



WORLD HEALTH ORGANIZATION

FIFTY-EIGHTH WORLD HEALTH ASSEMBLY

GENEVA, 16-25 MAY 2005

**SUMMARY RECORDS OF COMMITTEES
REPORTS OF COMMITTEES**

**GENEVA
2005**

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACHR	– Advisory Committee on Health Research	PAHO	– Pan American Health Organization
ASEAN	– Association of South-East Asian Nations	UNAIDS	– Joint United Nations Programme on HIV/AIDS
CEB	– United Nations System Chief Executives Board for Coordination (formerly ACC)	UNCTAD	– United Nations Conference on Trade and Development
CIOMS	– Council for International Organizations of Medical Sciences	UNDCP	– United Nations International Drug Control Programme
FAO	– Food and Agriculture Organization of the United Nations	UNDP	– United Nations Development Programme
IAEA	– International Atomic Energy Agency	UNEP	– United Nations Environment Programme
IARC	– International Agency for Research on Cancer	UNESCO	– United Nations Educational, Scientific and Cultural Organization
ICAO	– International Civil Aviation Organization	UNFPA	– United Nations Population Fund
IFAD	– International Fund for Agricultural Development	UNHCR	– Office of the United Nations High Commissioner for Refugees
ILO	– International Labour Organization (Office)	UNICEF	– United Nations Children’s Fund
IMF	– International Monetary Fund	UNIDO	– United Nations Industrial Development Organization
IMO	– International Maritime Organization	UNRWA	– United Nations Relief and Works Agency for Palestine Refugees in the Near East
ITU	– International Telecommunication Union	WFP	– World Food Programme
OECD	– Organisation for Economic Co-operation and Development	WIPO	– World Intellectual Property Organization
OIE	– <i>Office International des Epizooties</i>	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 Fifty-eighth World Health Assembly was held at the Palais des Nations, Geneva, from 16 to 25 May 2005, in accordance with the decision of the Executive Board at its 114th session. Its proceedings are issued in three volumes, containing, in addition to other relevant material:

Resolutions and decisions, Annex – document WHA58/2005/REC/1

Verbatim records of plenary meetings, list of participants – document WHA58/2005/REC/2

Summary records of committees, reports of committees – document WHA58/2005/REC/3

CONTENTS

	Page
Abbreviations	ii
Preface	iii
Officers of the Health Assembly and membership of its committees	xi
Agenda.....	xiii
List of documents	xvii

PART I

SUMMARY RECORDS OF MEETINGS OF COMMITTEES

GENERAL COMMITTEE

First meeting.....	3
Second meeting	16
Third meeting	18

COMMITTEE A

First meeting

1. Opening of the Committee	19
2. Organization of work	19
3. Technical and health matters	
Revision of the International Health Regulations	20
Health action in relation to crises and disasters	30

Second meeting

Technical and health matters (continued)	
Health action in relation to crises and disasters (continued).....	32
Poliomyelitis	42

Third meeting

Technical and health matters (continued)	
Poliomyelitis (continued).....	46
Health action in relation to crises and disasters (continued).....	57
Sustainable financing for tuberculosis prevention and control	61

Fourth meeting

1.	Technical and health matters (continued)	
	Health action in relation to crises and disasters (continued)	63
2.	Programme budget 2002-2003: performance assessment report	63
3.	Proposed programme budget 2006-2007	64

Fifth meeting

1.	First report of Committee A	78
2.	Proposed programme budget 2006-2007 (continued)	78
3.	Technical and health matters (continued)	
	Sustainable financing for tuberculosis prevention and control (continued)	80
	Malaria	88

Sixth meeting

	Technical and health matters (continued)	
	Malaria (continued)	96
	Smallpox	102

Seventh meeting

1.	Draft second report of Committee A	105
2.	Technical and health matters (continued)	
	Revision of the International Health Regulations (continued)	105
3.	Proposed programme budget 2006-2007 (continued)	107
4.	Technical and health matters (resumed)	
	Sustainable financing for tuberculosis prevention and control (continued)	110
	Smallpox (continued)	112
	Draft global immunization strategy	115

Eighth meeting

1.	Organization of work	127
2.	Technical and health matters (continued)	
	Sustainable financing for tuberculosis prevention and control (continued)	127
	Strengthening pandemic influenza preparedness and response	128
	Antimicrobial resistance: a threat to global health security	138

Ninth meeting

1.	Third and fourth reports of Committee A	144
2.	Technical and health matters (continued)	
	Antimicrobial resistance: a threat to global health security (continued)	144
	Sustainable financing for tuberculosis prevention and control (continued)	147
	Draft global immunization strategy (continued)	149
	Infant and young child nutrition	151

Tenth meeting

1.	Fifth report of Committee A.....	167
2.	Technical and health matters (continued)	
	Social health insurance.....	167
	Antimicrobial resistance: a threat to global health security (continued).....	176
	Infant and young child nutrition (continued)	178
	eHealth.....	180

Eleventh meeting

	Technical and health matters (continued)	
	eHealth (continued).....	185
	Implementation of resolutions (progress reports)	
	• Prevention and control of iodine deficiency disorders.....	187
	• Traditional medicine	195
	• Implementing the recommendations of the <i>World report on violence and health</i>	197
	• Strategic approach to international chemicals management	198
	• Promotion of healthy lifestyles	199
	• WHO Framework Convention on Tobacco Control	201

Twelfth meeting

1.	Sixth report of Committee A	203
2.	Organization of work	203
3.	Technical and health matters (continued)	
	Implementation of resolutions (progress reports) (continued)	
	• WHO Framework Convention on Tobacco Control	
	(continued)	203
	Ministerial Summit on Health Research	206
	Scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS (resolution WHA57.14).....	209
	Antimicrobial resistance: a threat to global health security (continued).....	218
	eHealth (continued).....	220

Thirteenth meeting

	Technical and health matters (continued)	
	Social health insurance (continued)	224
	Strengthening pandemic influenza preparedness and response (continued)	228

Fourteenth meeting

1.	Seventh report of Committee A.....	231
2.	Technical and health matters (continued)	
	Infant and young child nutrition (continued)	231
	Social health insurance (continued)	234
	Ministerial Summit on Health Research (continued)	236
3.	Eighth report of Committee A.....	240
4.	Closure	240

COMMITTEE B

First meeting

1.	Opening of the Committee	241
2.	Organization of work.....	241
3.	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine	242
4.	Report of the Internal Auditor	252
5.	Financial matters	
	Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution	254
6.	Staffing matters	
	Human resources: annual report.....	255
	Recruitment strategy integrating gender and geographical balance: progress report..	255

Second meeting

1.	Staffing matters (continued)	
	Amendments to the Staff Regulations and Staff Rules	257
	Report of the United Nations Joint Staff Pension Board.....	257
	Appointment of representatives to the WHO Staff Pension Committee	258
2.	Proposal for establishment of World Blood Donor Day.....	258

Third meeting

1.	Draft first report of Committee B	260
2.	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine (continued).....	260
3.	Implementation of multilingualism in WHO.....	261
4.	Technical and health matters (continued)	
	Cancer prevention and control	263

Fourth meeting

	Technical and health matters (continued)	
	Cancer prevention and control (continued).....	273
	Disability, including prevention, management and rehabilitation.....	274
	International Plan of Action on Ageing: report on implementation.....	281

Fifth meeting

	Technical and health matters (continued)	
	International Plan of Action on Ageing: report on implementation (continued).....	286
	Public health problems caused by harmful use of alcohol	289
	International migration of health personnel: a challenge for health systems in developing countries.....	298
	Achievement of health-related Millennium Development Goals.....	303

	Page
Sixth meeting	
1. Second report of Committee B.....	307
2. Financial matters	
Unaudited interim financial report on the accounts of WHO for 2004 and comments thereon made by the Programme, Budget and Administration Committee.....	307
Interim report of the External Auditor	308
Assessments for 2006-2007	311
Amendments to the Financial Regulations and Financial Rules.....	311
3. Real Estate Fund.....	312
4. Technical and health matters (continued)	
Cancer prevention and control (continued).....	313
Disability, including prevention, management and rehabilitation (continued)	317
Public health problems caused by harmful use of alcohol (continued).....	320
Seventh meeting	
Technical and health matters (continued)	
Public health problems caused by harmful use of alcohol (continued).....	321
Eighth meeting	
1. Third report of Committee B.....	323
2. Collaboration within the United Nations system and with other intergovernmental organizations	323
3. Technical and health matters (continued)	
Public health problems caused by harmful use of alcohol (continued).....	326
Ninth meeting	
Technical and health matters (continued)	
Achievement of health-related Millennium Development Goals (continued)	330
Tenth meeting	
1. Third report of Committee B.....	339
2. Fourth report of Committee B	339
3. Technical and health matters (continued)	
Achievement of health-related Millennium Development Goals (continued)	339
4. Fifth report of Committee B.....	346
5. Closure	346

PART II

REPORTS OF COMMITTEES

Committee on Credentials	349
Committee on Nominations.....	350
General Committee.....	352
Committee A	352
Committee B.....	355

OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Ms E. SALGADO (Spain)

Vice-Presidents

Mr S. MEKY (Eritrea)

Dr M. FERNÁNDEZ GALEANO
(Uruguay)

Dr M. FIKRI (United Arab Emirates)

Professor SUCHAI

CHAROENRATANAKUL (Thailand)

Ms A. KING (New Zealand)

Secretary

Dr LEE Jong-wook, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Algeria, Benin, Bhutan, Chad, Czech Republic, Honduras, Kiribati, Morocco, Peru, Serbia and Montenegro, Slovakia and Yemen.

Chairman: Dr T. KIENENE (Kiribati)

Vice-Chairman: Dr D. YEVIDE (Benin)

Rapporteur: Dr A. AL-RABI (Yemen)

Secretary: Mr G.L. BURCI, Legal Counsel

Committee on Nominations

The Committee on Nominations was composed of delegates of the following Member States: Bahamas, Bolivia, Bosnia and Herzegovina, Cameroon, China, Comoros, France, Gambia, Guatemala, Guyana, India, Kuwait, Lithuania, Palau, Paraguay, Russian Federation, Senegal, Seychelles, Timor-Leste, Togo, Turkey, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Viet Nam and Mr Muhammad Nasir Khan, Pakistan (President, Fifty-seventh World Health Assembly, ex officio).

Chairman: Mr Muhammad Nasir KHAN
(Pakistan)

Secretary: Dr LEE Jong-wook, Director-General

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Bhutan, Brazil, China, Congo, Cuba, Equatorial Guinea, Ethiopia, France, Latvia, Lebanon, Luxembourg, Malawi, Mongolia, Russian Federation, United Kingdom of Great Britain and Northern Ireland, United States of America and Zimbabwe.

Chairman: Ms E. SALGADO (Spain)

Secretary: Dr LEE Jong-wook, Director-General

MAIN COMMITTEES

Under Rule 35 of the Rules of Procedure of the World Health Assembly, each delegation was entitled to be represented on each main committee by one of its members.

Committee A

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)

Vice-Chairmen: Dr H. NTABA (Malawi) and Pehin Dato ABU BAKAR APONG (Brunei Darussalam)

Rapporteur: Dr R. BUSUTTIL (Malta)

Secretary: Dr Q.M. ISLAM, Director, Making Pregnancy Safer

Committee B

Chairman: Dr J. WALCOTT (Barbados)

Vice-Chairmen: Professor J. PEREIRA
MIGUEL (Portugal) and
Dr M.A. RAHMAN KHAN (Bangladesh)

Rapporteur: Mr YEE Ping Yi (Singapore)

Secretary: Dr M. YOUNES, Director, Office
of the Assistant Director-General,
Sustainable Development and Healthy
Environments

AGENDA¹

PLENARY MEETINGS

1. Opening of the Assembly
 - 1.1 Appointment of the Committee on Credentials
 - 1.2 Election of the Committee on Nominations
 - 1.3 Reports of the Committee on Nominations
 - Election of the President
 - Election of the five Vice-Presidents, the Chairmen of the main committees, and establishment of the General Committee
 - 1.4 Adoption of the agenda and allocation of items to the main committees
2. Reports of the Executive Board on its 114th and 115th sessions
3. Address by Dr Lee Jong-wook, Director-General
4. Invited speakers
5. [deleted]
6. Executive Board: election
7. Awards
8. Reports of the main committees
9. Closure of the Assembly

¹ Adopted at the second plenary meeting.

COMMITTEE A

10. Opening of the Committee¹
11. Programme budget 2002-2003: performance assessment report
12. Proposed programme budget 2006-2007
13. Technical and health matters
 - 13.1 Revision of the International Health Regulations
 - 13.2 [transferred to Committee B]
 - 13.3 Health action in relation to crises and disasters
 - 13.4 Sustainable financing for tuberculosis prevention and control
 - 13.5 Malaria
 - 13.6 Smallpox
 - 13.7 Poliomyelitis
 - 13.8 Draft global immunization strategy
 - 13.9 Strengthening pandemic influenza preparedness and response
 - 13.10 Antimicrobial resistance: a threat to global health security
 - 13.11 Infant and young-child nutrition
 - 13.12 [transferred to Committee B]
 - 13.13 [transferred to Committee B]
 - 13.14 [transferred to Committee B]
 - 13.15 [transferred to Committee B]
 - 13.16 Social health insurance
 - 13.17 eHealth
 - 13.18 Ministerial Summit on Health Research

¹ Including election of Vice-Chairmen and Rapporteur.

AGENDA

13.19 Implementation of resolutions (progress reports)

- Prevention and control of iodine deficiency disorders (resolution WHA52.24)
- Traditional medicine (resolution WHA56.31)
- Implementing the recommendations of the *World report on violence and health* (resolution WHA56.24)
- Strategic approach to international chemicals management (resolution WHA56.22)
- Promotion of healthy lifestyles (resolution WHA57.16)
- WHO Framework Convention on Tobacco Control (resolution WHA56.1)

13.20 Scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS (resolution WHA57.14)

13.21 [transferred to Committee B]

COMMITTEE B

14. Opening of the Committee¹

15. Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine

16. Report of the Internal Auditor

17. Financial matters

17.1 Unaudited interim financial report on the accounts of WHO for 2004 and comments thereon made by the Programme, Budget and Administration Committee

17.2 Interim report of the External Auditor

17.3 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution

17.4 Assessments for 2006-2007

17.5 [deleted]

17.6 Amendments to the Financial Regulations and Financial Rules

¹ Including election of Vice-Chairmen and Rapporteur.

- 18. Real Estate Fund
- 19. Staffing matters
 - 19.1 Human resources: annual report
 - 19.2 Recruitment strategy integrating gender and geographical balance: progress report
 - 19.3 Amendments to the Staff Regulations and Staff Rules
 - 19.4 Report of the United Nations Joint Staff Pension Board
 - 19.5 Appointment of representatives to the WHO Staff Pension Committee
- 20. Proposal for establishment of World Blood Donor Day
- 21. Implementation of multilingualism in WHO
- 22. Collaboration within the United Nations system and with other intergovernmental organizations
- 13. Technical and health matters
 - 13.2 Achievement of health-related Millennium Development Goals
 - 13.12 Cancer prevention and control
 - 13.13 Disability, including prevention, management and rehabilitation
 - 13.14 Public health problems caused by harmful use of alcohol¹
 - 13.15 International Plan of Action on Ageing: report on implementation
 - 13.21 International migration of health personnel: a challenge for health systems in developing countries (resolution WHA57.19)

¹ N.B. The subject of healthy lifestyles is dealt with under item 13.19.

LIST OF DOCUMENTS

A58/1 Rev.1	Agenda ¹
A58/2	Reports of the Executive Board on its 114th and 115th sessions
A58/3	Address by the Director-General to the Fifty-eighth World Health Assembly
A58/4	Revision of the International Health Regulations
A58/5	Achievement of health-related Millennium Development Goals
A58/6	Health action in relation to crises and disasters
A58/6 Add.1	Health action in relation to crises and disasters. WHO Conference on Health Aspects of the Tsunami Disaster in Asia (Phuket, Thailand, 4 to 6 May 2005): Summary report
A58/7	Sustainable financing for tuberculosis prevention and control
A58/8	Malaria
A58/9	Smallpox: global smallpox vaccine reserve
A58/10	Smallpox: destruction of variola virus stocks
A58/11	Poliomyelitis
A58/12 and A58/12 Add.1	Draft global immunization strategy ²
A58/13	Strengthening pandemic influenza preparedness and response
A58/14	Antimicrobial resistance: a threat to global health security. Rational use of medicines by prescribers and patients
A58/15	Infant and young child nutrition
A58/16	Cancer prevention and control
A58/17	Disability, including prevention, management and rehabilitation

¹ See page xiii.

² See document WHA58/2005/REC/1, Annex.

