in order to reduce the social and health-related effects of harmful use of alcohol. The excellent results of a zero-tolerance policy on drinking and driving constituted an argument for a strong multisectoral approach.

Dr THAKSAPHON THAMARANGSI (Thailand)<sup>1</sup> said that the draft strategy did not adequately address the impact of international trade agreements on alcohol-related harm, particularly visible in low- and middle-income countries. Freer markets brought lower prices, greater availability and powerful marketing practices, none of which was conducive to control of alcohol-related harm. Discussions about international trade might seem unrelated to health issues, but WHO's mandate dictated the need to discuss trade issues with adverse impacts on global health.

Most of the measures recommended in the draft strategy were backed by scientific evidence and independent research. The global community should take note of potential conflicts of interest in the efforts of countries to address alcohol-related problems. The alcohol industry was currently working to convince policy-makers to ignore the scientific evidence about policy interventions and claimed, instead, that the only successful approach was education: that people should simply be warned not to consume alcohol. That was not an effective approach. The global community had already delayed too long in dealing with the harmful use of alcohol because of fears about the possible impact on trade. More concern should be shown about the impact of alcohol on health.

Ms M'VILA (Congo)<sup>1</sup> expressed concern that insufficient attention was paid to the problem of advertising of alcoholic beverages. In particular, the advertising of beer was often connected with sporting events, but playing sports and alcohol consumption were mutually contradictory.

Mr HACKER (CMC–Churches' Action for Health), speaking at the invitation of the CHAIRMAN, said that the draft strategy effectively addressed issues critical to public health efforts to reduce the toll of harmful use of alcohol worldwide. It included strong, evidence-based policies affecting the marketing of alcoholic beverages; and argued the need for resources and prioritization in implementing alcohol-prevention strategies, and for the involvement of civil society to implement preventive strategies. He welcomed the focus on the young, non-drinkers and populations at risk. The health sector must lead in multisectoral collaboration to combat alcohol problems at all levels and the Board should recommend the Health Assembly to adopt the draft strategy.

Ms DELORME (The World Medical Association, Inc.), speaking at the invitation of the CHAIRMAN, welcomed the draft strategy, but considered that some parts could be improved: the role of health professionals in the prevention and treatment of alcohol abuse should have been given more attention, underlining their pivotal role in education, advocacy and research. The strategy recommended essential policy interventions regarding pricing policy, availability, drink-driving and marketing, but the measures proposed often lacked the necessary substance. The role of economic operators in the implementation of the strategy should be clearly limited so that policies and programmes at all levels were developed on the basis of public health interests, independent of commercial influence.

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

Dr ALWAN (Assistant Director-General) expressed the Secretariat's gratitude to Member States for their extraordinary efforts in progressively overcoming differences in views and reaching consensus on the draft global strategy for the sake of the common good.

The DIRECTOR-GENERAL endorsed those remarks: Member States had provided excellent support and shown great flexibility in the work on the global strategy.

The CHAIRMAN said that he took it that the Board wished to adopt the draft resolution contained in document EB126/13, as amended by the member for Canada.

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

**Strategic Approach to International Chemicals Management:** Item 4.17 of the Agenda (Document EB126/20)

The CHAIRMAN drew attention to a draft resolution on improvement of health through safe and environmentally sound waste management, proposed by Argentina, Armenia, Austria, Belgium, Brunei Darussalam, Bulgaria, Chile, Colombia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Guatemala, Hungary, Indonesia, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Nigeria, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and United Kingdom of Great Britain and Northern Ireland, and associated financial and administrative implications, which read:

The Executive Board,

Having considered the report on the Strategic Approach to International Chemicals Management;<sup>2</sup>

Having also considered the letter of President of the Ninth Meeting of the Conference of the Parties to the Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal to the Director-General of WHO,

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 the Strategic Approach to International Chemicals Management;

Recalling resolution WHA61.19 on climate change and health, and resolutions WHA59.15, WHA50.13, WHA45.32, WHA31.28 and WHA30.47 relating to chemical safety;

Recalling also resolutions of the United Nations General Assembly 44/226 of 22 December 1989 on traffic in and disposal, control and transboundary movements of toxic and dangerous products and wastes and 43/212 of 20 December 1988 on the responsibility of States for the protection of the environment;

Noting the principles set out in Agenda 21, including chapter 20 and chapter 21, as agreed upon at the United Nations Conference on Environment and Development in 1992;

Noting also the Johannesburg Declaration on Sustainable Development and the related Plan of Implementation of the World Summit on Sustainable Development in 2002;

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<sup>1</sup> Resolution EB126.R11.

<sup>2</sup> Document EB126/20.

Acknowledging decision 25/8 on Waste Management adopted by the Governing Council/Global Ministerial Environment Forum of the United Nations Environment Programme at its 25th session;

Alarmed that globally economic activities are generating in increasing volumes wastes containing hazardous chemicals in various forms, threatening human health and livelihood;

Convinced that the lack of environmentally sound management of waste will harm the environment and be detrimental to human health, through polluted air, water and land and food chain;

Concerned that poor management of health-care waste, including sharps, non-sharp materials, blood, body parts, chemicals, pharmaceuticals, and medical devices puts health-care workers, waste handlers and the community at risk of infections, toxic effects and injuries;

Welcoming the Bali Declaration on Waste Management for Human Health and Livelihood adopted at the ninth meeting of the Conference of the Parties to the Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal in 2008,

1. URGES Member States to assess the health aspects of environmentally sound waste management and to explore options to work more closely with the United Nations Environment Programme, the Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal and the WHO Secretariat towards achieving their shared objectives on the improvement of health through safe and environmentally sound waste management;
2. REQUESTS the Director-General:
  - (1) to support the implementation of the actions set out in the Bali Declaration on Waste Management for Human Health and Livelihood, within WHO's mandate and available resources;
  - (2) to work together with the United Nations Environment Programme and the secretariat of the Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal on environmentally sound waste management, including encouraging governments and donor organizations to provide new and additional resources for the implementation of the Bali Declaration on Waste Management for Human Health and Livelihood, with the aim in particular of:
    - (a) promoting awareness-raising of the link between waste management, health and livelihood, and the environment;
    - (b) strengthening subregional and regional cooperation on waste and health issues by promoting national, regional and international human and appropriate technical capacities;
    - (c) improving controls on waste shipment and border procedures in order to prevent illegal movements of hazardous and other wastes, through means that include capacity-building, technology transfer and technical assistance;
    - (d) improving cooperation between national authorities in the waste, chemicals and health sectors and, in collaboration with other relevant authorities and stakeholders, in the development and implementation of effective and sound waste management systems;
    - (e) increasing capacity building, promoting and, where possible, enhancing public and private investment for the transfer and use of appropriate technology for the safe and environmentally sound waste management;



- (3) to continue supporting the prevention of health risks associated with exposure to health-care waste and promoting environmentally sound management of health-care waste in order to support the work of the Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal and the Stockholm Convention on Persistent Organic Pollutants;
- (4) to invite governments, relevant intergovernmental organizations, members of the industry and business sector to provide resources and technical assistance to developing countries in developing and implementing instruments for use in dealing with health aspects of the environmentally sound waste management;
- (5) to report to the Sixty-fourth World Health Assembly, through the Executive Board, on implementation of this resolution.

<b>1. Resolution</b> The improvement of health through safe and environmentally sound waste management	
<b>2. Linkage to programme budget</b>	
Strategic objective:	Organization-wide expected result:
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.	8.2 Technical support and guidance provided to Member States for the implementation of primary prevention interventions that reduce environmental hazards to health, enhance safety and promote public health, including in specific settings (e.g. workplaces, homes or urban settings) and among vulnerable population groups (e.g. children).
<b>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</b>	
The resolution is consistent with the expected result and implementation would facilitate achievement of the target for 2011 of 12 Member States implementing primary prevention interventions in order to reduce environmental risks to health, with WHO technical support, in at least one of the following settings: workplaces, homes or urban settings. The baseline figure for 2010 (8) will remain the same.	
<b>3. Budgetary implications</b>	
<b>(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)</b>	
No additional costs will be incurred regarding activities. The resolution requests the Secretariat to support the implementation of the actions set out in the Bali Declaration, within the Organization's mandate and available resources. The workplan for the biennium 2010–2011 already includes activities aimed at responding to the problem of hazardous waste, in particular health care waste, in conjunction with other relevant bodies including UNEP and the Basel Convention secretariat.	
<b>(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)</b>	
No additional costs are envisaged specifically under the resolution.	
<b>(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?</b>	
Not applicable.	

**4. Financial implications**

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

Not applicable.

**5. Administrative implications**

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

Primary prevention activities will mainly be conducted at country level; multicountry projects will be undertaken through headquarters and the regional offices; and liaison with UNEP and the Basel Convention will mainly be managed through headquarters and the regional offices.

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

Yes.

**(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)**

Not applicable.

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

There will be a continuing need to tackle the problem of health-care and other hazardous waste to ensure that waste generation is minimized on a lasting basis. Therefore, the initial time frame under this resolution will follow the Medium-term strategic plan until 2013. Thereafter, it will be reviewed as necessary.

He also drew attention to a second draft resolution on improvement of health through sound management of obsolete pesticides and other obsolete chemicals, proposed by Hungary on behalf of the Member States of the European Union and cosponsored by Indonesia, Mauritius, Republic of Moldova and Switzerland, and associated financial and administrative implications, which read:

The Executive Board,

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 the Strategic Approach to International Chemicals Management;

Recalling resolution WHA59.15 on the Strategic Approach to International Chemicals Management;

Recognizing the need for a greater involvement of health sector, Member States<sup>1</sup> and the WHO Secretariat in the implementation of the Global Plan of Action of the Strategic Approach to International Chemicals Management<sup>2</sup> because of the adverse effects some chemicals may have on human health, and noting that some of the global priorities for cooperative action identified within the Strategic Approach to International Chemicals Management also have to be dealt with by the health sector;

<sup>1</sup> And, where applicable, regional economic integration organizations.

<sup>2</sup> Document WHA59/2006/REC/1, Annex 1.

Recognizing that pesticides are designed to kill or control harmful organisms and pests, and may have adverse acute and chronic effects, and that, although they are regulated in most countries, they may affect populations' health and the environment, particularly when improperly used and stored, including when they are obsolete;<sup>1</sup>

Recalling WHO's Constitution, the Bali declaration on waste management for human health and livelihood (2008), the United Nations Conference on Environment and Development (Rio de Janeiro, Brazil, 1992), the World Summit on Sustainable Development (Johannesburg, South Africa, 2002), the adoption of the Strategic Approach to International Chemicals Management by the International Conference on Chemicals Management (Dubai, 2006), the Basel Convention on the Control of the Transboundary Movements of Hazardous Wastes and Their Disposal (1989), the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade (2004, revised 2008), the Stockholm Convention on Persistent Organic Pollutants (Stockholm, 2004), and the Convention on the Prevention of Marine Pollution by Dumping of Wastes and Other Matter 1972 and 1996 Protocol Thereto (London 1972);

Recognizing that all the above-mentioned conventions and instruments are important global tools for the preservation and protection of human health and the environment that provide measures and guidelines to deal with certain aspects of chemicals life-cycle, and that, in that sense, the closely linked Stockholm Convention on Persistent Organic Pollutants and Basel Convention on the Control of the Transboundary Movements of Hazardous Wastes and Their Disposal<sup>2</sup> foresee the development of appropriate strategies for identification of persistent organic pollutant wastes, stockpiles of persistent organic pollutants and their management;

Recognizing that hazardous waste and highly toxic pesticides fall under the global priority areas identified for cooperative action within the Strategic Approach to International Chemicals Management, and that the Health Assembly in resolution WHA59.15 on Strategic Approach to International Chemicals Management urged Member States to participate in national, regional and international efforts to implement the Strategic Approach;

Mindful of the new challenges and determinants of health and of the need for additional action in order to preserve and protect human health and the environment;

Recognizing the risks to human health and environment from obsolete pesticides and other obsolete chemicals, particularly through local and global chemical accidents and catastrophes, linked to more frequent floods, fire and other disasters, due to climate change;

Recognizing also the risks to human health and environment from obsolete pesticides and other obsolete chemicals, linked to the creation of stockpiles resulting from their regulation (such as withdrawal from the market without appropriate phase-out period) of which might further lead to spreading of improperly stored chemicals worldwide;

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<sup>1</sup> The International HCH and Pesticides Association (IHPA) estimates that total amount of obsolete pesticides is about 260 000–265 000 tonnes in central and eastern Europe and the countries of the former Union of Soviet Socialist Republics. For example, estimated amounts in 25 members of the European Union are 22 000–24 000 tonnes, south-east Europe 36 000–41 000 tonnes, the countries of the former Union of Soviet Socialist Republics 199 000 tonnes, Africa 50 000 tonnes (estimated by FAO in its Africa Stockpiles Programme), South-East Asia 6500 tonnes (FAO, first rough indication), Central and South America 30 000 tonnes (FAO, 2005).

