



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

127TH SESSION

GENEVA, 22 MAY 2010

DECISIONS

SUMMARY RECORDS

GENEVA

2010



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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

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

PREFACE

The 127th session of the Executive Board was held at the Palais des Nations, Geneva, on 22 May 2010.

The Sixty-third World Health Assembly elected 12 Member States to be entitled to designate a person to serve on the Executive Board in place of those whose term of office had expired,¹ giving the following new composition of the Board:

Designating country	Unexpired term of office ²	Designating country	Unexpired term of office ²
Armenia.....	3 years	Mauritius.....	1 year
Bangladesh.....	1 year	Mongolia.....	3 years
Barbados.....	3 years	Morocco.....	3 years
Brazil.....	1 year	Mozambique.....	3 years
Brunei Darussalam.....	2 years	Niger.....	1 year
Burundi.....	2 years	Norway.....	3 years
Canada.....	2 years	Oman.....	1 year
Chile.....	2 years	Russian Federation.....	1 year
China.....	3 years	Samoa.....	1 year
Ecuador.....	3 years	Serbia.....	2 years
Estonia.....	2 years	Seychelles.....	3 years
France.....	2 years	Somalia.....	2 years
Germany.....	2 years	Syrian Arab Republic.....	2 years
Hungary.....	1 year	Timor-Leste.....	3 years
India.....	2 years	Uganda.....	1 year
Japan.....	2 years	United States of America.....	3 years
Mauritania.....	1 year	Yemen.....	3 years

Details regarding members designated by the above Member States will be found in the list of members and other participants.

¹ By decision WHA63(7). The retiring members were those designated by Bahamas, Indonesia, Malawi, New Zealand, Paraguay, Peru, Republic of Korea, Republic of Moldova, Sao Tome and Principe, Tunisia, United Arab Emirates, and United Kingdom of Great Britain and Northern Ireland.

² At the time of the closure of the Sixty-third World Health Assembly.

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1. Opening of the session and adoption of the agenda
2. Election of Chairman, Vice-Chairmen and Rapporteur
3. Outcome of the Sixty-third World Health Assembly
4. Report of the Programme, Budget and Administration Committee of the Executive Board
5. Technical and health matters
 - 5.1 Crimean-Congo haemorrhagic fever, hantavirus, and Alkhurma haemorrhagic fever, as emerging infectious diseases
 - 5.2 Cholera: mechanism for control and prevention
 - 5.3 Child injury prevention
 - 5.4 Strategies for the safe management of drinking-water for human consumption
6. Management and financial matters
 - 6.1 Committees of the Executive Board: filling of vacancies
 - 6.2 Future sessions of the Executive Board and the Health Assembly
 - 6.3 [deleted]
7. Staffing matters
 - 7.1 Statement by the representative of the WHO staff associations
 - 7.2 [deleted]
8. Matters for information

Report on meetings of expert committees and study groups
9. Closure of the session

¹ As adopted by the Board at its first meeting.

LIST OF DOCUMENTS

EB127/1 Rev.1	Agenda ¹
EB127/1 (annotated)	Provisional agenda (annotated)
EB127/2	Report of the Programme, Budget and Administration Committee of the Executive Board
EB127/3	Crimean-Congo haemorrhagic fever, hantavirus, and Alkhurma haemorrhagic fever, as emerging infectious diseases
EB127/4	Cholera: mechanism for control and prevention
EB127/5	Child injury prevention
EB127/5 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
EB127/6	Strategies for the safe management of drinking-water for human consumption
EB127/7 EB127/7 Add.1	Committees of the Executive Board: filling of vacancies
EB127/8	Future sessions of the Executive Board and the Health Assembly
EB127/9	Statement by the representative of the WHO staff associations
EB127/10	Report of meetings of expert committees and study groups
Diverse	
EB127/DIV/1 Rev.1	Provisional list of members and other participants
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¹ See page vii.

PART I

DECISIONS

DECISIONS

EB127(1) Membership of the Programme, Budget and Administration Committee of the Executive Board

The Executive Board appointed as members of the Programme, Budget and Administration Committee Dr N. Birintanya (Burundi), Dr K. Dodds (Canada), Dr Ren Minghui (China), Dr E. Seeba (Germany), Mme Y. Baddou (Morocco) and Ms M. Hanjan Soares (Timor-Leste) for a two-year period or until expiry of their membership on the Board, whichever comes first, in addition to Dr P.M. Buss (Brazil), Mr D. Houssin (France), Ms K. Sujatha Rao (India), Dr S. Omi (Japan), Dr A. Djibo (Niger), Dr A.J. Mohamed (Oman), Dr M. Kökény (Hungary), Chairman of the Board, member ex officio, and Professor A.F.M.R. Haque (Bangladesh), Vice-Chairman of the Board, member ex officio. It was understood that, if any member of the Committee, except the two ex officio members, was unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Committee.

(Second meeting, 22 May 2010)

EB127(2) Membership of the Executive Board's Standing Committee on Nongovernmental Organizations

The Executive Board appointed Professor A. Babloyan (Armenia) and Dr B. Valentin (Seychelles) as members of its Standing Committee on Nongovernmental Organizations for the duration of their term of office on the Executive Board, in addition to Professor A.F.M.R. Haque (Bangladesh), Dr A.J. Mohamed (Oman) and Mrs G.A. Gidlow (Samoa), already a member of the Committee. It was understood that, if any member of the Committee was unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Committee.

(Second meeting, 22 May 2010)

EB127(3) Membership of the Léon Bernard Foundation Committee

The Executive Board, in accordance with the Statutes of the Léon Bernard Foundation, appointed Dr M. Jesse (Estonia) as a member of the Léon Bernard Foundation Committee for the duration of her term of office on the Executive Board, in addition to the Chairman and Vice-Chairmen of the Board, members ex officio. It was understood that, if Dr Jesse was unable to attend, her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Committee.

(Second meeting, 22 May 2010)

EB127(4) Membership of the Sasakawa Health Prize Selection Panel

The Executive Board, in accordance with the Statutes of the Sasakawa Health Prize, appointed Mr S. Lambaa (Mongolia) as a member of the Sasakawa Health Prize Selection Panel for the duration of his term of office on the Executive Board, in addition to the Chairman and a representative appointed by the Founder, members ex officio. It was understood that, if Mr Lambaa was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Panel.

(Second meeting, 22 May 2010)

EB127(5) Membership of the United Arab Emirates Health Foundation Selection Panel

The Executive Board, in accordance with the Statutes of the United Arab Emirates Health Foundation, appointed Dr R. Said (Syrian Arab Republic) as a member of the United Arab Emirates Health Foundation Selection Panel for the duration of his term of office on the Executive Board, in addition to the Chairman and a representative of the Founder, members ex officio. It was understood that, if Dr Said was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Panel.

(Second meeting, 22 May 2010)

EB127(6) Membership of the State of Kuwait Health Promotion Foundation Selection Panel

The Executive Board, in accordance with the Statutes of the State of Kuwait Health Promotion Foundation, appointed Dr A.J. Mohamed (Oman) as a member of the State of Kuwait Health Promotion Foundation Selection Panel for the duration of his term of office on the Executive Board, in addition to the Chairman and a representative of the Founder, members ex officio. It was understood that, if Dr Mohamed was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Panel.

(Second meeting, 22 May 2010)

EB127(7) Appointment of representatives of the Executive Board at the Sixty-fourth World Health Assembly

The Executive Board, in accordance with paragraph 1 of resolution EB59.R7, appointed its Chairman, Dr M. Kökény (Hungary), and its first three Vice-Chairmen, Dr P.M. Buss (Brazil), Mr P.D.S. Osman (Brunei Darussalam) and Dr A.J. Mohamed (Oman), to represent the Executive Board at the Sixty-fourth World Health Assembly. It was understood that, if any of those members were not available for the Health Assembly, the other Vice-Chairman, Professor A.F.M.R. Haque (Bangladesh) and the Rapporteur, Dr A. Djibo (Niger), could be asked to represent the Board.

(Second meeting, 22 May 2010)

EB127(8) Date, place and duration of the 128th session of the Executive Board

The Executive Board decided that its 128th session should be convened on Monday, 17 January 2011, at WHO headquarters, Geneva, and should close no later than Tuesday, 25 January 2011. The Board further decided that the thirteenth meeting of the Programme, Budget and Administration Committee of the Executive Board should be held on Thursday and Friday, 13 and 14 January 2011, at WHO headquarters.

(Second meeting, 22 May 2010)

EB127(9) Place, date and duration of the Sixty-fourth World Health Assembly

The Executive Board decided that the Sixty-fourth World Health Assembly should be held at the Palais des Nations, Geneva, opening on Monday, 16 May 2011, and that it should close no later than Tuesday, 24 May 2011. The Board further decided that the fourteenth meeting of the Programme, Budget and Administration Committee of the Executive Board should be held on Thursday and Friday, 12 and 13 May 2011, at WHO headquarters, Geneva.

(Second meeting, 22 May 2010)

PART II

SUMMARY RECORDS

LIST OF MEMBERS AND OTHER PARTICIPANTS

MEMBERS, ALTERNATES AND ADVISERS

HUNGARY

Mr M. KÖKÉNY, President, Health Committee of the National Assembly, Budapest (**Chairman**)

Alternate

Dr A. MÉSZÁROS, Deputy Director-General, Ministry of Health, Budapest

Advisers

Ms J. MÁNYIK, Counsellor, Permanent Mission, Geneva

Ms N. KONDOROSI, Counsellor, Ministry of Health, Budapest

ARMENIA

Mr A.S. BABLOYAN, Chairman, Standing Committee on Health Care, and Maternity and Childhood, National Assembly, Yerevan

Alternate

Ms S. ABGARIAN, Deputy Permanent Representative, Geneva

BANGLADESH

Professor A.F.M.R. HAQUE, Minister of Health and Family Welfare, Dhaka (**Vice-Chairman**)

Alternates

Dr S.M. ALI, Adviser to the Prime Minister, Dhaka

Mr S.A. ALI, Secretary, Ministry of Health and Family Welfare

Dr S.M. HOSSAIN, Director-General, Directorate of Health Services, Dhaka

Mr F.M. KAZI, First Secretary, Permanent Mission, Geneva

Mr M. RAHMAN, Minister, Permanent Mission, Geneva

Advisers

Dr S.U. KHYYAM, Joint Secretary (Public Health and WHO), Ministry of Health and Family Welfare, Dhaka

Professor A.K. AZAD, Director (MIS), Directorate of Health Services, Dhaka

Dr F. QUADRI, Senior Scientist, ICDDR, Dhaka

BARBADOS

Mr D. INNIS, Minister of Health, Bridgetown

Alternate

Dr E. FERDINAND, Senior Medical Officer, Bridgetown

Advisers

Dr M. WILLIAMS, Ambassador, Permanent Representative, Geneva

Dr J. ST. JOHN, Chief Medical Officer, Bridgetown

Dr C. BABB-SCHAEFER, Counsellor, Permanent Mission, Geneva

BRAZIL

Dr P.M. BUSS, Director, Oswaldo Cruz Foundation, Rio de Janeiro (**Vice-Chairman**)

Alternates

Ms M.N.F. AZEVÊDO, Ambassador, Permanent Representative, Geneva

Mr F.E. DE CAMPOS, Secretary, Management in Work and Education in Health, Brasília

Advisers

Mr P.E.G. VIEIRA, President, Oswaldo Cruz Foundation, Rio de Janeiro

Mr F. BATISTA JUNIOR, President, Brazilian National Council of Health, Brasília

Mr S.J. DE ALBUQUERQUE E SILVA, Minister, Head of Division, Social Issues, Ministry of Foreign Affairs, Brasília

Mr E.B. BARBOSA, Minister, Special Assessor of the Minister of Health, Brasília

Ms M.L. ESCOREL DE MORAES, Minister Counsellor, Permanent Mission, Geneva

Mr E. DE ALMEIDA CADOSO, Counsellor, Permanent Mission, Geneva

Mr E.H. CARMO, Director, Epidemiology Surveillance, Secretariat, of Surveillance and Health, Brasília

Mr L.L. VIEGAS, Head of Division, Multilateral Affairs, Ministry of Health, Brasília

Mr L.R. STRAUSS, Head, Press Division

Mr C.L. MARTINS DA CUNHA, Second Secretary, Permanent Mission, Geneva

Mr C. PASSARELLI, Head, Division of International Cooperation, Secretariat of Surveillance and Health, Brasília

Ms J. VALLINI, Deputy Head, Division of International Cooperation, Secretariat of Surveillance and Health, Brasília

Mr O.A. BORGES LAYUNTA, Assessor, International Cooperation, Secretariat of Science, Technology and Strategic Input, Brasília

Mr W. CLEBER DE OLIVEIRA, General-Coordinator, Influenza Surveillance, Ministry of Health, Brasília

Ms M. CHAIMOVICH, Trainee, Permanent Mission, Geneva

BRUNEI DARUSSALAM

Mr P.D.S. OSMAN, Minister of Health, Bandar Seri Begawan (**Vice-Chairman**)

Alternates

Mr J. ERIH, Permanent Representative, Geneva

Mr A.S. MOMIN, Permanent Secretary, Ministry of Health, Bandar Seri Begawan

Dr R. SAID, Director-General, Health Services, Ministry of Health, Bandar Seri Begawan

Advisers

Dr H. BAHAR, Senior Medical Officer, Ministry of Health, Bandar Seri Begawan

Dr E. KASSIM, Medical Officer, Ministry of Health, Bandar Seri Begawan

Ms N. MANAP, Acting Assistant Director, International Affairs, Ministry of Health, Bandar Seri Begawan

Ms A. MORNI, Second Secretary, Permanent Mission, Geneva

Mr P.A. H. RAMBILI, Health Education Officer, Ministry of Health, Bandar Seri Begawan