A58/18	Public health problems caused by harmful use of alcohol
A58/19	International Plan of Action on Ageing: report on implementation
A58/20	Social health insurance. Sustainable health financing, universal coverage and social health insurance
A58/21	eHealth
A58/22	Ministerial Summit on Health Research
A58/23 and A58/23 Add.1	Implementation of resolutions (progress reports)
A58/24	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine
A58/25	Report of the Internal Auditor
A58/26	Unaudited Interim Financial Report for the year 2004: financial period 2004-2005
A58/26 Add.1	Unaudited Interim Financial Report for the year 2004: financial period 1 January 2004 – 31 December 2005. Annex: Extrabudgetary Resources for Programme Activities
A58/27	Unaudited interim financial report on the accounts of WHO for 2004 and comments thereon made by the Programme, Budget and Administration Committee. First report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-eighth World Health Assembly
A58/28	Interim report of the External Auditor
A58/29	Interim report of the External Auditor. Fifth report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-eighth World Health Assembly
A58/30	Assessments for 2006-2007
A58/31 and A58/31 Corr.1	Status of collection of assessed contributions. Second report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-eighth World Health Assembly
A58/32	Amendments to the Financial Regulations and Financial Rules
A58/33	Real Estate Fund
A58/34	Human resources: annual report

LIST OF DOCUMENTS

A58/35	Recruitment strategy integrating gender and geographical balance: progress report
A58/36 and A58/36 Corr.1	Report of the United Nations Joint Staff Pension Board
A58/37	Appointment of representatives to the WHO Staff Pension Committee
A58/38	Proposal for establishment of World Blood Donor Day
A58/39	Implementation of multilingualism in WHO
A58/40	Collaboration within the United Nations system and with other intergovernmental organizations
A58/41, A58/41 Add.1 and Add.2	Revision of the International Health Regulations
A58/42	Awards: amendments to the Statutes governing the Ihsan Dogramaci Family Health Foundation
A58/43 Rev.1	Special arrangements for settlement of arrears. Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution. Third report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-eighth World Health Assembly
A58/44 and A58/44 Corr.1	Real Estate Fund. Fourth report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-eighth World Health Assembly
A58/45	Report of the Internal Auditor. Sixth report of the Programme, Budget and Administration Committee of the Executive Board to the Fifty-eighth World Health Assembly
A58/46	Committee on Nominations. First report
A58/47	Committee on Nominations. Second report
A58/48	Committee on Nominations. Third report
A58/49	First report of Committee A (Draft)
A58/50	Committee on Credentials. First report
A58/51	Election of Members entitled to designate a person to serve on the Executive Board
A58/52	Committee on Credentials. Second report

A58/53	First report of Committee B (Draft)
A58/54	Second report of Committee A (Draft)
A58/55	Third report of Committee A
A58/56	Fourth report of Committee A (Draft)
A58/57	Fifth report of Committee A (Draft)
A58/58	Second report of Committee B (Draft)
A58/59 and A58/59 Corr.1	Third report of Committee B (Draft)
A58/60	Sixth report of Committee A (Draft)
A58/61	Fourth report of Committee B (Draft)
A58/62	Seventh report of Committee A (Draft)
A58/63	Fifth report of Committee B
A58/64	Eighth report of Committee A
PBPA/2002-2003 and PBPA/2002-2003 Corr.1	Programme budget 2002-2003: Performance assessment report
PB/2006-2007, PB/2006-2007 Corr.1 and Corr.2	Proposed programme budget 2006-2007
Information documents	
A58/INF.DOC./1	Proposed programme budget 2006-2007. Comparison with the Programme budget 2004-2005
A58/INF.DOC./2	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine (report of the Director of Health, UNRWA, for 2004)
A58/INF.DOC./3	Proposed programme budget 2006-2007. Implementing the normative and statutory functions of WHO

LIST OF DOCUMENTS

A58/INF.DOC./4	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine (report by the Israeli Ministry of Health)
A58/INF.DOC./5	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine (report submitted by the Permanent Observer of Palestine to the United Nations and Other International Organizations at Geneva)
Diverse	
A58/DIV/7	Speech by His Excellency Mr Maumoon Abdul Gayoom, President of the Republic of Maldives at the Fifty-eighth World Health Assembly, Geneva, Monday, 16 May 2005
A58/DIV/8	Presentation by Mr Bill Gates, Co-founder of the Bill and Melinda Gates Foundation at the Fifty-eighth World Health Assembly, Monday, 16 May 2005

PART I

**SUMMARY RECORDS OF MEETINGS
OF COMMITTEES**

GENERAL COMMITTEE

FIRST MEETING

Monday, 16 May 2005, at 12:25

Chairman: Ms Elena SALGADO (Spain)
President of the Health Assembly

1. ADOPTION OF THE AGENDA (Document A58/1)

The CHAIRMAN reminded the Committee that, under its terms of reference as defined in Rule 33 of the Rules of Procedure of the World Health Assembly, its first task was to consider item 1.4 (Adoption of the agenda and allocation of items to the main committees) of the provisional agenda, which had been prepared by the Executive Board and issued as document A58/1. The Committee would also consider proposals for the addition of two supplementary agenda items and the programme of work of the Health Assembly.

Deletion of agenda items

The CHAIRMAN indicated that, if there was no objection, two items on the provisional agenda would be deleted, namely item 5 (Admission of new Members and Associate Members) and item 17.5 (Assessment of new Members and Associate Members).

It was so agreed.

The CHAIRMAN invited comments on the provisional agenda, as amended, on the understanding that the proposals for two supplementary agenda items would be considered later.

A Vice-President of the Health Assembly (ERITREA), speaking on behalf of the African group, said that the subitem relating to HIV/AIDS should be treated as a substantive item.

The CHAIRMAN, seeing no objection, took it that the Committee accepted that proposal.

It was so agreed.

In response to a question from a Vice-President of the Health Assembly (ERITREA), speaking on behalf of the African group, the CHAIRMAN pointed out that the subject of malaria was already included in the agenda in its own right.

The observer of BENIN¹ expressed the view of the African group that diseases such as HIV/AIDS and malaria should be given a prominent place in the agenda. The same held for maternal health and the health of infants and children, as the African group wished to propose a resolution on that subject.

¹ Participating by virtue of Rule 32 of the Rules of Procedure of the World Health Assembly.

Mr AITKEN (Office of the Director-General), confirming that malaria was a substantive item on the agenda, said that HIV/AIDS would also be so treated. In regard to child and maternal health, a draft resolution could be considered under item 13.2, Achievement of health-related Millennium Development Goals.

It was so agreed.

The delegate of MALAWI said that the African group also considered that the subitem on international migration of health personnel should be upgraded to a substantive item.

Mr AITKEN (Office of the Director-General) said that, if the African group wished to present a draft resolution or decision on that subject, it was not necessary to move the item concerned from its current place in the agenda. There would be no procedural difficulty in the way of a proposal that might be presented by the African group.

The delegate of ZIMBABWE said that the African group felt strongly that the matter was more than a proposal of a draft resolution. The subject should be treated as an important agenda item since it was of great concern to countries in his region. A draft resolution could come later.

The CHAIRMAN said that she took it that the Committee wished to recommend that international migration of health personnel be treated as a separate item.

It was so agreed.

The delegate of the UNITED STATES OF AMERICA said that, as Members had received document A58/5 on achievement of health-related Millennium Development Goals only that morning and needed more time to study the document, Committee A should consider item 13.2 last under Technical and health matters.

The CHAIRMAN, seeing no objection, said that item 13.2 would be the last substantive item discussed. She took it that the Committee wished to approve the provisional agenda as amended, with the exception of the two additional proposed items to be considered forthwith.

It was so agreed.

2. PROPOSED SUPPLEMENTARY AGENDA ITEMS (Documents A58/GC/2 and A58/GC/4)

First proposed supplementary agenda item

The CHAIRMAN drew the Committee's attention to a proposal by the Director-General for inclusion of a supplementary agenda item, in accordance with Rule 12 of the Rules of Procedure of the World Health Assembly and contained in document A58/GC/2, on the WHO Framework Convention on Tobacco Control (resolution WHA56.1). Seeing no objection, she took it that the Committee wished to include that item in the agenda under item 13.19, Implementation of resolutions (progress reports).

It was so agreed.

Second proposed supplementary agenda item

The CHAIRMAN drew the Committee's attention to document A58/GC/4, which contained a proposal from the governments of Belize and Sao Tome and Principe for the inclusion of a supplementary agenda item, "Inviting Taiwan to participate in the World Health Assembly as an observer".

The delegate of CHINA strongly opposed the proposal. He asked the sponsoring countries directly why they did not abide by the United Nations Charter and why they showed disrespect for the United Nations General Assembly and the World Health Assembly. Resolutions 2758 (XXVI) and WHA25.1 of those two bodies, respectively, had long affirmed the Government of the People's Republic of China as the sole representative of China at the United Nations and in WHO. Membership of WHO was open only to sovereign States. As part of China, Taiwan was not qualified to be a full or Associate Member of WHO or attend the Health Assembly as an observer. It was irresponsible for a few countries to raise an issue that had already been resolved – politically, legally and procedurally. Most States, including China, could not accept such disrespect for the United Nations Charter, United Nations General Assembly and Health Assembly resolutions, the will of the majority of Member States, and Chinese sovereignty and territorial integrity. The issue was political: the health aspects were simply a pretext. In defiance of Health Assembly decisions, certain countries, instigated by others, had for the past eight years tabled Taiwan-related proposals. In the name of protecting the health rights and the interests of the Taiwanese people, they were attempting to create "two Chinas".

The issue was a domestic matter which should be resolved by the 1300 million Chinese people, including their 23 million Taiwan compatriots. Recently, there had been positive signs of interaction, including effective high-level exchanges and cooperation in the health field. Such initiatives would promote economic exchange and peaceful cross-Straits relations. The question of Taiwan's participation in WHO's activities could be discussed after resumption of the cross-Straits talks. The Chinese people were capable of solving their own problems and opposed interference by others.

The people of China and Taiwan were members of the same family, and the Chinese Government constantly gave priority to the interests of its people, including the health and well-being of its Taiwanese compatriots. At the previous Health Assembly, China had made four proposals on Taiwan-related issues,¹ and flexible and practical ways to implement them had been found. Recently, a Memorandum of Understanding had been signed by his Government's Ministry of Health and WHO, which stipulated that WHO could invite Taiwanese medical and public health experts to participate in technical activities, send staff or experts to Taiwan to study health and epidemic situations, and provide necessary medical and public health technical assistance. In the event of a health emergency, WHO could send experts to Taiwan, provide technical assistance or invite Taiwanese medical experts to participate in relevant technical activities. It would facilitate rapid access to accurate medical and health information and technical assistance. China was ready to discuss with Taiwan, on an equal footing, issues of health exchange and cooperation and expected an early and positive response from the Taiwanese authorities. The Chinese Government was sincerely addressing the concerns of its Taiwanese compatriots and protecting their legitimate rights and interests. It was untrue to say that Taiwan had no access to WHO information and technical assistance.

If the sponsoring countries gave serious consideration to such matters they would regret speaking against their conscience and hurting the feelings of the Chinese people.

At a time when public health issues were attracting increasing attention, the attempts by a few countries to disrupt the normal work of the Health Assembly and waste WHO's precious resources by taking advantage of Taiwan-related proposals should be opposed. Doing so would strengthen solidarity and promote closer cooperation for the attainment of the Millennium Development Goals.

¹ Document WHA57/2004/REC/3, summary record of the first meeting of the General Committee.

The Chinese Government was determined to safeguard its sovereignty and territorial integrity and to continue protecting the legitimate rights and interests of its Taiwanese compatriots. The repeated failure of similar proposals in the past should have ended such action against the law and the will of the people. The General Committee should, as in previous years, adhere to the principles of justice and oppose the proposal through a ruling of the Chairman.

The delegate of ZIMBABWE expressed regret that a proposal concerning Taiwan's participation at the Health Assembly as an observer was once again before the Committee. The issue had been settled by United Nations General Assembly resolution 2758 and resolution WHA25.1. WHO recognized the Government of the People's Republic of China as the sole representative of China. The Organization should not be deceived into considering any option that might imply two Chinas. Moreover, WHO had no mandate to decide on the matter and the Health Assembly was not the appropriate forum in which to discuss it. Like most of WHO's Members, Zimbabwe recognized and observed the one-China principle. Taiwan's health information and technical support requirements were met under the present arrangements, all such matters being covered by the recently signed Memorandum of Understanding. He therefore urged delegates to reject the proposal.

The delegate of ETHIOPIA said that it was both regrettable and incomprehensible that the matter had arisen once again. It was unacceptable to turn the legal and constitutional question of the representation of Taiwan into a political issue year after year. Moreover, the sponsors of the proposal were well aware of the ways and means by which Taiwan could participate in WHO's activities. The proposal, which was contrary to the resolutions cited by the two previous speakers, should be rejected.

The delegate of CUBA lamented the fact that the Health Assembly was considering the matter for the eighth consecutive year, despite the fact that all earlier proposals had been rejected. He categorically rejected the proposal, whose aim flagrantly violated the relevant resolutions of the United Nations General Assembly and the Health Assembly. WHO was a specialized agency of the United Nations with a membership of sovereign States. Those resolutions designated Taiwan as a province of China, which was therefore not qualified to become a Member or Associate Member of WHO, or to participate as an observer at the Health Assembly. The principle of respect for sovereignty and territorial integrity had underpinned the United Nations for more than 50 years. China had repeatedly explained the measures it was taking to facilitate relations between WHO and Taiwan in order to ensure that the province's inhabitants could take the necessary steps to solve its public health problems. Claims of discrimination against Taiwan were therefore unfounded.

The delegate of BRAZIL said that, as stated by his delegation in meetings of the General Committee at previous Health Assemblies and in other forums, Brazil observed the one-China principle, in conformity with the relevant resolutions of the United Nations General Assembly and the Health Assembly. He therefore opposed the proposal.

The delegate of URUGUAY said that he too had difficulty in accepting the proposal. The provisions of WHO's Constitution regarding membership were precise and precluded the arrangement suggested. It was regrettable that the Health Assembly's time was being taken up with extensive consideration of the matter, to the detriment of the discussion of health topics.

The delegate of BHUTAN also regretted that the matter was once again before the Committee despite previous resolutions of the United Nations General Assembly and the Health Assembly. It diverted international attention from WHO's specific mandate, which was to deal with global health issues, subjects of particular importance for the developing countries. He opposed the proposal.

The Chairman of Committee A (ISLAMIC REPUBLIC OF IRAN) expressed his Government's strong support for the position taken by the Government of the People's Republic of China, whose

concerns he fully comprehended. The one-China principle was the only solution to the dilemma faced by WHO over the previous few years. The Health Assembly should be guided by the relevant United Nations General Assembly and Health Assembly resolutions in resolving the matter.

The Chairman of Committee B (BARBADOS) registered his Government's opposition to the proposal. The two resolutions referred to by previous speakers constituted the legal basis for the representation of China in the United Nations and WHO. Furthermore, Taiwan did not qualify for membership or associate membership of WHO under the provisions of WHO's Constitution. Barbados maintained its long-standing adherence to the one-China principle and therefore continued to recognize the Government of the People's Republic of China as the only legitimate representative of China in the United Nations system, including WHO.

The delegate of the RUSSIAN FEDERATION affirmed that the Government of the People's Republic of China was the sole legitimate representative of China and that Taiwan was an inalienable part of China. That position, set out in formal Sino-Russian texts, was enshrined in Article 5 of the Treaty of Good Neighbourliness, Friendship and Cooperation between the People's Republic of China and the Russian Federation (16 July 2001), which had entered into force on 28 February 2002. He therefore opposed the participation of Taiwan in organizations of the United Nations system, in which only sovereign States could participate. Taiwan's membership of bodies such as WTO and the Asia-Pacific Economic Cooperation Forum was not sufficient grounds to justify its membership of WHO.

The delegate of MALAWI said that his country wished to be included as a sponsor of the proposal. WHO supported constitutionality and the rule of law and should therefore accept an open discussion on the participation of Taiwan as an observer at the Health Assembly. It went against principles of natural justice for the Organization to uphold the objections raised by the Government of the People's Republic of China without hearing and assessing Taiwan's position. Taiwan's participation as an observer, not as a Member State, touched on the very existence of WHO. The Organization had an ethical obligation to serve all human beings and to protect their health without any fear, discrimination or any other exclusions. The attainment of the highest possible levels of health for all people was fundamental and was reflected in several articles of WHO's Constitution. It was clear from the Constitution and practical experience that participation in WHO activities was not limited to Member States but also extended to other groups and organizations, as long as they subscribed to the Organization's objectives. There was no professional, moral, ethical or other sound reason for excluding Taiwan and its population of 23 million from WHO. Taiwan's observer status was a human rights imperative as well as a public health necessity, as evidenced by the recent response to infectious disease outbreaks, which required rapid identification and international support for their control.

The question of the observer status of Palestine had been considered at the Health Assembly for several years before it had been satisfactorily resolved, so it was not the first time that such matters had resurfaced.

If WHO marginalized the small and weak in response to political pressure from the large and strong, it would jeopardize its moral authority and institutional credibility. Many reputable international and national organizations and institutions, such as the World Medical Association and the United States Congress, had resisted such pressures, and WTO had admitted China and Taiwan as members. Why should WHO disagree?

The Memorandum of Understanding between China and WHO was an unusual expedient and raised more questions than it answered. It could not provide an adequate response on the matter, since it had been drawn up without any consultation with Taiwan.

The observer of PARAGUAY¹ expressed his country's support for the proposal. Recalling the theme of that year's World Health Day, to make every mother and child count, he said that the principle of universality enshrined in WHO's Constitution was far from being achieved. Taiwan's 23 million people had a right to direct, independent, comprehensive and immediate assistance and cooperation from WHO, and a right to participate in its activities. Communicable diseases did not respect geographical or political borders. Indeed, new diseases such as severe acute respiratory syndrome and avian influenza highlighted the need to enhance cooperation to prevent and contain the spread of infectious diseases; no potential risk could be ignored. Moreover, Taiwan had established the first universal health insurance system in Asia, and had eradicated infectious diseases such as plague, rabies, malaria and poliomyelitis. Clearly, Taiwan could and should contribute to improving public health in the world, and it deserved WHO's support and cooperation. Taiwan's participation in WHO was a moral, humanitarian and practical imperative, which should be dealt with in a pragmatic manner rather than from a political point of view in order to achieve universality and the attainment by all peoples of the highest possible level of health.

The observer of NICARAGUA¹ expressed support for inclusion of the proposed supplementary agenda item. The international community must take joint action to deal with the health problems that affected all, and, if there were to be no missing links in the world health system, Taiwan must be included. Indeed, having eradicated malaria, it could provide assistance to other countries in that regard. It should directly and independently participate in all WHO's activities and be in a position to share its concerns, strategies, programmes and activities; anything less could be detrimental.

The observer of PAKISTAN¹ regretted that the matter had been raised once again, diverting precious time away from the proceedings of the Health Assembly. Taiwan's participation as an observer would violate international law and the Constitution of WHO and was inconsistent with the established principle of interstate relations as laid down in the Charter of the United Nations. Pakistan firmly supported the one-China principle and considered Taiwan to be an indivisible part and province of China. The Government of the People's Republic of China had the sole responsibility for representing its provinces and territorial units in international forums, and inviting any province of China to the Health Assembly would infringe its territorial integrity and violate international law. The proposal was motivated by political considerations that called into question the one-China policy of the United Nations.

Pakistan welcomed the efforts of the Chinese Government to promote cross-Straits exchanges and recalled that, at the previous Health Assembly, China had put forward a four-point proposal to demonstrate its concern for the health of the people in Taiwan.² It was also his understanding that the Chinese Government had finalized a Memorandum of Understanding with the Secretariat to facilitate technical exchanges between Taiwan and WHO.

The observer of UZBEKISTAN¹ said that his country did not support Taiwan's independent participation in international organizations and therefore opposed the inclusion of the proposed supplementary agenda item. Political considerations should be taken into account and the matter should be resolved at a bilateral level between Beijing and Taipei. Taiwan's participation would run counter to the position and politics of one of the Member States of WHO.

The observer of SAINT VINCENT AND THE GRENADINES¹ said that his Government strongly supported the proposal. Taiwan's exclusion from WHO was detrimental not only to the people of Taiwan but to the global battle against the transmission of diseases in an era of globalization in which travel was increasingly commonplace. Diseases did not take account of national borders,

¹ Participating by virtue of Rule 32 of the Rules of Procedure of the World Health Assembly.