<sup>2</sup> The fundamental aims of the Basel Convention are the control and reduction of transboundary movement of hazardous and other wastes subject to the Convention, the prevention and minimization of their generation, the environmentally sound management of such wastes and active promotion of the transfer and use of cleaner technologies.

Recalling the fact that the exposure of humans and the environment to obsolete pesticides and other obsolete chemicals may also be due to their long-range transport;

Recognizing the threat of unsafe storage of obsolete pesticides and other obsolete chemicals, which, owing to illegal use, package deterioration, or accidents may cause localized or widespread pollution and represent a potential risk to human health and the environment;

Mindful of the clear evidence that, besides environmental benefits, economic benefits can be expected derived from safe and efficient recovery, reuse, recycling and disposal of obsolete pesticides and other obsolete chemicals;

Acknowledging the progress regarding obsolete pesticides made by African countries through the interagency Africa Stockpiles Programme with the support of the FAO, Global Environment Facility, the World Bank and other partners;

Welcoming the work of the Basel Convention on the Control of the Transboundary Movements of Hazardous Wastes and Their Disposal in developing technical guidelines on the environmentally sound disposal of wastes containing persistent organic pollutants;

Further recognizing that only a comprehensive and long-term strategy of sound management of obsolete pesticides and other obsolete chemicals can be effective,

1. URGES Member States:

- (1) to adopt, where necessary, and strengthen sound national policies, legislation on safe handling and disposal of obsolete pesticides and other obsolete chemicals;
- (2) to adopt, where this has not already been done in the context of the Stockholm Convention on Persistent Organic Pollutants and other existing instruments, comprehensive national implementation plans or other strategies as the basis for taking action towards the elimination of risks from obsolete pesticides and other obsolete chemicals;
- (3) to enhance social responsibility through awareness-raising in the area of obsolete pesticides and other obsolete chemicals;
- (4) to increase support for training and capacity building;
- (5) to encourage and promote cooperation between Member States in this regard;

2. INVITES all relevant stakeholders, including Member States, regional economic integration organizations, bodies in the United Nations system and other intergovernmental organizations including regional, international and national nongovernmental organizations and foundations, waste-management companies, pesticide manufacturers, donors and the remaining international community:

- (1) to promote sound management of obsolete pesticides and other obsolete chemicals in order to minimize and, wherever possible, to avoid adverse impacts to human health and the environment;
- (2) to mobilize efforts and cooperate with other stakeholders on the implementation of national implementation plans and strategies, inter alia via local, regional and global networks;

3. REQUESTS the Director-General:

- (1) to support the development of appropriate and efficient strategies (at national, regional and international levels) to minimize the risks of obsolete pesticides and other obsolete chemicals and thus promote the relevant WHO policy goals and practices;
- (2) to enhance WHO's capacity to foster these strategies;
- (3) to facilitate implementation of the strategies on sound management of obsolete pesticides and other obsolete chemicals with a view to reducing inequities in health and securing an unpolluted living environment;

- (4) to work with UNEP, in connection with the WHO/UNEP Health Environment Linkages Initiative, as well as with UNDP, FAO, World Bank and other appropriate institutions in assisting Member States to implement their national strategies and existing guidance, for instance under Basel Convention on the Control of the Transboundary Movements of Hazardous Wastes and Their Disposal<sup>1</sup> and strategies for sound management of obsolete pesticides and other obsolete chemicals at the global level;
- (5) to include obsolete pesticides and other obsolete chemicals among WHO's priorities in order to reduce and prevent risks to human health and the environment from their adverse effects and to support their safe disposal worldwide;
- (6) to report to the Sixty-fourth World Health Assembly through the Executive Board on progress in implementing this resolution.

The CHAIRMAN further said that, following informal consultations between Member States since the issue of the preceding draft resolution, a revised text had been agreed upon, which read:

The Executive Board,

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 the Strategic Approach to International Chemicals Management;

Recalling resolution WHA59.15 on the Strategic Approach to International Chemicals Management;

Recognizing **the outcomes of the Second Session of the International Conference on Chemicals Management (ICCM-2) regarding the human health and, in particular, resolution II/8 which drew attention to the need** for a greater involvement of health sector, Member States<sup>2</sup> and the WHO Secretariat in the implementation of the Global Plan of Action of the Strategic Approach to International Chemicals Management<sup>3</sup> because of the adverse effects some chemicals may have on human health, and noting that some of the global priorities for cooperative action identified within the Strategic Approach to International Chemicals Management also have to be dealt with by the health sector;

Recognizing that pesticides are designed to kill or control harmful organisms and pests, and may have adverse acute and chronic effects, and that, although they are

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<sup>1</sup> Technical guidelines on the safe disposal of obsolete pesticides (<http://www.basel.int/meetings/sbc/workdoc/techdocs.html>);

- Updated general technical guidelines for the environmentally sound management of wastes consisting of, containing or contaminated with persistent organic pollutants,
- Technical guidelines for the environmentally sound management of wastes consisting of, containing or contaminated with 1,1,1-trichloro-2,2-bis(4-chlorophenyl)ethane (DDT),
- Technical guidelines on the environmentally sound management of wastes consisting of, containing or contaminated with the pesticides aldrin, chlordane, dieldrin, endrin, heptachlor, hexachlorobenzene (HCB), mirex or toxaphene or with HCB as an industrial chemical.

<sup>2</sup> And, where applicable, regional economic integration organizations.

<sup>3</sup> Document WHA59/2006/REC/1, Annex 1.

regulated in most countries, they may affect populations' health and the environment, particularly when improperly used and stored, including when they are obsolete;<sup>1</sup>

Recalling WHO's Constitution, **and recognizing the following relevant international agreements and instruments**; the Bali declaration on waste management for human health and livelihood (2008), the United Nations Conference on Environment and Development (Rio de Janeiro, Brazil, 1992), the World Summit on Sustainable Development (Johannesburg, South Africa, 2002), the adoption of the Strategic Approach to International Chemicals Management by the International Conference on Chemicals Management (Dubai, 2006), the Basel Convention on the Control of the Transboundary Movements of Hazardous Wastes and Their Disposal (1989), the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade (2004, revised 2008), the Stockholm Convention on Persistent Organic Pollutants (Stockholm, 2004), and the Convention on the Prevention of Marine Pollution by Dumping of Wastes and Other Matter 1972 and 1996 Protocol Thereto (London 1972); **and the International Health Regulations (2005)**;

Recognizing that all the above-mentioned **fora**, conventions and instruments are important global tools for the preservation and protection of human health and the environment that provide measures and guidelines to deal with certain aspects of chemicals life cycle, and that, in that sense, the closely linked Stockholm Convention on Persistent Organic Pollutants and Basel Convention on the Control of the Transboundary Movements of Hazardous Wastes and Their Disposal<sup>2</sup> foresee the development of appropriate strategies for identification of persistent organic pollutant wastes, stockpiles of persistent organic pollutants and their management;

Recognizing that hazardous waste and highly toxic pesticides fall under the global priority areas identified for cooperative action within the Strategic Approach to International Chemicals Management, and that the Health Assembly in resolution WHA59.15 on Strategic Approach to International Chemicals Management urged Member States to participate in national, regional and international efforts to implement the Strategic Approach;

Mindful of the new challenges and determinants of health and of the need for additional action in order to preserve and protect human health and the environment;

Recognizing the risks to human health and environment from obsolete pesticides and other obsolete chemicals, particularly through local and global chemical accidents and catastrophes, linked to more frequent floods, fire and other disasters, due to climate change;

Recognizing also the risks to human health and environment from obsolete pesticides and other obsolete chemicals, linked to the creation of stockpiles resulting from their regulation (such as withdrawal from the market without appropriate phase-out period) of which might further lead to spreading of improperly stored chemicals worldwide;

Recalling the fact that the exposure of humans and the environment to obsolete pesticides and other obsolete chemicals may also be due to their long-range transport;

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<sup>1</sup> The International HCH and Pesticides Association (IHPA) estimates that total amount of obsolete pesticides is about 260 000–265 000 tonnes in central and eastern Europe and the countries of the former Union of Soviet Socialist Republics. For example, estimated amounts in 25 members of the European Union are 22 000–24 000 tonnes, south-east Europe 36 000–41 000 tonnes, the countries of the former Union of Soviet Socialist Republics 199 000 tonnes, Africa 50 000 tonnes (estimated by FAO in its Africa Stockpiles Programme), South-East Asia 6500 tonnes (FAO, first rough indication), Central and South America 30 000 tonnes (FAO, 2005).

<sup>2</sup> The fundamental aims of the Basel Convention are the control and reduction of transboundary movement of hazardous and other wastes subject to the Convention, the prevention and minimization of their generation, the environmentally sound management of such wastes and active promotion of the transfer and use of cleaner technologies.

Recognizing the threat of unsafe storage of obsolete pesticides and other obsolete chemicals, which, owing to illegal use, package deterioration, or accidents may cause localized or widespread pollution and represent a potential risk to human health and the environment;

Mindful of the clear evidence that, besides environmental benefits, economic benefits can be expected ~~derived~~ from safe and efficient recovery, reuse, recycling and disposal of obsolete pesticides and other obsolete chemicals;

Acknowledging the progress regarding obsolete pesticides made by African countries through the inter-agency Africa Stockpiles Programme with the support of the FAO, Global Environment Facility, the World Bank and other partners;

Welcoming the work of the Basel Convention on the Control of the Transboundary Movements of Hazardous Wastes and Their Disposal in developing technical guidelines on the environmentally sound disposal of wastes containing persistent organic pollutants;

Further recognizing that only a comprehensive and long-term strategy of sound management of obsolete pesticides and other obsolete chemicals can be effective,

1. URGES Member States:<sup>1</sup>

- (1) to adopt, where necessary, and strengthen sound national policies, legislation on safe handling and disposal of obsolete pesticides and other obsolete chemicals;
- (2) to adopt, where this has not already been done in the context of the Stockholm Convention on Persistent Organic Pollutants and other existing instruments, comprehensive national implementation plans or other strategies as the basis for taking action towards the elimination of risks from obsolete pesticides and other obsolete chemicals;
- (3) to enhance social responsibility through awareness-raising in the area of obsolete pesticides and other obsolete chemicals **and chemicals with transboundary risks to human health**;
- (4) to increase support for training and capacity building; **and coordinated technical activities for implementing relevant international conventions and instruments**;
- (5) to encourage and promote cooperation between Member States in this regard;

2. INVITES all relevant stakeholders, including Member States, regional economic integration organizations, bodies in the United Nations system and other intergovernmental organizations including regional, international and national nongovernmental organizations and foundations, waste-management companies, pesticide manufacturers, donors and the remaining international community:

- (1) to promote sound management of obsolete pesticides and other obsolete chemicals in order to minimize and, wherever possible, to avoid adverse impacts to human health and the environment;
- (2) to mobilize efforts and cooperate with other stakeholders on the implementation of national implementation plans and strategies, inter alia via local, regional and global networks;
- (3) **to consider the synergies to be gained from sharing technical experience, expertise and capacity building efforts among international instruments, conventions, regulations and processes**;

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<sup>1</sup> And, where applicable, regional economic integration organizations.