BURUNDI

Dr N. BIRINTANYA, Directeur général de la Santé publique, Ministère de la Santé, Bujumbura

Alternate

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CANADA

Dr K. DODDS, Assistant Deputy Minister, Health Policy Branch, Health Canada, Ottawa

Alternate

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Advisers

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Ms C. REISSMANN, Director, AIDS and TB Programming and Health Institutions Division, Canadian International Development Agency, Ottawa

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Ms J. AUGER, Senior Policy Analyst, International Public Health Division, Public Health Agency of Canada, Ottawa

Dr R. RODIN, Medical Fellow, Centre for Immunization and Respiratory Infectious Diseases, Public Health Agency of Canada, Ottawa

Ms J. HAMILTON, Counsellor, Permanent Mission, Geneva

Mr P. BLAIS, Counsellor, Permanent Mission, Geneva

CHILE

Dra. L. JADUE, Subsecretaria de Salud Pública, Ministerio de Salud, Santiago

Alternate

Sr. P. OYARCE, Embajador, Misión Permanente, Ginebra

Advisers

Sr. A. ROGERS, Ministro Consejero, Misión Permanente, Ginebra

Sr. O. ÁLVAREZ-PÉREZ, Segundo Secretario, Misión Permanente, Ginebra

Sr. J.M. HUERTA, Jefe, Oficina de Cooperación Internacional, Ministerio de Salud Pública, Santiago

Dra. M.-J. RONCARATI, Jefa, Oficina de Relaciones Internacionales, Ministerio de Salud Pública, Santiago

CHINA

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Advisers

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Dr ZHANG Lingli, Division Director, Department of Maternal and Child Health and Community Health, Ministry of Health, Beijing

Dr ZHANG Xudong, Division Director, Bureau of Food Safety Coordination and Health Supervision, Ministry of Health, Beijing

Dr FENG Yong, Division Director, Department of International Cooperation, Ministry of Health, Beijing

Mr TENG Fei, Attaché, Permanent Mission, Geneva

Dr LIU Peilong, Senior Adviser, Department of International Cooperation, Ministry of Health, Beijing

Ms LIU Hua, Counsellor, Permanent Mission, Geneva

ECUADOR

Dr. D. CHIRIBOGA, Ministro de Salud Pública, Quito

Alternate

Dr. J. MOREIRA, Ministerio de Salud Pública, Quito

Advisers

Sr. M. MONTALVO, Embajador, Representante Permanente, Ginebra

Srta. L. RUIZ, Ministerio de Salud Pública, Quito

Srta. V. POVEDA, Ministerio de Salud Pública, Quito

Sr. G. GILER, Ministerio de Salud Pública, Quito

Sr. J. HOLGUÍN, Misión Permanente, Ginebra

Sr. C. SANTOS, Misión Permanente, Ginebra

Sr. L. VAYAS, Misión Permanente, Ginebra

ESTONIA

Dr M. JESSE, Director of the National Institute for Health Development, Tallinn

Alternate

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Mr J. SEILENTHAL, Ambassador, Permanent Representative, Geneva

Ms K. SIBUL, Third Secretary, Permanent Mission, Geneva

FRANCE

Professeur D. HOUSSIN, Directeur général de la Santé, Ministère de la Santé et des Sports, Paris

Alternates

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Mme B. ARTHUR, Chef, Bureau international, Santé et Protection sociale, Délégation aux Affaires européennes et internationales, Ministère de la Santé et des Sports, Paris

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Adviser

Mme D. CHAMPETIER DE RIBES, Chargée de Mission, Mission permanente, Genève

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Alternate

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Advisers

Mrs G. REITENBACH, Head of Division, Federal Ministry of Health, Berlin

Dr B. GEHRMANN, Second Secretary, Permanent Mission, Geneva
Mrs C. TZIMAS, Adviser, Federal Ministry of Health, Berlin
Mr H. VOIGTLÄNDER, Former Director, Federal Ministry of Health, Berlin

INDIA

Mr A. GOPINATHAN, Ambassador, Permanent Representative, Geneva
(alternate to Ms K. Sujatha Rao)

Alternates

Mr K. DESIRAJU, Additional Secretary, Ministry of Health and Family Welfare, New Delhi
Mr V. CHAUDHRY, Joint Secretary (International Health), Ministry of Health and Family Welfare, New Delhi
Mr P. SATPATHY, Minister, Permanent Mission, Geneva
Mr S. SUDHIR, Counsellor, Permanent Mission to the World Trade Organization, Geneva

JAPAN

Dr S. OMI, Special Assistant for International Affairs to the Minister of Health, Labour and Welfare, Tokyo

Alternate

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Advisers

Mr A. ISOMATA, Minister, Permanent Mission, Geneva
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Mr Y. OTAKE, First Secretary, Permanent Mission, Geneva
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MAURITANIA

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Alternate

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M. T.K. OULD ABDI SALEM, Premier Conseiller, Mission permanente, Genève

MAURITIUS

Dr N. GOPEE, Chief Medical Officer, Ministry of Health and Quality of Life, Port Louis

Alternates

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Mr V. MUNGUR, Minister Counsellor, Permanent Mission, Geneva
Mr S. GUJADHUR, First Secretary, Permanent Mission, Geneva
Mrs T. PRAYAG-GUJADHUR, Second Secretary, Permanent Mission, Geneva
Miss S. KOA WING, Second Secretary, Permanent Mission, Geneva

MONGOLIA

Mr S. LAMBAA, Minister of Health, Ulaanbaatar

MOROCCO

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(**alternate to Mrs Y. Baddou**)

Alternates

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M. J. HAZIM, Directeur, Planification et Ressources, financières, Ministère de la Santé, Rabat

MOZAMBIQUE

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(**alternate to Dr M.O. de Assunção Saúde**)

Alternate

Mr J.A. DENGGO, First Secretary, Permanent Mission, Geneva

NIGER

Dr A. DJIBO, Directeur général de la Santé publique, Ministère de la Santé publique, Niamey

Alternate

Mme M. KOUNTCHE GAZIBO, Premier Secrétaire, Mission permanente, Genève

NORWAY

Mr B.-I. LARSEN, Director-General, Chief Medical Officer, Norwegian Directorate of Health, Oslo

Alternate

Ms H.C. SUNDREHAGEN, Deputy Director-General, Ministry of Health and Care Services,
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Advisers

Ms B. ANGELL-HANSEN, Ambassador, Permanent Mission, Geneva

Ms T. WROLDSEN, Senior Advisor, Ministry of Health and Care Services, Oslo

Ms B. BLAKER, Senior Adviser, Ministry of Health and Care Services, Oslo

Mr A.P. SANNE, Director, Norwegian Directorate of Health, Oslo

Mr B. SKOTHEIM, Higher Executive Officer, Norwegian Directorate of Health, Oslo

Ms S.H. STEEN, Counsellor, Permanent Mission, Geneva

Mr T.E. LINDGREN, Counsellor, Permanent Mission, Geneva

OMAN

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RUSSIAN FEDERATION

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Mr A.V. PAVLOV, Counsellor, Permanent Mission, Geneva

Mr A. ABASHKIN, Senior Counsellor, Permanent Mission, Geneva

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Mr E. KOVALEVSKIY, Chief, Researcher, Scientific Research Institute, Occupational Health, Russian Academy of Medical Science, Moscow

Ms N. KULESHOVA, Consultant, Department of International Cooperation, Ministry of Health and Social Development, Moscow

Mr A. MARKOV, First Secretary, Permanent Mission, Geneva

Mr R. SHMYKOV, First Secretary, Permanent Mission, Geneva

Mr E. KALUGIN, Second Secretary, Permanent Mission, Geneva

Mr K. FEDOTOV, Second Secretary, Permanent Mission, Geneva

SAMOA

Mrs G.A. GIDLOW, Minister of Health, Apia

Advisers

Ms P.T. TOELUPE, Chief Executive Officer, Ministry of Health, Apia

Mr R. GIDLOW, Apia

SERBIA

Dr I. MIŠIĆ, Assistant Minister of Health, Belgrade (**alternate to Dr T. Milosavljević**)

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Twelfth meeting, 14 May 2010: Dr M. Dahl-Regis (Bahamas, Chair), Dr A.J. Mohamed (Oman, Vice-Chair), Mr S.A. Ali (Bangladesh, alternate to Professor A.F.M.R. Haque), Mr L.L. Viegas (Brazil, alternate to Dr P. Buss), Mr A. Allo (France, alternate to Mr D. Houssin), Dr M. Kökény Hungary, Mr S. Prasad (India, alternate to Ms K. Sujatha Rao), Dr T. Takei (Japan, alternate to Dr S. Omi), Dr S. Kabuluzi (Malawi), Mr S. McKernan (New Zealand, alternate to Mr T. Ryall), Dr A. Djibo (Niger), and Dr S. Zaramba (Uganda), Chairman of the Executive Board, member ex officio.

2. Standing Committee on Nongovernmental Organizations

Professor A. Babloyan (Armenia), Professor A.F.M.R. Haque (Bangladesh), Dr A.J. Mohamed (Oman), Mrs G.A. Gidlow (Samoa) and Dr B. Valentin (Seychelles).

3. Léon Bernard Foundation Committee

Dr M. Jesse (Estonia), together with the Chairman and Vice-Chairmen of the Executive Board, members ex officio.

4. Sasakawa Health Prize Selection Panel

Chairman of the Executive Board and a representative of the founder, members ex officio, and Mr S. Lambaa (Mongolia).

5. United Arab Emirates Health Foundation Selection Panel

Chairman of the Executive Board and a representative of the founder, members ex officio, and Dr R. Said (Syrian Arab Republic).

6. State of Kuwait Health Promotion Foundation Selection Panel

Chairman of the Executive Board and a representative of the founder, members ex officio, and Dr A.J. Mohamed (Oman).

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

SUMMARY RECORDS

FIRST MEETING

Saturday, 22 May 2010, at 09:40

Chairman: Dr S. ZARAMBA (Uganda)

later: Dr M. KÖKÉNY (Hungary)

- 1. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA:** Item 1 of the provisional agenda (Documents EB127/1 and EB127/1 (annotated))

The CHAIRMAN declared open the 127th session of the Executive Board and invited the Board to consider the provisional agenda. He proposed the deletion of items 6.3 (Amendments to the Financial Regulations and Financial Rules) and 7.2 (Confirmation of amendments to the Staff Regulations and Staff Rules) as no amendments had been proposed.

The agenda, as amended, was adopted.¹

Dr M. KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, said that the European Union worked closely with WHO on a wide range of subjects both within the European Region and at a global level. As agreed in the exchange of letters in the year 2000 between WHO and the European Commission concerning the consolidation and intensification of cooperation, and without prejudice to any future conclusion of a general agreement between WHO and the European Union, the European Union attended sessions of the Executive Board as an observer. He therefore requested that, as at previous sessions, the European Union should be invited to participate as an observer, without vote, in meetings of the Executive Board and of its subcommittees or other subdivisions.

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

It was so agreed.

- 2. ELECTION OF CHAIRMAN, VICE-CHAIRMEN AND RAPPORTEUR:** Item 2 of the Agenda.

The CHAIRMAN invited nominations for the office of Chairman.

Mrs REITENBACH (adviser to Dr Seeba, Germany) nominated Dr Kökény (Hungary), the nomination being seconded by Dr JESSE (Estonia).

Dr M. Kökény (Hungary) was elected Chairman.

¹ See page vii.

The Director-General presented Dr Zaramba, the outgoing Chairman, with a gavel.

Dr ZARAMBA (Uganda) said that it had been an honour and an enriching experience to serve as Chairman of the Executive Board. He thanked members for their dedication and support, and the Secretariat for its valuable assistance, and expressed appreciation of the Director-General's commitment to the Organization. Member States were right to have every confidence in her ability to continue to steer WHO in the right direction.

Dr Kőkény took the Chair.

The CHAIRMAN, having expressed appreciation to Dr Zaramba for his work, said that he was honoured to have been elected Chairman of the Executive Board and would do his utmost to discharge his duties efficiently, in accordance with the Rules of Procedure of the Executive Board and in a spirit of consensus.

He invited nominations for the four posts of Vice-Chairman.

Dr DODDS (Canada), seconded by Dr JADUE (Chile), nominated Dr Buss (Brazil).

Dr RASAE (Yemen), seconded by Dr ABDI (Somalia), nominated Dr Mohamed (Oman).

Mr CHAWDHRY (alternate to Mr Gopinathan, India), seconded by Ms HANJAM SOARES (Timor-Leste), nominated Professor Haque (Bangladesh).

Dr OMI (Japan), seconded by Mr LAMBAA (Mongolia), nominated Mr Osman (Brunei Darussalam).

Dr Buss (Brazil), Dr Mohamed (Oman), Professor Haque (Bangladesh) and Mr Osman (Brunei Darussalam) were elected Vice-Chairmen.

The CHAIRMAN noted that, under Rule 15 of the Rules of Procedure of the Executive Board, if the Chairman was unable to act in between sessions, one of the Vice-Chairmen should act in his place; the order in which the Vice-Chairmen would be requested to serve should be determined by lot at the session at which the election had taken place.

It was determined by lot that the Vice-Chairmen would serve in the following order: Dr Buss (Brazil), Mr Osman (Brunei Darussalam), Dr Mohamed (Oman) and Professor Haque (Bangladesh).

The CHAIRMAN invited nominations for the office of Rapporteur.

Dr GOPEE (Mauritius), seconded by Dr BIRINTANYA (Burundi), nominated Dr Djibo (Niger).

Dr Djibo (Niger) was elected Rapporteur.