² Document WHA57/2004/REC/3, summary record of the first meeting of the General Committee.

sovereignty and territoriality. Taiwan was therefore entitled to be accepted within WHO and to participate in the Health Assembly as an observer; to do otherwise would deny it the fundamental benefits for which WHO had been established, namely the attainment by all peoples of the highest possible level of health. Nothing was politically right which was morally wrong, and it was morally wrong to exclude Taiwan, with its population of 23 million, from the Health Assembly.

The observer of ARGENTINA,¹ having expressed support for legal arguments put forward by the observers of Brazil and Uruguay, said that his country opposed the proposal. The People's Republic of China was the only legitimate representative of the Chinese people. It was regrettable that the matter had been raised once again in the Health Assembly.

The observer of INDONESIA¹ said that the proposal was essentially political and diverting precious time from pressing health issues. The resolutions on the matter already passed by the United Nations General Assembly and the Health Assembly must be respected. The Government of the People's Republic of China had signed a Memorandum of Understanding with WHO to remove any doubts about facilitation of support and exchanges while respecting the important principle of sovereignty. He therefore urged the Committee to reject the proposal.

The observer of MEXICO¹ said that her country supported the sovereignty and territorial integrity of the People's Republic of China and did not consider inclusion of the proposed supplementary agenda item to be in WHO's interests. The validity of the relevant resolutions adopted by the United Nations General Assembly and the Health Assembly should not be called into question.

The observer of BELIZE¹ said that the reason why countries continued to fight for Taiwan's participation as an observer was clear. Taiwan had been making every effort to participate for many years but had been continually refused for purely political reasons. Its absence not only violated the health rights of the 23 million people of Taiwan but also represented an important missing link in the global network of health and medical help. The theme of the World Health Day and the work of the Health Assembly should be consistent with the principle of universality enshrined in WHO's Constitution, and, if every mother and child really were to count, Taiwan should be allowed to participate as an observer.

The observer of NEPAL¹ expressed regret that, despite previous decisions, a proposal had again been made for Taiwan to participate as an observer at the Health Assembly. Recalling previously cited resolutions, he said that the People's Republic of China was the sole representative of China and the proposal therefore had no legal or constitutional basis. So far as health-related issues were concerned, the People's Republic of China had signed a Memorandum of Understanding with WHO to facilitate technical exchanges between Taiwan and WHO. Nepal supported the one-China policy; the issue of Taiwan was an internal affair for China to be resolved by the Chinese people themselves. Nepal considered that the proposal was an attempt to divert precious time from the important business of the Health Assembly.

The observer of CHILE¹ expressed his country's support for the one-China principle. Taiwan was an inalienable part of China and the Government of China was the only legal representative of the Chinese people. Taiwan, as a province of China, could not become a Member or Associate Member of WHO or participate as an observer.

¹ Participating by virtue of Rule 32 of the Rules of Procedure of the World Health Assembly.

The observer of SAINT KITTS AND NEVIS¹ said that her Government firmly supported the proposal. Taiwan could make a substantial contribution to international medical care, and its population of 23 million people should not be denied representation within WHO.

The observer of HAITI¹ said that a distinction should be drawn between an ad hoc and a permanent observer, and he noted that Taiwan's proposed participation as an observer was on an ad hoc basis. The People's Republic of China and Taiwan were both rich in medical experience that could be used to benefit developing countries. He supported the proposal, stressing that it was not intended to cause offence to the People's Republic of China.

The observer of MYANMAR,¹ expressing regret that the matter had once again been brought before the Health Assembly, said that the issue was political rather than health-related. Under WHO's Constitution, there were no grounds for admitting Taiwan in any capacity. He recalled the proposal made by the delegate of China at the Fifty-seventh World Health Assembly, since when the Chinese Government had adopted policies to implement that proposal, and he welcomed the Memorandum of Understanding signed by WHO and China to facilitate technical exchanges between Taiwan and WHO. Myanmar had consistently followed a one-China policy and enjoyed long-standing ties of close friendship with China. He urged the Committee to reject the proposal.

The observer of TANZANIA¹ expressed support for the Government of China as the sole representative of that country, of which Taiwan was an inalienable part. WHO was composed of sovereign States, and as Taiwan was not a sovereign State it could not become a Member or Associate Member of WHO, nor participate as an observer. The issue was not health-related but political, and it encroached on the internal affairs of China. He urged the Health Assembly to avoid dealing with political issues and instead to respect the territorial integrity of China as enshrined in resolutions adopted by the United Nations General Assembly and the Health Assembly.

The observer of HONDURAS,¹ pointing out that universal health was the only issue with which the Health Assembly should concern itself, reiterated his delegation's view, stated in previous years, that Taiwan should be admitted as an observer during the Health Assembly. It was Taiwan's fundamental right to have direct and unhindered access to up-to-date information from WHO concerning the prevention and control of diseases and to all the benefits of technical cooperation with the Organization. The request was not political but was based on human rights – the right to health and the right to information for Taiwan and its population of 23 million people – and the universality of WHO and its objectives. Taiwan, with its progress in health care, could make a substantial contribution to the work of WHO. He urged all Members to support the proposal and expressed the conviction that the perseverance of the international community would eventually lead to Taiwan being granted its right to be an observer at the Health Assembly.

The observer of PALAU¹ expressed support for Taiwan's application to participate in the work of the Health Assembly as an observer, recalling the arguments already given. It was not regrettable that the health wishes of 23 million people should be discussed again. As long as WHO continued to be the premier health organization for all the people of the world, the Member States, which subscribed to the ideals of the universality and total inclusiveness of the goal of health for all, should not shrink from their moral and ethical responsibilities to uphold those ideals, nor rest until the health needs, health concerns and health aspirations of Taiwan's population were properly met by the Health Assembly, in a democratic, transparent and non-politicized process. No Member State could in all conscience deny 23 million people access to the work of WHO while claiming "to make every mother and child count". Recalling the words of the outgoing President of the Health Assembly earlier in the

¹ Participating by virtue of Rule 32 of the Rules of Procedure of the World Health Assembly.

day, that nothing was politically right which was morally wrong, he urged all members to think not of politics but of health, humanity and fairness, and to invite Taiwan to join the Health Assembly.

The observer of MAURITANIA,¹ citing resolutions of the United Nations General Assembly and the Health Assembly, said that the issue of the representation of China had been resolved and should not be reopened, and that the sovereignty and territorial integrity of China should be respected. Including the issue of Taiwan as an agenda item not only went against those resolutions and the will of the vast majority of Member States, but also detracted from the important work of the Health Assembly, and he opposed its inclusion.

The observer of BELARUS,¹ recalling the bilateral agreements signed between his country and China, and the resolutions cited by previous speakers, said that there was only one China, of which Taiwan was an inalienable part, and as such Taiwan could not participate in any intergovernmental organization. Taiwan could achieve its aim of participating in the work of WHO through full cooperation with the Chinese Government, and he urged Member States to respect the territorial integrity and national unity of China.

The observer of TUVALU¹ strongly supported the proposal, since cooperation between all the peoples of the world, including the 23 million living in Taiwan, was essential if the goal of “the attainment by all peoples of the highest possible level of health” was to be achieved.

The observer of the DEMOCRATIC REPUBLIC OF CONGO,¹ regretting that the matter of Taiwan had been raised once more, said that, as a province of China, Taiwan could not be admitted to the Health Assembly as an observer, and that its health issues could be adequately addressed through the health-care programmes of the People’s Republic of China.

The observer of the DEMOCRATIC PEOPLE’S REPUBLIC OF KOREA¹ reiterated his country’s adherence to the one-China policy and rejected any proposal to invite Taiwan to participate in the Health Assembly as an observer. At the same time, he welcomed China’s proposal to include Taiwanese medical professionals in relevant WHO technical activities through cooperation with the Chinese Government.

The observer of NIGER,¹ recalling that only sovereign States could become Members of WHO, reaffirmed his country’s view that the People’s Republic of China represented all the Chinese people and opposed the inclusion of the supplementary agenda item.

The observer of FIJI¹ said that Taiwan ought to be granted observer status at the Health Assembly because WHO was the most important international organization in the fields of public health and disease control, which should be free from politics. As communicable diseases did not respect geographical or political borders, international cooperation to curb the spread of such diseases was essential. The fact that Taiwan had been barred from participation in the Health Assembly for more than 30 years for purely political reasons not only violated the health rights of the Taiwanese people but also seriously weakened the global network of health and medical care.

The observer of the SOLOMON ISLANDS¹ said that his country and other island nations in the South Pacific supported Taiwan’s participation as an observer in order that it might share its considerable resources and experience in health development and combating infectious diseases. The exclusion of Taiwan was not justified on any legal or political grounds. The fight against emerging diseases called for international cooperation, not division.

¹ Participating by virtue of Rule 32 of the Rules of Procedure of the World Health Assembly.

The observer of SENEGAL¹ said that his Government was in favour of including the supplementary item on the Health Assembly agenda. Such a step would be in keeping with WHO's principles and Constitution. The current exclusion of Taiwan meant that more than 22 million people were bereft of the health protection offered by WHO. That situation certainly did not serve the Organization's noble cause of promoting health worldwide.

The observer of BURUNDI¹ said that his Government recognized only one indivisible and sovereign China. The repeated discussion of the Taiwan issue amounted to a surreptitious attempt to endorse a process leading to the recognition of several Chinas. His delegation was therefore against the inclusion of that question on the agenda of the Health Assembly.

The observer of EL SALVADOR¹ firmly supported adding the proposed supplementary agenda item, since the people of Taiwan should no longer be denied access to a forum where the global control of diseases was discussed, especially as recent health emergencies had demonstrated the need for international cooperation and solidarity. His country therefore supported the universal participation of all health entities in the Organization, in keeping with the principles of the Charter of the United Nations and various human rights instruments. The awarding of observer status to Taiwan must not be interpreted as interference in the domestic affairs of a State, or as action to divide a sovereign State or impede its reunification, but would simply signify that WHO was prepared to include the people of Taiwan in the global health system and to listen to their views. It would not endanger the dialogue between Taiwan and the People's Republic of China. The admission of Taiwan as an observer was a moral, humanitarian and health issue.

The observer of SRI LANKA¹ said that, in view of the relevant United Nations General Assembly and Health Assembly resolutions, the proposal to grant Taiwan observer status at the Health Assembly was devoid of any legal basis. His Government did not, therefore, support that proposal and wished that the Committee would dispose of the issue so that it did not disturb the smooth functioning of the Health Assembly.

The observer of JAMAICA¹ said that his country did not support the proposal because his Government recognized the People's Republic of China as the sole legitimate representative of China. For that reason, he urged the Committee to reject the renewed attempt to include that item on the agenda of the Health Assembly, as that would be the only course of action consistent with the relevant United Nations resolutions, international law and practice, and the intergovernmental nature of WHO.

The observer of GUATEMALA¹ emphasized that WHO was the most important international organization in the health field and that its purpose was to ensure that all peoples attained the highest possible level of health, that being a precondition for world peace and security. Hence, it was impossible, for humanitarian reasons, to deny 23 million people access to the global health system. Her Government therefore supported the inclusion of the additional item on the agenda.

The observer of GUINEA-BISSAU¹ considered that the participation of Taiwan as an observer was unacceptable, since his country recognized the sovereignty of the People's Republic of China and was in favour of one China.

The observer of the LAO PEOPLE'S DEMOCRATIC REPUBLIC¹ said that it was a waste of time to discuss a point that had been rejected year after year. The anti-secession law adopted in March 2005 by the National People's Congress had reflected the Chinese people's strong will to protect their legitimate national integrity. Her Government therefore held that the one-China principle was the basis

¹ Participating by virtue of Rule 32 of the Rules of Procedure of the World Health Assembly.

for safeguarding regional peace and ensuring the peaceful unification of the nation. It accordingly opposed the inclusion of the supplementary agenda item.

The observer of KAZAKHSTAN¹ fully supported the position of the People's Republic of China in respect of the participation of Taiwan as an observer and also took the view that Taiwan was an integral part of the territory of the People's Republic of China.

The observer of the DOMINICAN REPUBLIC¹ was in favour of including the supplementary item on the agenda. His Government's position was based solely on health considerations and had nothing to do with legal or political issues.

The observer of CHAD¹ said that WHO should confine itself to health questions and not deal with political matters. Bacteria and viruses knew no borders. The inhabitants of territories could become the victim of disease in the same way as those of sovereign States. The 23 million people who lived in Taiwan should not be deprived of health protection. Given that it was the mission of WHO to help all the peoples of the world to attain the highest possible level of health, his Government strongly supported the proposal to include the supplementary agenda item.

The observer of NAURU¹ expressed firm support for the participation of Taiwan as an observer at the Health Assembly. The proposal was based on health concerns only. It had nothing to do with sovereign issues, nor was it a request for Taiwan's membership or associate membership of WHO. The delegate of the People's Republic of China had mentioned a Memorandum of Understanding that claimed to address Taiwan's participation in WHO activities, but that arrangement would not work because the Memorandum had been drawn up without consulting or involving Taiwan. Continuing to exclude the 23 million people of Taiwan from full and direct participation in all WHO activities went against the interests of all Members; furthermore, it was a professionally and morally unjustifiable act and a violation of the principle of universality enshrined in the WHO Constitution and in the goal of health for all. Taiwan deserved to be protected under the health umbrella of WHO. Nauru called on Member States to support the proposal and not be swayed by misplaced political considerations.

The observer of PAPUA NEW GUINEA¹ said that his country recognized the one-China policy. Taiwan was seeking to participate in the Health Assembly as an observer, however, not as a full Member, in order to allow the work of WHO to proceed without creating any political frictions and to demonstrate Taiwan's willingness to put aside political controversies for the common good of global health. The request was based on health grounds; it had nothing to do with political issues such as sovereignty and statehood. In accordance with its Constitution, WHO had an obligation to reach all peoples throughout the world, regardless of state boundaries. It was time to accommodate Taiwan as an observer.

The observer of COSTA RICA¹ said that WHO should be guided by the principle of universality, but that principle could not be fulfilled while the 23 million people of Taiwan were not allowed to participate in the activities of WHO. The proposal was being made for health and humanitarian reasons, not for political reasons.

The observer of THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA¹ expressed firm support for the position of the Government of the People's Republic of China.

The observer of BANGLADESH¹ said that his country strongly opposed the inclusion of the supplementary item on the agenda and reiterated its belief in the one-China principle. The issue of

¹ Participating by virtue of Rule 32 of the Rules of Procedure of the World Health Assembly.

Taiwan's participation had been settled long ago. United Nations General Assembly and Health Assembly resolutions had clearly established that Taiwan was a province of China and could not separately take part in any activities of WHO. The situation had not changed from past years when similar proposals had been rejected in both the General Committee and in plenary. At the Fifty-seventh World Health Assembly, the Chinese government had put forward a four-point proposal for dealing with Taiwan-related issues in WHO. As part of the implementation of that proposal, China and WHO had signed a Memorandum of Understanding on arrangements to facilitate technical exchanges between Taiwan and WHO. Taiwan thus had full access to health information and technical assistance from WHO. He found no compelling reason or change in circumstances that would warrant the tabling of a Taiwan-related item during the current Health Assembly. The issue had been discussed at length in plenary the previous year. In order to avoid further wastage of time, he proposed that when the Committee's recommendation on the proposal was discussed in plenary, the procedure should be followed whereby only two speakers in favour and two against would be recognized.

The observer of the MARSHALL ISLANDS¹ said that his country full supported the participation of Taiwan as an observer at the Health Assembly.

The CHAIRMAN said that, having heard the various speakers, in particular those members of the Committee, she took it that the Committee agreed not to recommend the inclusion of the supplementary item on the agenda and that a recommendation to that effect should be conveyed to the plenary. The agenda, as amended, would therefore be submitted in plenary later that day.

It was so agreed.

3. ALLOCATION OF ITEMS TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY (Documents A58/1 and A58/GC/1 Rev.1)

The CHAIRMAN said that the Committee's recommendations on agenda item 1 would be transmitted to the plenary meeting later that afternoon. Items 2-4 and 6-9 would also be taken up in plenary.

Given the workload facing Committee A she proposed that the following agenda items should be transferred to Committee B: item 13.12 (Cancer prevention and control), 13.13 (Disability, including prevention, management and rehabilitation), 13.14 (Public health problems caused by harmful use of alcohol), and 13.15 (International Plan of Action on Ageing: report on implementation). She suggested that the supplementary subitem on the WHO Framework Convention on Tobacco Control, the proposal for whose inclusion as a supplementary agenda item the Committee had accepted, should be considered under item 13.19 (Implementation of resolutions (progress reports)). Further, two subitems in item 13.19 should be discussed as separate items: Scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS (item 13.20) and International migration of health personnel: a challenge for health systems in developing countries (item 13.21), and Committee A should consider agenda item 13.2 (Achievement of health-related Millennium Development Goals) last.

It was so agreed.

¹ Participating by virtue of Rule 32 of the Rules of Procedure of the World Health Assembly.

The CHAIRMAN drew attention to the preliminary timetable prepared by the Executive Board.¹ A second meeting of the Committee was scheduled for Wednesday, 18 May. She proposed that a third meeting of the Committee should be held on Friday, 20 May to review progress and decide on any change in the allocation of items to the committees or alteration in the timetable, if necessary.

It was so agreed.

The General Committee then drew up the programme of work for the Health Assembly until Thursday, 19 May.

The CHAIRMAN drew attention to decision EB115(1) whereby the Executive Board had decided that the Fifty-eighth World Health Assembly should close no later than Wednesday 25 May 2005.

Referring to the list of speakers for the general discussion of agenda item 3, Address by Dr Lee Jong-wook, the Director-General, she suggested that the list would close at noon, Tuesday, 17 May. In the absence of any objections, she would inform the Health Assembly of those arrangements at the following plenary meeting.

It was so agreed.

The meeting rose at 15:00.

¹ Document A58/GC/1 Rev.1.

SECOND MEETING**Wednesday, 18 May 2005, at 18:15****Chairman:** Ms Elena SALGADO (Spain)
President of the Health Assembly**1. PROPOSALS FOR THE ELECTION OF MEMBERS ENTITLED TO DESIGNATE A PERSON TO SERVE ON THE EXECUTIVE BOARD (Document A58/GC/3)**

The CHAIRMAN reminded members that the procedure for drawing up the list of proposed names to be transmitted by the General Committee to the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board was governed by Article 24 of the Constitution and by Rule 102 of the Rules of Procedure of the World Health Assembly. To help the General Committee in its task, three documents were before it. The first indicated the present composition of the Executive Board by region, on which list were underlined the names of the 10 Members whose term of office would expire at the end of the Fifty-eighth World Health Assembly and which had to be replaced. The second (document A58/GC/3) contained a list, by region, of the 10 Members that it was suggested should be entitled to designate a person to serve on the Executive Board. The third document tabulated, by region, Members of the Organization that were or had been entitled to designate persons to serve on the Executive Board. Vacancies, by region, were: Africa, 4; the Americas, 1; South-East Asia, 1; Europe, 2; the Eastern Mediterranean, 1; and the Western Pacific, 1.