3. REQUESTS the Director-General:
- (1) to support the development of appropriate and efficient strategies (at national, regional and international levels) to minimize the risks of obsolete pesticides and other obsolete chemicals and thus promote the relevant WHO policy goals and practices;
  - (2) to enhance WHO's capacity to foster these strategies;
  - (3) to facilitate implementation of the strategies on sound management of obsolete pesticides and other obsolete chemicals with a view to reducing inequities in health and securing an unpolluted living environment;
  - (4) to work with UNEP, in connection with the WHO/UNEP Health Environment Linkages Initiative, as well as with UNDP, FAO, **the SAICM Secretariat**, World Bank and other appropriate institutions in assisting Member States to implement their national strategies and existing guidance, for instance under Basel Convention on the Control of the Transboundary Movements of Hazardous Wastes and Their Disposal<sup>1</sup> and strategies for sound management of obsolete pesticides and other obsolete chemicals at the global level;
  - (5) to include obsolete pesticides and other obsolete chemicals among WHO's priorities in order to reduce and prevent risks to human health and the environment from their adverse effects and to support their safe disposal worldwide;
  - (6) to ensure full support of WHO to the SAICM Secretariat activities;**
  - ~~(6)~~ (7) to report to the Sixty-fourth World Health Assembly, through the Executive Board on progress in implementing this resolution.

The associated financial and administrative implications were unchanged.

Dr SEDYANINGSIH (Indonesia), introducing the first draft resolution on improvement of health through safe and environmentally sound waste management, said that the text urged Member States to assess the health aspects of waste management in order to make it safe and environmentally sound. The draft resolution also urged Member States to work with various bodies, including WHO, towards achieving the shared objective of improving health by such means. It, too, had been revised after informal consultations between Member States, and the revised text read:

The Executive Board,  
Having considered the report on the Strategic Approach to International Chemicals Management,<sup>2</sup>

Having also considered the letter of President of the Ninth Meeting of the Conference of the Parties to the Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal to the Director-General of WHO,

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<sup>1</sup> Technical guidelines on the safe disposal of obsolete pesticides  
(<http://www.basel.int/meetings/sbc/workdoc/techdocs.html>):

- Updated general technical guidelines for the environmentally sound management of wastes consisting of, containing or contaminated with persistent organic pollutants,
- Technical guidelines for the environmentally sound management of wastes consisting of, containing or contaminated with 1,1,1-trichloro-2,2-bis(4-chlorophenyl)ethane (DDT),
- Technical guidelines on the environmentally sound management of wastes consisting of, containing or contaminated with the pesticides aldrin, chlordane, dieldrin, endrin, heptachlor, hexachlorobenzene (HCB), mirex or toxaphene or with HCB as an industrial chemical.

<sup>2</sup> Document EB126/20.



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 the Strategic Approach to International Chemicals Management;

Recalling resolution WHA61.19 on climate change and health, and resolutions WHA59.15, WHA50.13, WHA45.32, WHA31.28 and WHA30.47 relating to chemical safety;

Recalling also resolutions of the United Nations General Assembly 44/226 of 22 December 1989 on traffic in and disposal, control and transboundary movements of toxic and dangerous products and wastes and 43/212 of 20 December 1988 on the responsibility of States for the protection of the environment;

Noting the principles set out in Agenda 21, including chapter 20 and chapter 21, as agreed upon at the United Nations Conference on Environment and Development in 1992;

Noting also the Johannesburg Declaration on Sustainable Development and the related Plan of Implementation of the World Summit on Sustainable Development in 2002;

Acknowledging decision 25/8 on Waste Management adopted by the Governing Council/Global Ministerial Environment Forum of the United Nations Environment Programme at its 25th session;

**Mindful of the outcomes of the second session of the International Conference on Chemicals Management which relate to human health;**

~~Alarmed that globally economic activities are generating in increasing volumes wastes containing hazardous chemicals in various forms, threatening human health and livelihood;~~

**Aware that wastes, if not properly managed, in a safe and environmentally sound manner, may have serious consequences for human health and livelihood;**

Convinced that the lack of environmentally sound management of waste will harm the environment and be detrimental to human health, through polluted air, water and land and food chain;

Concerned that poor management of health-care waste, including sharps, non-sharp materials, blood, body parts, chemicals, pharmaceuticals, and medical devices puts health-care workers, waste handlers and the community at risk of infections, toxic effects and injuries;

Welcoming the Bali Declaration on Waste Management for Human Health and Livelihood adopted at the ninth meeting of the Conference of the Parties to the Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal in 2008,

1. URGES Member States<sup>1</sup> to assess the health aspects of **waste management in order to make it safe and** environmentally sound ~~waste management~~ and to explore options to work more closely with the United Nations Environment Programme, **the Strategic Approach to International Chemicals Management**, the Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal and the WHO Secretariat towards achieving their shared objectives on the improvement of health through safe and environmentally sound waste management;

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<sup>1</sup> And regional integration organizations where applicable.

2. REQUESTS the Director-General:
  - (1) to support the implementation of the actions set out in the Bali Declaration on Waste Management for Human Health and Livelihood, within WHO's mandate and available resources;
  - (2) to work together with the United Nations Environment Programme and the secretariat of the Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal on environmentally sound waste management, including ~~encouraging~~ **collaborating with** governments and donor organizations to ~~provide new and additional resources for~~ **strengthen** the implementation of the Bali Declaration on Waste Management for Human Health and Livelihood, with the aim in particular of:
    - (a) promoting awareness-raising of the link between waste management, health and livelihood, and the environment;
    - (b) strengthening subregional and regional cooperation on waste and health issues by promoting national, regional and international human and appropriate technical capacities;
    - (c) improving controls on waste shipment and border procedures in order to prevent illegal movements of hazardous and other wastes, through means that include capacity building, technology transfer and technical assistance;
    - (d) improving cooperation between national authorities in the waste, chemicals and health sectors and, in collaboration with other relevant authorities and stakeholders, in the development and implementation of effective and sound waste management systems;
    - (e) increasing capacity building, promoting and, where possible, enhancing public and private investment for the transfer and use of appropriate technology for the safe and environmentally sound waste management;
  - (3) to continue supporting the prevention of health risks associated with exposure to health-care waste and promoting environmentally sound management of health-care waste in order to support the work of the Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal and the Stockholm Convention on Persistent Organic Pollutants;
  - (4) to explore the development of strategies aimed at minimizing the generation of health-care waste;**
  - ~~(4)~~ **(5)** to invite governments, relevant intergovernmental **and regional economic integration** organizations, members of the industry and business sector to provide resources and technical assistance to developing countries in developing and implementing instruments ~~for use in dealing with health aspects of the~~ **to improve health through safe and** environmentally sound waste management;
  - ~~(5)~~ **(6)** to report to the Sixty-fourth World Health Assembly, through the Executive Board, on implementation of this resolution.

She added that much synergy was to be gained from moving forward on several fronts simultaneously; Indonesia was therefore also sponsoring the revised version of the draft resolution on sound management of obsolete pesticides.

Dr STARODUBOV (Russian Federation) expressed general support for the report on sound management of chemicals, including hazardous waste, for the protection of human health. His country's control of potentially hazardous and chemical substances was reasonably effective and international approaches to the management of chemical contamination were also being applied. Nevertheless, hundreds of chemical substances and their compounds that had long been in use would threaten human health and the environment if improperly handled. The International Conference on Chemicals Management at its second session (Geneva, 11–15 May 2009) had pointed to new

emerging risks. Referring specifically to factors that did not necessarily reflect the most pressing problems for some countries and regions reduced the value of the text. He would therefore be submitting some amendments to the Secretariat. He was willing, however, to support the draft resolution put forward by the member for Indonesia.

Mr CHAUDHRY (alternate to Ms Sujatha Rao, India) said that the substantial presence of chemical industries in developing countries, which was in many cases detrimental to health, would increase further. In his country, the Bhopal tragedy in 1984 was still affecting the lives of thousands and was a grim reminder of disasters waiting to happen. Coordination on chemicals management at the international, national and local levels was lacking in spite of intersectoral efforts. Preparedness and response to chemical emergencies on the part of the health sector clearly needed more robust mechanisms in order to mitigate the health impact of chemical emergencies. WHO should take the lead in developing practical and affordable models for managing the medical aspects of chemical disasters. With regard to the draft resolution proposed by Hungary, he asked how the term “obsolete” was to be construed in the context of pesticides and chemicals.

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region, said that the worldwide output of chemical products was increasing. Regrettably, many chemicals entered the market each year in Africa without adequate quality controls, thereby endangering human health. The chemical emergencies in the Region referred to in the report were among many, often undocumented, cases of exposure. A policy framework should be established to ensure that chemicals were produced and used in such a way as to minimize the adverse effects on human health and the environment. After the second African regional meeting on the Strategic Approach to International Chemicals Management (Dar es Salaam, United Republic of Tanzania, 14–19 July 2008), some countries had requested funding from the Strategic Approach to International Chemicals Management secretariat for implementing the Libreville Declaration on Health and Environment in Africa (August 2008). He also recalled that the elimination of lead from paint had been included among resolutions adopted at the second session of the International Conference on Chemicals Management (Geneva, 11–15 May 2009). The rational management of chemical products in Africa was hindered by a shortage of technical and human capacity, poor or insufficient information regarding the health effects of chemicals, and inadequate legislation on sales of products with suspected health risks. Strengthened capacities and mobilization of resources would be needed in order to achieve the deadline in 2020. He, too, requested clarification of the term “obsolete pesticides”.

Dr KHYYAM (adviser to Professor Haque, Bangladesh) said that sound chemical management was important given the projected growth in the production and use of chemicals. The existing divide between policy and practice at the national and international levels needed urgent action. The negative health impacts arising from exposure to hazardous chemicals could be mitigated through cooperation with other sectors, including transport, agriculture and industry. He supported the draft resolution on improved health through safe and environmentally sound waste management. He also supported in principle the draft resolution on improvement of health through sound management of obsolete pesticides and other obsolete chemicals, which might be amended as follows: the third line of the ninth preambular paragraph should be deleted and the end of the paragraph should read “and global chemical accidents and disasters”; the end of the tenth preambular paragraph should be modified to read “phase-out period), which might further lead to spreading of improperly stored chemicals”. In paragraph 1(3), the word “potential” should be inserted before “transboundary risks”, and the phrase “and to support their safe disposal worldwide” should be deleted from the end of paragraph 3(5).

Mr JUCA PINHEIRO DE VASCONCELLOS (adviser to Dr Buss, Brazil) recalled that the Strategic Approach to International Chemicals Management had been developed in 2006 to achieve the goal agreed at the World Summit on Sustainable Development (Johannesburg, South Africa, 2002) of ensuring that by 2020 chemicals were produced and used in ways that led to the minimization of significant adverse effects on human health and the environment. The provision of such a policy

framework to foster the safe management of chemicals required sufficient and predictable financial and technical resources. WHO's Secretariat should continue to support the Strategic Approach, not only by providing a staff member to the Strategic Approach secretariat, but also by making full use of its capabilities and resources.