3. OUTCOME OF THE SIXTY-THIRD WORLD HEALTH ASSEMBLY: Item 3 of the Agenda

The CHAIRMAN said that Member States expected high quality work from WHO. Health governance and systems were challenged by economic recession, unemployment, growing inequalities and poverty in many parts of the world. Climate change and the food crisis were also contributing to the burden of disease and increasing pressure on health-care systems, and many Member States faced serious shortages of staff. Pandemic (H1N1) 2009 appeared to have slowed down but the risks remained. The effectiveness of the global response to the pandemic should be reviewed to ensure that the International Health Regulations (2005) remained an appropriate instrument to lead the international community through future crises. He commended the Director-General, who had acted in accordance with the Regulations and with wisdom and responsibility.

The Sixty-third World Health Assembly had achieved progress on major public health issues. It had adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel; endorsed the global strategy to reduce the harmful use of alcohol; adopted resolutions on marketing of food and non-alcoholic beverages to children, advancing food safety initiatives, availability, safety and quality of blood products, the international management of obsolete chemicals and progress on the health-related Millennium Development Goals; and adopted a decision on measures to combat counterfeit medical products. Unified efforts and strong commitments from the international health community were needed to build on those achievements.

The Executive Board had much to accomplish over the coming year, including reaching a conclusion on the future of financing for WHO; in that regard the report on a consultation convened by the Director-General¹ could initiate the Board's discussion. In addition to budgetary matters, the 128th session of the Board was expected to deal with items such as climate change and health, the global immunization strategy and the rational use of medicines.

He questioned, however, whether the Executive Board should put so many items on its agenda. Agendas of the governing bodies must be prioritized. In order to make the meetings more effective, less time-consuming and more transparent, some of the agenda items that concerned single diseases might be discussed at the regional level, so that the Board could focus more on issues that required effective global governance. Other health actors would need to become more accountable; the establishment of an additional committee of the Health Assembly should be considered, to enable those actors to participate in the Health Assembly's deliberations.

A major challenge for health governance in the twenty-first century was to deal with the impact of globalization. In this new environment WHO was called upon to meet an enormous need for information, assistance and guidance. WHO needed to be more responsive in serving its Member States in a strategic and selective manner in order to preserve its leadership and credibility. A serious debate on global health governance was required, reflecting recent United Nations resolutions and the initiatives of the European Union and some Member States. The Executive Board should provide guidance in that process.

Dr OMI (Japan) agreed that significant progress had been achieved during the Health Assembly. However, he was concerned at the increasing politicization and the divisive nature of Health Assembly debates in recent years. Every sovereign Member State had the right to pursue its national interests, of course, and it was clear that some technical matters had a political element. Nevertheless, Member States needed to work with each other and with the Secretariat to turn the time and resources spent at the Health Assembly into health improvements, and to make those discussions more efficient and more relevant to the needs of all peoples, and thus balance their own interests with those of the

¹ The future of financing for WHO: report of an informal consultation convened by the Director-General, Geneva, Switzerland, 12–13 January 2010. (Document WHO/DGO/2010.1).

international community and WHO. He agreed that consideration must be given to improved methods of work and reduced numbers of agenda items, possibly through more effective use of the regional committees. He proposed that the Secretariat should be requested to review possible options and submit a proposal to the governing bodies for consideration.

Referring to the report on eradication of poliomyelitis discussed during the Health Assembly,¹ he pointed out that despite the time and resources spent on the Global Polio Eradication Initiative and significant progress achieved, the epidemiological situation had stagnated in recent years, albeit more as a result of security concerns than of technical difficulties. He was encouraged that the Director-General was considering the possibility of convening a high-level meeting on the subject; WHO should urge the health ministers and heads of State of countries in which the disease was endemic to redouble their eradication efforts.

Dr ALI (alternate to Professor Haque, Bangladesh) commended the Director-General on her admirable objectivity in the face of the often divergent views expressed during the Health Assembly discussions. Despite differences of opinion, WHO was making real progress in its leadership in the health field.

Dr MOHAMED (Oman) thanked the Director-General and her team for another successful Health Assembly. He endorsed the view of the member for Japan that it was important to find the right balance between technical and political discussions. However, in some cases the two aspects were inextricably linked, for example in relation to the WHO Framework Convention on Tobacco Control and the issue of public health, innovation and intellectual property. He agreed that role of the regional committees might be expanded.

With regard to poliomyelitis, he proposed that the heads of delegations of the Member States in which the disease remained endemic and of those in which it had re-emerged should be invited to report to the next Health Assembly on the status of poliomyelitis. He expressed the hope that the Global Polio Eradication Initiative Strategic Plan 2010-2012, which included use of the bivalent oral poliovirus vaccine, would finally lead to eradication of poliomyelitis.

Mr LARSEN (Norway) said that, as a new member of the Board, he looked forward to participating in discussions to improve the performance and effectiveness of WHO. Progress made at the Health Assembly had been significant: there was now a good understanding across all Member States of the importance of noncommunicable diseases; and the adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel showed the willingness of Member States to work together.

When items of political significance were clearly related to public health, such as the Global Code of Practice, the Health Assembly should pay serious attention. However, some of the recent debates had concerned political matters that were not directly linked to the health agenda. For the sake of global health, the Secretariat and Member States should seek opportunities to build consensus in the preparation for Health Assemblies. The lengthy agenda of the Health Assembly had made it difficult to discuss the items properly and had left little opportunity for delegates to meet informally – an important aspect of such international gatherings. The Board should prioritize items when developing the agendas for future Health Assemblies and ensure that the number of items was manageable. A systematic approach to determine which items should be dealt with by the Health Assembly and which by the regional committees would improve efficiencies.

Dr LIU Peilong (adviser to Dr Ren Minghui, China) welcomed the significant progress made by the Health Assembly. However, delegates must exercise greater self-discipline in restricting the length

¹ Document A63/27.

of their statements. If necessary, the Chairmen of the main committees should interrupt speakers to remind them of the agreed limits. Fuller preparation of some items by the Secretariat in advance of Health Assemblies and better orientation of the elected officers would also enhance efficiency. The Board's Programme, Budget and Administration Committee also had an important role in laying the groundwork for the discussion of items by the Health Assembly.

Dr DODDS (Canada), commending the Secretariat's thorough preparations for the Health Assembly, said that the methods of work could be improved. In the prioritization of potential agenda items, it must be recognized that some issues were global and others regional. Differences should be acknowledged and commonalities sought; and priority should be assigned to attainment of the health-related Millennium Development Goals. She was committed to collaborating with Board members and with representatives of other Member States in the work of the Organization.

Dr OULD JIDDOU (alternate to Dr Ould Horma, Mauritania) commended the Director-General on the organization of the Health Assembly and endorsed the comments of previous speakers on its methods of work.

In the African Member States where poliomyelitis was endemic or had re-emerged, significant investment was being made in supplementary vaccination campaigns to compensate for insufficient spending on routine immunization. Strengthening of routine immunization programmes should therefore be a priority. Support was needed for the Millennium Development Goals as in Africa many Member States were falling behind in the achievement of the relevant targets.

Mr CHAWDHRY (alternate to Mr Gopinathan, India) said that there had been repeated calls for better time management at the Health Assembly, and yet delegates failed to exercise self-discipline in their interventions. Member States could not expect the Secretariat to impose rules in order to resolve the problem; they must examine their own conduct. Circulation of detailed notes on the agenda and regional office briefings before the Health Assembly would help Member States in preparing their responses. Such information should be provided well in advance in order to allow sufficient time for consultations at national level.

In regard to poliomyelitis, he emphasized that his Government was making every effort to achieve eradication. Its poliomyelitis control programme, one of the largest disease-control programmes in the world, was implementing all the activities recommended by the international community. He would welcome further guidance from the international community as to how the programme might be improved.

Dr RASAE (Yemen), commending the Secretariat's preparations for the Health Assembly and the Executive Board, agreed that there was a need to focus on technical and health matters rather than political issues in Health Assembly discussions. He endorsed the preceding comments on poliomyelitis eradication. Yemen, which had recorded no cases of poliomyelitis in 2009, stood ready to support other countries in the Eastern Mediterranean Region where the disease remained endemic.

Dr JADUE (Chile) agreed that the methods of work of the Health Assembly could be improved. Much more preparatory work should be undertaken by Member States jointly at the regional level, either through the WHO regional offices or through regional integration groups. The technical and political content of health activities could not be separated, and health officials had to implement technical programmes in a political context; nonetheless, efforts should be made to reduce attention to political issues in Health Assembly debates and improve preparation. She suggested that an item for discussion at the next Health Assembly should be the impact of natural disasters and emergencies on public health; the item should cover restoration and rehabilitation of health services in the aftermath of disasters and attention to the mental health needs of persons affected by the disaster, including health workers.

Dr BUSS (Brazil) welcomed the significant progress achieved during the Health Assembly, in particular the adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel, which should help Member States to retain their health workers and strengthen their health systems. He supported the comments made by the Chairman in relation to globalization and suggested that, over the coming year, the Board should consider in depth the role of international cooperation in promoting global health, equity and solidarity. The Board's discussions should take as a basis the United Nations General Assembly resolution 63/33 and the declaration adopted at the annual ministerial review of the United Nations Economic and Social Council, (2009), both of which dealt with global health. Initiatives that should also be taken into account included the Global Health Initiative launched by the United States of America in 2009, the European Union Global Health Security Initiative and emerging South–South cooperation in the area of health.

Mr OSMAN (Brunei Darussalam) agreed that work was needed in order to improve the effectiveness of the Health Assembly and of the Organization as a whole, and that discussions should be more productive and focus on technical rather than political issues. He expressed concern that poliomyelitis remained endemic in four countries and that there had been reports of reintroduction and importation in other countries. It was vital to remain focused on the goal of eradication.

Mr EL MAKKAOUI (Morocco) said that political discussion had not affected the success of the Health Assembly. Airing views was important for achieving consensus. A spirit of solidarity and cooperation had generally prevailed and should be continued. He welcomed the important inclusion on the Board's agenda of strategies for the safe management of drinking-water for human consumption.

Mr INNIS (Barbados) said that the Health Assembly had indeed been successful. However, more efficient use should be made of time, with less attention to political matters and more to major international health issues. There should be clear and enforced rules regarding the length of statements; regional statements should be encouraged in order to reduce the number of speakers on each item; and more focus should be given to chronic noncommunicable diseases, which had become a major topic on the international health agenda.

Dr DAULAIRE (United States of America), concurring with the views expressed by previous speakers, observed that more than three-quarters of the statements made on technical issues during the Health Assembly had been reports on the situation in individual countries, not constructive comments on resolutions. Recalling the extensive debate on the election of the Director-General during the Health Assembly, he emphasized that Member States should work together to ensure that the world's health organization was truly reflective of the world it was intended to serve. He planned to devote his term on the Board to helping to strengthen WHO in its role as the premier institution for promoting and protecting the health of the world's citizens, reflecting the renewed spirit of multilateral cooperation and international partnership within his Government.

Dr KHADRA (adviser to Dr Said, Syrian Arab Republic) suggested that the agenda for each Health Assembly should be provided well in advance in order to allow for in-depth study, and that the time limit for statements should be specified so that delegations could prepare statements of suitable length. Delegations should avoid making repetitive statements.

Dr JESSE (Estonia) said that greater prioritization and focus in the work of the governing bodies was needed. The continuing consultations on the future of financing for the Organization would provide Member States with debate on the appropriate direction for WHO's work and inform the Director-General, further enhancing her leadership of the Organization to ensure that it continued to make progress on its main goal: improving global public health.

Mrs MACHATINE (Mozambique) endorsed the suggestion of the member for Brazil regarding consideration by the Health Assembly of the topic of global health and international cooperation.

Mrs YAHAYA (Nigeria),¹ speaking on behalf of the Member States of the African Region, expressed satisfaction with the manner in which the work of the Health Assembly had been conducted and welcomed the progress made. However, she emphasized that further work was needed on other issues that affected the Region.

Dr BLOOMFIELD (New Zealand)¹ expressed support for the various suggestions of Board members with regard to improving efficiency at the Health Assembly. He sought information on the timetable for the continuing consultations on the future of financing for WHO.

The DIRECTOR-GENERAL expressed gratitude to Member States for their flexibility and willingness to work long hours during the Health Assembly, which had made it possible to complete an exceptionally long and complex agenda in only five days. She agreed that, although the Health Assembly had been a success, there was still room for improvement. Nevertheless, gains in efficiency must not be achieved at the expense of the quality of the work produced. Timely distribution of documents was indeed important. However, informal consultations and intergovernmental working group meetings that generated essential contributions for reports to the Health Assembly were often held immediately prior to the start of the session, making it impossible to meet the deadline for circulation of documents. In regard to the scheduling of informal consultations, which were unquestionably useful, she appealed to Member States to be mindful of time constraints for the production of documents. She looked forward to working with Member States and with the Regional Directors to identify ways of enhancing the effectiveness and efficiency of the Organization's work.

The informal consultations on the future of financing for WHO had been completed in January 2010 and the outcome document distributed to all Member States. Electronic consultations were continuing. Comments received would be consolidated in another document prior to the 2010 regional committee meetings and would form the basis for a report to the Executive Board in January 2011. Subject to approval by the Board, the report would then be submitted for consideration by the Sixty-fourth World Health Assembly.

The CHAIRMAN observed that there was a clear link between public health and politics, and the political importance of some technical issues must be acknowledged; however, that acknowledgement should not lead to unproductive and divisive debates. He requested the Secretariat to draft proposals for enhancing the effectiveness of the governing bodies, bearing in mind the Board's comments on the distribution of work between the Health Assembly and the regional committees, prioritization of agenda items and time management before and during the Health Assembly. He also requested the Secretariat to provide recommendations in respect of the concerns raised by the member for Brazil and others regarding how best to address global health issues.

4. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 4 of the agenda (Document EB127/2)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chair, Programme, Budget and Administration Committee, said that the Committee had reviewed progress in implementing the Global Management System, noting that its introduction in three regions had gone relatively smoothly,

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

in part because the System was now more stable. The Committee had also noted the work done on the new risk-management framework and had requested regular updates on progress in that area. It had reviewed WHO's activities with regard to United Nations reform and urged the Organization to continue that work. The Committee had voiced concerns about continued disparities and lack of progress in the distribution of resources between headquarters and regions and had proposed that criteria should be developed for achieving a more equitable distribution of voluntary resources.

Mr LARSEN (Norway) commended the Director-General's initiative to define the core functions of the Organization and examine the future of its financing. It was important to discuss how WHO could best fulfil its dual role: establishing norms and standards in relation to health and serving as a development partner. The funding of WHO's normative work should also be considered and how that work could serve the Organization's role as a development partner at country level. In the context of United Nations reform and the One United Nations approach, it should be asked whether the Organization was maximizing cooperation with other organizations of the United Nations system in development activities at country level. It was a source of concern that many of the voluntary contributions provided for such activities were earmarked for specific purposes; they could not always, therefore, be applied towards the achievement of the strategic objectives established under the Programme budget by the Health Assembly. Those issues should be addressed in the report on the future of financing for WHO to be submitted to the regional committees later in 2010 and then to the Board in January 2011.

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chair, Programme, Budget and Administration Committee, said that it had been a pleasure to serve as Chair of the Committee and thanked the Secretariat and the Committee members for their support.

The CHAIRMAN expressed the Board's appreciation to Dr Dahl-Regis for her service and commended the balanced and diplomatic manner in which she had conducted the Committee's deliberations. (*Applause*)

The Board noted the report.

5. TECHNICAL AND HEALTH MATTERS: Item 5 of the Agenda

Crimean-Congo haemorrhagic fever, hantavirus, and Alkhurma haemorrhagic fever, as emerging infectious diseases: Item 5.1 of the Agenda (Document EB127/3)

Professor HAQUE (Bangladesh) said that the emerging infectious diseases discussed in the report were endemic in many countries and spreading to others, creating a public health challenge for the whole world. Other emerging diseases of a similar nature included Ebola haemorrhagic fever, Nipah virus disease and severe acute respiratory syndrome. Nipah virus disease was endemic in rural Bangladesh and was associated with a high case-fatality ratio. International collaboration and a joint action plan were needed in order to understand and combat locally endemic infectious diseases that could pose an international public health threat. With a view to preparing such a plan, the Secretariat should organize regional expert consultations and report to the Board or the Health Assembly on their conclusions and recommendations.

Dr REN Minghui (China) said that his country was seriously affected by haemorrhagic fever with renal syndrome caused by hantavirus and had confirmed cases of Crimean-Congo haemorrhagic fever in border areas. Given China's diverse natural environment, extensive animal husbandry and

frequent international exchanges, there was high risk of the emergence or importation of other haemorrhagic fevers. He encouraged Member States to cooperate within the framework of the International Health Regulations (2005) in order to control such diseases and minimize the threat they posed to human health.

Mr CHAWDHRY (alternate to Mr Gopinathan, India) drew attention to the annual International Ministerial Conference on Animal and Pandemic Influenza, which had, since 2007, been developing a road map for dealing with infectious diseases of zoonotic origin. Those conferences had also given rise to the “one world, one health” concept, which embraced human, animal and environmental health. At the most recent such conference, FAO, WHO and OIE had presented a proposal for collaboration in addressing health risks that might emerge at the interface between animals, humans, and the ecosystem. An interagency secretariat, also involving UNICEF and the World Bank, should be established promptly to support that work. He requested the Secretariat to provide details on the proposed collaboration.

Mr OSMAN (Brunei Darussalam) said that the report highlighted the need to maintain a high level of vigilance against the threat of emerging diseases. He supported its call for a comprehensive strategy to control such diseases and agreed on the need to organize regional and interregional technical consultations in order to formulate a strategy. As there was limited information on emerging diseases, research would be an important component of the strategy, as would sharing of resources and expertise. He called upon the Organization to provide leadership, and to guide and support Member States in enhancing preparedness and establishing measures for response and mitigation.

Dr KESKINKILIÇ (Turkey)¹ urged the Board to do more than simply note the report, and to take steps to put the issue of emerging haemorrhagic fevers on the global public health agenda and stimulate work to produce relevant vaccines.

Dr CHAWETSAN NAMWAT (Thailand)¹ endorsed the view of the member for India regarding the need for shared responsibility among FAO, WHO and OIE in relation to human, animal and environmental health.

Dr RYAN (Global Alert and Response), responding to the Board’s comments, acknowledged that many emerging infectious diseases other than the three covered in the report posed threats in the various regions. However, while responses and strategies in different regions might vary slightly, the overall approach should remain the same. The origin, transmission dynamics and path of physiology of emerging infectious diseases were often poorly understood, and effective vaccines and therapeutics often unavailable. It was therefore necessary to rely on traditional public health interventions while at the same time developing new ones. He noted with appreciation that the Government of China would host an international workshop on the control of hantavirus later in 2010.

He affirmed that the Organization was working closely with FAO and OIE at the technical level, but pointed out that two thirds of zoonotic diseases emerged from wildlife as opposed to domestic animals and that cooperation with international organizations and nongovernmental organizations that dealt with wildlife was therefore also important.

The DIRECTOR-GENERAL, reviewing the history of collaboration among FAO, WHO, OIE and the World Bank on pandemic influenza preparedness, recalled that in 2005 and 2006 the four bodies had organized conferences in order to mobilize technical and financial support for pandemic preparedness activities. At the same time, governments had begun organizing international gatherings

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

on pandemic preparedness in various cities around the world. It had recently been proposed that those gatherings, which had come to be known as the International Ministerial Conference on Avian and Pandemic Influenza, should be institutionalized under the aegis of FAO, WHO and OIE, rather than relying on governments to host them. She and her counterparts at FAO and OIE had therefore agreed to put forward a proposal to that effect at the International Ministerial Conference held in Hanoi in April 2010. It should be emphasized, however, that the proposal was still at the concept stage. No concrete action had been taken as yet.

She was open to the idea of establishing an interagency secretariat or task force but she was also wary of “mandate creep” and of the administrative difficulties and fragmentation that might result from the involvement of agencies other than FAO, WHO and OIE. Certainly, the World Bank had an important role to play with regard to the financial aspects of combating emerging infectious zoonotic diseases, but in her view the partnership should be led by FAO, WHO and OIE, as the technical agencies in the United Nations system for animal and human health.

Mr CHAUDHRY (alternate to Mr Gopinathan, India) asked whether the funding that Member States had already committed towards pandemic preparedness, which was held by the Avian and Human Influenza Facility administered by the World Bank, would be separate from funding for the FAO/WHO/OIE collaboration. He had not meant to suggest that the World Bank should have responsibility for technical aspects of disease control, but close coordination with it would obviously be important in order to make the best use of resources.

The DIRECTOR-GENERAL emphasized that WHO worked in close collaboration with the World Bank and expressed gratitude to the Bank for its commitment of considerable resources to support Member States in mobilizing resources to implement the technical recommendations made by FAO, WHO and OIE. That was the role of the Bank. The three technical agencies would have to commit their own separate resources to cover the costs of organizing the International Ministerial Conference on a regular basis, although World Bank support would certainly be welcome. But, she reiterated, the main role of the Bank would be to support countries.

Mr BABLOYAN (Armenia) underlined the importance of coordinating work on global health and of avoiding fragmentation of efforts.

The Board noted the report.

Cholera: mechanism for control and prevention: Item 5.2 of the Agenda (Document EB127/4)

The CHAIRMAN drew attention to a draft resolution proposed by Bangladesh, which read:

The Executive Board,
Having considered the report on cholera: mechanism for control and prevention;¹

RECOMMENDS to the World Health Assembly the adoption of the following resolution,

The Sixty-fourth World Health Assembly,
PP1 Recalling resolution WHA44.6 on cholera, which led to the establishment of the Global Task Force on Cholera Control with the aim of providing support to Member States in reducing morbidity and mortality associated with the disease and in diminishing its social and economic consequences;

¹ Document EB127/4.

PP2 Recognizing that cholera not only occurs in epidemics but is also a common cause of endemic morbidity that results in the suffering of millions of people;

PP3 Reiterating that the spread of cholera is a consequence of poverty, lack of adequate supply of potable water, deficient sanitation, poor hygiene, contamination of food, unplanned human settlement, especially in urban areas, and inadequate health care;

PP4 Acknowledging that effective public health interventions such as proper and timely case management, improved environmental management and adequate use of cholera vaccines all depend on a solid system of surveillance and a coordinated programmatic and multisectoral approach that includes access to appropriate health care, community involvement, open and transparent sharing of information, and sustained policy dialogue;

PP5 Affirming that progress in achieving the health-related Millennium Development Goals would decrease the occurrence and spread of cholera and that improving prevention and control of cholera will have a positive effect on other diarrhoeal diseases;

PP6 Recognizing that control of cholera is now entering a new phase with the development of safe, effective and affordable oral vaccines, and that this approach is complementary to, and should not substitute for, traditional prevention and control measures;

1. URGES all Member States:

- (1) to consider health, water and environmental issues as integral and interrelated parts of development policies and plans, and accordingly to allocate resources and undertake action, including health education and public information in order to prevent the risks of cholera epidemics occurring or to diminish these risks, giving due attention to the situation and needs of population groups most at risk;
- (2) to strengthen surveillance and reporting of cholera in accordance with International Health Regulations (2005), and effectively to integrate surveillance of cholera into overall surveillance systems by building local capacities for data collection and analysis and encompassing information on crucial determinants such as water sources, environmental conditions and cultural practices;
- (3) to work towards mobilizing sufficient technical and financial resources for coordinated and multisectoral measures for prevention and control of cholera, as well as other diarrhoeal diseases, in the spirit of international solidarity;
- (4) to refrain from imposing on affected or at-risk countries any trade or travel restrictions, that cannot be justified on the grounds of public health concerns;
- (5) to make proper planning and preparations, while undertaking mass vaccination campaigns with oral cholera vaccines, and administer vaccination in conjunction with other recommended prevention and control methods and not as a substitute for such methods;

2. REQUESTS the Director-General:

- (1) to strengthen and enhance measures to ensure that the Organization continues to respond expeditiously and effectively to the needs of the countries affected by or at risk of outbreaks of cholera;
- (2) to revitalize the Global Task Force on Cholera Control through improved coordination of, and greater synergy among, the activities of WHO and other relevant stakeholders, and to strengthen the secretariat of the Global Task Force on Cholera Control in terms of human and financial resources with a view to increasing support to countries affected by or at risk of cholera;

- (3) to provide support to countries for building their capacity for effective control and prevention measures, including surveillance, risk assessment, data collection and monitoring, and vaccine deployment;
- (4) to promote interventions to change behaviour and food safety measures, including training and advocacy programmes, in order to improve sanitary and hygienic practices as critical components of cholera prevention and control;
- (5) to continue to support further research on, including clinical trials of, safe, efficacious and affordable cholera vaccines, and to promote transfer of technology to countries affected by or at risk of cholera in order to build capacity for local production of cholera vaccines;
- (6) to liaise with the GAVI Alliance in exploring possible support for introducing oral cholera vaccines in low-income developing countries;
- (7) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on the global cholera situation and efforts made in cholera prevention and control.

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

1. Resolution Cholera control and prevention	
2. Linkage to programme budget	
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.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
Baseline: focus on two regions (the African and Eastern Mediterranean regions) with three countries in each.	
Target: implementation in three additional regions during the following biennium.	
Indicators: to be developed.	
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).	
Current biennium: activities, US\$ 1 150 000; staff, US\$ 3 892 000. Total, US\$ 5 042 000.	
Following bienniums (per biennium): activities, US\$ 5 million; staff, US\$ 4 040 000. Total, US\$ 9 040 000.	
Total for 10 years: US\$ 41 202 000.	
(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).	
Staff: US\$ 2 284 000 (at headquarters level); US\$ 1 608 000 (two regional offices).	
Activities: US\$ 1 150 000 (65% at regional level: African and Eastern Mediterranean regions).	
(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?	
No.	

4. Financial implications**How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?**

Through fundraising at international and country levels.

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

Global coordination, support and standard setting at headquarters.

Activities will be undertaken at regional and country levels with a focus during the first biennium on two regions (the African and Eastern Mediterranean regions), scaling up to an additional three regions during the following bienniums (the South-East Asia, European and Western Pacific regions).

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

No.

(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).

At headquarters: for coordination, 1 P6 staff member, 2 staff at grade P4, 2 at grade P3 and 1 at grade G5.

Regional level (current biennium): for each regional office (the regional offices for Africa and the Eastern Mediterranean), 1 public health specialist/epidemiologist and 1 water and sanitation specialist (each at grade P4).

Regional level (following bienniums) for each of the regional offices concerned (the regional offices for Africa, South-East Asia, Europe, the Eastern Mediterranean and the Western Pacific): 1 public health specialist/epidemiologist and 1 water and sanitation specialist (each at grade P4).

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

10 years.

As the draft resolution had been distributed only very recently, the CHAIRMAN suggested that the Board might discuss it briefly, deferring full consideration of the item to a future session.

Professor HAQUE (Bangladesh), acknowledging the late submission of the draft resolution, suggested that there should be at least a preliminary discussion of it.

Dr MÉSZÁROS (alternate to Mr Kökény, Hungary), speaking on behalf of the Member States of the European Union, suggested that discussion should be postponed until the Board's 128th session in January 2011 in order to allow members sufficient time to analyse the draft resolution.