As no additional suggestion was made by the General Committee, she noted that the number of candidates was the same as the number of vacant seats on the Executive Board. She therefore presumed that the General Committee wished, as was allowed under Rule 80 of the Rules of Procedure, to proceed without taking a vote since the list apparently met with its approval.

There being no objection, she concluded that it was the Committee's decision, in accordance with Rule 102 of the Rules of Procedure, to transmit a list comprising the names of the following 10 Members to the Health Assembly, for the annual election of Members entitled to designate a person to serve on the Executive Board: Azerbaijan, Bhutan, Iraq, Japan, Liberia, Madagascar, Mexico, Namibia, Portugal and Rwanda.

It was so agreed.**2. ALLOCATION OF WORK TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY**

The General Committee heard a report from Dr SADRIZADEH (Islamic Republic of Iran), Chairman of Committee A, on the progress of work in that committee.

The CHAIRMAN proposed to review progress of work with the Chairmen of the committees and to revise the programme accordingly, if necessary.

It was so agreed.

The General Committee then drew up the programme of meetings for Thursday, 19 May and Friday, 20 May.

The CHAIRMAN reminded the Committee that it would next meet on Friday, 20 May, but proposed advancing the time of the meeting to 14:30.

It was so agreed.

The delegate of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, recalling that the Committee had deferred consideration of agenda item 13.2, Achievement of health-related Millennium Development Goals to the end of Committee A's deliberations, asked whether arrangements could be made for linking more closely the discussion with that of agenda item 22, Collaboration within the United Nations system and with other intergovernmental organizations, scheduled for debate in Committee B on Saturday, 21 May. Some countries were working on a resolution relating to the latter subject.

Mr AITKEN (Office of the Director-General) said that he would consult and report to the Committee at its third meeting.

The meeting rose at 18:30.

THIRD MEETING**Friday, 20 May 2005, at 14:35****Chairman:** Ms Elena SALGADO (Spain)
President of the Health Assembly**1. ALLOCATION OF WORK TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY**

The General Committee heard reports from Dr SADRIZADEH (Islamic Republic of Iran), Chairman of Committee A, and Dr WALCOTT (Barbados), Chairman of Committee B, on the progress of work in their committees.

In response to comments made in the two previous meetings, the CHAIRMAN proposed that agenda item 13.2, Achievement of health-related Millennium Development Goals, should be transferred to Committee B for consideration in sequence with agenda item 22, Collaboration within the United Nations system and with other intergovernmental organizations. She also proposed the transfer of agenda item 13.21, International migration of health personnel: a challenge for health systems in developing countries, from Committee A to Committee B.

It was so agreed.

The General Committee then drew up the programme of work of the Health Assembly until Wednesday, 25 May.

2. CLOSURE

After the customary acknowledgements, the CHAIRMAN declared the work of the Committee closed.

The meeting rose at 14:45.

COMMITTEE A

FIRST MEETING

Tuesday, 17 May 2005, at 09:20

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)

1. OPENING OF THE COMMITTEE: Item 10 of the Agenda (Document A58/1 Rev.1)

The CHAIRMAN welcomed the participants and introduced Mr Gunnarsson and Dr Yin Li, who would attend the Committee's meetings in their capacity as representatives of the Executive Board.¹ Any views they expressed would therefore be those of the Board, not of their national governments.

Election of Vice-Chairmen and Rapporteur (Document A58/48)

The CHAIRMAN drew attention to the third report of the Committee on Nominations in which Dr H. Ntaba (Malawi) and Pehin Dato Abu Bakar Apong (Brunei Darussalam) were nominated as Vice-Chairmen of Committee A and Dr R. Busuttil (Malta) as Rapporteur.²

Decision: Committee A elected Dr H. Ntaba (Malawi) and Pehin Dato Abu Bakar Apong (Brunei Darussalam) as Vice-Chairmen and Dr R. Busuttil (Malta) as Rapporteur.³

2. ORGANIZATION OF WORK

The CHAIRMAN encouraged delegates to limit the length of their interventions to three minutes. He suggested that the Committee should meet each day from 09:00 to 12:30 and from 15:00 to 18:00, the times to be adjusted, if necessary, in line with the progress of work. He proposed the transfer to Committee B of agenda items 13.12 (Cancer prevention and control), 13.13 (Disability, including prevention, management and rehabilitation), 13.14 (Public health problems caused by harmful use of alcohol) and 13.15 (International Plan of Action on Ageing: report on implementation). He also suggested that the Committee should consider item 13.7 (Poliomyelitis) immediately after the discussion of item 13.3 (Health action in relation to crises and disasters) and agenda item 13.2 (Achievement of health-related Millennium Development Goals at the end of item 13 (Technical and health matters).

It was so agreed.

¹ By virtue of Rules 44 and 45 of the Rules of Procedure of the World Health Assembly.

² See page 351.

³ Decision WHA58(4).

3. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda

Revision of the International Health Regulations: Item 13.1 of the Agenda (Documents A58/4, A58/41, A58/41 Add.1 and A58/41 Add.2)

Ms WHELAN (Ireland), speaking in her capacity as Chair of the Intergovernmental Working Group on Revision of the International Health Regulations, said that the Working Group, established by the Fifty-sixth World Health Assembly, had been able to fulfil its mandate and agree on a draft revision. Pursuant to resolution WHA48.7, the Secretariat had prepared an initial draft of the revised Regulations in January 2004. Consultations were subsequently held in all six WHO regions, the outcome being a text that had served as a basis for the Working Group's first session in November 2004, attended by some 500 delegates representing more than 150 Member States. Although progress had been made towards a consensus on key concerns, the work could not be completed in the two weeks allotted. A second session was therefore held from 21 to 26 February 2005 to review a new text prepared by the Chair on the basis of Member States' proposals. Some 160 Member States participated. Although agreement had been reached on most of the text, certain outstanding issues had remained unsolved. The session had been suspended and resumed on 12 and 13 May 2005, and a complete revised draft text had been endorsed by the delegates present on 14 May 2005.

All sessions had been marked by strong political will to finalize the work, respect for the positions of delegations and careful attention to practical consequences. Delegates had cooperated in regional groupings, and the final text stemmed from the willingness of many delegations to compromise for the sake of consensus. For reasons that would be reflected in the Working Group's official record, one delegation had been unable to agree to the draft revision as a whole and, in particular, to Articles 7 and 44. She appreciated the efforts of all delegates participating in the Working Group, particularly the officers, regional group coordinators and chairmen of the subgroups, drafting groups and other discussions. She also conveyed the thanks of all participants to the Secretariat for its support in every aspect of the work to finalize the text for consideration by the Health Assembly.

Dr BÁEZ (Dominican Republic) said that his country had attached great importance to the efforts to revise the International Health Regulations. Governments could not act in isolation, however, and had to give priority to international cooperation, especially in preventing the international spread of disease, as experience with severe acute respiratory syndrome (SARS) and avian influenza had shown.

The Dominican Republic had hosted one of the subregional meetings and had been one of the countries representing the Americas in the group of experts that had prepared Annex 2. It was pleased, therefore, that one of the principles underlying the Regulations was their universal application in order to protect the entire world from the international spread of disease, in accordance with the WHO's objective of achieving the highest possible health standards for all people. He trusted that the international community would be provided with an instrument capable of application by all, in good faith, for those purposes. It was to be hoped that his country's Congress would ratify the instrument within 18 months, as laid down in Article 59. The support of WHO and international cooperation were needed in order to give effect to the revised Regulations.

Dr SAMB (Senegal), speaking on behalf of the 46 Member States in the African Region, said that the decision at the Fifty-sixth World Health Assembly to establish an intergovernmental working group¹ reflected the inadequacy of existing legal mechanisms to deal with new challenges, as the outbreak of SARS had amply demonstrated. The task of developing an international legal instrument adapted to the new context had not been easy. He applauded the outcome, and paid tribute to the Chair

¹ Resolution WHA56.28.

of the Working Group. Although grounds for discouragement had not been lacking, her determination to succeed had made it possible to complete a text, after late-night negotiations, for submission to the Health Assembly. The Director-General, too, had spared no effort to advance the negotiations. He also thanked all parties in the negotiations for the spirit of openness and dialogue essential to the success of such a task.

The Region's Member States firmly supported the adoption by the Health Assembly of the draft revised International Health Regulations. That draft was a result of a triple balance which should be maintained. First, the need to provide a set of rules to cover epidemic prevention and response in the context of ever-growing movements of people and goods must be balanced against the need to respect human rights and the sovereignty of each State. Secondly, full cooperation with other bodies in the United Nations system on health promotion had to respect each of those bodies' mandates. Thirdly, the draft revised Regulations reflected a balance between the legitimate aim of dealing with epidemics and the actual response capabilities of the various parties – which meant that the established obligations and mechanisms must be realistic.

Although the draft revised Regulations were a step in the right direction, there remained many obstacles and success would depend on their effective handling. One related to Articles 21 and 29 on ground crossings; in that regard, the Region's Member States were proud to see documented, for the first time, regulations relating to terrestrial as well as air and maritime transport. The Region's Member States were also gratified that the draft revision took note of the capacity needed to give effect to the instrument. Another challenge was that of institutional architecture to promote implementation of the provisions that came under the exclusive responsibility of the Director-General. He invited the Director-General to take immediate steps to foster universal support for the revised Regulations. He looked forward to discussions on the draft resolution, noting that it requested the Director-General to draw up, in consultation with Member States, guidelines for the application of health measures at ground crossings in accordance with Article 29.

Dr AGARWAL (India) welcomed the finalization of the draft and commended WHO's efforts in that regard. India had held three national consultations and participated in regional consultations organized by the Regional Office for South-East Asia. The revision would significantly contribute to improved disease surveillance and response and ultimately ensure global health security. National capacities needed to be improved in order to ensure effective implementation of the revised Regulations.

Dr YUSHARMEN (Indonesia) said that Indonesia accepted all the articles and annexes in the revised draft. Describing the International Health Regulations as the key global instrument for protecting against the international spread of disease, he underlined the importance of capacity building, especially of human resource development, for their implementation, and called upon WHO to assist his country in that regard.

Mr LANGAT (Kenya) thanked the Secretariat and the Chair of the Working Group for their contributions towards bringing about the draft revised Regulations, which would be an important element in future efforts to control emerging and re-emerging diseases and to improve global health.

Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the Member States of the European Union, the acceding countries Bulgaria and Romania, and Croatia as a candidate country, said that the exemplary commitment of the Chair of the Working Group had enabled an agreement to be reached that was satisfactory to all. She thanked the Director-General and his staff for their indefatigable support to the process. The flexibility and spirit of compromise shown had enabled difficult decisions to be taken and reflected the broad commitment to public health at the global level. It was to be hoped that the Health Assembly would adopt the new instrument swiftly and by consensus.

Mr SEADAT (Islamic Republic of Iran), speaking on behalf of Member States of the Eastern Mediterranean Region, welcomed the draft revised Regulations as the culmination of a multilateral process that had not always been easy but which had been marked by a spirit of cooperation, a sense of pragmatism and flexibility. He expressed his appreciation to the Chair of the Working Group and her team for their hard work and perseverance. The final outcome was good and had the full support of Member States in the Region. The main objective should be to ensure the early adoption of the revised Regulations. He warned that any attempt to reopen the debate on points of detail would jeopardize the delicate balance that had been achieved in the final, provisionally agreed draft. He had taken note of the draft resolution and strongly supported a short, procedural text. The Region's Member States would take an active part in any consultation process established to tackle the issue at hand. Capacity building was crucial to the implementation process, for which financial, technical and personnel assistance would be required.

Dr TSHABALALA-MSIMANG (South Africa) observed that the African Region had spoken with one voice throughout the negotiations. The significance of that solidarity in ensuring that African issues were dealt with seriously and appropriately could not be overestimated. Revision of the International Health Regulations had been a matter of urgency, especially in the light of recent outbreaks of SARS and avian influenza and the health consequences of an international tragedy like the recent Asian tsunami. She congratulated the Director-General and his staff for organizing the Intergovernmental Working Group sessions, including the timely provision of documentation, and congratulated the Chair for her energy, commitment and skill in guiding what had been difficult negotiations. South Africa was satisfied with the outcome. The final draft represented a significant compromise and a delicate balance and should be adopted by the Health Assembly, by consensus, it was to be hoped. The effectiveness of the revised Regulations would depend on countries' ability to build and maintain the structures and systems necessary for their implementation. The capacity necessary for surveillance, preparedness and response to meet public health emergencies of international significance had to be put in place. She appealed to WHO – Member States and the Secretariat – to provide support as necessary, to enable African countries to meet their obligations under the new Regulations.

Professor HORVATH (Australia) strongly supported adoption of the revised Regulations and welcomed the new global cooperation they embodied. He praised the Working Group for the excellent outcome and its spirit of cooperation. He thanked the Chair for her leadership throughout the negotiations and to the Director-General and his staff for their commitment to the practical process, both of which elements had been crucial to the outcome. Implementation of the revised Regulations would bring significant benefits to Australia and the Western Pacific Region, and would encourage new public health partnerships and cooperation. The fact that pandemic disease did not respect borders, as the experience of SARS and avian influenza had clearly shown, combined with the dramatically increased speed with which disease could spread as a result of modern transport, had made it imperative that all those who could do so should contribute to disease control. Health security was not divisible, and only the universal application of the revised Regulations would ensure the protection of all. He therefore urged Member States and all others who would be involved in the new administrative mechanisms underpinning the Regulations to work fast and in the same spirit of cooperation that had marked the negotiations.

Mr CHO Choong-Hyun (Republic of Korea), congratulating the Working Group on the consensus reached, expressed full support for the revised Regulations and the draft resolution. In order to facilitate implementation of the new Regulations, his country would shortly begin work on reviewing and revising the relevant national legislation.

Dr HETLAND (Norway), welcoming the draft revised Regulations, observed that the previous Regulations would have been grossly inadequate if any of the 16 current verified outbreaks of infectious diseases with potential international implications turned into international emergencies.

Transparency, collaboration and balance best described the new format. Transparency would be increased as Member States notified the Secretariat of potential public health emergencies of international concern, triggering a process of verification of the event and determination of whether it constituted a public health emergency of international concern; increased collaboration would come about as WHO and the international community joined forces to assist the affected State to stop the outbreak; and an appropriate balance would be struck between the measures needed to stop epidemics and the need for international traffic and trade to continue, between national sovereignty and the need to protect the international community. He too praised the Chair of the Working Group for her part in bringing the negotiations to a successful conclusion, the Secretariat for its tireless work in support of the process, and participating countries for their willingness to find compromises. He encouraged Members to endorse the revised text.

Dr MADIES (Argentina), speaking also on behalf of Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay and the Bolivarian Republic of Venezuela, thanked the Director-General and his staff for their contribution in producing the draft of the revised Regulations and commended in particular the contribution made by the Chair of the Working Group. The resulting instrument represented a delicate balance between the responses States and the Secretariat could make in the face of major health risks and the need to avoid major obstruction to trade and the rights of the individual. She encouraged adoption of the draft resolution by consensus.

Dr MATSUTANI (Japan) said that Japan fully supported, and had been strongly committed to, the process of revising the International Health Regulations. He commended the efforts of the Secretariat and the Chair of the Working Group in achieving an outcome with which his country was content. The revised Regulations should come into effect at the earliest opportunity and serve as the key public health alert and response instrument at national and global levels. Japan expected the Secretariat to take the lead in enabling implementation of the revised Regulations and capitalizing on the opportunities they presented, including, where necessary, helping countries to build the core capacities required in technical areas such as surveillance and verification. WHO should also cooperate and coordinate its activities with other competent intergovernmental organizations whose skills might be needed in view of the enlarged scope of the revised Regulations. International collaboration was important in providing a public health response that prevented, protected against and controlled the international spread of disease. Japan was committed to full implementation of the revised Regulations within its own borders, and to continued support at an international level as a contribution towards global health security. Successful implementation of the revised Regulations would create a more effective infectious disease preparedness and response capacity.

Dr GAMBOA PEÑARANDA (Costa Rica) said that adoption of the revised Regulations was a major public health priority for his government. The 1969 Regulations were not adequate to cope with the new public health threats and risks. The new instrument, based on the principle of universality, would be an indispensable tool for ensuring an efficient, effective and swift response to international public health needs. He thanked PAHO for its assistance during the negotiating process and joined previous speakers in paying tribute to the skilful way in which the Chair of the Working Group had guided the negotiations, and to the support provided by the Director-General and his staff.

Ms GILDERS (Canada) said that from the beginning her country had been an active supporter of and participant in the revision of the International Health Regulations. Although the need to update the existing Regulations had long been recognized, the impact of SARS had underlined their importance for global collective health security. The revised Regulations would respond to the need for a more transparent and effective process for determining public health emergencies of international concern. Canada strongly supported their adoption and her Government would work with other Member States on their implementation. She expressed special gratitude to the Chair of the Working Group, without whose excellent stewardship and commitment the negotiations might not have reached

a successful conclusion, and praised the Director-General, his staff and PAHO for their hard work and support throughout the process of consultation and negotiation. She supported the draft resolution.

Dr PIRA (Guatemala) also thanked the Chair of the Working Group for her special contribution in bringing to a successful conclusion the revision of the International Health Regulations, which would constitute an indispensable tool in protecting people from the international spread of infectious diseases. Implementation of the revised Regulations should be universal and without any gaps that might jeopardize their effectiveness, so that people everywhere could enjoy the best possible health without any discrimination.

Dr MALEFOASI (Solomon Islands) too thanked the Chair of the Working Group and the Secretariat for helping to bring about a breakthrough in the negotiations in time for the current Health Assembly. He stressed the importance of Article 64, which covered States not Members of WHO. The recent outbreak of SARS had demonstrated the need for international support and transparency. He favoured allowing such States to be invited to participate in relevant meetings and conferences, in the interests of universal application. He strongly urged WHO to support national focal points in smaller countries with limited resources and capacity, such as those in the Pacific, to ensure that the basic requirements and technology were in place locally. He endorsed the draft revised Regulations.