He commended the draft resolution on the improvement of health through safe and environmentally sound waste management. The Secretariat would help to improve human health, particularly among the poor and vulnerable, by working closely with the Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and their Disposal and by supporting the actions set out in the Bali Declaration on Waste Management for Human Health and Livelihood.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, said that the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates, Albania, Bosnia and Herzegovina, Montenegro, Serbia, as well as Ukraine, the Republic of Moldova and Armenia associated themselves with his statement. The time had come to evaluate the actions taken in the four years since adoption of the Strategic Approach to International Chemicals Management. It was appropriate for WHO to enhance its commitment to the Strategic Approach and put further emphasis on the actions listed in paragraph 12 of the report. The European Union looked forward to the implementation, in cooperation with other global actors, of the global plan of action designed to give effect to the Strategic Approach, particularly in the light of emerging policy issues such as nanotechnology and manufactured nanomaterials. Special attention should be given to the financing of the Strategic Approach, to synergies with relevant international instruments, and on how to strengthen WHO's already commendable work with the Strategic Approach.

Obsolete chemicals were one of the consequences of the growing and evolving production of chemicals. The European Union was concerned by obsolete pesticides that were left unprotected in nature and had an impact on the health of local populations and the environment. That problem had first been identified as a serious issue in eastern Europe in the 1990s, and several chemical emergencies caused by obsolete chemicals and toxic waste had occurred recently, most notably in Africa. The European Union had therefore proposed a draft resolution on improvement of health through sound management of obsolete pesticides and other obsolete chemicals. It aimed to bring together the efforts of all relevant stakeholders involved in the lifecycle of chemicals in order to avoid or minimize any adverse impact on human health and the environment.

The European Union supported the highly relevant draft resolution on improvement of health through safe and environmentally sound waste management proposed by Indonesia. The footnote to which paragraph 1 referred should read "And, where applicable, regional economic integration organizations".

Mr ALVAREZ (alternate to Dr Muñoz, Chile), expressing support for both draft resolutions, said that Chile had contributed to the texts. Referring to the report, he drew attention to the outcomes of the second session of the International Conference on Chemicals Management (Geneva, 11–15 May 2009). In response to the member for India, he said that the meaning of "obsolete pesticides" was defined in the Basel Convention's Technical guidelines on the safe disposal of obsolete pesticides, to which the footnote in paragraph 3(4) of the corresponding draft resolution referred. The text under consideration was a broad policy statement, not a specific regulatory instrument. It was not within the Board's competence to decide which pesticides should be considered obsolete.

Dr MOHAMED (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that chemical products should be used and managed so as not to have a harmful effect on human health and the environment. The Secretariat could provide support in that regard within the framework of the Strategic Approach, and he supported the two draft resolutions.

Dr TAKEI (adviser to Dr Omi, Japan) said that chemicals management based on risk assessment and risk management was essential to protect human health. He highlighted the need for intersectoral collaboration, in particular between the agricultural, industrial and transportation sectors. In 2009, Japan had begun an occupational health project in collaboration with the Regional Office for the Western Pacific and the ILO Regional Office for Asia and the Pacific, which aimed to improve health in the working environment and included chemicals management and asbestos control. Japan trusted that the Secretariat would facilitate continued cooperation on chemicals management for health, and supported both draft resolutions before the Board.

Dr GIMÉNEZ (Paraguay) said that the sound management of pesticides in use and of obsolete pesticides was paramount for protecting populations from the dangers of exposure. Incidents in Paraguay over the previous decade and related to pesticide management indicated the need for appropriate technical instruments and firmer legislation. As lobby groups sought to undermine the authority of health ministries by conducting media campaigns, exploiting legal loopholes and exerting pressure on officials, the Secretariat should provide support to countries such as his own in strengthening the authority of the health sector.

Mr CHAUDHRY (adviser to Ms Sujatha Rao, India), thanking the member for Chile for his comments, stressed that India was not opposed to the proposed draft resolution on sound management of obsolete pesticides. In the interests of transparency, it would be preferable to include a definition of the term “obsolete pesticides” in the text of the draft resolution.

Ms BILLINGS (alternate to Dr Dodds, Canada) said that the health sector had a unique role to play in the sound management of chemicals. She supported the two draft resolutions. With regard to the amendment suggested by the member for Bangladesh to paragraph 3(5) of the draft resolution on sound management of obsolete pesticides, she could only accept deletion of the term “worldwide”, not of the phrase “to support their safe disposal”.

Dr SADRIZADEH (Islamic Republic of Iran),<sup>1</sup> referring to the draft resolution on the sound management of obsolete pesticides, proposed the insertion of a reference to the International Code of Conduct on the Distribution and Use of Pesticides, which had been adopted by the FAO Council at its Hundred and Twenty-third Session in November 2002. He also proposed an insertion recommending that Member States strengthen capacities for regulating pesticides and other chemicals; that would ensure sound management throughout their life-cycle as a preventive measure to avoid accumulation of obsolete chemicals. A further insertion should recommend the Director-General’s continued support for FAO and WHO joint efforts in that respect.

Dr SOPIDA CHAVANICHKUL (Thailand),<sup>1</sup> emphasizing intersectoral cooperation for sound management of chemicals and protection of human health, said that in Thailand the formulation of national policy on chemicals management had involved all stakeholders, including the Government, civil society and academia.

In regard to the draft resolution on sound waste management, the activities described under subparagraphs 2(2)(c)–(e) did not fall within WHO’s mandate; those activities should be undertaken by Member States, and the subparagraphs should be moved to paragraph 1.

Mrs MUKHANOVA (Kazakhstan),<sup>1</sup> referring to the report, said that a global campaign to eliminate diseases caused by asbestos was needed; however, a distinction should be drawn in paragraph 3 between the different types of asbestos and substances containing asbestos. She noted that amphibole asbestos was listed in the Rotterdam Convention on the Prior Informed Consent Procedure

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

for Certain Hazardous Chemicals and Pesticides in International Trade whereas chrysotile asbestos was not; she supported the controlled use of chrysotile asbestos and objected to the proposal that all types of asbestos should be banned. It was therefore appropriate from a socioeconomic point of view for Kazakhstan to continue developing its mining industry, carefully controlling the use of chrysotile asbestos and products manufactured from it; measures had been introduced to protect the health of workers in that industry. She expressed support for the draft resolution on sound waste management.

Ms BULLINGER (Switzerland),<sup>1</sup> commenting that the two draft resolutions proposed were complementary, said that Switzerland wished to cosponsor the draft resolution on sound waste management.

Mr SCHOISWOHL (United Nations Environment Programme), speaking at the invitation of the Chairman and acknowledging the attention accorded by WHO to the Strategic Approach to International Chemicals Management, said that commitment by all relevant intergovernmental organizations was a key feature of the Strategic Approach and essential to the achievement of its goals. The International Conference on Chemicals Management at its second session (Geneva, 11–15 May 2009) had invited the Health Assembly to consider endorsing the outcomes regarding human health, and invited WHO to intensify activities in the area of sound management of chemicals, which was critical to strengthening regional and national capacities and establishing information networks. Implementation of the outcomes of the second session was already under way, with vital contributions from WHO, national health ministries and nongovernmental organizations from the health sector, on a specific strategy to strengthen the involvement of the health sector in the Strategic Approach, which would be adopted at the third session of the International Conference in 2012. The Conference at its second session had decided on action to be taken regarding emerging policy issues. Further consideration of chemicals management at the forthcoming Health Assembly would provide an important opportunity for Member States to express their views on implementation of the Strategic Approach.

Dr MOHAMED (Oman) and Mr ALVAREZ (alternate to Dr Muñoz, Chile) supported the amendments proposed by the representative of Iran.

Dr NEIRA (Protection of the Human Environment) said that she had taken note of comments made, especially with regard to such areas as WHO's role in contributing to the Strategic Approach, coordination between the relevant agencies and sectors, and creating links between health and environmental issues. She acknowledged the need to work with UNEP to provide a clear definition of obsolete pesticides in accordance with existing conventions. With respect to asbestos, in May 2009 IARC had re-evaluated all forms of asbestos, including chrysotile asbestos, and concluded that they were all carcinogenic to humans, causing mesothelioma and cancer of the lung and larynx. With respect to the point raised by the representative of Thailand regarding subparagraphs 2(2)(c)–(e) of the draft resolution on sound waste management, she pointed out that paragraph 2(2) simply requested the Director-General to collaborate with other organizations to strengthen implementation of the Bali Declaration on Waste Management for Human Health and Livelihood. The aims of that collaboration, as set out in those subparagraphs, did not go beyond WHO's mandate.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)<sup>1</sup> said that paragraph 1 of the draft resolution on sound waste management was poorly drafted since it urged Member States only to assess the health aspects of waste management, whereas there were many other dimensions of implementation of the Basel Convention that required huge national efforts. The actions described under subparagraphs 2(2)(c)–(e) should be undertaken by Member States.

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

Dr STARODUBOV (Russian Federation) asked that the amendments to the report that he had submitted in writing with respect to asbestos be incorporated in the report.

Mr PRASAD (adviser to Ms Sujatha Rao, India) repeated his request for the insertion of a definition of obsolete chemicals and pesticides in the body of the draft resolution on sound management of obsolete pesticides.

Mr ALVAREZ (alternate to Dr Muñoz, Chile) said that Chile, having sponsored the draft resolution on the sound management of obsolete pesticides, would propose a way of incorporating the amendments suggested by the members for Bangladesh and India.

The DIRECTOR-GENERAL, noting that the draft resolution on sound waste management had been prepared by Member States and not the Secretariat, asked whether the representative of Thailand was proposing to include the information contained in subparagraphs 2(2)(c)–(e) in paragraph 1, in which case a Board member would have to support the proposal.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)<sup>1</sup> confirmed that that had been his intention but said that he was not making a formal proposal. Given the importance of the subject, he simply asked Board members to take note of his concerns that paragraph 1 was not asking Member States to do enough.

Dr SEDYANINGSIH (Indonesia) pointed out that paragraph 1 should be read in its entirety. Member States were being asked not only to assess the health aspects of waste management but also to explore options for further cooperation to achieve their shared objectives in that respect. She suggested that it was not worth entering into a debate on that point.

Dr YOUNES (Office of Governing Bodies) read out the proposed amendment to the draft resolution on waste management: the insertion of the word “economic” between the words “regional” and “integration” in the footnote to paragraph 1.

**The resolution on improvement of health through safe and environmentally sound waste management, as amended, was adopted.<sup>2</sup>**

The CHAIRMAN asked the Board to consider the draft resolution on improvement of health through sound management of obsolete pesticides and other obsolete chemicals.

Dr YOUNES (Office of Governing Bodies) read out the proposed amendments to the draft resolution. In the ninth preambular paragraph, the words “catastrophes, linked to more frequent floods, fire and other disasters, due to climate change” should be replaced with “disasters”; in the tenth preambular paragraph, the word “of” should be deleted and a comma should be added after the words “phase-out period”; in paragraph 1(3), the word “potential” should be inserted between “with” and “transboundary”; a new subparagraph 1(6) should be added, to read “to establish/strengthen capacity for the regulation of pesticides and other chemicals for their sound management throughout their life-cycle as a preventive measure to avoid an accumulation of obsolete chemicals”; in subparagraph 3(5), the word “worldwide” should be deleted; and a new subparagraph 3(7) should be added, to read “to support ongoing FAO and WHO joint efforts in capacity building of Member States in sound management of pesticides”.