Mr HOUSSIN (France) supported the suggestion of the member for Hungary. He welcomed the inclusion of the item on the Board's agenda, noting that prevention and control of cholera was closely linked to the achievement of the Millennium Development Goals and to another topic on the Board's agenda: safe management of drinking-water. Cholera control demanded intersectoral policies on water, health and education in order to ensure satisfactory sanitation, personal hygiene and access to drinking-water. He suggested that the report should highlight the reduction of economic and social inequalities in health as they related to the subject of cholera. He welcomed the draft resolution proposed by the member for Bangladesh.

Dr BIRINTANYA (Burundi), welcomed the Board's discussion of the issue of cholera, which was a grave concern in many Member States of the African Region, including Burundi, where floods in the low-lying lands around Lake Tanganyika often created conditions favourable to epidemic outbreaks. A global response with financial and technical support was needed in order to: strengthen national health information systems and all aspects of surveillance and case-reporting; ensure the supply of safe drinking-water to all communities; and improve hygiene and food security. He was in favour of leaving consideration and adoption of the draft resolution to a later session.

Ms HANJAM SOARES (Timor-Leste) said that evidence suggested the probable link between climate change and the spread of cholera. She was in favour of discussion and adoption of the draft resolution at the current session.

Dr DAULAIRE (United States of America) supported the proposal by the member for Hungary that the discussion should be deferred to a later session. Referring to subparagraph 1(4) of the draft resolution, he pointed out that numerous countries currently imposed travel restrictions on people with HIV infection, which might be considered justified on the basis of public health concerns, but were not, in his view, justifiable. Accordingly, he proposed that the phrase "that cannot be justified on the grounds of public health concerns" should be replaced by "that are not based on technically justifiable grounds of public health" or wording to that effect.

Professor HAQUE (Bangladesh) expressed appreciation for the Secretariat's report and for its neutrality. The rising incidence of cholera cases worldwide was alarming. In Bangladesh, the disease was endemic and two peaks occurred each year, before and after the monsoon. Outbreaks also often followed cyclones and floods. Along with the conventional prevention and control measures, his Government was also investigating the effectiveness of cholera vaccine in reducing the incidence of cholera. It aimed to expedite liaison between vaccine manufacturers abroad and national companies for production of cholera vaccine in Bangladesh at sustainable and affordable cost.

The role of the WHO Global Taskforce on Cholera Control in global surveillance, data monitoring and analysis and knowledge-sharing was well recognized but should be revitalized as cholera remained a largely neglected disease. Furthermore, recent developments in cholera prevention needed to be recognized by the international health community. On the basis of those considerations his Government had proposed the draft resolution.

He had already received several suggested amendments to the text. The second preambular paragraph should be amended to read: "Recognizing that cholera is being neglected despite its prevalence in epidemic form in an endemic area causing suffering to millions, particularly among vulnerable populations". In the fourth preambular paragraph, the words "adequate use of cholera vaccines" should be replaced by "appropriate use of cholera vaccines"; and in the sixth preambular paragraph, the word "cholera" should be inserted between "oral" and "vaccines" and the word "traditional" should be replaced by "the existing effective". In the operative part of the draft resolution, the phrase "preparations, while undertaking mass vaccination campaigns with" in subparagraph 1(5) should be replaced by "considerations to administer, where appropriate"; subparagraph 2(2) should be amended to read "to revitalize the Global Taskforce on Cholera Control and to strengthen WHO's work in this area, including through improved collaboration with other relevant stakeholders"; in subparagraph 2(3), the words "laboratory capacity" should be inserted after "surveillance"; in subparagraph 2(5), the phrase "including clinical trials of" should be deleted and the words "transfer of technology" should be replaced by "transfer of relevant vaccine manufacturing technologies"; and in subparagraph 2(6), the words "the GAVI Alliance" should be replaced by "relevant international funding agencies".

In view of time constraints, he agreed that the item should be deferred to the Board's next session.

Dr ABDI (Somalia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that cholera had been a persistent but often overlooked public health concern. It was endemic in many countries in the Region, which also suffered conflicts and emergencies that posed health risks for the affected populations. Effective regional strategies and tools for prevention and control of cholera outbreaks had been adopted, but effective implementation remained a challenge.

Accelerated global efforts were needed to tackle cholera and he supported the adoption of a resolution urging Member States to establish targets for prevention and control of cholera, to strengthen health systems and communicable disease surveillance and to equip all health-care providers with the capacity and materials needed to detect and manage cholera cases. A resolution should call for urgent public health actions in complex emergencies in order to provide access to acceptable levels of environmental sanitation and safe drinking-water so as to reduce the risk of cholera in situations in which health systems were disrupted.

Mrs REITENBACH (adviser to Dr Seeba, Germany), observing that the report highlighted the difficulties of carrying out vaccination campaigns and other preventive measures in parallel, asked whether analysis had been conducted with a view to optimizing the combination of vaccination with traditional interventions.

Dr JESSE (Estonia) said that she was not prepared to discuss the draft resolution at the current session and suggested that a deadline might be set for the submission of amendments, so that an amended version could be circulated in advance of the Board's next session.

Mrs NYAGURA (Zimbabwe)¹ noted that the report emphasized that vaccination should not disrupt the provision of other high-priority health interventions. Her country had recently brought a severe outbreak of cholera under control with the support of partners. However support was still needed in addressing the risk factors underlying outbreaks of cholera and consequently the draft resolution was very timely.

Dr NEIRA (Protection of the Human Environment) said that the Secretariat had taken note of the Board's comments, particularly in regard to the importance of intersectoral work and policies and of the relationship between cholera and global warming. She undertook to provide the member for Germany with information on studies that had shown the difficulty of conducting vaccination campaigns at the same time as prevention activities relating to water and sanitation, given the need for advance planning.

The CHAIRMAN enquired whether the Board wished to defer further consideration of the item until its next session and requested, if that were to be the case, that members should submit any amendments to the draft resolution to the Secretariat as early as possible. He emphasized that he wished to work in a spirit of consensus and apologized if his earlier remarks regarding deferment of the draft resolution had been negatively interpreted by Board members. If there was no objection, he would take it that the Board wished to defer further consideration of the draft resolution on cholera until its 128th session.

It was so agreed.

The meeting rose at 12:40.

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

SECOND MEETING

Saturday, 22 May 2010, at 13:35

Chairman: Dr M. KÖKÉNY (Hungary)

1. TECHNICAL AND HEALTH MATTERS: Item 5 of the Agenda (continued)

Child injury prevention: Item 5.3 of the Agenda (Documents EB127/5 and EB127/5 Add.1)

The CHAIRMAN invited comments on the draft resolution contained in document EB127/5.

Dr MÉSZÁROS (alternate to Dr Kökény, Hungary), speaking on behalf of the Member States of the European Union, expressed concern that large numbers of children died annually from unintentional injuries. Although most injuries occurred in low- and middle-income countries, high-income countries were also affected, with child injury accounting for 40% of all child deaths. Child injuries were also a major socioeconomic problem and greater prevention would be crucial to attainment of Millennium Development Goal 4 (Reduce child mortality). It was important to raise awareness of preventive measures; some countries had successfully reduced rates of death from injury by more than 50%. A recent resolution adopted by the Regional Committee for Europe on the prevention of injuries,¹ and the European Council Recommendation on the prevention of injury and promotion of safety, had stimulated action on an issue that tended to be overlooked in public and child health programmes. A multisectoral approach was required in the implementation of child injury prevention programmes. With the *World report on child injury prevention*,² which contained various prevention policy options, and WHO support, all Member States should step up child injury prevention programmes. The European Union supported the draft resolution.

Dr MOHAMED (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, thanked the Director-General for her efforts to promote child injury prevention. Primary prevention strategies were cost-effective but rarely implemented in the low- and middle-income countries of his Region. A few countries had effectively used the recommendations contained in the *World report on child injury prevention* to scale up their primary prevention programmes. The high number of child deaths and injuries in low- and middle-income countries could be explained by the lack of child safety measures and the low standard of trauma care services.

Oman had been a cosponsor of the United Nations General Assembly resolution 58/289 on improving global road safety, which also included an invitation to WHO to act as a coordinator on road safety within the United Nations system. He supported the draft resolution. A multisectoral approach to child injury prevention was needed that would include other specialized agencies of the United Nations system. He suggested that the draft resolution should include a proposal that the Director-General might establish an interagency forum or committee to support low- and middle-income countries. Owing to the high number of child injuries related to the workplace, the words “unintentional injuries” should also be included.

¹ Resolution EUR/RC55/R9.

² Peden M et al, eds. *World report on child injury prevention*, Geneva, World Health Organization, and New York, United Nations Children’s Fund, 2008.

The CHAIRMAN asked the member for Oman to submit his amendments to the draft resolution in writing.

Dr LIU Peilong (adviser to Dr Ren Minghui, China) appreciated the Secretariat's report. In developing countries, child injury deaths had not received sufficient attention and further research and interventions were needed. In China, child injuries were the primary cause of death among children aged one to eight years. In the period 2004–2005, the child mortality rate due to injuries accounted for between 42.2% and 61.1% of deaths throughout all child age groups. His Government strongly supported the draft resolution, with two amendments. He proposed that subparagraph 1(5) should be amended to read: "to integrate child injury prevention in both national child development programmes and public health programmes, and to establish multisectoral coordination and collaboration mechanisms". An additional paragraph after subparagraph 2(3) should be added to read: "to assist Member States to develop and implement child injury prevention measures".

Mrs MACHATINE (Mozambique), commending the Director-General's leadership in the area of child injury prevention, said that injuries resulting from road traffic accidents, injuries, burns, drowning and falls overburdened the health-care system. Her country's programmes to reduce child injuries included a child injury database, a road safety strategy and a forthcoming injury research centre, which would also support policy-making. She supported the draft resolution.

Dr STARODUBOV (Russian Federation), commending the report, said that the first global ministerial conference on road safety (Moscow, 19–20 November 2009) had demonstrated the need to increase efforts to prevent child injuries. Road traffic injuries, a main cause of child injury, had been reduced by 15% as a result of government interventions. He supported the draft resolution.

Mrs REITENBACH (adviser to Dr Seeba, Germany) observed that effective interventions could greatly reduce the high numbers of child injury deaths. A multisectoral approach should be used in child injury prevention strategies in accordance with the WHO principle of "health in all policies" and should form an integral part of child health programmes. Effective treatment was also essential in limiting long-term damage for children and their families. A campaign to increase use of seat belts among children aged 4 to 12 years had produced positive results. She encouraged Member States to introduce similar cost-effective campaigns to raise awareness about safety measures and online information on child injury prevention. She supported the draft resolution.

Professor HAQUE (Bangladesh) welcomed the inclusion of the subject on the agenda, as that reflected the global need to improve the prevention and treatment of adult and child trauma. Inconsistent reporting mechanisms among Member States meant that the figures for child injury deaths mentioned in the report were probably understated. Effective prevention measures could significantly reduce child injury deaths in developing countries and also contribute towards the attainment of Millennium Development Goal 4 (Reduce child mortality). Drowning, the major cause of child injury death in Bangladesh, was exacerbated by climatological factors such as monsoons and floods. Sociocultural factors also contributed generally to the incidence of child injury, especially where overburdened mothers of large families were unable to supervise all their children.

The preventive measures listed in the report could have better reflected the epidemiological factors in child injuries in developing countries. At least 90% of the global budget for tackling child injuries should go to developing countries, particularly those in the African and South-East Asia regions, which bore the highest burden of those injuries. He supported the draft resolution, to which he proposed two amendments. In the fifth preambular paragraph, the words "particularly in the low- and middle-income countries and in the countries of South-East Asia and Africa, where there exists more than 95% of the global burden of child injuries" should be added at the end of the paragraph. Consequently, subparagraph 2(6) should be amended to read: "to collaborate with Member States,

organizations of the United Nations system, international development partners and nongovernmental organizations to mobilize resources and augment the capacities needed to prevent child injury and undertake related rehabilitation programmes, and to raise awareness that in the absence of urgent action this problem will hamper attainment of the Millennium Development Goals particularly in the low- and middle-income countries of South-East Asia and Africa where there exists more than 95% of the global burden of child injuries”.

Dr FERDINAND (alternate to Mr Inniss, Barbados) welcomed the priority given to the issue of child injury prevention, often neglected in the developing world. The leading causes of child injury deaths – notably road traffic injuries, drowning, fire-related burns, falls and poisoning – should be given specific attention.

Supporting the draft resolution, she proposed that the wording in subparagraph 1(9) should read: “to strengthen emergency rehabilitation services and capacities, including first response teams, the acute pre-hospital management at health facilities and suitable rehabilitation programmes for injured or disabled children”; and that in subparagraph 2(3), the words “high-income countries to low- and middle-income settings” should be replaced by “developed to developing settings”, so that developing countries could also benefit from the interventions used in high-income countries.

Dr DODDS (Canada) commended the report and welcomed the inclusion of child injury prevention on the Board’s agenda. Noting the importance of a multisectoral approach, she affirmed Canada’s commitment to working in partnership with nongovernmental organizations and WHO in order to elaborate a national strategy for child injury prevention. She supported the draft resolution and would submit minor editorial revisions to the Secretariat in writing.

Mr HOHMAN (alternate to Dr Daulaire, United States of America) spoke of an initiative in his country to focus attention on the dangers of using cellular telephones and other devices while driving. He proposed that in subparagraph 1(11), the words “including the use of cell phones or other such mobile devices while driving” should be added after the word “transport”, in order to draw attention to that hazard.