Dr CHAOUKI (Morocco) said that his country, located as it was at a crossroads between Africa, the Arab world and Europe, was a popular route for migrants and thus particularly susceptible to the spread of communicable diseases. The International Health Regulations were a crucial tool for coordination but they must be applied with wisdom, calm and flexibility, qualities that were apparent in the revised version of Article 62, dealing with reservations to the Regulations. The epidemics of SARS and avian influenza and the resurgence of poliomyelitis in a number of countries showed how important it was to apply the Regulations strictly, while still safeguarding the freedom of movement of people and goods. That would require international cooperation, capacity building and the transfer of skills. It was to be hoped that the revised Regulations would be adopted by consensus and implemented as soon as possible.

Dr TENNAKOON (Sri Lanka) said that revision of the Regulations had become urgent following the emergence of new diseases and the resurgence of old ones. His country had taken measures to prepare for possible epidemics, although fortunately none had yet occurred. It had established a focal point for implementation of the revised Regulations; the responsible official had participated in the negotiations at regional level and in the Intergovernmental Working Group. An epidemic surveillance and response mechanism was already in place. His Government endorsed the revised Regulations. Developing countries, however, would need assistance with human resources, equipment and logistics if they were to meet the new requirements.

Dr AL-MAZROU (Saudi Arabia), noting that his country had participated fully in the regional and intergovernmental negotiations, supported the draft resolution. His country welcomed many foreign visitors and was well aware of the need to prevent the spread of disease. The proposed revision met the needs of States without impeding freedom of movement.

Mr YANG Xiaokun (China) expressed his satisfaction that the negotiations to revise the Regulations, which had gone on for almost 10 years in total, were concluding. He commended the experience and wisdom of the Chair of the Working Group, which had brought the negotiations to a successful conclusion. The revised text was the fruit of the concerted efforts of Member States. His country had participated actively and constructively in the negotiations. The Working Group had approved the revised text, despite certain reservations.

The universal application of the Regulations was a vital principle, which his country fully endorsed. The Regulations constituted an important international legal instrument, and it was incumbent on sovereign States to implement them.

The Health Assembly should adopt the revised Regulations at its current session, taking the first step towards their full entry into force. As the draft resolution had been issued only the previous day, his delegation was still studying it and would be willing to participate in any further exchange of views. He stated two points of principle. First, the draft resolution should emphasize the adoption of the revised Regulations as the final stage in the revision process and the first step towards their implementation by countries. Secondly, the remaining controversial issues should not be addressed in the draft resolution: above all, there should be no reopening of negotiations.

Mr HOHMAN (United States of America) strongly supported the draft of the revised Regulations. His Government would support their adoption by the Health Assembly, although he would point out the remaining issues of concern. In the meantime, he would participate in any informal discussions of the draft resolution.

Dr AL KHARABSEH (Jordan) also strongly supported the revised text. A fixed percentage of the WHO regular budget should be earmarked for training and capacity building in epidemiological and laboratory surveillance, since implementation of the revised Regulations would require many more trained staff than were currently available in most Member States in the Eastern Mediterranean Region.

Dr BLOOMFIELD (New Zealand) said that, despite its apparent geographical isolation, his country had not been spared the social, economic and health system effects of the SARS epidemic. New Zealand had participated fully in the negotiations to revise the Regulations and strongly supported the revised text.

Mrs HOMANOVSKA (Ukraine) said that her country, which had participated in all stages of the revision process, supported the final draft. The Regulations were an important tool for coordinating activities to prevent the spread of the most dangerous diseases. A consensus had been reached, thanks to the political will and flexibility displayed by Member States and the sterling work of the Chair.

Dr PREECHA PREMPREE (Thailand) congratulated the Director-General and the Working Group on the successful revision of the Regulations. However, much remained to be done before the Regulations could enter into force. He called on the Director-General and the regional directors to provide resources for capacity building in disease surveillance, investigation and rapid response, particularly in resource-limited States. Capacity building was a major priority of his country's Ministry of Public Health. His Government would work with WHO at regional and country levels to strengthen the infrastructure needed for implementation of the Regulations. He supported the draft resolution.

Dr KONTOROVSKY (Nicaragua) said that the original language of Article 3, paragraph 3 should be maintained in the draft resolution. The proposed revision would leave too much to the discretion of the Health Assembly, which met only once a year: it would thus be tantamount to leaving the decision to individual Member States. That would make it impossible to apply the principle of universality in practice.

Dr ACHARYA (Nepal) said that his country had held a national workshop and had participated in regional and intergovernmental negotiations. Nepal was committed to implementing the revised Regulations: however, that would require a strong and effective health-care delivery system and a systematic surveillance mechanism, particularly for countries like Nepal which had open borders with their neighbours. He supported the draft resolution.

Mrs NADAKUITAVUKI (Fiji) welcomed the efforts of individuals, organizations and Member States that had led to the draft revised Regulations. Her country had been involved in the negotiations at regional and international levels. The Regulations formed the main global framework to prevent the

international spread of disease. Member States must cooperate and increase their capacity to implement the Regulations in the immediate future; WHO technical assistance would be essential in that area. She strongly supported the draft resolution.

Dr MOHAMMAD (Oman) said that many countries, especially those in the Eastern Mediterranean Region, would require technical support in implementing the revised Regulations. Funding should be made available from WHO's regular budget.

WHO must cooperate with other international organizations whose spheres of competence would be affected by diseases such as SARS. Bodies associated with trade, tourism or transport would be adversely affected by an epidemic. An international fund, perhaps financed by a small levy on air travel, should be set up to support implementation of the Regulations and provide funding for the training of human resources. He supported the draft resolution.

Mr SHEIKH (Pakistan) said that the revised text of the Regulations agreed upon by the Working Group represented a delicate balance, which must not be upset when the draft came before the Health Assembly for adoption. He called on all Member States to facilitate the adoption process.

Health was a fundamental human right, but the capacity to improve the health of the population varied from State to State. WHO must provide as much assistance as possible in capacity building to promote the implementation of the Regulations.

Dr M'BENGUE (Côte d'Ivoire) said that, during the revision process, her country had expressed its concerns, particularly those related to definitions, mechanisms and the applicability of the Regulations. Some points had been taken into consideration, notably the inclusion of points of entry and departure used by trains and road vehicles and the emphasis on resource mobilization for developing countries. Her Government's request for a reference to respect for human rights at the beginning of the revised Regulations had been partially fulfilled. However, one issue raised by African countries that had not yet been resolved was the balance to be maintained between the mandate of WHO and the sovereignty of individual States. Some States had been reticent about the procedures for expressing an objection to a reservation as laid down in Article 62, including the time limit for expressing a reservation and the number of States that needed to agree for the reservation to be accepted.

Mr WANGCHUK (Bhutan) endorsed the revised text of the Regulations, and commended the work of the Secretariat and the Working Group. The revised Regulations would have an immense impact on disease surveillance, but their implementation would require adequate resources. WHO's stewardship would be important.

Mr RECINOS TREJO (El Salvador) said that the revised text represented a delicate compromise which his Government supported. The Regulations were vital in order to ensure an immediate response to international public health emergencies, but, if they were to be fully implemented, they must be universally applicable and all States must be involved. He commended the dedication and excellent work of the Chair of the Working Group and the Director-General and his staff.

Mr ABID (Iraq) said that the International Health Regulations were vital in helping to safeguard the health of citizens. His Government therefore fully supported the revised version. A specific issue for Iraq was the existence of holy places in several cities, visited every year by thousands of people from both within Iraq and abroad. Over the past two years, the relevant Iraqi authorities had discovered that such visitors had imported many items as food that were unfit for human consumption. A working group had been set up to prepare the mechanisms needed under the International Health Regulations, but Iraq would require technical support to ensure their proper implementation. He fully supported the draft resolution.

Dr BETHEL (Bahamas), speaking on behalf of the Member States of the Caribbean Community, also supported the revised International Health Regulations. As small island developing states with economies relying heavily on tourism, they welcomed the strengthening of the Regulations as a means of containing and managing communicable diseases. Those States would work dutifully to fulfil all aspects of the Regulations, but many such States would require technical support from WHO. He supported the adoption of the draft resolution and early implementation of the revised Regulations.

Mr STARODUBOV (Russian Federation) commended WHO's work in revising the International Health Regulations. Much work had gone into agreeing the guiding principles for the revision, and consensus had been achieved on the difficult issues. All that created a firm basis for the successful implementation of the revised Regulations, to maximize health protection while minimizing disruption of movement of people and goods. Work nevertheless had to be stepped up directly in countries, both in strengthening national surveillance systems and in bringing them into line with the revised Regulations. Without such coordination of diverse surveillance systems and information sources, there could be no reliable harmonious and effective activity under the new Regulations. He supported the revised Regulations and the draft resolution.

Dr MBAIONG MALLOUM (Chad) expressed satisfaction with the outcome of the negotiations on the International Health Regulations and paid tribute to the Chair of the Intergovernmental Working Group. His country had participated in the entire revision process. The revised Regulations constituted a valuable weapon in the fight against the spread of disease, were well crafted, complete, and had been agreed by most members of the Working Group. Chad therefore keenly sought their adoption by the current Health Assembly.

Ms VALLE (Mexico) acknowledged the excellent work of the Chair of the Intergovernmental Working Group, the Secretariat and all the participants, who had shown great flexibility during the negotiations. Mexico was basically in agreement with the wording of the draft resolution, but considered that it might be necessary to set up a drafting group, in which she would be pleased to participate in a constructive spirit, recognizing the desirability of achieving as quickly as possible a final wording that would permit adoption of the revised Regulations during the current Health Assembly.

Dr ESTÉVEZ TORRES (Cuba), acknowledging the patience and hard work of the Chair of the Working Group, noted that health problems were a foremost priority for Cuba, whose achievements in the health field were jealously preserved and had been recognized by the international community. However, its advances were seriously impeded by a lack of access to medicines and medical and diagnostic equipment, due to the unilateral economic and financial blockade applied by the United States of America against Cuba in breach of international law. Cuba had participated actively in the negotiations on the International Health Regulations and had attempted to reflect its accumulated health experience in the resulting text. Unfortunately, insufficient account had been taken of its concerns with respect to access to medicines and medical and diagnostic equipment, a matter of concern to all developing countries. He had taken note of the wide support expressed for the revised version of the International Health Regulations but considered that delegations should be given a chance to discuss the draft resolution for adoption of the revised Regulations with a view to achieving the consensus needed. He was willing to continue working within whatever framework the Chairman considered appropriate.

Dr LEVENTHAL (Israel) remarked that, for many years, health professionals had wondered why the International Health Regulations of 1969 were still in place. Those who had taken part in the work of the Intergovernmental Working Group currently understood the reason. Israel was convinced that the new version of the Regulations would similarly stay in place for decades to come. The outcome of the negotiation process was an outstanding achievement by the Chair of that Group and her team, the Director-General and his staff and all Member States. Drawing attention to the need for

enthusiasm and cooperation during the implementation period, he called for adoption of the draft resolution.

Dr AZMI bin ABDUL RAHIM (Malaysia) observed that recent catastrophic events had demonstrated the need for revision of the International Health Regulations, to make them both current and relevant. The proposed revised version would encompass the needs of all Member States. The decision instrument in Annex 2 to the Regulations would be the key to achieving global health security. Although the revised Regulations would assist Member States in identifying, verifying and responding to public health emergencies of international concern, in some countries, including Malaysia, surveillance and response had to be improved at all levels of the health-care system. His Government was reviewing its national legislation, particularly that regulating the import and export of human tissue, human remains and pathogenic organisms, and was pleased to note that the revised Regulations would cover that area. Malaysia awaited any guidelines that WHO might introduce in the future to assist countries in implementing the revised Regulations.

Dr YOOSUF (Maldives) welcomed the commitment shown by WHO to revise the existing International Health Regulations, which were widely recognized as inadequate to tackle emerging global health threats and expressed satisfaction with the outcome. Given the desirability of adopting the revised Regulations in advance of any fresh pandemic, there should be no reopening of issues already resolved after much discussion.

Mr NASSER (Egypt) said that his country had positively contributed to the revision and negotiation processes at all phases of the work of the Intergovernmental Working Group, convinced of the importance of the International Health Regulations in protecting the world at large from the threat of epidemics. Supporting the draft resolution, he called on the Secretariat to provide the necessary support in order to help countries to implement the revised Regulations, especially training of personnel and support to the necessary laboratories.

Dr BRIEM (Iceland), recalling that Iceland had participated in the work of the Intergovernmental Working Group, expressed the hope that the revised International Health Regulations would be adopted at the current Health Assembly. He commended the efforts by the Chair of the Working Group and the Director-General and his staff to bring the work on the Regulations to a successful conclusion.

Dr OTTO (Palau) also acknowledged the hard work of the Chair of the Intergovernmental Working Group and all those who had participated in the negotiations. The International Health Regulations were of extreme importance to Palau, especially in view of its experience with SARS and the potential threat of avian influenza. Strengthening capacity for surveillance and rapid response was also critically important. Drawing particular attention to subparagraph 4(6) of the draft resolution, on universality of application, he expressed the hope that that would include the 23 million people of Taiwan.

Mr YANG Xiaokun (China), rising to a point of order, objected to the raising of an issue that had no bearing on the matter under discussion.

Mr ZAPATA (Honduras) congratulated the Chair of the Intergovernmental Working Group, and expressed full support for the revised International Health Regulations. He urged that they be applied effectively, comprehensively and universally, since only in that way could they be of benefit to the health and well-being of all peoples of the world, and supported adoption of the draft resolution as submitted.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland), speaking as the regional coordinator for the European Region on behalf of those European Member States that had not

yet spoken, expressed appreciation for the work of the Chair of the Intergovernmental Working Group and the Secretariat, both in Geneva and particularly in the Regional Office in Copenhagen, in supporting the revision process.

From the outset, the Member States of the European Region had fully supported the need for revised International Health Regulations and the revision process, in order to take account of developments since 1969 and the importance of enhancing protection of global public health. Support for the text that had been finalized the previous weekend was becoming evident in the discussion. With regard to the draft resolution, he confirmed that the Member States of the European Region were committed to collaborating in drawing up a resolution that would seek adoption of the revised International Health Regulations as set out in document A58/4.

Dr CHITUWO (Zambia) noted that, pursuant to resolution WHA48.7, his country had been involved in the consultative revision process since 2001, including attendance at the meetings organized by the Regional Office for Africa and headquarters in Johannesburg in April 2004. Before the first session of the Intergovernmental Working Group in November 2004, Zambia had gathered regional consensus views. It had been a member of the Expert Advisory Group which had reported to the second session of the Working Group in February 2005. He was confident that the revised Regulations, when adopted, and the leadership of WHO would enable each country's health-related requirements to be met.

Ms THOMPSON (European Commission), speaking on behalf of the European Community and in support of the statement by the delegate of Luxembourg, recalled that the European Community had negotiated the International Health Regulations with a view to obtaining speedily a strong set of international rules that would better protect the world from disease risks. The revised version fulfilled that aim. The next challenge was implementation. Several provisions in the revised Regulations fell under the competence of the European Community and could not be put into practice properly without recourse to its rules and decision-making practices. That would involve screening the European Union's legislation to see how it could be improved to ensure the best protection as prescribed in the new Regulations. The common will of the European Union to prevent and protect against the spread of disease had been clearly demonstrated by the setting up of the European Centre for Disease Prevention and Control, in Stockholm, which would link with WHO's Global Outbreak Alert and Response Network and play an important role in effectively implementing and enforcing the revised International Health Regulations.

Dr AL-KHAYAT (United Arab Emirates), after expressing appreciation to the Director-General and his staff and all who had worked so hard in the Intergovernmental Working Group, said that with the discussions completed the time had come for prompt action. Consequently, the United Arab Emirates supported the revised version of the International Health Regulations.

The CHAIRMAN announced that an open-ended drafting group would be working on the wording of the draft resolution contained in document A58/4; he proposed that it be chaired by Mr Silberschmidt of Switzerland.

It was so agreed.

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

Health action in relation to crises and disasters: Item 13.3 of the Agenda (Resolution EB115.R11; Documents A58/6 and A58/6 Add.1)

Dr YIN Li (China, Representative of the Executive Board), introducing the agenda item, said that, with one Member State in five affected by humanitarian crises and disasters, the topic was particularly important, not only for the affected individuals but for the world's population. At its 115th session in January 2005, the Executive Board had emphasized the importance of rapid recovery of public health systems and essential health services following disasters, the need for Member States to invest more in risk management, vulnerability reduction and disaster preparedness, and the importance of community participation in that work. Board members had stressed the need for responses in times of crisis to focus on the needs of all people, particularly women and children, older people, persons with psychological and physical trauma and those at risk of or affected by diseases. Member States had been urged to do more to protect all health personnel involved in providing humanitarian relief.

The Board had requested the Director-General to intensify WHO's support to communities affected by disasters, particularly with regard to communicable disease surveillance, water, hygiene and sanitation, mental health, management of bodies, and forensic medicine, and to do more with the media to dispel myths, to coordinate more closely with national and international bodies and to assist with the redesign of health services in affected communities. It had further requested the Director-General to redesign, where necessary, the area of work covering emergency preparedness and response, to secure adequate funding and to establish clear lines of command in order to facilitate rapid and effective early response. WHO had been asked to ensure that reliable health assessments were undertaken during and after disasters and crises, that health-related action was coordinated in a way that responded to those assessments, that gaps in response were identified and filled, that local and national capacities were built up, and that logistical services within the Organization were strengthened. WHO had also been asked to foster continued and active cooperation with the International Strategy for Disaster Reduction, thereby ensuring adequate emphasis on health-related concerns in the implementation of the outcomes of the World Conference on Disaster Reduction (Kobe, Hyogo, Japan, 18 to 22 January 2005).

Dr NABARRO (Representative of the Director-General for Health Action in Crises) stressed that WHO's health action in relation to disasters embraced a wide range of expertise spanning the entire Organization. Discussions at the Conference on the Health Aspects of the Tsunami Disaster in Asia (Phuket, Thailand, 4 to 6 May 2005) had therefore involved a broad spectrum of health response issues. Participants had concluded in particular that governments needed to prepare better for major disasters by increasing their ability to incorporate health issues into the management of disaster risks and by reducing the vulnerability of their people. That required updating policies and legislation, restructuring disaster-management authorities and securing the necessary financing. Furthermore, immediately after a disaster, there was an absolute need for prompt assessments of health needs and for effective health-programme management.