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

<sup>2</sup> Resolution EB126.R12.

The CHAIRMAN recalled the request by the member for India for a definition of obsolete chemicals and pesticides to be included in the draft resolution.

Dr YOUNES (Office of Governing Bodies) said that a definition would be included as a footnote to the title, based on the definition provided in the Basel Convention.

Mr ALVAREZ (alternate to Dr Muñoz, Chile) proposed that in subparagraph 3(4), the words “and SAICM” should be inserted after “to work with UNEP” and the words “the SAICM secretariat” should be deleted, since the Director-General would be working with the institutions and Member States themselves and not the Strategic Approach secretariat.

Dr YOUNES (Office of Governing Bodies) pointed out that subparagraph 3(4) was in fact correct as it stood since the Strategic Approach secretariat was part of the United Nations Environment Programme whereas the Strategic Approach was composed of the Member States.

**The resolution on improvement of health through sound management of obsolete pesticides and other obsolete chemicals, as amended, was adopted.<sup>1</sup>**

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

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<sup>1</sup> Resolution EB126.R13.



## TWELFTH MEETING

Friday, 22 January 2010, at 18:15

**Chairman:** Dr S. ZARAMBA (Uganda)

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

**Guidance on the WHO review of psychoactive substances for international control: proposed revision:** Item 4.18 of the Agenda (Document EB126/21)

The CHAIRMAN said that, in May 2009, the Board had postponed discussion on the matter in order to implement a consultation process with Member States on the proposed revisions to the Guidelines.<sup>1</sup> The proposed amendments to the Guidelines were included as an annex to the report and he invited further comments.

Mr OULD ABDI SALEM (adviser to Dr Ould Horma, Mauritania), speaking on behalf of the Member States of the African Region, thanked the Secretariat for the report. The purpose of the review was to consolidate international recommendations on pharmacodependence and clarify the WHO review process, ensuring that it was based on scientific and public health-related principles.

The proposed amendments to the Guidelines, prepared by a group comprising six Member States from four regions and three experts, suggested the use of current good practices for assessing the abuse liability of substances, the use of the Internet to improve the transparency of the process, and the reporting and publishing of the Expert Committee's procedures. He supported the proposed amendments.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, expressed appreciation for the work carried out by Member States, the Expert Committee on Drug Dependence, the Expert Advisory Panel on Drug Dependence, and other experts and proposed the following amendments to the wording of paragraph 23: subparagraph 23(5) should be separated into two points so that subparagraph 23(5) read "toxicology", and a new subparagraph 23(6) would read "adverse reactions in humans"; in subparagraph 23(8) "and epidemiology of medical use" should be added to the end of the sentence; and in subparagraph 23(12) the words "of medical and" should be deleted so that the phrase read "epidemiology of non-medical use, abuse and dependence".

Ms ROCHE (New Zealand) proposed the following amendment: in paragraph 45 the phrase "Any proposal for a change in the existing status of the substance should be made only if specific new control measures are necessary ..." should be changed to "Any proposal to move a substance from one convention to another should be made only if specific new control measures are necessary ..." with the paragraph then continuing unchanged.

Ms BLACKWOOD (United States of America)<sup>2</sup> reported that her country had submitted comments to the online discussion and emphasized that the modifications had improved the review guidelines, allowing for a more precise and scientific assessment in the review of substances.

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<sup>1</sup> See document EB125/2009/REC/1, summary record of the first meeting, section 5.

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

The steps in the control process for substances with narcotic abuse potential was the responsibility of multiple organizations and bodies, including the International Narcotics Control Board, the Commission on Narcotic Drugs and WHO. Decisions relating to drug scheduling should be made based on several factors, including the abuse potential and the drug's availability for medical and scientific use.

She proposed the following amendments: the sixth line of paragraph 4 should be changed to read "including the risk of abuse and the need to ensure medical availability, as well as the relevant resolutions ..."; and in paragraph 45, "universal access to essential medicines for" should be deleted, so the last line would read "and will not unduly limit availability for medical and scientific purposes."

In addition, she commented that the phrase "essential medicines" should not be used in guidelines for narcotic drugs scheduling as the term had a specific meaning to WHO and the list of essential medicines was not reviewed by the Expert Committee. The term "universal access" could also cause confusion, as it did not appear in either the Single Convention on Narcotic Drugs, 1961 or the 1971 Convention on Psychotropic Substances.

Dr DAHL-REGIS (Bahamas), in response to the CHAIRMAN's request for support for the amendments proposed by the representative of the United States of America, offered her support, and emphasized the importance of the removal of the term "essential medicines".

Dr ETIENNE (Assistant Director-General) expressed her appreciation for the contributions of the Member States on the issue. It was essential that the medical needs of patients who use psychoactive drugs were addressed without limiting access, while addressing the dependency and abuse potentials of those drugs. She had noted the proposed amendments; the changes would be implemented accordingly.

**The Board approved the revised guidelines on the WHO review of psychoactive substances for international control, as amended.<sup>1</sup>**

**Availability, safety and quality of blood products:** Item 4.16 of the Agenda (Documents EB126/19, EB126/19 Add.1 and EB126/19 Add. 2) (continued from the eleventh meeting)

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, thanked Board members and the Secretariat for their work and patience on the issue and announced that he was ready to adopt the draft resolution.

Dr TAKEI (adviser to Dr Omi, Japan) thanked the member for the United Kingdom of Great Britain and Northern Ireland for his proposals, and announced that he too wished to adopt the draft resolution.

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

**Treatment and prevention of pneumonia:** Item 4.20 of the Agenda (Document EB126/40)

The CHAIRMAN, introducing the item, noted that the end of the first sentence of paragraph 6 of the report should read "under-five mortality is estimated at US\$ 38 billion." He also drew attention to a draft resolution proposed by the United Kingdom of Great Britain and Northern Ireland, which read:

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<sup>1</sup> See EB126/2010/REC/1, Annex 6.

<sup>2</sup> Resolution EB126.R14.

Accelerating progress towards achievement of Millennium Development Goal 4  
(Reduce child mortality): prevention and treatment of pneumonia

The Executive Board,

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

The Sixty-third World Health Assembly,

Aware of the joint WHO/UNICEF report on a global action plan for the prevention and control of pneumonia, presented in November 2009;<sup>1</sup>

Noting the first advance market commitment on the pneumococcal vaccine and the progress made so far in integrating the *Haemophilus influenzae* type b vaccine into routine immunization programmes;

Noting also the introduction of the pneumococcal Accelerated Development and Introduction Plans;

Concerned at the lack of substantial progress towards reducing morbidity and mortality from pneumonia, despite it being globally the leading cause of mortality of children under the age of five years, and recognizing that prevention of pneumonia in children would significantly help progress towards reaching Target 4.A (Reduce by two thirds, between 1990 and 2015, the under-five mortality rate) of Millennium Development Goal 4 (Reduce child mortality);

Noting that safe and highly effective tools are available for pneumonia control in the form of the WHO's Integrated Management of Childhood Illness approach for case management at all levels, universal childhood immunization against *Haemophilus influenzae* type b and *Streptococcus pneumoniae* infections, improvement of nutrition and low birth weight, control of indoor air pollution, and prevention and management of HIV infection;

Concerned that pneumonia continues to cause more than 1.8 million preventable deaths in children less than five years of age globally each year;

Noting that the GAVI Alliance and other donors have made substantial resources available, and that the International Finance Facility for Immunisation provides a powerful mechanism for directing resources to immunization programmes;

Welcoming the contribution to the mobilization of resources for development of voluntary innovative financing initiatives taken by groups of Member States;

Mindful that decreasing the global burden of pneumonia will be essential for reaching Target 4.A (Reduce by two thirds, between 1990 and 2015, the under-five mortality rate) of Millennium Development Goal 4 (Reduce child mortality);

Noting in addition that efforts to strengthen the capacity of health systems to detect and manage pneumonia effectively are likely also to contribute positively to efforts to achieve Millennium Development Goal 5 (Improve maternal health);

Aware that pandemic (H1N1) 2009 has raised awareness of the need for system-wide strengthening of management of serious acute respiratory infections, and noting that the time is therefore opportune to build upon investments made related to the pandemic and to continue efforts to ensure that patients with acute respiratory infections receive prompt and effective treatment,

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<sup>1</sup> Document WHO/FCH/CAH/NCH/09.04.

1. URGES Member States:
  - (1) to apply according to their specific contexts, the policies, strategies and tools recommended by WHO;
  - (2) to establish evidence-based national policies and operational plans for strengthening health systems in order to expand coverage of populations at risk with major preventive and curative interventions;
  - (3) to assess programme performance and the coverage and impact of interventions in an effective and timely manner, particularly with use of WHO's country-profile database;
  - (4) to identify national and international resources, both human and financial, for strengthening health systems and for the provision of technical support in order to ensure that the most locally and epidemiologically appropriate strategies are implemented and target populations reached;
  - (5) to seek to implement, where appropriate, the recommendations in the joint WHO/UNICEF global action plan for the prevention and control of pneumonia, noting the importance of:
    - (a) immunization
    - (b) case management at community, health centre and hospital levels
    - (c) exclusive breast-feeding for six months
    - (d) improvement of nutrition and prevention of low birth weight
    - (e) control of indoor air pollution, and
    - (f) prevention and management of HIV infection;
  - (6) to encourage integrated approaches to pneumonia prevention and treatment through multisectoral collaboration and community responsibility and participation;
2. REQUESTS the Director-General:
  - (1) to strengthen human resources for prevention and control of pneumonia at all levels, especially the country level, thereby improving the capacity of WHO's country offices to provide support to national health programmes for coordinating the work of partners on preventing and controlling pneumonia;
  - (2) to bring together interested Member States, organizations in the United Nations system, the GAVI Alliance, medical research councils, and other interested stakeholders in a forum in order to improve coordination between different stakeholders in the fight against pneumonia;
  - (3) to report to the Sixty-fourth World Health Assembly, through the Executive Board, on progress made in implementation of this resolution as part of the progress report on the achievement of the health-related Millennium Development Goals.

The financial and administrative implications of the resolution would be:

<b>1. Resolution</b> Accelerating progress towards achievement of Millennium Development Goal 4 (Reduce child mortality): prevention and treatment of pneumonia	
<b>2. Linkage to programme budget</b>	
Strategic objective:	Organization-wide expected result:
1. To reduce the health, social and economic burden of communicable diseases.	1.1 Policy and technical support provided to Member States in order to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies, and to integrate other essential child-health interventions with immunization.

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.

4.5 Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.

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

The resolution is consistent with the listed expected results and supports the following indicators: for strategic objective 1 – (i) Number of Member States with at least 90% immunization coverage (DPT 3); and (ii) Number of Member States that have introduced *Haemophilus influenzae* type b vaccine into their national immunization schedule; and for strategic objective 4 – (i) Number of targeted Member States that have an integrated policy on universal access to effective interventions for improving maternal, newborn and child health and (ii) Number of Member States implementing strategies for increasing coverage with child health and development interventions.

### 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)**

US\$ 110 million are required for the period 2010–2015 in respect of costs at headquarters and at regional and country office levels.

**(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)**

In respect of strategic objective 1: headquarters – total US\$ 5.9 million (US\$ 900 000 for staff, US\$ 5 million for activities); regional and country offices – total US\$ 27.4 million (US\$ 5 million for staff, US\$ 22.4 million for activities).

In respect of strategic objective 4: headquarters – total US\$ 600 000 (US\$ 450 000 for staff, US\$ 150 000 for activities); regional and country offices – total US\$ 8 million (US\$ 2.4 million for staff, US\$ 5.6 million for activities).