Ms HANJAM SOARES (Timor-Leste), commending the *World report on child injury prevention*, welcomed the draft resolution, to which she proposed the following amendments. In subparagraph 1(3) she proposed that the word “and” between “injury” and “prevention” should be deleted; at the end of the subparagraph the words “emergency pre-hospital care, treatment and rehabilitation services;” should be inserted. In subparagraph 1(6) she proposed that the words “or surveillance systems” should be inserted after the word “sectors”; and the words “the demographic, socioeconomic and epidemiological profile of,” should be inserted after the word “quantifies”. She proposed that subparagraph 1(8) be amended to read “to promulgate legislations and regulations where necessary, strengthen and effectively enforce the existing laws and regulations relevant to the prevention of child injury;”. In subparagraph 1(11) she proposed that the words “and health literacy” be inserted after the word “awareness”, “child safety” after “in particular” and “, children” after “parents”. A new paragraph 10bis, should be inserted, to read: “to work closely with research and development communities, manufacturers and distributors of safety products to be relevant to the child injury profiles, and affordable by developing countries;”. In subparagraph 2(2), the phrase “including translation of this evidence into affordable safety products, policy interventions and effective implementation;” should be added at the end of the subparagraph.

Ms ARRINGTON AVIÑA (Mexico)¹ said that, in Mexico, children under 15 years of age were among the groups most affected by all accidents, and those injuries accounted for 32% of deaths within that age group. Action to prevent and control accidents among children formed part of a global strategy that Mexico was implementing in the area of health and safety.

Of the points covered in the Secretariat's report, the following were of central importance: successful prevention measures, building technical capacity to improve the quality of care of injured children, and strengthened legislation and regulations in order to reduce the risk of accidents, particularly traffic accidents. In addition, epidemiological surveillance systems to monitor injuries resulting from accidents among children would provide reliable evidence for making decisions. She welcomed the fact that WHO had placed the issue of child injury prevention among its priorities and expressed support for the draft resolution. The *World report on child injury prevention* was of vital importance and would contribute to the formulation of prevention policies. Her Government requested that it should be translated into Spanish for the benefit of the Member States in her Region. She thanked the Secretariat for the report.

Dr WACHARA RIEWPAIBOON (Thailand)¹ said that the evidence that child injury was preventable was convincing and that responsibility for prevention was shared by parents, governments, nongovernmental organizations and civil society. The profile of accidental injury among children in Thailand correlated with that described in the report, with drowning and road traffic injuries most prevalent. Safety literacy among parents could be improved, for example by encouraging the use of seat belts or restraints for children. Thailand welcomed the draft resolution as amended by the members for Bangladesh and Timor-Leste.

Dr MUKHERJEE (Rehabilitation International), speaking at the invitation of the CHAIRMAN, said that injury prevention was an important but neglected issue. Injuries contributed both to the mortality burden of countries and to the disability burden. He supported the draft resolution.

Mr MACKIE (International Society for Burn Injuries), speaking at the invitation of the CHAIRMAN, said that burn injuries, as well as being the third most common cause of injury and death in childhood, could result in lifelong disability and disfigurement. Burns disproportionately afflicted children in lower- and middle-income countries and those living in poverty. The most common location for injuries was in the home, especially the kitchen. Scald burns were the most frequent cause of burns in young children in all countries. Among older children, burns from open fires, kerosene-powered domestic appliances and the ignition of loose flammable clothing were common.

Burn prevention plans should include awareness-building; elaboration and enforcement of policy, particularly for the domestic environment; and regulations to improve the safety of appliances. Education, training and improved expectation among caregivers would reduce the burden of mortality and morbidity. The adoption of a resolution on child injury prevention would significantly encourage prevention efforts.

Dr ROGMANS (European Association for Injury Prevention and Safety Promotion), speaking at the invitation of the CHAIRMAN, welcomed the increased level of activities by WHO on child injury prevention, and commended the quality of the *World report on child injury prevention*. He supported the draft resolution, which would help to synergize policy directions at global and regional levels. Targets should be adapted to reflect the changed epidemiology, as injury had become a leading cause of death and disability for children; many countries had not yet capitalized on the knowledge that injuries were preventable.

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

The health sector was uniquely placed to play a leading role in the compilation and dissemination of injury data and provide policy-makers with the relevant evidence base for prevention. Under the United Nations Convention on the Rights of the Child, each child had the right to the highest attainable level of health, and to a safe environment. He drew attention to the first European Public Health Ministerial Conference on Injury and Violence Prevention to be held as an adjunct to the World Conference on Injury Prevention and Safety Promotion in London in September 2010. The meeting would help to launch the development of a 10-year action plan for the prevention of accidents in children and young people in the Region.

Professor GUILLEMIN (International Commission on Occupational Health), speaking at the invitation of the CHAIRMAN and on behalf of the International Ergonomics Association and the International Occupational Hygiene Association, said that the draft resolution on child injury prevention should place emphasis on reducing the injuries and deaths occurring to children engaged in child labour, especially those subject to the worst forms of child labour. As noted in the *World report on child injury prevention*, globalization, poverty and economic pressures contributed to child labour. Many parents, health practitioners, employers, educators and policy-makers did not realize that certain forms of work posed risks to children under 18 years of age. A series of Good Practices on Child Labour in countries worldwide was published by ILO. The organizations on whose behalf he spoke also provided specific guidance, for the workplace, schools, education of parents, and engagement with the public health sector. He noted that the Health Assembly resolutions WHA62.12 on primary health care and WHA60.26 on workers' health both called for integration of attention to child injuries, including those due to hazards at work, into primary health care.

Dr ALWAN (Assistant Director-General) said that work would focus on the priorities that had been emphasized by speakers and that were indicated in the draft resolution. In response to the member for Oman, he agreed that interagency coordination was important. The United Nations Road Safety Collaboration was a relevant example. However, he suggested that the Board might wish to include, perhaps in subparagraph 2(6) of the draft resolution, a specific reference to the importance of strengthening interagency mechanisms.

The CHAIRMAN said that he took it the Board wished to suspend consideration of the item while the Secretariat incorporated the proposed amendments into a document containing the draft resolution.

It was so decided.

(For resumption of the discussion, see page 54 below.)

Strategies for the safe management of drinking-water for human consumption: Item 5.4 of the Agenda (Document EB127/6)

Mr HOUSSIN (France) said that access to drinking-water was central to Millennium Development Goal 7 and that ensuring the availability of water was essential for achieving Goals 4, 5 and 6. As indicated in the draft resolution proposed by Bangladesh,¹ the gains made so far were precarious; intensive and sustained efforts would be required to ensure access to safe drinking-water. More information was needed on water resources, sanitary controls, treatment and health impacts. Different methods for treating and managing drinking-water should also be compared. In addition to monitoring the progress made in improving access to drinking-water worldwide, WHO should

¹ See summary record of the first meeting, section 5.

contribute to international initiatives in the area of water-related hygiene, in particular hand hygiene. He stressed the urgent need for a new strategy so that the goal of providing safe drinking-water for all might be achieved.

Dr FERDINAND (alternate to Mr Inniss, Barbados) said that many diseases were linked to water quality and millions of deaths could be prevented if Member States paid attention to environmental factors that contaminated water used for drinking, such as lack of proper sanitation, agricultural wastewater and other toxic wastes. She requested the Director-General to continue to urge Member States to strive to meet the standards in the drinking-water guidelines.

Mrs REITENBACH (adviser to Dr Seeba, Germany) said that access to safe drinking-water, sanitation and hygiene had an essential preventive function for protection of people's health in the developing world and expressed appreciation to WHO for providing guidance on standards related to water quality and the monitoring of water and sanitation. Certain aspects of sanitation, hygiene and wastewater management were missing from the report. A separate strategy might also be developed or even guidelines and plans on sanitation safety, using the same approach as for water safety. WHO's *Guidelines for drinking-water quality* and *Guidelines for the safe use of wastewater, excreta and greywater* did not cover all aspects of sanitation. Comprehensive guidelines on sanitation and hygiene-related issues were urgently needed in order to improve human health and reduce child mortality. The integration of water and sanitation into prevention strategies within WHO's broader policies and guidance, as well as in international health initiatives, should be encouraged. National health policies should adequately reflect the health burden caused by water-related diseases and recognize water and sanitation as a form of "preventive medicine" that required cross-sectoral collaboration. Greater attention should have been paid in the report to poor urban areas where population density often led to high levels of water contamination and pollution of the living environment, posing serious health risks. She would welcome a transparent and participatory review of the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation to allow targets to be monitored more effectively after 2015. She also urged WHO to include on the agenda of the Sixty-fourth World Health Assembly an item on "health, water and sanitation".

Professor AZAD (adviser to Professor Haque, Bangladesh), noting the relevance of the subject under discussion to agenda item 5.2, said that the report reinforced the link between safe drinking-water and waterborne diseases such as cholera, diarrhoea and enteric fever, and the need for coordinated action. Although 98% of the population of Bangladesh currently had access to better quality water, data released in 2009 had shown that the drinking-water of 20 million people contained unsafe levels of arsenic, effectively reducing coverage to 86%. Many people still consumed water that was contaminated by bacteria either at source, in transit or at the point of use. Waterborne infectious diseases continued to pose a heavy burden. With urban migration increasing, access to safe drinking-water, sanitation and drainage in the densely populated urban slums and their fringes was precarious. The effects of climate change would increase the need to invest in resilient and safe water supplies and sanitation systems, and to ensure that sanitation options did not place a further strain on water supplies or pollute water resources. His Government was committed to supplying safe water and sanitation to the whole population by 2011 and 2013, respectively, and looked forward to receiving support in order to achieve that end.

Mr LARSEN (Norway) said that current pressure on vital water resources was behind the move to register water as a human right. Water was a significant medium in the transmission of disease: diarrhoea alone accounted for 1.8 million deaths, of which 1.4 million were among children under five years of age. WHO should, therefore, strengthen its role among the many organizations that were working to improve the quality and availability of water worldwide.

Dr RASAE (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that water was already scarce in the Region and would become scarcer as a result of climate change. Water resources were often used unwisely and inefficiently, and as much as 40% of drinking-water currently leaked from supply systems in the Region, leaving the population short of water. Providing safe drinking-water and ensuring the security of household water supplies remained a major challenge for countries in the Region. Even well-established water supply systems in cities and communities were unreliable or at risk of running dry. Contamination through leaky supply systems often resulted in localized outbreaks of waterborne diseases. The scarcity of fresh water meant that wastewater was used for irrigation; although most countries regulated agricultural use of wastewater, such use was often uncontrolled and the associated risks unmanaged, threatening the health of farmers, their families, agricultural communities and consumers. Many Member States in the Region had well-established regulatory standards for drinking-water; however, quality-control interventions often only resulted after the detection of a problem.

Measures provided by the Regional Office for technical, normative and capacity-building support in order to address those health concerns included: completion of a regional water management initiative; establishing and updating national standards on drinking-water quality; strengthening management systems; introducing plans for preventive management of water safety from source to tap; producing guidelines on desalination for safe drinking-water; and supporting States in defining national policies on water safety for the protection of health and in managing and updating standards on the safe agricultural use of wastewater.

WHO should provide further guidance in areas such as preventive water safety management; water quantity requirements to safeguard health; elaboration of water-supply policies and investment plans; safe desalination of seawater and brackish water for domestic water supplies; and integrated management systems for safe wastewater use in agriculture.

Dr JADUE (Chile) said that maintaining the healthy conditions for a safe supply of drinking-water could be difficult. The report also referred to the recent natural disasters in Chile and Haiti. In her country, re-establishing access to drinking-water in the affected area had been hindered by the breakdown in the health infrastructure. Furthermore, the only chlorine factory in Chile was located in the disaster zone, so that for about two months chlorination of water was not possible. An unexpected consequence had been an outbreak of 30 000 cases of diarrhoea 2000 kilometres from the earthquake's epicentre, which had been caused by the use of inadequately treated water to irrigate vegetable crops.

Dr ZHANG Xudong (adviser to Dr Ren Minghui, China) said that, in recent years, his Government had adopted legislation on safe drinking-water so that the after-effects of national disasters could be dealt with better. The Organization should introduce measures, including a set of standards, that would guarantee safe drinking-water supplies in emergencies. Pollution of drinking-water by parasites also needed to be addressed. He pointed out that as a result of rapid climate change, industrialization and urbanization, drinking-water sources were increasingly being polluted by household water, pesticides and industrial waste, particularly in rural areas.

Dr OMI (Japan) said that despite globalization, development and advances in science and technology, millions of people still lacked access to basic sanitation. Therefore, the same level of attention should be given to addressing low-visibility issues, such as drinking-water management, as that currently focused on high-visibility areas, including intellectual property rights. His Government was committed to supporting Member States in less developed countries in establishing safe water supplies.

Mr EL MAKKAOUI (Morocco) welcoming the inclusion of safe management of drinking-water on the agenda, said that the subject needed to be addressed in an environmental context, given the significance of aspects such as waste management, desertification and natural disasters. Although

water quality was often discussed, quantity should not be neglected. A shortage of safe drinking-water and ineffective management of demand, especially in agriculture, often resulted in essential drinking-water needs not being met because less conventional methods, such as recycling of wastewater and desalination of seawater were usually unavailable in developing countries. He also drew attention to the impact of unsafe drinking-water on children's health, especially in developing countries, where access to drinking-water remained problematic.