Such needs assessment must provide population-based information, expressed as rates and not absolute numbers. WHO had been asked to encourage coordinated needs assessment and follow-up data in order to monitor vulnerable populations and facilitate planning and management of interventions. It had also been asked to help to provide updated, evidence-based guidance and support for professional networks in the areas of psychological trauma and mental ill-health, nutritional threats, women's health, child health and nutrition, and the management of corpses, including the use of forensic medicine. The management and coordination of disaster responses involving large numbers of external groups also needed to be improved through more practical steps, which should include providing support to national authorities for the health aspects of such coordination, even to the extent of directing and controlling external offers of human resources, equipment and materials. Effective supply systems and logistics had also been identified as being critical to disaster management. Logistical capacity was a prerequisite for ensuring that external support did not impose additional burdens on affected communities. WHO had been asked to work with other agencies to provide

additional logistics support; work with nongovernmental organizations had been suggested to help to ensure that they contribute fully to the health aspects of emergency responses through more efficient coordination and effective action.

The Conference had also approved public and private financial support for emergency preparedness and response, indicating that funding should be timely, sustained, appropriate and flexible enough to be applied to emerging needs. The involvement of private and military groups in the response to the tsunamis of December 2004 had generally been considered positive, but concerns had been expressed about their ability to operate within accepted humanitarian principles. Careful work was therefore needed to understand the motives and fears of different parties and ensure cooperation between relief workers, military forces and private-sector groups. Journalists had been identified as key partners in shaping the policy agenda for disaster preparedness and response, and the Conference had asked WHO to establish more effective relations with key media groups to advance work on health issues and dispel the myths that hindered response efforts. It had called for complete transparency on the part of all humanitarian parties in terms of standards of performance, accountability principles and the extent to which they encouraged the participation of affected communities. The Conference had agreed on the need to ensure improved capacity for vulnerability reduction and disaster preparedness. WHO had committed itself to follow-up and reporting back to participants within the ensuing six months on progress made in applying the lessons learnt to future disaster response efforts.

The meeting rose at 12:20.

SECOND MEETING

Tuesday, 17 May 2005, at 15:10

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Health action in relation to crises and disasters: Item 13.3 of the Agenda (Resolution EB115.R11; Documents A58/6 and A58/6 Add.1) (continued)

Dr AGARWAL (India), welcoming the comprehensive draft resolution, said that India had several institutions with the capacity and skills to provide prompt assistance in crises and disasters. The tsunami of December 2004 had engulfed coastal areas in five Indian States and island territories, taking a heavy toll on life and property. With its experience in evolving mechanisms to respond to the health aspects of such crises, India had provided prompt health care to stricken neighbours and its own population.

Such disasters provoked a variety of psychiatric problems; knowledge of the such consequences would facilitate early interventions and thus foster speedy rehabilitation. He therefore suggested that paragraphs 2 and 3 of the draft resolution should contain a separate reference to “mental health service needs and service delivery models in disaster-affected populations”.

Dr BELLO DE KEMPER (Dominican Republic) said that her country had first-hand experience of the negative consequences of natural disasters. She therefore supported the draft resolution. She agreed with the conclusions of the Conference on Health Aspects of the Tsunami Disaster in Asia (Phuket, Thailand, 4 to 6 May 2005), which emphasized the development and coordination of national capacities, including education. As natural disasters were largely outside human control, international preparedness was important to enable national authorities to avoid disease outbreaks, and to re-establish health services in affected areas – in 2004, natural disasters in her country had severely damaged several rural clinics. She welcomed the strengthening of WHO’s commitment to help countries and health professionals to apply the experience gained from coping with such disasters and commended its efforts during the Asian crisis.

Professor BELATECHE (Algeria), speaking on behalf of Members States of the African Region, said that the health-sector response to disasters was a new and important aspect of public health. The African Region was working towards improving the health and socioeconomic well-being of its peoples, but faced catastrophe every day through child mortality (including deaths from malaria), HIV/AIDS (from which 2.3 million people died annually) and epidemics such as that of Marburg haemorrhagic fever in Angola. Common illnesses became more lethal during a disaster, and people in the most vulnerable groups suffered more and ran a greater risk of dying. Each year, one of WHO’s regions was faced with a humanitarian disaster that disrupted local health systems. Hundreds of millions of people were at risk, and more than 40 million lived in crisis conditions. An effective, rapid, well-planned response, including recovery mechanisms for health services, was crucial to reduce avoidable loss of life, epidemics and disability.

She welcomed the setting up of the Department of Health action in crises and commended WHO’s prompt response to recent crises and the establishment in 2003 of a three-year programme for strengthening its response to disasters. She acknowledged the remarkable support given by the international community. African Member States were concerned about the decrease in the regular budget allocation to that area of work and she urged the Director-General to intensify support for

tsunami-affected States; to continue providing technical support and guidance; to encourage cooperation between WHO and other international organizations, donor agencies and national governments; to mobilize international funding to develop operational capacity; to increase WHO's material support for tackling the health aspects of disaster preparedness and the situation of permanent catastrophe in Africa; and to allocate more resources from the regular budget to health action to enable WHO to contribute effectively to crisis preparedness and response.

She stressed the urgency of developing partnerships to provide sustained financial support to health systems in general and in African countries in particular to help them upgrade their plans for disaster preparedness.

Mr JAYATHILAKE (Sri Lanka), recalling that Sri Lanka had been one of the countries most affected by the tsunami, thanked WHO for prompt assistance and all the countries that had provided assistance. The disaster had caused nearly 38 000 deaths and displaced one million people; 89 health centres, including some big hospitals, had been seriously damaged. Despite its limited resources, Sri Lanka had responded by deploying thousands of health workers from other areas and, with the help of WHO and other agencies, establishing temporary health-care facilities and a preventive health-care programme. Epidemiological teams had been sent to the affected areas from the second day of the crisis. Currently, long-term health care and rehabilitation, were being provided with the help of several countries, United Nations agencies and nongovernmental organizations. He strongly supported the draft resolution.

Dr RAHMAN KHAN (Bangladesh) commended the important and timely reports. Many countries, including Bangladesh, had to face such events, and more emphasis was needed on ways and means of reducing their human, economic and environmental costs. He emphasized the importance of enhancing national disaster preparedness and risk management, including the need for national action plans; disease surveillance and a global alert and response network for emerging diseases; an early warning system and prompt communication through the media; international cooperation and assistance, especially for developing countries; and the important role of national and interagency cooperation in the management of disasters.

Dr MATSUTANI (Japan) said that emergency disaster response was essential for preventing further damage, such as disease epidemics. Japan commended the efforts and cooperation of the affected countries, international organizations and nongovernmental organizations in responding to the earthquakes and tsunamis. Coordination was important to avoid duplication, and he commended WHO's efforts in that domain. Japan had sent disaster relief teams to the affected countries and was also supporting recovery and reconstruction efforts. It had donated US\$ 6 million for WHO emergency activities. The World Conference on Disaster Reduction (Kobe, Hyogo, Japan, 18 to 22 January 2005) had adopted the Hyogo Declaration and Framework for Action 2005-2015 outlining priorities for the next International Decade for Natural Disaster Reduction. Japan would strengthen its efforts in disaster reduction and would continue to cooperate on emergency responses through, inter alia, the establishment of a global tsunami global warning system in the Indian Ocean.

Dr PECORARO (Italy) said that her Government had responded immediately and effectively to the tsunami in south-east Asia, working with in-country humanitarian organizations, local and national authorities and nongovernmental organizations. She acknowledged the great collaboration between all the stakeholders, especially within the European Union. In the first phase, her Government had set up an operations room to support the emergency task force, which had been already in place 12 hours after the alarm, working closely with national authorities to meet the immediate needs of the local population and international tourists. Italy had quickly repatriated more than 4000 people. Specialized health staff, with medical treatment kits and technical support material, were mobilized on 27 December from all Italian regions. Those staff had worked in local hospitals, collaborating closely with local staff. Advanced medical posts and field hospitals had been set up in various areas, some of which would continue to function until the reconstruction of local hospitals. In the post-emergency

phase, the field hospitals ensured essential services, especially to the most vulnerable segments of the population. Priority had also been given to provision of safe water, sanitation, food and shelter. In the second phase, the Italian Government had worked with numerous organizations to restore health systems and help the population to return to normal life. Projects focused on housing, schools, hospitals, fisheries, water and sanitation had been implemented.

She reaffirmed Italy's interest in health emergency responses. All Member States needed support to improve their preparedness for, emergency response to and recovery from a disaster and to respond as Italy had done to such an event.

Mr ABID (Iraq) expressed thanks for the comprehensive documentation and WHO's unfailing support for health activities in Iraq since the first days of the recent military action. It had helped Iraq to cope with emergency situations and in reconstruction. Although the reports referred to natural disasters, Iraq was faced with the manmade disaster of violence and terrorism, which not only caused the deaths of many people but also resulted in the loss of financial and human resources. An operations room had been set up for rapid response to emergency situations, but the biggest challenge was lack of an early warning system. It was difficult to protect schools and markets. Iraq had tried to rebuild its health system and had prepared long-term strategies and priorities to improve health services; nevertheless, it still lacked the capacity to set up an effective system and needed WHO assistance. Owing to the current situation, the United Nations was not sending experts to his country. It was to be hoped that exceptions would be made, especially in regard to emergency situations. He supported the draft resolution.

Dr MUHARSO (Indonesia) said that the unprecedented scale of the disaster due to the earthquake and tsunami had caused untold suffering in at least 12 countries, but the worst hit area had been the province of Aceh in his country, where more than 128 000 people had been killed, over 93 000 were still missing and upwards of 600 000 had been internally displaced. The Government and people of Indonesia were sincerely grateful to WHO, UNICEF and other United Nations agencies, nongovernmental organizations and the governments of some 37 countries, whose support had helped to alleviate the plight of the people of Aceh. Despite difficulties on the ground, the concerted relief effort had succeeded in preventing epidemics of cholera, malaria and dengue fever. His Government hoped that it would soon be able to improve its national disaster preparedness and issue manuals on disaster management which would be widely used at national, provincial and district levels.

The CHAIRMAN expressed the deep regret of all present about the fate that had befallen the peoples of Indonesia and of other areas hit by the tidal wave.

Dr THAKSAPHON THAMARANGSI (Thailand) voiced his Government's deep gratitude to the international community for contributing to his country's recovery from the consequences of the tsunami. It also appreciated WHO's assistance, particularly crucial technical support. The important lesson learnt had been that international cooperation and preparedness were crucial for crisis management, as a disaster-stricken country was unlikely to be able to cope alone.

Disaster preparedness programmes should be given the same priority as response and rehabilitation measures. Although it was extremely difficult to prepare for disasters, the establishment of an effective early warning system would help to minimize loss of life. Action to mitigate the health impact of catastrophes should disregard ethnic, religious, gender or political considerations.

Natural disasters were only one type of crisis; any preparedness, response and recovery programme should cover a whole range of eventualities. He therefore proposed the addition in the draft resolution contained in resolution EB115.R11 of a new subparagraph in paragraph 2, which should read "to strengthen the information system, including by working closely with national and international media to provide accurate and updated information". In paragraph 3, a phrase should be inserted in subparagraph (8), which would then be worded "to mobilize WHO's own health expertise, to increase its ability to locate outside expertise, to effectively secure the collaboration of local and international expertise, to ensure that such knowledge and skills are updated and relevant and to make

this ...". A new subparagraph should be included in paragraph 3 requesting the Director-General "to develop the post-crisis health impact rapid assessment model and guidelines to support a prompt and effective response to affected communities."

Mr McKERNAN (New Zealand) said that his Government supported the draft resolution and encouraged other Member States to engage in collective efforts to establish global and regional preparedness plans covering all kinds of hazard. WHO should link its plans for responding to natural disasters with those for dealing with pandemics and other major public health emergencies, as much of the basic infrastructure required was similar, regardless of the catastrophe.

Dr YAN Jun (China) supported the draft resolution, as experience had shown that effective emergency preparedness and response on the part of health authorities, coupled with close international cooperation, could greatly reduce not only the immediate effects of disasters but also ensuing casualties and health risks. After the earthquake and tidal wave on 26 December 2004, the Chinese Government had also provided material assistance and had sent medical relief teams to the stricken countries.

In order to prevent health problems arising in the aftermath of disasters and crises and to streamline disaster prevention and relief, it would be advisable to establish a network for collecting information and reporting on casualties and any outbreaks of disease. Depending on the nature of the disaster, it would be necessary to define the diseases that should be monitored and to set up monitoring points. Various emergency plans should be formulated, and stocks of goods and materials should be kept in reserve for contingencies. Relief teams must be formed and technical training provided. Communication among different sectors ought to be strengthened. It would also be desirable to educate the public about possible health risks stemming from disasters.

The effects of the tsunami had shown that national preparedness and international cooperation should be strengthened to prevent and manage disasters. At the same time, it was essential to prevent the occurrence of international public health emergencies. WHO should therefore continue to mobilize resources, promote epidemic surveillance, share information and coordinate activities to enhance its ability to deal with such emergencies.

Mr DI BARTOLOMEO (Luxembourg), speaking on behalf of the Member States of the European Union, the acceding countries Bulgaria and Romania and the candidate countries Croatia and Turkey, announced that Turkey also endorsed the European Union's stance on the International Health Regulations. Despite the huge number of deaths and the health threats caused by the tidal wave in south-east Asia and Africa five months earlier, the ceaseless efforts of the governments of the countries concerned, local communities and the international community had prevented the outbreak of any major epidemics. Although early warning systems and other measures to prevent disease had been put in place, the stricken communities were still vulnerable to further tsunamis. Moreover, assistance from the international community was still needed to prevent disease in those countries where the health systems had been severely weakened.

The Member States of the European Union had noted with satisfaction the ability of WHO to mobilize resources and take action in such crises. Thus, in early January 2005, they had entrusted WHO with the coordination of health aid to the countries affected. In June, their health ministers would be meeting with the Director-General to take stock of the assistance supplied and of that still required for rebuilding health systems. The European Union appreciated the quality of its institutional cooperation with WHO. The time had come to ensure a harmonious transition from the provision of emergency aid to the task of rehabilitating and rebuilding the devastated areas. Like WHO, the European Union gave priority to the rehabilitation of health systems in order to enable the countries concerned to withstand catastrophes better. At the same time, it was essential to look at ways of preventing disasters.

HIV/AIDS, tuberculosis and malaria worsened people's vulnerability to natural threats in the poorest countries. Donor fatigue in the wake of the tsunami should not result in the neglect of other

humanitarian needs elsewhere in the world. For that reason, the European Union would continue to support WHO's activities on evaluation, coordination and prevention.

Dr CHITUWO (Zambia) supported the draft resolution. The overwhelming scale of the emergency relief offered to the survivors of the tsunami disaster had been a touching example of human good will. Prompt and massive assistance was fully justified in such situations. There was, however, a risk that international solidarity might be exhausted when dramatic disasters struck thousands of citizens in industrialized countries, leaving the insidious effects of longstanding disasters overlooked.

Through good governance, poor countries had to use their available resources to deliver sustainable services in sectors vital for the protection and promotion of human life, but their domestic resources were insufficient to cope with major disasters. While commending the response of WHO and the international community to the tsunami disaster, he issued a global appeal for more support to meet longstanding but less spectacular disasters like HIV/AIDS and malaria, which were decimating the population of sub-Saharan Africa. In his country alone, 50 000 children died from malaria every year.

Ms NKONYENI (South Africa) pointed out that, in addition to determining outstanding priorities in providing support to meet the immediate and longer-term reconstruction needs of populations affected by the tsunami, it was vital to build on existing initiatives to improve all aspects of disaster management. The lessons learnt should encourage countries across the globe to unite to ensure that better early warning systems, risk reduction and preventive measures and humanitarian response actions were developed and implemented. The South African Government and people had donated some 40 million rand to support countries affected by the tsunami, of which 50% had been earmarked for areas on the north-eastern coast of Africa, in particular in Somalia. The assistance had included provision of relief supplies and the services of a health technical team. South Africa had also joined efforts by WHO and the United Nations Office for the Coordination of Humanitarian Affairs to determine the best means of aiding reconstruction. In addition, forensic pathology teams had been sent to Maldives and Thailand to assist in victim identification. South Africa had responded to the call for assistance despite experiencing severe flooding in three provinces at the time of the tsunami disaster.

South Africa remained committed to supporting global initiatives to develop adequately resourced plans for disaster preparedness, risk reduction and humanitarian response nationally and internationally. There should be a community-based approach to disaster management, including training and empowerment and giving high priority to high-risk communities. It was important to ensure that all affected populations had equal access to essential health care at times of crisis. With the implementation of proposed interventions South Africa would be able to respond appropriately and swiftly to any disaster.

She supported the draft resolution.

Dr PARIRENYATWA (Zimbabwe) said that Zimbabweans had contributed in cash and kind to the support effort. The world continued to be threatened by natural and man-made disasters including outbreaks of emerging and re-emerging communicable diseases, and urgent action was needed to avoid malnutrition, diarrhoeal diseases and deaths resulting from droughts. He welcomed the continued technical support provided by WHO to increase national capacity for emergency preparedness and response and to develop appropriate plans and integrated disease surveillance and response. Zimbabwe was reviewing national, provincial and district civil protection units and was developing community skills for responding to emergencies in the face of a high rate of attrition of health staff. There was a need to continue investment in training and retraining in disaster management and to improve disease surveillance. He proposed that the draft resolution should be amended to emphasize the need for human resources in health. Emergency-preparedness plans at all levels should receive adequate financing. In Zimbabwe, as in many other developing countries, health facilities to manage conditions caused by highly infectious, dangerous pathogens were inadequate, and steps were being taken to upgrade hospitals to meet new demands. Such measures were expensive, and he urged

WHO to call on partners to mobilize resources to support countries in developing national capacity in such areas.

Ms VALDEZ (United States of America) urged WHO to take a leading role in helping Member States to prepare better to respond to crises and to support the recovery of health systems weakened by them. In line with the Director-General's commitment to strengthening health systems overall, the Secretariat had provided technical cooperation with that aim as a critical component of good governance, strong economies and healthy populations. The United Nations responses to crises sometimes lacked effective coordination owing to unclear delineation of responsibilities. WHO must clearly outline its role in relation to other bodies in the United Nations system, as exemplified in its response to the tsunami disaster, and focus on areas that took maximum advantage of its technical competencies and resources.

She supported the draft resolution.

Dr YOOSUF (Maldives) remarked that the tsunami disasters had opened many eyes to the need for emergency preparedness and response, to ensure that affected populations, relief workers and the donor community were better prepared in the future. The recent conference in Phuket had highlighted many weaknesses and had suggested appropriate measures, as reflected in document A58/6 Add.1.