**(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)?**

In respect of strategic objective 1: funds for 2010 are available through the GAVI Alliance and the Gates Foundation. Some of the funding required for 2011 may be available through the same sources, but a funding gap is likely to appear in 2011.

In respect of strategic objective 4: voluntary contributions will be sought to fund these activities.

### 5. Administrative implications

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

All levels of WHO, with a specific focus on the 68 priority countries that are the focus of the “Countdown to 2015” initiative, on which the disease places a high burden. Most of the countries concerned are also eligible for funding from the GAVI Alliance.

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

No. Additional staff will be needed to implement the resolution, especially in countries with a high burden of the disease.

**(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)**

Three staff members (full-time equivalent) at the P4 grade: 1 at headquarters, 1 at the Regional Office for South-East Asia and 1 at country level.

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

The period 2010–2015.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) recalled that pneumonia was the leading cause of death of children under five years of age. When discussing the approach to the disease, it was important to consider also the economic impact of the disease, on both communities or governments and individual families, such as lost hours at work, hospital and treatment costs and sometimes funeral costs. In order to achieve Millennium Development Goal 4 (Reduce child mortality), it was vital that control of pneumonia be given priority.

Besides his own, the following countries had agreed to cosponsor the draft resolution: Austria, Belgium, Burundi, the Czech Republic, Denmark, France, Ghana, Hungary, Ireland, Italy, Israel, Malawi, Malta, Monaco, New Zealand, Niger, Nigeria, Oman, Paraguay, Peru, Poland, Portugal, Serbia, Slovenia, Spain, Sao Tome and Principe, and Uganda. Following further discussion with other Member States, he proposed the following, minor amendments to the original text: in the fourth preambular paragraph “and recognizing that prevention of pneumonia in children would significantly help progress towards reaching Target 4.A (Reduce by two thirds, between 1990 and 2015, the under-five mortality rate) of Millennium Development Goal 4 (Reduce child mortality)” be deleted; a new paragraph should be inserted between the fourth and fifth preambular paragraphs to read “Mindful that decreasing the global burden of pneumonia will be essential for reaching Target 4.A of Millennium Development Goal 4;”; the last line of the fifth preambular paragraph should read “control of indoor air pollution arising from household use of solid fuels ...”; the first line of the seventh preambular paragraph should read “Noting that the GAVI Alliance and the PAHO Revolving Fund for Immunization ...”; the ninth preambular paragraph, beginning “Mindful that decreasing ...”, should be deleted; in operative paragraph 1(1), the words “to prevent and treat pneumonia” should be inserted at the end; in subparagraph 1(2), “major” should be replaced by “effective”; and subparagraph 1(3) be changed to read “to assess programme performance including the coverage and impact of interventions in an effective and timely manner, and use this assessment to inform WHO’s country profile database;”.

Dr DAHL-REGIS (Bahamas) asked with regard to the reported 67% reduction in deaths due to pneumonia (paragraph 7 of the report) what proportion was expected to be from prevention of disease due to *Streptococcus pneumoniae*? She also asked for clarification of the financial and administrative implications of the Board’s adoption of the resolution, in particular how Member States that were not among the 68 priority countries that were the focus of the “Countdown to 2015” initiative would benefit from the existing procurement mechanisms. Furthermore, how would the PAHO procurement fund apply to the 68 priority countries or remaining Member States? What infrastructure was available to deliver vaccines, in relation to for instance vaccine costs and formulations and human resources? The administrative implications document indicated that work would be done at all levels of the Organization; what preparatory work had been done? Finally, what commitment was there to financial sustainability beyond the period during which the GAVI Alliance supplied the vaccine? Previous experience showed that political commitment rather than donor commitment was the problem.

Ms TOELUPE (Samoa) agreed with the points raised by the member for the Bahamas relating to procurement of vaccines, human resources and financial issues, but expressed further concern about the aspects of equity and universal access inherent in the philosophy of primary health care and instruments such as the United Nations Convention on the Rights of the Child. Other countries, including small island countries such as her own, would also benefit from the investment in pneumococcal conjugate vaccine programmes.

Dr MUÑOZ (Chile) said that, every winter, his country set up so-called “acute respiratory infection rooms” in primary health care centres, with medical staff, including kinesiologists, and supplies of bronchodilator medicines. An extensive immunization campaign and wide-ranging awareness-raising activities were also conducted. Since 1990, mortality from pneumonia among children under the age of one year had fallen from 242 to 33 per 100 000 live births, or from 600 deaths per year to about 15. He welcomed the measures for primary health care, hospital care and pneumococcal vaccination campaigns advocated in the draft resolution. His country wished to be included as a sponsor.

Dr KABULUZI (Malawi), speaking on behalf of the Member States of the African Region, welcomed the inclusion on the agenda of the item on pneumonia, which was a significant cause of death in children under five years of age, particularly in Africa, and placed a heavy burden on families and health systems. Its control was essential if the Millennium Development Goal 4 (Reduce child mortality) was to be achieved.

In Malawi, with a population of some 30 million people, more than 800 000 cases of acute respiratory tract infection had been reported in children under five years of age in 2008 alone, leading to about 1500 deaths. Malawi needed more national and international resources to tackle the problem. He called upon international agencies to intensify their support for the implementation of the Global Action Plan for the Prevention and Control of Pneumonia in developing countries and upon WHO and partners to help to fill gaps in knowledge about pneumonia control in Member States, coordinate their efforts and develop appropriate tools.

Mr KAZI (adviser to Professor Haque, Bangladesh) proposed the following amendments to the draft resolution, which had been drawn up after consultation with the delegation of Thailand. In the title, the brackets around the words “Reduce child mortality” should be removed. A new preambular paragraph should be added after the current third paragraph, along the following lines: “Recalling that World Health Assembly resolution WHA58.15 on the Global Immunization Vision and Strategy requested the Director-General to mobilize resources to promote the availability and affordability in countries of future new vaccines based on evidence of epidemiological profiles”. Another new preambular paragraph should be added after the fifth preambular paragraph along the following lines: “Further noting that affordable price of vaccines in preventing pneumonia and significant scaling-up of cold-chain capacities determine the adoption and implementation of vaccination programmes, particularly in developing countries”.

Paragraph 1(5) should be amended to read: “to implement the recommendations ...”. Subparagraph 1(5)(a) should be amended to read: “immunization by accelerating the adoption of affordable and cost-effective vaccines based on evidence of national epidemiological profiles”. Paragraph 2(2) should be amended to read: “the fight against pneumonia, and mobilize resources to promote the availability of *Haemophilus influenzae* type b and pneumococcal vaccines”.

Dr MOHAMED (Oman) said that reducing mortality from pneumonia, especially among children under five years of age, was a major priority for primary health care in general and the achievement of Millennium Development Goal 4 in particular. If reductions in mortality were to be achieved, a programme of universal immunization would be required. That had been achieved in most Member States of the Eastern Mediterranean Region, including his own. The price of vaccines had fallen by 50% owing to increased competition among vaccine manufacturers and cooperation between countries through the GAVI Alliance. However, prices needed to fall even further. A funding

mechanism similar to the PAHO Revolving Fund had been established in the Region five years before, although it had yielded few quantifiable results as yet. He called upon the Secretariat to continue its work to help countries to increase their vaccination coverage and reduce the associated costs.

Mr PRASAD (alternate to Ms Sujatha Rao, India) supported the draft resolution as amended by the member for Bangladesh and agreed with the concerns raised by the member for the Bahamas. He remained concerned about the financial, logistical and human-resource implications for a large country such as his own. In addition, more research was needed into the pneumococcal strains circulating in India. He called for more consultation on the subject before it was brought up at the Health Assembly.

Dr BUSS (Brazil) expressed full support for the draft resolution, as amended by the member for Bangladesh. Brazil had added pneumococcal vaccines to its immunization programme and had begun to manufacture those vaccines itself through the Oswaldo Cruz Foundation.

Ms BULLINGER (Switzerland)<sup>1</sup> said that her country had been omitted from the list of sponsors of the draft resolution, and asked for it to be restored.

Dr NAKORN PREMSI (Thailand)<sup>1</sup> welcomed the draft resolution as amended by the member for Bangladesh. His country valued the joint WHO/UNICEF global action plan for the prevention and control of pneumonia. The report gave the impression that immunization against bacterial causes of pneumonia was a major contributor to mortality reduction. Evidence cited in the *Bulletin of the World Health Organization*, however, had identified respiratory syncytial virus as the major cause of childhood pneumonia;<sup>2</sup> bacterial vaccines were not a “magic bullet”. Good case management at the community, health-centre and hospital levels was the most significant factor, and the report should reflect that fact. All pneumonia-control measures should be integrated into general health care interventions.

Dr REN Minghui (China)<sup>1</sup> sought clarification of paragraph 2(3) of the draft resolution. He recalled resolution WHA61.18, in which the Director-General was requested to report annually to the Health Assembly on progress towards achievement of the health-related Millennium Development Goals. He understood the draft resolution to mean that reports on pneumonia-control activities should form a major component of those annual reports.

Dr MAFUBELU (Assistant Director-General) said that WHO’s policy on pneumonia control took an integrated approach, which certainly did not treat vaccination as a “magic bullet”. Replying to the points raised by the member for the Bahamas, she said that almost 97% of child deaths from pneumonia occurred in the 68 priority countries mentioned in the report. Demand for vaccines was expected to rise, which should cause prices to fall for all countries. Moreover, new manufacturers were expected to enter the market, including some from developing countries, a move that should also bring prices down.

In respect of delivery systems, WHO and UNICEF were working together to help countries to meet the requirements relating to cold chains and appropriate human resources necessary to obtain funding from the GAVI Alliance. As for financial sustainability, there were various issues related to reliance on the GAVI Alliance as a source of funding, but consideration needed to be given to cofinancing or use of a country’s own domestic resources; political commitment was important.

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

<sup>2</sup> Rudan I et al. Epidemiology and etiology of childhood pneumonia. *Bulletin of the World Health Organization*, 2008;**86**:408–416.



Some US\$ 110 million would be required to implement the measures proposed in the draft resolution. It would be necessary to mobilize additional resources, and the Secretariat would provide assistance with that process, at Member States' request.

WHO worked with UNICEF, UNFPA and the World Bank to intensify support to countries, including conducting research to fill the gaps in knowledge that still existed and disseminating the resulting information.

Dr OKWO-BELE (Immunization, Vaccines and Biologicals) said that the figure for the potential reduction in mortality of 67% was based on estimates that indicated that 30% to 40% of pneumonia deaths were attributable to streptococcal infection and a further 20% to *Haemophilus influenzae* type b. In some cases, bacterial and viral coinfection could occur.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) apologized for the omission of Switzerland as a sponsor and announced that Chile wished also to be a sponsor.

Dr YOUNES (Office of Governing Bodies), affirming that the title of the draft resolution would be adjusted in line with the request from the member for Bangladesh, read out the proposed amendments to the draft resolution, beginning with the preambular paragraphs. A new paragraph should be inserted after the third, reading: "Recalling that resolution WHA58.15 on the global immunization strategy requested the Director-General to mobilize resources to promote the availability and affordability in countries of future new vaccines based on evidence of epidemiological profiles". The latter part of the fourth paragraph, from "and recognizing that prevention" to "Millennium Development Goal 4 (Reduce child mortality)", should be deleted. A new paragraph should be added after the fourth, reading: "Mindful that decreasing the global burden of pneumonia will be essential for reaching Target 4.A of Millennium Development Goal 4". The end of the fifth paragraph should be amended to read: "... indoor air pollution arising from household use of solid fuels, and prevention and management of HIV infection". A new paragraph should be added after the fifth, reading: "Further noting that affordable price of vaccines in preventing pneumonia and significant scaling up of cold-chain capacities determine the adoption and implementation of vaccination programmes particularly in developing countries;". The first line of the seventh paragraph should be amended to read: "Noting that the GAVI Alliance and the PAHO Revolving Fund for Immunization have made substantial resources available ...". The ninth paragraph should be deleted.