Mr MONTOYA (Colombia)¹ welcomed the discussion on the safe management of drinking-water as the issue was so closely linked to Millennium Development Goals 4, 5 and 6. In recent years, structural inefficiencies that had hampered plans to extend coverage of safe drinking-water and sanitation had been a major challenge for Colombia and had also affected its ability to achieve Target 7.C. Several institutional, regulatory, environmental and financial reforms had been implemented in order to facilitate attainment of the Goals connected with hygiene and drinking-water in both urban and rural areas. The Government had established a fund, which was administered by local authorities, to be used exclusively for improving drinking-water and sanitation. It had also assigned the role of coordinating national and local efforts in that regard to intermediate-level government departments and had created a new department of water and sanitation, the remit of which was to develop water-related policies. It also coordinated the various actors that were investing in drinking-water and sanitation in order to achieve economies of scale, plan and develop infrastructure and initiate sustainable public projects capable of meeting demand and of responding to people's expectations. As a result, a programme had been launched that it was hoped would attract some US\$ 4000 million in the coming years. Officials from the environment sector were also participating in the programme in order to ensure that water resources were properly managed and adequate supplies made available. Additional measures included the establishment of a financing scheme with the support of the National Bank, a system to monitor water quality, and the launching of a "wash your hands" campaign. While Colombia was now on target to achieve Target 7.C, a number of challenges remained, including: ensuring reliable drinking-water and sanitation services and developing simple technical solutions to increase coverage of those services in rural areas. He urged WHO to continue promoting an exchange of experiences to allow all countries to meet Target 7.C, and to disseminate best practices that could be used to increase coverage of good-quality drinking-water and sanitation in a sustainable manner, particularly in rural areas.

Mrs YAHAYA (Nigeria)¹ said that having access to good-quality drinking-water was a social determinant of health and the basis for preventing and controlling waterborne diseases, particularly as many children under five died as a result of poor sanitation and unsafe water. Recalling general comment no.15 of the Committee on Economic, Social and Cultural Rights on the right to water, and the provisions of Target 7.C, she emphasized that progress towards establishing such a right would contribute significantly to reducing child mortality and improving the quality of life of slum dwellers and the health of workers in the Region.

The Millennium Villages project was based on the idea that simple and inexpensive changes to water systems, among other variables such as nutrition and sanitation, could lift rural Africans out of severe poverty. The project aimed to improve access to clean water, and boreholes were being drilled where groundwater was not available. Improving access would also contribute to the safe management of drinking-water. However, a number of challenges would need to be overcome: hygienic toilet facilities remained deficient, many water sources were contaminated and drinking unfiltered water from streams or rivers infected with guinea-worm larvae caused dracunculiasis.

The report could have contained more information about interrupting dracunculiasis transmission by educating civil society and detecting larvae early, as well as about the proper disposal

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

of clinical waste to avoid contaminating water supplies. HIV/AIDS patients also needed to have access to clean water in order to maintain a good level of health and prevent opportunistic infections.

Dr NEIRA (Protection of the Human Environment), welcoming the comments made, said that the report would be revised to include greater emphasis on urbanization and urban poverty. Work had been undertaken on the safe use of wastewater in agriculture, and the Secretariat would now focus on developing the relevant technical frameworks. Climate change would further threaten the availability of safe drinking-water and WHO had prepared guidance to strengthen the resilience of communities.

In response to the comments made by the members for Morocco and Norway, WHO would, in future, focus on areas within its core competencies where its contribution would create added value, such as providing policy recommendations and technical guidance within the framework established by UN-Water. The revised report would also include more information on sanitation, to reflect the comments made by the member for Germany, and on the link between water safety and the Millennium Development Goals as highlighted by several members. The comments made by the member for Chile regarding the impact of natural disasters had also been noted.

The Board noted the report.

Child injury prevention: Item 5.3 of the Agenda (Documents EB127/5 and EB127/5 Add.1) (resumed)

Dr YOUNES (Office of Governing Bodies) read out the various proposed amendments to the draft resolution on child injury prevention.

The CHAIRMAN suggested that the Board postpone a decision on the draft resolution until later in the meeting when the Secretariat could provide a written version, incorporating all proposed amendments. Owing to time constraints, the text could only be provided in English and not all six languages and he requested members' understanding in that regard.

It was so agreed.

(For resumption of the discussion, see page 60 below.)

2. MANAGEMENT AND FINANCIAL MATTERS: Item 6 of the Agenda

Committees of the Executive Board: filling of vacancies: Item 6.1 of the Agenda (Documents EB127/7 and EB127/7 Add.1)

The CHAIRMAN introduced the report contained in document EB127/7 and invited the Board to consider his proposals for filling vacant posts.

Programme, Budget and Administration Committee

Decision: The Executive Board appointed as members of the Programme, Budget and Administration Committee Dr N. Birintanya (Burundi), Dr K. Dodds (Canada), Dr Ren Minghui (China), Dr E. Seeba (Germany), Mme Y. Baddou (Morocco) and Ms M. Hanjan Soares (Timor-Leste) for a two-year period or until expiry of their membership on the Board, whichever comes first, in addition to Dr P.M. Buss (Brazil), Mr D. Houssin (France),

Ms K. Sujatha Rao (India), Dr S. Omi (Japan), Dr A. Djibo (Niger), Dr A.J. Mohamed (Oman), Dr M. Kőkény (Hungary), Chairman of the Board, member ex officio, and Professor A.F.M.R. Haque (Bangladesh), Vice-Chairman of the Board, member ex officio. It was understood that, if any member of the Committee, except the two ex officio members, was unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Committee.¹

Standing Committee on Nongovernmental Organizations

Decision: The Executive Board appointed Professor A. Babloyan (Armenia) and Dr B. Valentin (Seychelles) as members of its Standing Committee on Nongovernmental Organizations for the duration of their term of office on the Executive Board, in addition to Professor A.F.M.R. Haque (Bangladesh), Dr A.J. Mohamed (Oman) and Mrs G.A. Gidlow (Samoa), already a member of the Committee. It was understood that, if any member of the Committee was unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Committee.²

Foundation Committees

Léon Bernard Foundation

Decision: The Executive Board, in accordance with the Statutes of the Léon Bernard Foundation, appointed Dr M. Jesse (Estonia) as a member of the Léon Bernard Foundation Committee for the duration of her term of office on the Executive Board, in addition to the Chairman and Vice-Chairmen of the Board, members ex officio. It was understood that, if Dr Jesse was unable to attend, her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Committee.³

Sasakawa Health Prize Selection Panel

Decision: The Executive Board, in accordance with the Statutes of the Sasakawa Health Prize, appointed Mr S. Lambaa (Mongolia) as a member of the Sasakawa Health Prize Selection Panel for the duration of his term of office on the Executive Board, in addition to the Chairman and a representative appointed by the Founder, members ex officio. It was understood that, if Mr Lambaa was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Panel.⁴

¹ Decision EB127(1).

² Decision EB127(2).

³ Decision EB127(3).

⁴ Decision EB127(4).

United Arab Emirates Health Foundation Selection Panel

Decision: The Executive Board, in accordance with the Statutes of the United Arab Emirates Health Foundation, appointed Dr R. Said (Syrian Arab Republic) as a member of the United Arab Emirates Health Foundation Selection Panel for the duration of his term of office on the Executive Board, in addition to the Chairman and a representative of the Founder, members ex officio. It was understood that, if Dr Said was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Panel.¹

State of Kuwait Health Promotion Foundation Selection Panel

Decision: The Executive Board, in accordance with the Statutes of the State of Kuwait Health Promotion Foundation, appointed Dr A.J. Mohamed (Oman) as a member of the State of Kuwait Health Promotion Foundation Selection Panel for the duration of his term of office on the Executive Board, in addition to the Chairman and a representative of the Founder, members ex officio. It was understood that, if Dr Mohamed was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Panel.²

Representatives of the Executive Board at the Sixty-fourth World Health Assembly

The CHAIRMAN proposed that the Board should be represented by the Chairman and first three Vice-Chairmen. In the event that any of them were not available, the fourth Vice-Chairman and/or the Rapporteur could be asked to act in that capacity. He took it that the Board wished to accept his proposals.

It was so agreed.

Decision: The Executive Board, in accordance with paragraph 1 of resolution EB59.R7, appointed its Chairman, Dr M. Kőkény (Hungary), and its first three Vice-Chairmen, Dr P.M. Buss (Brazil), Dr P.D.S. Osman (Brunei Darussalam) and Dr A.J. Mohamed (Oman), to represent the Executive Board at the Sixty-fourth World Health Assembly. It was understood that, if any of those members were not available for the Health Assembly, the other Vice-Chairman, Professor A.F.M.R. Haque (Bangladesh) and the Rapporteur, Dr A. Djibo (Niger), could be asked to represent the Board.³

Future sessions of the Executive Board and the Health Assembly: Item 6.2 of the Agenda (Document EB127/8)

Mr LARSEN (Norway) asked whether it would be possible for the Secretariat to provide before the 128th session of the Executive Board in January 2011 an overview of all agenda items that were to be reported on or discussed in all future sessions of the Executive Board and Health Assembly as a

¹ Decision EB127(5).

² Decision EB127(6).

³ Decision EB127(7).

result of decisions taken in previous meetings. Such an overview would aid Member States in their preparation for meetings.

In the European Region, the provision of similar overviews to the Standing Committee to the Regional Committee facilitated an evaluation of the appropriateness of items on the agenda.

Dr MOHAMED (Oman) sought clarification regarding the proposed dates for the Sixty-fourth World Health Assembly, as it was his recollection that, at the Health Assembly in 2009, it had been agreed that future Health Assemblies would not exceed six days when the Proposed programme budget had to be adopted and five days in other years.

The CHAIRMAN endorsed the suggestion made by the member for Norway.

Dr YOUNES (Office of Governing Bodies), responding to points raised, welcomed the suggestion made by the member for Norway, which would contribute to rationalizing the work of the Executive Board. Although the Sixty-second World Health Assembly had decided to pursue the goal of reducing the length of meetings, it had become apparent that the schedule of the Sixty-third World Health Assembly, which had ended the previous day, had allowed insufficient time for informal negotiations between delegations and greatly increased the workload for the Secretariat, the quality of whose work had suffered as a result.

The CHAIRMAN pointed out that the formulation of the draft decision allowed for a degree of flexibility in the dates of the Health Assembly.

Mr HOHMAN (alternate to Dr Daulaire, United States of America) said that the dates of the Health Assembly should be finalized as soon as possible so as to facilitate logistical arrangements. Although extra time was customarily allowed in alternate years for discussion of the Proposed programme budget, he observed that prior consideration of the budget within countries and regions usually led to less extensive discussion by the Health Assembly. He therefore suggested that the proposed maximum length of the Sixty-fourth World Health Assembly should be reduced by one day.

Mr LARSEN (Norway) requested clarification on the procedure for deciding the dates of the Health Assembly. Given that the items on that body's agenda would depend on decisions taken in January 2011 by the Executive Board, which was responsible for setting priorities, he asked whether it would be possible to finalize the dates of the Health Assembly at the same juncture.

Dr MOHAMED (Oman) expressed support for the suggestion made by the member for the United States to shorten the Health Assembly by one day. The length of the Health Assembly should determine the breadth of its agenda, not vice versa.

The CHAIRMAN took it that the Board wished to adopt the draft decisions contained in paragraph 5 of document EB127/8, amended to reflect the suggestion of the member for the United States.

Decision: The Executive Board decided that its 128th session should be convened on Monday, 17 January 2011, at WHO headquarters, Geneva, and should close no later than Tuesday, 25 January 2011. The Board further decided that the thirteenth meeting of the Programme,

Budget and Administration Committee of the Executive Board should be held on Thursday and Friday, 13 and 14 January 2011, at WHO headquarters.¹

Decision: The Executive Board decided that the Sixty-fourth World Health Assembly should be held at the Palais des Nations, Geneva, opening on Monday, 16 May 2011, and that it should close no later than Tuesday, 24 May 2011. The Board further decided that the fourteenth meeting of the Programme, Budget and Administration Committee of the Executive Board should be held on Thursday and Friday, 12 and 13 May 2011, at WHO headquarters, Geneva.²

Mr HOHMAN (alternate to Dr Daulaire, United States of America) asked whether the dates of the 129th session of the Executive Board would be affected by the decision to curtail the Sixty-fourth World Health Assembly.

The CHAIRMAN explained that it was normal practice to confirm the dates of the Executive Board session that followed a Health Assembly at the Board's session in the preceding January, at which meeting the proposed length of the Health Assembly could also be re-examined if necessary.

3. STAFFING MATTERS: Item 7 of the Agenda

Statement by the representative of the WHO staff associations: Item 7.1 of the Agenda (Document EB127/9)

Mr BAILEY (representative of the WHO staff associations) highlighted the importance of genuine collaboration between staff and management, particularly in the current economic climate. Staff should be consulted, not merely informed, when reorganization threatened job security and working conditions. He expressed satisfaction at recent improvements in the situation that had resulted in a more participatory process and growing optimism among staff, which in turn would enhance the functioning of the Organization and its capacity to respond to global health needs.

Mr HOHMAN (alternate to Dr Daulaire, United States of America), expressing appreciation for the vital work of WHO's staff throughout the world, drew attention to the case of eight staff members, including three United States nationals, who had been made redundant from headquarters and the Global Service Centre in Kuala Lumpur. In that regard, he welcomed the positive atmosphere referred to in the statement. He acknowledged that Member States had called for efficiency savings and more effective use of resources within WHO, but it was nevertheless essential to ensure transparency and accountability in the termination of staff contracts and proper treatment of staff. The WHO staff associations must play an active role in such circumstances.

Mr BAILEY (representative of the WHO staff associations) said that, in the case in question, greater involvement of the staff associations could have improved matters. Part of the role of the staff associations was to promote an appropriate balance between economic considerations and staff protection. In the wake of the global financial crisis, further redundancies were likely, but the staff associations would make every effort to ensure that management acted in a transparent and accountable fashion and that staff were treated with the necessary dignity and respect.

¹ Decision EB127(8).

² Decision EB127(9).

The DIRECTOR-GENERAL highlighted the serious financial situation of WHO since the onset of the global financial crisis, which had resulted in a budget deficit of US\$ 200 million in 2009. Despite economic measures to offset the deficit in the short term, difficult management decisions had been required for the future of the Organization and the continuation of its core work, while minimizing the impact on job security and on staff members and their families. Every effort had been made to redeploy staff where possible; however, where redundancy was the only option, staff must be treated with dignity and respect and given sufficient notice to enable them to plan for the future. Although the final decision must rest with management, the staff associations had an important consultative role to play, and discussions had already been held between the two sides to consider possible developments over the following 18 to 24 months and ensure the system functioned in the best interests of staff and the Organization.