Most of Maldives' islands had been badly affected by the tsunami, with significant economic losses for a country reliant on tourism and fishing. Increased salinity of groundwater had jeopardized the safety of water supplies, and many health facilities had been damaged. The psychological damage to the survivors, in particular orphans, was considerable. His Government had been moved by the scale of the international response to the disaster, but the sudden influx of aid workers and relief supplies had represented a substantial burden in itself. A strong well-functioning health system and infrastructure and strong local capacity and resilience were key elements in successful disaster management. A similar disaster in the near future would cause similar damage in developing countries with poor emergency preparedness and response plans, so that every effort must be made to expedite capacity-building efforts.

He supported the draft resolution with the amendments proposed by Thailand.

Mr GARCIA GONZÁLEZ (Spain) supported the draft resolution, but emphasized the need to maintain the recommended activities and proposed that the Director-General be requested to report to the Fifty-ninth World Health Assembly on the progress made in Member States and by WHO. WHO should collaborate with other United Nations organizations and interested parties to enhance crisis prevention and mitigation measures. Increasing globalization demanded new rules to remove current imbalances, which increased the vulnerability of some countries to emergencies. He therefore proposed insertion in the draft resolution contained in resolution EB115.R11 of a new preambular paragraph, to read "recognizing that improvement in the socioeconomic conditions of poorer countries is a preventive action that will reduce the risk of crises and disasters and their consequences", and a new subparagraph 12 in paragraph 3, to read "to report, through the Executive Board, to the Fifty-ninth World Health Assembly on the progress made in implementing this resolution".

Dr RAHANTANIRINA (Madagascar) welcomed the increase made in the allocation for WHO's emergency preparedness and response activities in the Proposed programme budget 2006-2007. She requested additional support from Member States and international organizations in mobilizing resources to strengthen management of emergencies and establish an efficient early warning system. She further requested WHO to continue its support for capacity building in Member States in the area of integrated surveillance of diseases and in order to improve health information and emergency preparedness and response. She supported the draft resolution.

Dr AL-MUTAWA (United Arab Emirates) said that disasters and emergencies of all types had far-reaching consequences and caused great damage to national and local infrastructures, preventing adequate responses, for example, to disease outbreaks. Those effects slowed progress towards

attainment of the Millennium Development Goals. The establishment of early warning systems was vital and should include a clear delineation of responsibilities within countries in the case of an emergency. Capacity building through training and response programmes and strengthening of health systems were also essential.

Dr CHAOUKI (Morocco) supported the draft resolution. Morocco had experienced various natural and man-made disasters in the previous decade, which had led to loss of life and significant economic and material losses. Improved international cooperation was essential to ensure successful coordination of such support. WHO should take a lead in that area and in strengthening support for development of integrated national, regional and local emergency preparedness and response plans.

Dr KYAW NYUNT SEIN (Myanmar) said that his country had not suffered as much as others following the tsunami, but the experience had nevertheless shown the need to strengthen emergency preparedness and response plans and surveillance. He expressed appreciation for the prompt support given by the WHO country office and the Regional Office for South-East Asia in assessing the situation and coordinating the health sector and the supply of essential services. The world was threatened by a variety of disasters, including the possibility of an avian influenza pandemic, and every country must therefore develop emergency preparedness and response plans to deal with national emergencies and provide support for others affected by emergencies. Such plans would require intercountry networks and should be supported by the International Health Regulations. He supported calls for the international community to maintain long-term support for the countries affected by the tsunami and to give similar support to countries affected by other such humanitarian crises.

Mr PALU (Australia), observing that WHO was an important partner and source of technical advice in responding to health-related crises and the effects of natural disasters on health, commended the leadership shown in the 2003-2004 outbreaks of severe acute respiratory syndrome and avian influenza. Given the importance of global communicable disease outbreaks and the increasing frequency of natural disasters, WHO should give greater emphasis to improving health-sector emergency response and recovery through preparedness and mitigation activities. He commended also WHO's cooperation with the international community to learn lessons from the tsunami disaster at the recent Phuket conference. He urged that the vulnerable position of the small Pacific island countries, in particular in respect of cyclones, should not be forgotten; those countries required ongoing support to build national capacity for disaster preparedness, mitigation and response.

Mr RYAZANTSEV (Russian Federation) recalled the intervention made by the member from the Russian Federation at the 115th session of the Executive Board during discussion of responding to health aspects of crises which had provided information on the humanitarian support provided by his country to the countries affected by the tsunami disaster.¹ He supported the draft resolution, which set out comprehensive provisions for dealing with emergency situations.

Dr AKBARI (Islamic Republic of Iran) said that his country's experience of natural disasters had shown the need for greater collaboration between WHO and other United Nations organizations involved in disaster relief, in particular earthquakes and flooding. As the effects of a disaster remained long after the acute phase, disease surveillance by WHO was essential. The response of Member States also needed to be strengthened in accordance with their respective priorities, for example through capacity building, education and training. In addition, the management of aid provided in the wake of a disaster should be governed by international regulations.

¹ Document EB115/2005/REC/2, summary record of the second meeting, section 2.

Mr PERDOMO (Bolivarian Republic of Venezuela) acknowledged the important role played by WHO to safeguard the health of the populations affected by the tsunamis. An increasing number of countries in the Caribbean was facing the dangers of climate change, hurricanes and storms that cost lives and caused significant economic damage, and it was important to develop capacities for a central alert mechanism. In the draft resolution, he proposed that the words “safe foodstuffs and good-quality essential medicines” should be inserted after “access to clean water” in subparagraph 3(1).

Dr DUALE (Somalia) said that, although his country had been affected on a small scale by the tsunami, it had been greatly affected by man-made disasters. The civil war in particular had devastated the country’s infrastructure, including hospitals and schools, and had left the population vulnerable to infectious diseases. His country was grateful for the assistance that it had already received, and hoped that it would continue.

Mrs BELLA ASSUMPTA (Cameroon) said that, although her country enjoyed a stable political situation, it frequently faced natural disasters including earthquakes and emissions of toxic natural gas; it also took in many displaced persons. Against that background, the country’s health sector had an essential coordinating role to play. She supported the draft resolution, but proposed that subparagraph 2(3) should be amended to read: “to formulate, on the basis of a risk assessment, national emergency-preparedness plans that give due attention to the essential role of the health sector in the management of crisis situations in order to improve the effectiveness of responses to crises and of contributions to the recovery of health systems”.

Mr WIERINGA (Canada) said that his Government attached particular importance to needs assessments, partner capacity and access, and welcomed the focus not only on enhancing response capacities, but also on preparedness and recovery efforts. More attention should be paid, however, to mitigation, and increased collaboration between WHO and PAHO was necessary in that regard.

Generally speaking, he supported the draft resolution, but proposed that the numbers in the first preambular paragraph should be updated; that, in paragraph 1, the words “to humanitarian action that lays emphasis in saving lives and sustaining survival” should be replaced by “in response to”; that the words “that integrate risk reduction planning into the health sector” should be inserted after “regional preparedness plans” in subparagraph 2(2); that, in subparagraph 2(3), the words “including health infrastructure” should be inserted after “due attention to public health”, and that the words “and other United Nations system partners” should be added at the end of subparagraph 3(7).

Dr OVIEDO (Costa Rica) said that, as his country was located in an area prone to natural disasters, his Government attached high priority to actions and initiatives that would ensure an adequate institutional and social emergency response to minimize the loss of life and reduce vulnerability. Officials from international organizations involved in disaster relief had recently met in Panama to further the establishment of a Central American disaster information network, which was already in operation for other Latin American and Caribbean countries. Costa Rica already had an evacuation plan, funded by the Pan American Development Foundation, for the central Pacific region, one of the most popular tourist destinations, covering training in early recognition of a tsunami and appropriate action. Signs in Spanish and English warning of the dangers and indicating escape routes were to be placed in strategic locations.

Mr FERRER RODRÍGUEZ (Cuba) said that, immediately after the tsunamis, Cuba had dispatched doctors, foodstuffs, equipment, medicines and consumables to Indonesia and Sri Lanka. In response to hurricane Mitch in 1998, the Government had created an integrated health programme for support to the worst-hit countries, which had subsequently been extended to 64 countries, primarily in Africa and Latin America, affected by not only natural disasters but also the silent disasters caused by unjust and inequitable trade rules and international finance, poverty, underdevelopment and AIDS and malaria pandemics. About 25 000 Cuban health professionals, including more than 20 000 doctors, were currently working in those 64 countries. As part of the same programme, the Latin American

School of Medical Sciences had been set up to provide free medical training for thousands of Latin American and Caribbean students. About 1000 new doctors would graduate in 2005, and 10 000 new medical students from Venezuela would be joining the school.

The report contained in document A58/6 contained some elements that tended to downgrade the important role of the State and national authorities and departed from the intergovernmental consensus achieved within the United Nations and WHO. It was important to bear in mind that, in accordance with the guiding principles for United Nations emergency humanitarian assistance, every State had primary responsibility for assistance to victims and for initiating, organizing, coordinating and implementing humanitarian assistance on its territory. Cuba supported the draft resolution and some of the proposed amendments, in particular those by India, Thailand and other Asian countries directly affected by the tsunami. The draft resolution should also reflect the need to ensure appropriate use of new investments, and the need for a stronger political commitment, more effective national and international financial policies, and international solidarity, to mitigate the effects of disasters.

Dr DA COSTA SEMEDO (Guinea-Bissau) expressed support for the draft resolution, and stressed the importance of strengthening the capacity of WHO country offices in order to ensure timely emergency response. With regard to the integrated disease surveillance initiative launched by WHO, in many countries health systems lacked resources, making it more difficult to cope with epidemics.

Dr ST JOHN (Barbados) supported the draft resolution. Her country was particularly concerned about the degree of preparedness in the Caribbean Community and sought assurance that the necessary technical assistance would be available to ensure the resilience of health facilities and to provide for the strengthening of the health infrastructure.

Barbados, for its part, had made a concerted effort to strengthen its emergency preparedness situation, ensuring greater interaction, not only between health institutions, but also with the armed forces, the police and the fire service. Drills had been developed and practiced to improve response, and WHO had been called on to support efforts to increase the speed of response. With regard to recovery, a regional response system was in place to assist any country in the region affected by a natural disaster.

National emergency plans that gave priority to the health sector should be reported by WHO, and she asked whether part of the proposed increase in contributions would be used for that purpose.

Mr GEORGE (Portugal) said that, following the problems that his country had experienced the previous year in connection with its western islands, and in the light of the support it had provided to other countries facing crises, the health ministry had recently established a situation room for public health emergencies in Lisbon, with the collaboration of WHO.

Dr MARSCHANG (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that for the Federation disaster response meant being the first one on the spot, saving lives through search and rescue, providing first aid and early referral, preventing suffering, re-establishing and maintaining health, and being internationally prepared and ready to support or complement the efforts of national societies in caring for the most vulnerable and most severely affected through established response systems and tools. It applied a "public health in emergencies" approach tackling immediate needs by filling any temporary gaps or alleviating overloads, as a complement to the action of governmental and other agencies. The Federation provided basic, standardized and targeted high-quality services through specialized units for basic health care, district-level hospital services, and water and sanitation. It also carried out health promotion activities for disease prevention and epidemic control, focusing in particular on the five major killer diseases in emergencies and on maternal and child health needs, which often went neglected in disasters. In addition, since the Kosovo crisis, the Federation had continuously expanded efforts to meet psychosocial needs of victims, volunteers and staff.

The Federation had been a reliable partner to WHO and other United Nations organizations in joint work on reproductive health in emergencies since 1994. It had contributed to the development of the Inter-Agency Field Manual for Reproductive Health in Refugee Situations, published in 1999, and to the Inter-Agency Global Evaluation of Reproductive Health Services for Refugees and Internally Displaced Persons, conducted in 2004. Together with its partners on the Inter-Agency Standing Committee Task Force on HIV/AIDS in Emergency Settings, the Federation was committed to intensifying its efforts to address HIV/AIDS in disaster and crisis situations. It had recently signed a joint letter on cooperation with WHO with a view to extending cooperation on public health in emergencies; it was committed to remaining a strong health partner to governments and agencies in disaster response and post-disaster rehabilitation.

Dr CHAN (International Pediatric Association), speaking at the invitation of the CHAIRMAN, noted that children were particularly vulnerable in times of disaster, with physical and psychosocial needs that differed from those of adults yet were intertwined with those of the mother and the family. Adequate attention to children caught up in disasters therefore required knowledge of child health and child development and the participation of specially trained and aware personnel. Specific considerations to meet children's needs in times of disaster should include a clear definition and understanding of child and family needs by emergency relief personnel, empowerment of child-health personnel in disaster assessment and planning, and attention to broad concepts of child health, encompassing not only the physical and psychosocial dimensions, but also maternal and family health. Initial assessments of disaster areas should include attention to the numbers and needs of children involved, and establishment of acute and long-term priorities. Paediatricians and child health personnel at regional and local levels should also be trained in disaster preparedness and response, and adequate resources should be allocated for children's needs.

His Association conducted training courses, developed teaching materials on children's needs in disaster relief, and ran courses and recent workshops in disaster preparedness for country and regional child health personnel. Recent successful training events, included a course organized in Thailand in response to the recent tsunami. The Association also proposed to establish a registry of trained child health personnel who could be called on by governments and relief agencies in times of need; mobilization of such staff after the tsunami testified to the value of that approach.

Dr NABARRO (Representative of the Director-General for Health Action in Crises) recalled that WHO's efforts in response to the tsunami had been supported by donations from 25 countries. Delegates had not only focused on the tsunami but had also mentioned many other kinds of crises and disasters, the difficulty of realizing the Millennium Development Goals for communities living in such conditions, and the need for a comprehensive response. Expectations of WHO included coordination, assessment, preparedness, mitigation and prevention; the main themes emerging in relation to preparedness were the need for an adequate budget, planning at all levels, drills, community involvement and sharing of information between the different groups involved. He had noted the stress on mitigation, early warning, vulnerability reduction and risk management, particularly in small island states, and Canada's specific request for closer cooperation between WHO headquarters and PAHO on improving the resilience of hospitals and other structures.

Comments on the need to evaluate responses and to identify and apply lessons learnt would be taken into consideration. Other comments, such as the need for WHO's help in mobilizing funds for emergency responses and preparedness in countries, its role in helping to coordinate financing, the need to clarify its role vis-à-vis other organizations, and the importance of mental health in disaster responses had been noted. The interesting proposition by the delegate of Iran for international regulations on the health aspects of disaster response management had also been put forward during the Conference on Health Aspects of the Tsunami Disaster in Asia (Phuket, Thailand, 4 to 6 May 2005).

Areas in which Member States wished to see additional emphasis by WHO included emergency funds for disaster response, having experts on stand-by and pre-positioning of supplies, putting national authorities at the centre of any support and making sure that at all times the views of the

national government were kept in mind, ensuring an adequate regular budget allocation for the Organization's work in relation to crises and disasters, sustained attention to capacity building and proper alignment of disaster and epidemic responses. The Secretariat would incorporate those suggestions into its work.

The CHAIRMAN proposed that the Secretariat should prepare a revised version of the draft resolution, incorporating the amendments proposed, for consideration in a subsequent meeting.

It was so agreed.

(For continuation of the discussion, see summary record of the third meeting, page 57.)

Poliomyelitis: Item 13.7 of the Agenda (Document A58/11)

Dr HEYMANN (Representative of the Director-General for Polio Eradication) said that newspaper headlines in the previous two weeks had come as a stark reminder that, as long as poliomyelitis was present in any country, it remained a risk to the entire world. In 1988, the Health Assembly had resolved to eradicate poliomyelitis by 2000. A strong and lasting partnership had soon developed between countries and the spearheading partners, Rotary International, the Centers for Disease Prevention and Control (Atlanta, Georgia, United States of America), UNICEF and WHO. Because routine immunization programmes in many cases had not been attaining the coverage necessary to obtain the herd immunity required to interrupt transmission, increased emphasis had been placed on supplementary immunization activities. Active surveillance for acute flaccid paralysis had also been established, supported by a quality-controlled global network of 145 national laboratories and 22 reference laboratories that ensured genetic sequencing of each isolated poliovirus.

At the end of 2000, 20 countries had remained endemic for poliomyelitis. In 2003, the target date for eradication had been re-set to 2005, and six countries had been declared endemic. Eradication activities had been intensified in 2003, and slightly more than 1000 children had been afflicted with paralytic poliomyelitis during 2004; in contrast, an estimated 1000 children had contracted the disease each day in 1988. Currently, six countries remained endemic for poliomyelitis, and poliovirus had recently spread to 16 previously poliomyelitis-free countries. In six of the previously poliomyelitis-free countries, endemic transmission had been re-established, but the other 10 had successfully prevented imported virus from re-establishing transmission or were working to do so.

Poliovirus transmission could be interrupted in all countries. The Region of the Americas, the European Region and the Western Pacific Region had already been certified poliomyelitis-free, and one strain of poliovirus, type 2, had been eliminated worldwide since 1999. Existing poliomyelitis-eradication strategies remained effective but there were several risks to global eradication, namely, ongoing transmission in the six countries that had not yet interrupted transmission; transmission in the six countries that had re-established transmission; vulnerability of countries that had not maintained high levels of poliomyelitis immunity through routine immunization, particularly those in the Horn of Africa; and surveillance gaps, especially in sub-Saharan Africa, where viruses that had been circulating undetected since 1999 had recently been identified.

Political engagement for poliomyelitis eradication had never been higher. In Asia and northern Africa, it had resulted in a halving of the number of reported cases in 2004 with respect to the previous year and in a three-fold increase in the sensitivity of surveillance. In sub-Saharan Africa, it had led to synchronized campaigns in 23 countries, beginning in October 2004. In 2000 and 2001, similar campaigns had succeeded in eradicating poliomyelitis in one year in all but two countries in west and central Africa.

A powerful new tool for eradication had become available: a monovalent oral vaccine, which, with fewer doses, provided up to three times higher seroconversion rates than the trivalent vaccine and was being used in areas where only type-1 wild poliovirus remained in circulation. The monovalent vaccine was also important in responding to the current international spread of type-1 poliovirus throughout the world.

As poliomyelitis continued to wane, preparations were under way for the cessation of oral poliomyelitis vaccine use after global certification of eradication. That vaccine could cause paralytic poliomyelitis, and in September 2003 a WHO consultation had concluded that its continued use after the interruption of transmission of wild-type poliovirus would be inconsistent with eradication. In preparation for that cessation, the immediate priorities were to strengthen routine immunization levels, to ensure that all wild-type polioviruses at vaccine-manufacturing sites and in research and diagnostic laboratories were placed under appropriate biocontainment, and to sustain highly sensitive surveillance. The eventual cessation of the use of the vaccine would require the same level of international cooperation and coordination that had brought the world to the verge of eradication. Guidelines for containment of Sabin polioviruses would be presented to the governing bodies in 2006. The Health Assembly would need to agree on the precise timing and process for eventual simultaneous cessation, and each Member State would need to have decided by that time whether to stop immunization or to continue using the inactivated vaccine. WHO would provide support to countries in that decision-making process.