In paragraph 1, the end of subparagraph 1(1) should be amended to read: "... recommended by WHO, to prevent and treat pneumonia;". The word "major" towards the end of subparagraph 1(2) should be replaced by "effective". Subparagraph 1(3) should be amended to read: "to assess programme performance including the coverage and impact of interventions in an effective and timely manner, and use this assessment to inform WHO's country-profile database;". The words "where appropriate" in the first line of subparagraph 1(5) should be deleted. Subparagraph 1(5)(a) should be amended to read: "immunization by accelerating the adoption of affordable and cost-effective vaccines based on evidence of national epidemiological profiles;". Finally, the end of subparagraph 2(2) should be amended to read: "... stakeholders in the fight against pneumonia and mobilize resources to promote the availability of Hib and pneumococcal vaccines;".

Dr DAHL-REGIS (Bahamas), with regard to the seventh preambular paragraph, requested clarification as to the connection between the GAVI Alliance and the PAHO Revolving Fund for Immunization, which was a procurement fund.

The DIRECTOR-GENERAL said that the GAVI Alliance was both a funding mechanism and a co-investment partnership, working with governments, whereas the PAHO fund was strictly a procurement mechanism – Member States in the Region of the Americas had to pay for the vaccines.

Dr GIMÉNEZ (Paraguay) stressed the importance of the PAHO fund for Latin American Member States in affording them equitable access to vaccines through group purchases, as well as in offering technical support.

The DIRECTOR-GENERAL concurred, but clarified that the PAHO fund was not a mechanism to provide funds but to facilitate collective purchasing. The paragraph in question aimed to recognize the role of the GAVI Alliance and the International Finance Facility for Immunisation in mobilizing resources to assist countries.

The CHAIRMAN added that the PAHO fund made vaccines available at slightly reduced prices, thereby enabling Member States to pay less or procure more.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) proposed that, in order to remove any confusion, the paragraph could read: “Noting that the GAVI Alliance and other donors have made substantial resources available, and that the International Finance Facility for Immunisation and the PAHO Revolving Fund for Immunization provide powerful mechanisms for directing resources to immunization programmes”.

Dr GIMÉNEZ (Paraguay) said that the mention of the PAHO Revolving Fund should appear immediately after that of the GAVI Alliance.

Dr REN Minghui (China)<sup>1</sup> asked whether paragraph 2(3) meant to say that the Director-General would only report on progress in implementing the resolution to the Sixty-fourth World Health Assembly, and that the pneumonia component would not figure in any subsequent progress reports on the achievement of Millennium Development Goal 4.

The DIRECTOR-GENERAL said that paragraph 2(3) had been intended to mean that the contribution of the pneumonia component to overall achievement of Millennium Development Goal 4 would not be reported to the Health Assembly before 2011, and that it would then form part of every subsequent annual report. The Secretariat would rewrite the paragraph appropriately.

Dr VIROJ TANGCHAROENSATHIEN (Thailand),<sup>1</sup> drawing attention to the evidence published in 2008 that second-hand smoking was another major risk factor contributing to childhood pneumonia,<sup>2</sup> suggested that the words “and second-hand smoking in households” should be inserted after “household use of solid fuels” at the end of the fourth preambular paragraph.

Mr PRASAD (adviser to Ms Sujatha Rao, India) and Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) supported the amendment proposed by the representative of Thailand.

In the absence of any further comments, the CHAIRMAN took it that the Board wished to adopt the draft resolution, as amended.

**The resolution, as amended, was adopted.<sup>3</sup>**

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

<sup>2</sup> Anthony J, Scott G. The global epidemiology of childhood pneumonia 20 years on. *Bulletin of the World Health Organization*, 2008; **86**:494-495.

<sup>3</sup> Resolution EB126.R15.

**Leprosy (Hansen disease):** Item 4.21 of the Agenda (Document EB126/41)

The CHAIRMAN drew attention to a draft resolution on leprosy proposed by Brazil, which reads:

The Executive Board,  
Having considered the report on leprosy;<sup>1</sup>

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 leprosy;  
Considering the history of certain other diseases that demonstrates the impossibility of their eradication, as in the case of leprosy;

Considering that leprosy is a contagious disease, caused by slow-growing mycobacteria and, consequently, with a prolonged incubation period;

Recognizing that the diagnosis of leprosy is based on clinical examination of patients and epidemiologic data, as no test yet exists that enables an early diagnosis, in either the subclinical phase or the incubation period;

Considering that only diseases for which there are vaccines have been eradicated or eliminated and that there is no vaccine for leprosy;

Considering that the control of leprosy is based on early diagnosis of cases, with the aim of eliminating the sources of infection and avoiding the sequelae resulting from late diagnosis and the absence of adequate monitoring;

Recognizing that the target for elimination of leprosy as a public health problem is reduction of the prevalence to less than one case per 10 000 population was adopted, with the objective of breaking the transmission chain and reducing the number of cases among the population, by the Health Assembly in resolution WHA44.9 in 1991;

Recognizing that, for the reasons stated in the previous paragraphs and despite having added political strength to the control programmes, this objective was not achieved, as has been demonstrated by several studies and confirmed in WHO's epidemiological reports;

Considering that since the year 2000 the Health Assembly has not adopted a specific resolution on the theme;

Aware that, recognizing the need to review WHO's targets, the managers of leprosy programmes of 44 Member States, with the participation of WHO regional offices as well as nongovernmental organizations, representing the people affected by leprosy (New Delhi, 20–22 April 2009), agreed an enhanced global strategy for further reducing the disease burden due to leprosy: 2011–2015 which focused on the reduction of new cases, and operational guidelines;<sup>2</sup>

Further considering that, according to WHO, eliminating a disease is achieving a condition in which there are no occurrences of new cases, or achieving incidence zero with the need to maintaining control measures,

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<sup>1</sup> Document EB126/41.

<sup>2</sup> Documents SEA-GLP-2009.3 and SEA-GLP-2009.4, respectively.

1. URGES Member States:
  - (1) to adapt appropriately their national policies to the “enhanced global strategy for further reducing the disease burden due to leprosy: 2011–2015”,<sup>1</sup> with a reduction target up to 35% until 2015;
  - (2) to consider the following as the main technically sustainable indicators for monitoring progress of the endemic: the number and the coefficient of detected new cases per 100 000 population, the coefficient of detected new cases with grade 2 incapacity in the general population, and the proportion of cured patients;
  - (3) to adopt as indicators for evaluating the detection of leprosy the proportion of new cases with grade 2 incapacity, and the proportion of cases of in women and children and the proportion of multibacillary cases among new cases;
  - (4) to incorporate into their specific contexts policies, strategies and WHO’s recommended instruments to define and implement actions to promote health, prevention, diagnosis and assistance to those affected with leprosy;
  - (5) to strengthen leprosy control programmes at the national level;
2. REQUESTS the Director-General:
  - (1) to provide the necessary support to Member States for introducing into their public policies the targets and indicators referred to in paragraphs 1(1)–1(3) of this resolution;
  - (2) to provide the necessary support for the development of scientific research related to prevention, diagnosis and treatment of leprosy;
  - (3) to consider the possibility of allocating additional resources in order to ensure that the knowledge arising from research be translated into efficient public health policies for the control and prevention of leprosy, including in accordance with the global strategy on public health, innovation and intellectual property;<sup>2</sup>
  - (4) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on progress in implementing this resolution.

The financial and administrative implications of the draft resolution, if adopted, would be:

<b>1. Resolution Leprosy (Hansen disease)</b>	
<b>2. Linkage to programme budget</b>	
Strategic objective: 1. To reduce the health, social and economic burden of communicable diseases.	Organization-wide expected result: 1.3 Effective coordination and support provided to Member States in order to provide access for all populations to interventions for the prevention, control, elimination and eradication of neglected tropical diseases, including zoonotic diseases.
<b>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</b>	
The resolution is consistent with the indicator on leprosy for the expected result.	
<b>3. Budgetary implications</b>	
<b>(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).</b>	
The estimated cost for the period 2010 to 2015 is about US\$ 16 580 000.	

<sup>1</sup> Document EB126/41.

<sup>2</sup> Adopted in resolution WHA61.21.

- (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).**

The estimated cost for the biennium is US\$ 5 320 000 (African Region, US\$ 1 980 000; Region of the Americas, US\$ 510 000; South-East Asia Region, US\$ 1 350 000; Eastern Mediterranean Region, US\$ 140 000; Western Pacific Region, US\$ 150 000 and headquarters, US\$ 1 190 000).

- (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)?**

From voluntary contributions from donors such as the Nippon Foundation and some individual members of the International Federation of Anti-Leprosy Associations.

#### **5. Administrative implications**

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

The Global Leprosy Programme is based in the Regional Office for South-East Asia under the leadership of the Regional Director. The technical and administrative management of the leprosy-control activities in WHO will be carried out by the Programme. The donation for the supply of drugs for multidrug therapy and logistics pertaining to distribution are to be handled by headquarters.

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

Yes.

- (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).**

No additional staff required.

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

2010–2011. The following activities will be implemented: improving quality of currently reported data on grade 2 incapacity among new cases; improving monitoring and evaluation including surveillance of drug resistance; capacity building of health workers; promoting early detection of new cases and treatment with multidrug therapy; strengthening integration of leprosy-control activities into general health-care services; promoting activities aimed at reducing stigma and discrimination against persons affected by leprosy and their families.

2012–2015. The following activities will be implemented: promoting early detection of new cases and treatment with multidrug therapy; improving monitoring and evaluation including surveillance of drug resistance; capacity building of health workers; promoting activities aimed at reducing stigma and discrimination against persons affected by leprosy and their families; improving referral services for management of acute and chronic complications including rehabilitation services.

Mr HAGE (adviser to Dr Buss, Brazil), introducing the draft resolution, recalled that the Health Assembly had adopted resolution WHA44.9 on leprosy, in 1991 amid the great optimism generated by the early successes of multidrug therapy, and had given a major political boost to national leprosy control programmes. However, evidence of increasing resistance to that therapy over 25 years had been confirmed in review published in 2005. In 2009 the Regional Office for South-East Asia had issued an enhanced global strategy for further reducing the disease burden due to leprosy for the period 2011–2015,<sup>1</sup> based on the recommendations of 44 programme managers attending a meeting on leprosy control strategy (New Delhi, 20–22 April 2009). The outcome included a new deadline and fresh guidelines for (and indicators to monitor progress towards) eliminating leprosy as a public health problem. Resolution WHA44.9 had set the target of a reduction in prevalence to a level below one case per 10 000 population; that figure did not amount to zero incidence and might be interpreted as effective elimination, possibly leading to a relaxation of leprosy-control measures and a dismantling of surveillance and health-care services, which might in turn lead to a greater risk of tardy diagnosis and more serious new cases. Furthermore, if governments ceased regarding leprosy as a priority, financial and technical resources for existing programmes might become harder to come by, thereby undermining the political impetus initially provided by resolution WHA44.9. The three main indicators contained in the enhanced global strategy were far more comprehensive and clear than their predecessors; they made it possible to identify which strategies to prioritize in order to have a better impact on the disease; and they had been developed, and the guidelines had been updated, on the basis of proposals from the managers in countries endemic for leprosy, of which Brazil itself was a major example, as well as on more recent and sounder scientific evidence. He therefore recommended that the Board adopt the draft resolution.