In order to protect as many existing staff as possible, external recruitment had been frozen. Vacant posts were being filled through lateral transfers, a procedure that she had requested the Health Assembly to approve some time previously in view of worrying financial signals. Staff members who had to be transferred to new duties or locations were given the necessary support and retraining. The possibility of placing staff in the private sector had also been explored. Of the eight people referred to by the member for the United States, five had been reassigned and one had left the Organization under a mutual separation agreement. She would do her utmost to find acceptable solutions for the remaining two. She urged Member States to respect the difficult position of management in balancing the economic viability of the Organization with ensuring proper treatment of staff. Redundancy would only be used as a last resort. While financial difficulties persisted, changes would be needed not only to staffing but also to the Organization's activities. All concerned would strive to ensure the impact was kept to a minimum.

The CHAIRMAN took it that the Board wished to take note of the statement by the representative of the WHO staff associations.

The Board noted the statement.

4. MATTERS FOR INFORMATION: Item 8 of the Agenda

Report on meetings of expert committees and study groups (Document EB127/10)

Mr DE ALMEIDA CADOSO (adviser to Dr Buss, Brazil) asked whether, in light of the recently adopted decision on substandard/spurious/falsely-labelled/falsified/counterfeit medical products,¹ the Organization's activities with the International Medical Products Anti-Counterfeiting Taskforce would be affected while the intergovernmental working group discussed the items within its remit.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)² said that he had understood that all WHO activities with the Taskforce were to be suspended pending a decision by the working group. In addition he sought clarification as to when the next meeting of the Expert Committee on Specifications for Pharmaceutical Preparations would take place.

¹ Decision WHA63(10).

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

Dr DODDS (Canada) recalled that, during discussions in the Health Assembly on the resolution, some delegates had suggested including a reference to continuing the Organization's current work with the Taskforce. Subsequent to those discussions, it had been decided that such a reference was unnecessary as the decision did not state or imply that any activities should be stopped. The Health Assembly had adopted that decision, and therefore the suggestion by the members for Brazil and Thailand that any current work should be suspended was incorrect.

Mr HOHMAN (alternate to Dr Daulaire, United States of America) noted that the decision contained a reference to the Organization's current work. As the working group could take two years to produce a final report, it was incorrect to suggest that current activities would be suspended.

The DIRECTOR-GENERAL said that from a public health perspective, the issue of substandard, spurious, falsely-labelled, falsified and counterfeit medical products was extremely important as it affected patients directly and increased resistance to important medicines such as artemisinin-based combination therapy or HIV/AIDS treatments, as well as damaging the reputation of health professionals and governments. She urged members to continue to work on the issue, and said that the Secretariat would do the same, as well as working with other agencies to change the perception of the Organization's role in the enforcement of intellectual property rights.

The Board noted the report.

5. TECHNICAL AND HEALTH MATTERS: Item 5 of the Agenda (resumed)

Child injury prevention: Item 5.3 of the Agenda (Documents EB127/5 and EB127/5 Add.1) (resumed)

The CHAIRMAN invited the Board to consider the revised draft resolution, which read:

The Executive Board,
Having considered the report on child injury prevention,¹

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

The Sixty-fourth World Health Assembly,

PP1 Recalling resolution WHA57.10 on road safety and health, which affirmed that road traffic injuries constitute a major public health problem that required coordinated international efforts;

PP2 Recalling also that the Health Assembly in resolution WHA57.10 accepted the invitation by the United Nations General Assembly for WHO to act as a coordinator on road safety issues within the United Nations system, working in close collaboration with the United Nations regional commissions;

PP3 Further recalling resolution WHA60.22 on health systems: emergency-care systems, which recognized that improved organization and planning for provision of trauma and emergency care is an essential part of integrated health-care delivery, and resolution WHA58.23 on disability, including prevention, management and rehabilitation,

¹ Document EB127/5.

which urged Member States to take all necessary steps for the reduction of risk factors contributing to disabilities in childhood;

PP4 Acknowledging the responsibilities to ensure safety in the care and protection of children affirmed in the Convention on the Rights of the Child (1989), and the safety and protection of persons with disabilities set out in the Convention on the Rights of Persons with Disabilities (2006);

PP5 Recognizing that child injuries are a major threat to child survival and health, that they are a neglected public health problem with significant consequences in terms of mortality, morbidity, quality of life, social and economic costs, and that in the absence of urgent action this problem will hamper attainment of the Millennium Development Goals, **particularly in low and middle income countries and in the countries of South East Asia and Africa where there exists more than 95% of the global burden of child injuries**[BANGLADESH]

PP6 Further recognizing that multisectoral approaches to preventing child injury and limiting their consequences through implementation of evidence-based interventions have resulted in dramatic and sustained reductions in child injury in countries that have made concerted efforts;

PP7 Welcoming the joint WHO/UNICEF *World report on child injury prevention*¹ and its recommendations for public health policy and programming;

PP8 Considering that existing child survival and child health and development programmes should introduce child injury prevention strategies, ensuring these are an integrated part of child health services, and that success of child health programmes should not only be measured through the use of traditional measures of infectious disease mortality but also by indicators of fatal and non-fatal injury;

1. URGES Member States:

- (1) to prioritize the prevention of child injury **among child issues** [CANADA] and ensure that intersectoral coordination mechanisms necessary to prevent child injury are established or strengthened;
- (2) to **continue and if necessary to** [CANADA] strengthen their commitments under the Convention on the Rights of the Child (1989) to respect, protect and fulfil the rights of children to the highest attainable standard of health and to take all appropriate legislative, administrative, social and educational measures to protect children from injury;
- (3) to ensure that funding mechanisms for **public health** programmes that support child survival or child health and development ~~also are adapted to make financial resources available to expand those programmes to~~ [CANADA] cover child injury and prevention, **emergency, prehospital care, treatment and rehabilitation services** [TIMOR LESTE];
- (4) to implement, as appropriate, the recommendations of the WHO/UNICEF *World report on child injury prevention*, including, if not already done, the assignation of a leadership role to a government agency or unit for child injury prevention and the appointment of a focal person for injury prevention, while ensuring that such leadership facilitates collaboration between relevant sectors of government, communities and civil society; to implement the key strategies identified in the *World report* as effective interventions to preventing child injury; and to monitor and evaluate the impact of these interventions;

¹ Peden M et al, eds. *World report on child injury prevention*, Geneva, World Health Organization, and New York, United Nations Children's Fund, 2008.

(5) to integrate child injury prevention in **both national child development programmes and [CHINA] public health programmes, and establish multisectoral coordination and collaboration mechanism [CHINA]** in particular ensuring that prevention of child injury is accorded appropriate importance within programmes for child survival and health;

(6) to ensure that national data collection across relevant sectors **or surveillance systems [TIMOR LESTE]** quantifies **the demographic, socio economic and epidemiological profile [TIMOR LESTE]** of the burden of, risk factors for, and costs of child injury, and to assure that the resources available are commensurate with the extent of the problem;

(7) to develop and implement a multisectoral policy and plan of action that contain realistic targets for child injury prevention, and include promotion of standards and codes on product safety, school and play spaces, construction regulations and laws, as either a stand-alone policy or plan, or incorporated within the national child health policy or plan;

(8) to **promulgate legislations and regulations where necessary, strengthen and effectively enforce, and if necessary strengthen, the existing laws and regulations relevant to the prevention of child injury; [TIMOR LESTE]**

(9) to strengthen emergency and rehabilitation services and capacities, including first-response teams, the acute **prehospital** management ~~during pre-hospital care and within~~ at health facilities of ~~injured children~~, and suitable rehabilitation programmes for injured or disabled children; **[BARBADOS]**

(10) to define priorities for research, and support research on the impact of, ~~and [CANADA]~~ risk factors for, child injury, and on interventions needed to prevent child injury, including research on the effectiveness of strategies defined as promising in the WHO/UNICEF *World report on child injury prevention*;

10 BIS to work closely with research and development communities, manufacturers and distributors on safety products relevant to child injury profiles and affordable by developing countries [TIMOR LESTE]

(11) to raise awareness **and health literacy**, | in particular **on child safety** among parents, **children [TIMOR LESTE]** and relevant professional groups **[DELETED CANADA]** |, about risk factors for child injury, especially transport, **including the use of cell phones and other such mobile devices while driving, [USA]** water and fire hazards, and lack of child supervision and protection of children, and to advocate dedicated child injury prevention programmes;

2. REQUESTS the Director-General:

(1) to collaborate with Member States in improving data collection and analysis systems for child injuries and in establishing science-based public health policies and programmes for preventing and mitigating the consequences of child injury;

(2) to encourage research that expands the evidence base for interventions to prevent child injuries, mitigate their consequences and the evaluation of the effectiveness of such interventions through collaborating centres and other partners, **including translation to affordable safety products, policy interventions and effective implementations [TIMOR LESTE]**

(3) to facilitate the adaptation and transfer of knowledge on measures **and instruments [BRAZIL]** to prevent child injury from ~~high income countries to low and middle income~~ **developed to developing** settings; **[BARBADOS]**

3 bis To assist Member States in developing and implementing child injury prevention measures [CHINA]

- (4) to provide additional **support** to national injury prevention focal persons by organizing regular global and regional meetings and providing technical assistance;
- (5) to provide technical **support** for strengthening systems and capacities for emergency and rehabilitation services;
- (6) to collaborate with Member States, organizations of the United Nations system, **and international development partners** and nongovernmental organizations **to mobilize resources and** to augment the capacities needed to prevent child injury **and undertake related rehabilitation programme**, and to raise awareness **that in the absence of urgent action this problem will hamper attainment of the millennium development goals particularly in low and middle income countries and in the countries of South-East Asia and Africa where there exists more than 95 % of the global burden child injuries of the problem** [BANGLADESH];
- 6 bis To constitute an interagency forum/committee so that a coordinated mechanism for supporting low and middle income countries, as injury prevention is widely a multisectoral issue, and other UN agencies can play an effective role** [OMAN]
- 6 ter To invest more on building institutional and individual capacities among Member States so that they are able to develop cost effective interventions at national and sub-national levels** [OMAN]
- (7) to report progress **made** in implementing this resolution, through the Executive Board, to the Sixty-seventh World Health Assembly in May 2014.

The CHAIRMAN asked the member for Timor-Leste whether he agreed to the deletion of the phrase “in particular on child safety among parents, children and relevant professional groups” in subparagraph 1(11).

Dr JESSE (Estonia) asked for time to read the revised text.

The meeting was suspended at 16.20 and resumed at 16.30.

Dr DODDS (Canada), recognizing the importance of the issue and noting the clear support for the draft resolution, suggested deferring further consideration to the Board's next session in January 2011 so as to allow time to prepare for more in-depth discussion, and the preparation of the financial and administrative implications for the Secretariat of the implementation of the resolution. The draft resolution could therefore still be submitted for approval at the next World Health Assembly.

Mr ÁLVAREZ-PÉREZ (adviser to Dr Jadue, Chile) and Dr MOHAMED (Oman) supported the proposal by the member for Canada.

Dr FERDINAND (alternate to Mr Inniss, Barbados), while agreeing with the proposal to defer the item, clarified the amendments she had proposed to the draft resolution. Subparagraph 1(9) should read “to strengthen emergency and rehabilitation services and capacities, including first response teams, acute prehospital care, management...”. Furthermore, in the sixth line of subparagraph 2(6) and in the second line of subparagraph 2(6bis) the words “developing and” should be inserted before “low and middle income”.

The CHAIRMAN took it that the Board agreed to defer the item to its next session in January 2011.

It was so decided.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)¹ sought clarification of which version of the draft resolution would form the basis for subsequent consideration.

The CHAIRMAN indicated that discussions would be based on the revised consolidated version of the draft resolution, together with any additional amendments submitted before the next meeting.

6. OTHER BUSINESS

Mr CHAUDHRY (alternate to Mr Gopinathan, India), referring to document A63/44 on partnerships, said that the Health Assembly had adopted a resolution requesting the Secretariat to provide details of all WHO's partnerships,² on which he had been unable to speak at the time. He asked that the information be included in a public registry, and that the disclosure not be limited only to formal partnerships, but also include collaborative arrangements, along with the financial impact of those arrangements on WHO, and any relevant conflicts of interest. Moreover, periodic updates should also be sent to the Board and the Health Assembly.

The DIRECTOR-GENERAL agreed in principle with the request made by the member for India, but said that it would first be necessary to clarify the definitions of partnerships and collaborative arrangements and noted that the development of such a registry would require substantial resources.

Mr HOHMAN (alternate to Dr Daulaire, United States of America) welcomed the proposal by the member for India, which would help to clarify the partnerships in which WHO was engaged, but expressed concerns about publishing all the information in a public registry, in particular regarding conflicts of interest.

Professor HAQUE (Bangladesh) supported the proposal by the member for India and said that he hoped that the resource constraints would not be prohibitive.

7. CLOSURE OF THE SESSION

The DIRECTOR-GENERAL thanked members for their cooperation and wisdom during the sessions of the Health Assembly and the Executive Board. WHO should be fit for purpose and appropriately financed, and needed careful governance in an increasingly globalized world. Although many health issues were inherently political in nature, it was important that political differences were not allowed to disrupt debates. She acknowledged the role of the Board in ensuring the smooth running of the Health Assembly, and welcomed all suggestions for a more efficient and effective meeting.

After the customary exchange of courtesies, the CHAIRMAN declared the 127th session closed.

The meeting rose at 16.50.

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

² Resolution WHA63.10.