Mr CHAUDHRY (adviser to Ms Sujatha Rao, India) outlined the progress his country had made in combating leprosy from 1955 through to its elimination as a public health problem at the national level, according to the indicator of fewer than one case per 10 000 population, in December 2005. The three remaining states yet to reach that goal were expected to do so by 2012. Although the national prevalence had fallen to less than 100 000 cases, some 134 000 new cases were still being detected each year, a situation that would only improve gradually owing to the lengthy incubation period of the infection. In the meantime, the Indian national health system, aware of the risk of an accumulation of hidden and untreated cases, remained vigilant and committed to early detection and treatment.

Dr DAHL-REGIS (Bahamas) supported the draft resolution, especially the target in paragraph 1.

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, said that they had managed to reach the target of reducing the prevalence of leprosy to a level below one case per 10 000 population – thereby eliminating it as a public health problem – at the national level, and had set themselves the target of doing likewise at the health-district level. Understandably, they therefore remained attached to resolution WHA44.9 and resolution AFR/RC44/R5 Rev.1 on elimination of leprosy in the African Region adopted by the Regional Committee for Africa in 2004, and would regard it as a step in the wrong direction for the Region to call their validity into question.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, said that the commitment set out in resolution WHA44.9, to attain the global elimination of leprosy as a public health problem, remained as valid today as it had been in 1991. Anything less would constitute a serious step backwards. The Secretariat should continue to work towards the elimination of leprosy in the small number of countries that had not yet achieved the target of reaching prevalence below one case per

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<sup>1</sup> Document SEA-GLP-2009.3.

10 000, while providing support to countries with a low prevalence of leprosy in order to sustain their leprosy activities through a combination of integrated services supported by specialized referral facilities.

Dr TAKEI (adviser to Dr Omi, Japan) thanked all stakeholders for their efforts to achieve the target of attaining the global elimination of leprosy. When that objective had been set in 1991, there had been about 4.5 million cases of the disease, whereas in 2008 slightly more than 213 000 cases had been notified; 120 of the 122 countries in which leprosy had previously been endemic had achieved the elimination target. WHO and the international community should help the countries that continued to encounter difficulties in attaining that goal.

Japan was concerned that the draft resolution was much weaker than resolution WHA44.9. There was no evidence indicating that it was impossible to eradicate leprosy; vaccination was not the only medical tool for achieving eradication of a particular disease, as had shown for dracunculiasis. Multidrug therapy was a powerful weapon in reducing prevalence, and BCG vaccine had been scientifically proven to offer some protection against leprosy. Insufficient evidence had been provided to ascertain whether the indicators and targets referred to in subparagraphs 1(1)–(3) were scientifically appropriate. WHO should convene the Expert Committee on Leprosy in order to examine the scientific evidence and distribute the findings to Member States. The past gains achieved in eliminating leprosy should be built on in order to eradicate the disease.

Dr SADRIZADEH (Islamic Republic of Iran)<sup>1</sup> thanked WHO for its significant efforts to eliminate leprosy since 1991. The number of cases had been drastically reduced, and the disease had been eliminated in 120 of the countries considered to be endemic for leprosy, including Iran. The argument that leprosy could not be eradicated because of the long incubation period and the absence of a vaccine was therefore questionable. WHO should continue to work towards the elimination of leprosy in countries where the disease remained a public health problem, and assist the countries in which the prevalence was low in sustaining their activities against leprosy, through a combination of integrated services supported by specialized referral facilities. He too encouraged WHO to convene the Expert Committee on Leprosy to review the current situation, establish new leadership of the WHO Global Leprosy Programme, and strengthen the efforts to eliminate leprosy by building on past gains.

Mr HAGE (adviser to Dr Buss, Brazil) said that representatives of countries where leprosy remained endemic had held discussions within the framework of the WHO Global Leprosy Programme. They had identified the need to develop indicators, considering that the more scientific evidence available, the easier it would be to control the disease. Brazil, for its part, had made sustained efforts to reduce the prevalence of leprosy, which had fallen by more than 30% over the previous five years. However, for a number of countries the target of reaching prevalence below one case per 10 000 was not sufficient in view of the need to avoid a resurgence of the disease. He welcomed the suggestion by the member for Japan of a review of the scientific evidence available.

Dr DAHL-REGIS (Bahamas) supported the proposed convening of the Expert Committee on Leprosy.

The CHAIRMAN suggested that, as the Board had not reached consensus on the draft resolution, the Director-General should convene the Expert Committee before the 128th session of the Executive Board in order to consider the scientific information. She should circulate the Committee's findings to Member States.

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

The DIRECTOR-GENERAL thanked Brazil for its flexibility. There was no conflict with Brazil's intention to raise awareness of the important work on leprosy. The concern was the length of time that had passed since a resolution had been adopted in order to raise political commitment and technical awareness of the leprosy issue. It was her understanding that Brazil would wish to participate in work of the Expert Committee, which she would convene as soon as possible, to consider the latest evidence and review existing indicators of progress in order to ascertain whether better indicators could be introduced. Countries would be able to propose a draft resolution at a future date depending on the outcome of the Expert Committee's work.

Mr HAGE (adviser to Dr Buss, Brazil) said that his country sought to ensure continued progress in the control of leprosy given the fact that political commitment could dwindle as more countries achieved the target of reaching prevalence below one case per 10 000. Brazil's concern was based not only on its own assessment but also on discussions with other countries where leprosy was endemic. The aim was to ascertain whether more recent scientific evidence and the use of other indicators would provide for more effective control. He agreed with the recommendation for the Director-General to convene the Expert Committee during 2010.

The CHAIRMAN said that he took it that the Board agreed to the convening of the Expert Committee on Leprosy, and to take up the subject again at its 128th session in January 2011.

**It was so agreed.**

## **2. MANAGEMENT MATTERS: Item 7 of the Agenda (continued)**

### **Provisional agenda of the Sixty-third World Health Assembly and date and place of the 127th session of the Executive Board: Item 7.4 of the Agenda (Document EB126/27)**

Dr YOUNES (Office of Governing Bodies) said that the Secretariat had noted one amendment to the draft provisional agenda for the Sixty-third World Health Assembly contained in the report. A new subitem had been proposed for Committee A, under item 11, Technical and health matters, namely item 11.23 on Treatment and prevention of pneumonia. The subitem entitled "Progress reports" would thus become subitem 11.24.

The DIRECTOR-GENERAL, responding to a request for clarification from Dr DAHL-REGIS (Bahamas) as to the duration of the Health Assembly, said that, in accordance with the conclusion of the Programme, Budget and Administration Committee, an optimal duration of the Health Assembly would be five days for non-budget years; accordingly, the Health Assembly in May 2010 would span five days. Appropriate agenda management, good time management and discipline on the part of Member States would be required if the full agenda was to be completed. The Secretariat would circulate information in that regard to the broader membership of WHO.

The CHAIRMAN said that he took it that the Board wished to adopt the draft decision contained in paragraph 3 of document EB126/27, as amended.

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

The CHAIRMAN said that, since the Board had elected a new officer at its current session, namely Dr E.R. Sedyaningsih (Indonesia), it would be appropriate to update the decision taken in 2009 on

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<sup>1</sup> Decision EB126(3).



representation of the Board at the Sixty-third World Health Assembly. He therefore invited the Board to consider the following draft decision:

Further to decision EB125(4) of 23 May 2009, and in accordance with paragraph 1 of resolution EB59.R7, the Executive Board decided to appoint its Chairman, Dr S. Zaramba (Uganda), and its first three Vice-Chairmen, Dr E.R. Sedyaningsih (Indonesia), Dr E. Giménez (Paraguay) and Professor Sohn Myongsei (Republic of Korea) to represent the Executive Board at the Sixty-third World Health Assembly. It was understood that if any of those members were not available for the Health Assembly, the other Vice-Chairman, Dr A.J. Mohamed (Oman) and the Rapporteur, Professor T. Milosavljević (Serbia), could be asked to represent the Board.

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

The CHAIRMAN suggested that the 127th session of the Executive Board should be held in Geneva from 24 May 2010, closing no later than 26 May 2010, although in fact it was envisaged that it would last only one day.

Dr KÖKÉNY (Hungary), noting that it had just been agreed that the Health Assembly would finish on Friday, 21 May, asked whether it would be possible to schedule the Board's session for Saturday, 22 May 2010.

The DIRECTOR-GENERAL pointed out that the election of new Board members was scheduled to take place on Friday, 21 May and that it might be difficult for the newly elected members to make the necessary visa and travel arrangements in order to be present on Saturday, 22 May.

After an exchange of views in which Dr JESSE (Estonia), Dr DJIBO (Niger), Dr SADRIZADEH (Islamic Republic of Iran),<sup>2</sup> Dr MOHAMED (Oman), Dr DAHL-REGIS (Bahamas), the DIRECTOR-GENERAL and the CHAIRMAN participated, the CHAIRMAN invited the Board to agree that the 127th session of the Board should be held on Saturday, 22 May 2010, it being understood that the Secretariat would determine whether the timetable of the Health Assembly could be adjusted to permit the election of new Board members early in the week and in accordance with the Rules of Procedure.

**It was so agreed.**

The DIRECTOR-GENERAL appealed to Member States to ensure, with the support of the Regional Directors, that the mechanisms for proposing Members entitled to designate members to serve on the Board and for making the visa and travel arrangements for those so designated were implemented as expeditiously as possible so that all the newly elected Board members could attend the 127th session.

(For continuation of the discussion of Management matters, see summary record of the thirteenth meeting, section 2.)

**The meeting rose at 20:40.**

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<sup>1</sup> Decision EB126(2).

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

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

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 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;

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<sup>1</sup> Document EB126/15.

Considering the need to reduce the liver cancer mortality rates and that viral hepatitis 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;<sup>1</sup>
  - (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;

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<sup>1</sup> 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)<sup>1</sup> expressed support for the draft resolution, including the designation of a World Hepatitis Day.

Dr NAKORN PREMSRI (Thailand)<sup>1</sup> 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.<sup>2</sup>**

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

<sup>2</sup> Resolution 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.<sup>1</sup>**

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

**The decision was adopted.<sup>2</sup>**

- **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.<sup>3</sup>

#### **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.

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<sup>1</sup> Resolution EB126.R17.

<sup>2</sup> Decision EB126(5).

<sup>3</sup> 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.<sup>1</sup>

**United Arab Emirates Health Foundation Prize**

**Decision:** The Executive Board, having considered the report of the United Arab Emirates Health Foundation Selection Panel, awarded the United Arab Emirates Health Foundation Prize 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.<sup>2</sup>

**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.<sup>3</sup>

**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.

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<sup>1</sup> Decision EB126(7).

<sup>2</sup> Decision EB126(8).

<sup>3</sup> 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 CHAUDHRY (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)<sup>1</sup> 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)<sup>1</sup> 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.

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

Ms LANTERI (Monaco)<sup>1</sup> 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)<sup>1</sup> 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.

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

Ms NATTAYA THAENNIN (Thailand)<sup>2</sup> 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)<sup>2</sup> 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,<sup>1</sup> 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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<sup>1</sup> WHO. *Women and health: today's evidence tomorrow's agenda*. Geneva, World Health Organization, 2009.

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

Ms ORAPHAN SRISUKWATANA (Thailand)<sup>1</sup> 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.

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

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

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

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<sup>1</sup> 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,<sup>1</sup> 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)<sup>2</sup> 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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<sup>1</sup> Resolution AFR/RC58/R3.

<sup>2</sup> 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.**

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