Lessons from the smallpox eradication initiative highlighted the need to ensure that the vaccines, antiviral agents and diagnostic tests required were available before eradication was achieved, while research on the poliovirus was still possible. Accordingly, in addition to the oral vaccine cessation strategy, new products for poliomyelitis control were being developed: an inactivated vaccine manufactured through a safer method, using the Sabin strain rather than wild-type poliovirus as the source of vaccine virus. Antiviral agents were being developed to decrease viraemia and shedding of poliovirus, as were polymerase chain reaction and serological tests that would facilitate detection of poliovirus within 24 to 48 hours, rather than the four to six weeks currently required for isolation and genetic characterization.

The recent international spread of poliomyelitis provided a challenge to finish the job of eradication and to protect the 10 million children who would otherwise be paralysed during the coming 40 years.

Professor LAMBO (Nigeria) reaffirmed the commitment of both his country and the health ministers of the African Region to the global effort to eradicate poliomyelitis. As a continent, Africa had continued to implement intensified Global Polio Eradication Initiative activities in a concerted manner, with the participation of all tiers of Government, traditional, religious and media institutions, the private sector, and communities, with the aim of interrupting wild-type poliovirus transmission by December 2005. Those activities had been in line with decisions made by the health ministers of priority countries at a meeting held in Geneva on 13 January 2005.

The commitment and involvement of all tiers of Government was being led by the President of Nigeria, who was also Chairman of the African Union and had continued to demonstrate his personal commitment to deliver a poliomyelitis-free Nigeria and Africa to the next generation, echoing the joint statement made by African Heads of Government at the Fourth Ordinary African Union Summit of the African Heads of State and Government (Abuja, 24 to 31 January 2005) to ensure that every child received poliomyelitis immunization in 2005. Furthermore, the launch of the 23-nation synchronized National Immunization Days for 2005 by the presidents of Benin and Nigeria on 20 February 2005 demonstrated their dedication to joint efforts under the Initiative, reaching more than 100 million children aged 0-59 months in the participating countries in 2005. Launch activities had also been conducted at national, zonal, state/province and local government/district levels.

As Nigeria accounted for the highest number of cases of poliomyelitis due to wild-type poliovirus, the Initiative's efforts had been further intensified through innovative strategies, such as: a focus on the ward-by-ward microplanning and mapping of settlements, allowing vaccination teams to reach every child in Nigeria; the implementation of ward-specific strategies for transport and logistics for National Immunization Day operations, in order to ensure that vaccination teams could cover the whole country, including its nomadic population; extended monitoring and supervision of National Immunization Day activities, focusing on the ward and settlement levels, by independent monitors, members of the executive and legislative branches of Government and staff of the partner agencies;

and zonal and national meetings of commissioners for health and directors of primary health care for each National Immunization Day, with feedback to improve future such activities.

Further efforts to improve the acute flaccid paralysis surveillance system in Africa were ongoing. Strategic alliances within communities were being strengthened to improve routine immunization services, to ensure, among other things, that the Initiative's efforts were sustained, since they were the best defence against imported wild-type poliovirus. Active participation and coordination by all partners and other stakeholders in the Initiative and routine immunization activities through the Inter-agency Coordinating Committee mechanism continued to be among the best practices in the region. The result had been a reduction in cases of poliomyelitis due to wild-type poliovirus in Nigeria and the African Region of more than 50% in the first quarter of 2005, compared with the same period in 2004. However, challenges remained. Continued commitment by Member States to organize National Immunization Days would ensure that every child aged 0-59 months was reached by vaccination teams through the district and ward system. Increased funding was required to support extended monitoring and supervision of all planned supplemental immunization activities for 2005, and to provide early support to states and local government for social mobilization, logistics and National Immunization Day operations. Country plans should be developed to allow for a rapid response to importations, which would remain a risk until poliomyelitis had been eradicated, and efforts should be continued to strengthen, on a sustainable basis, routine immunization service delivery.

He thanked all the bodies within the United Nations system, including national governments, that continued to provide financial and technical support to Africa, and asked for continued support and partnership to achieve the goal of eradicating poliomyelitis by the end of 2005.

Professor HORVATH (Australia), expressing his country's continued support for the efforts of WHO and the Global Polio Eradication Initiative, recalled that Australia had contributed Aus\$ 7.6 million to Rotary International for poliomyelitis eradication activities between 2001 and 2005 and a further Aus\$ 1.7 million per annum to WHO in 2003-2004 and 2004-2005 for the Expanded Programme on Immunization in the Asia-Pacific area.

The recent detection of wild-type poliovirus in West Java, Indonesia, in the first confirmed case in that country since 1995, had highlighted the continuing need for vigilant surveillance and maintenance of high immunization levels, and Australia was working with the Indonesian Government, WHO and UNICEF to respond to the outbreak, contributing Aus\$ 1 million to the operational costs of administering poliomyelitis vaccine to the 5.2 million children at risk of infection and offering its expertise in mass immunization logistics.

The Western Pacific Region had been declared poliomyelitis-free but remained vulnerable to vaccine-preventable diseases. The geographical and resource challenges of the Pacific, coupled with the fragile and changing nature of global vaccine supplies, required continued attention. Support for immunization efforts in the Pacific was needed to maintain the gains made and to strengthen systems and practices, which were also essential components of regional health security.

Professor SHRESTHA (Nepal) said that, although Nepal had been free of poliomyelitis for almost three years, one case had recently been detected in a child who had contracted the disease while visiting a relative in a neighbouring country. That cross-border transmission meant that Nepal could not be declared poliomyelitis-free. WHO should provide support for effective monitoring of borders between countries with no cases of poliomyelitis and countries with many cases. The matter needed urgent attention to prevent cross-border transmission in the future.

Dr YUSHARMEN (Indonesia) observed that his country had not had any cases of poliomyelitis due to wild-type poliovirus since 1995. The Ministry of Health had conducted national immunization campaigns annually from 1995 to 1997, followed by sub-national campaigns in 2000 and 2001, with a further campaign in 2002 to maintain high levels of immunity in children. Routine immunization coverage of infants had consistently been above 90% nationally. Indonesia's surveillance system for acute flaccid paralysis in children met accepted standards, and a review by a team of international

experts in 2003 had concluded that the surveillance was adequate to detect wild-type poliovirus transmission.

On 21 April 2005, the National Polio Laboratory in Bandung had isolated a wild-type poliovirus from a case of acute flaccid paralysis identified by the national surveillance system. A previously unimmunized 20-month-old child had displayed onset of paralysis on 13 March 2005. Results from laboratories in India and the United States of America had indicated a match with Sudan-type virus circulating in Saudi Arabia. Eight more cases had been confirmed in the same area of Indonesia between 21 April and 17 May, and 10 cases were still being investigated. Of 157 specimens taken from house or neighbour contacts, 29 were positive; the rest were still being examined. The Ministry of Health, supported by WHO, had immediately initiated a surveillance response in the district and surrounding areas, with outbreak-response immunization in six villages within 72 hours of confirmation of the first case and later in five other villages. The surveillance response had included an active search for other cases due to wild-type poliovirus, which had resulted in identification of 17 additional cases of recent paralysis in children in the area. Specimens from those cases were being investigated at the National Polio Laboratory. The surveillance response had been widened to 17 districts, including the five districts of Jakarta, with active surveillance visits to all key reporting sites and a review of records to identify any recent cases of acute flaccid paralysis that might have been missed. All the actions taken were in accordance with WHO recommendations on outbreak response.

Experience worldwide had shown that a well-planned response could quickly stop an outbreak of poliomyelitis in a previously poliomyelitis-free area. The Ministry of Health and partner agencies, including WHO, UNICEF and various countries, such as Australia – to which he expressed gratitude – were notifying all Indonesia's provinces and surveillance units of the suspected outbreak, to ensure that no new case was missed. They were also organizing two rounds of immunization for all children under five in three provinces, as a mop-up response, in May and June 2005 to ensure that any transmission of wild-type poliovirus was rapidly interrupted and to improve population immunity over a wide area of Java. Indonesia needed support for its mop-up and routine immunization campaigns to achieve the goal of global poliomyelitis eradication.

Ms RIZZO (Italy), commending WHO's role in the Global Polio Eradication Initiative, underlined the efforts and successes of the partnership between WHO, UNICEF, the Centers for Disease Control and Prevention, and Rotary International to overcome cultural and social differences and allow children, the most vulnerable section of the population, to be immunized. Her Government was fully committed to eradicating poliomyelitis and would be contributing €5 million to WHO in 2005. She shared concern over the new cases reported and stressed the importance of collaboration between UNICEF and WHO, each organization bringing benefits to the partnership.

Dr VIOLAKI-PARASKEVA (Greece) said that the Initiative would be helped by the selective use of oral poliomyelitis vaccine in addition to the implementation of improved strategies to reach every child in underserved population subgroups. Greece was free of poliomyelitis, and every child living in the country was entitled to free immunization against the disease. Eradication strategies had been effective, but intensified surveillance and repeated immunization campaigns would be required.

The meeting rose at 18:00.

THIRD MEETING

Wednesday, 18 May 2005, at 09:40

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Poliomyelitis: Item 13.7 of the Agenda (Document A58/11) (continued)

Mr SPEZIA (Brazil) strongly supported WHO's recommendations on the eradication of poliomyelitis. Recent outbreaks had highlighted the need to accelerate the final steps in order to prevent outbreaks related to international traffic and migration. No country would be completely protected until the disease was eradicated. The action taken by the Brazilian Government to maintain the status of eradication nationwide included strengthening surveillance of acute flaccid paralysis and a two-stage annual vaccination programme in all states in which more than 16 million children were vaccinated at each stage. The systematic monitoring of operational indicators showed that the surveillance goals were being attained.

Dr MOHAMMAD (Oman) expressed his appreciation for WHO's cooperation with the countries of the Eastern Mediterranean Region in the eradication of poliomyelitis. Permanent contacts with ministries were important, as were rapid alerts when new cases arose. Isolation of wild-type poliovirus should be notified and declared in countries where routine vaccination coverage was low, campaigns had been suspended or the skills and knowledge of health workers fell short of the required level. National immunization days were the best means of ensuring the broadest possible coverage. Since poliovirus knew no geographical boundaries, even the three WHO regions that had been declared poliomyelitis-free could not be sure of remaining so, and the fight had to go on. The Secretariat should assist in assessing the prevalence in countries where poliomyelitis had not been eradicated to determine whether the number of cases was increasing and to disseminate that information through the PolioFax bulletin. Evaluation of the global situation in August 2005 would be useful. In Oman routine coverage had been above 97% for about 15 years, and the last case had occurred in 1983. But since poliomyelitis continued to occur in neighbouring Yemen, Oman had decided to organize national immunization days. Effective coordination between the WHO regions and programmes was essential if the disease was to be combated effectively.

Dr EGAMI (Japan) commended WHO's efforts towards the global eradication of poliomyelitis. She expressed concern at the failure to keep to the original timetable and at the increasing number of reported cases. The current year marked a critical phase, and a concerted effort would be required to eradicate poliomyelitis as early as possible. WHO should provide technical support from poliomyelitis-free regions to regions with the disease, concentrating resources on the areas with the greatest needs. Political commitment was essential for eradication. Japan eagerly awaited WHO's further action towards the prevention of imported cases. High immunization coverage and maintaining good surveillance systems were important, even in disease-free areas. The route of recent viral transmission in Indonesia and Yemen should be determined quickly and immediate action taken. WHO should maintain its focus on poliomyelitis, even after the new disease-eradication programmes had been introduced. Japan had contributed to poliomyelitis eradication in the Western Pacific Region in 2000 and would continue to contribute its technical expertise to the programme.

Mr RYAZANTSEV (Russian Federation) said that, three years after certification of the eradication of poliomyelitis in the European Region, the Russian Federation was continuing its work under national action plans to support its poliomyelitis-free status, in view of the real possibility of wild-type poliovirus being imported from endemic countries. Since 1997 no case of paralytic poliomyelitis caused by wild-type virus had been registered in the country, but each year there were some 10 to 15 cases of vaccine-associated poliomyelitis. To prevent that, consideration was being given to changing over to a combined regimen of vaccination using inactivated vaccine.

In the Russian Federation, laboratories remained the only sources of wild-type poliovirus and its safe handling was critically important. In 2002 a national register had been set up; 83 laboratories were currently recorded. Work remained to be done on maintaining at a high level basic indicators of epidemiological surveillance for poliomyelitis and acute flaccid paralysis; sustaining high levels of routine immunization coverage; preventing cases of vaccine-associated paralytic poliomyelitis; elaborating a poliomyelitis immunization strategy for the post-certification period; improving the operations of the laboratory network; and ensuring safe handling of the poliovirus in laboratories. He wanted further cooperation with WHO to improve epidemiological surveillance for poliomyelitis and acute flaccid paralysis in the Russian Federation, as part of the efforts towards global eradication, and thanked WHO for assistance already provided.

A concerted effort was required by the governments of affected countries, nongovernmental organizations and volunteers if the 2008 goal was to be achieved. The international community would have to make larger financial inputs to solve the specific problems of endemic countries; his country would make a voluntary contribution of US\$ 8 million. Full global eradication depended on implementation of the appropriate strategies.

Dr AL-MAZROU (Saudi Arabia) commended international action to eradicate poliomyelitis, but was concerned that obstacles had arisen in the past two years, particularly in Africa. Their impact represented an additional burden and meant that donors would have to continue providing generous assistance if the programme was to succeed. The measures adopted by the programme and by the technical advisory groups to end recent epidemics, particularly in Egypt and India, were a good example of the use of scientific method based on laboratory-confirmed information. However, no country could consider itself completely free of poliomyelitis so long as cases still occurred in other countries. The frequency and speed of international travel encouraged cross-border contamination. Saudi Arabia had been endeavouring to establish surveillance programmes at national level to ensure extensive of coverage.

Mr BELOT (South Africa) reported that wild-type poliomyelitis had last been reported in South Africa in 1989 and that each province had met the certification standard of surveillance since 2003. South Africa was therefore confident of detecting any case of poliomyelitis. Efforts were continuing to intensify surveillance and maintain the standard reached. South Africa had drafted a national strategic plan to guard against the possibility of wild-type poliovirus being imported, and it was keeping a close watch on developments in neighbouring countries. A long-planned national immunization campaign had been conducted in 2004 after a case of poliomyelitis had been reported in the region. If necessary, supplementary immunization would be carried out. South Africa remained committed to working with governments and other partners to eradicate poliomyelitis in southern Africa: national certification, laboratory containment and expert committees had been set up, and an Inter-Country Certification Committee had been established with neighbouring Lesotho and Swaziland. Aware that no child would be safe so long as the wild-type poliovirus persisted in the world, South Africa remained committed to global eradication of poliomyelitis.

Dr ZOMBRE (Burkina Faso) said that Burkina Faso had fully subscribed to the Global Polio Eradication Initiative. The country had implemented relevant strategies since 1996, carried out more than 11 national immunization days, stepped up surveillance of acute flaccid paralysis and significantly increased routine vaccination coverage. Transmission of wild-type poliovirus had been

interrupted between 1998 and 2001, but the virus had reappeared in 2002, since when, with the support of its traditional partners, eradication efforts had been stepped up. Those efforts had been slow to bear fruit, but after an intensive vaccination campaign in 2004, no case of wild-type poliovirus had been registered for eight months. The campaign was continuing in 2005, to prevent endemic transmission. However, eradication efforts would not be successful without adequate levels of financing. The current level of activity was placing undue strain on health systems and beneficiaries alike.

Mrs AREEKUL PUANGSUWAN (Thailand) said that the information on interrupting the final chains of wild-type poliovirus transmission worldwide in the report raised grave concerns. Clearly, there was an urgent need for: better performance of poliomyelitis programmes, more support from WHO and other development partners such as UNICEF; serious action by all the parties concerned; and regional collaboration. Noting the funding gap for the 2004-2008 period, she called on international development partners to provide the necessary financial and technical support.

Professor TLOU (Botswana) acknowledged WHO's support provided to Botswana in tackling a case of imported poliomyelitis in 2004. Immunization and surveillance in the country had been subsequently extended and no new case had been reported. Thanks to good surveillance of acute flaccid paralysis in 2004, other poliomyelitis eradication strategies and, not least, the quality of the Secretariat's technical support, Botswana had been selected as one of eight countries to be considered for poliomyelitis-free certification status later in 2005. She expressed her country's resolve to continue helping to rid Africa of poliomyelitis.

Dr MIAKA MIA BILENGE (Democratic Republic of the Congo) recalled that his country was suffering the after-effects of armed conflict and unprecedented political, economic and social crisis since 1990. In 1995, it had experienced the worst epidemic of poliomyelitis in the world, with more than 1000 cases in children in one town alone. Since 1996, national and local immunization days had been organized, with temporary cessation of hostilities where necessary and using the "door-to-door" vaccination strategy, and a surveillance system for acute flaccid paralysis had been introduced. Infection with wild-type poliovirus had last been reported in 2000. Since then, routine vaccination campaigns had continued, with a special campaign in 2004 along the border with the Central African Republic after an outbreak of poliomyelitis in that country.

Given his country's 9000 kilometres of border with nine different States and consequent high the risk of imported cases of poliomyelitis, continued vigilance was essential. In April and May 2005, a mass immunization campaign had been organized in conjunction with the Central African Republic and Sudan. Further synchronized campaigns in conjunction with the Central African Republic, Chad and the Republic of the Congo were planned for October and November 2005.

His country was willing to share the experience it had gained from organizing large-scale, cross-border and synchronized vaccination campaigns. Routine vaccination coverage aimed at every district had reached more than 60% for all antigens in the Expanded Programme on Immunization, compared with less than 50% for the diphtheria/pertussis/tetanus vaccine 10 years before. He asked for assistance in the strengthening of human-resources capacity, restoration of the basic infrastructure of the health system and strengthening of the cold chain, particularly since his country was eligible to introduce vaccines against hepatitis B and *Haemophilus influenzae* type b.

Dr NABLI (Tunisia) said that more needed doing to control and monitor poliomyelitis in all regions. She thanked WHO for its activities to raise funds for poliomyelitis control in affected areas, although more effort would be needed to eradicate wild-type poliovirus. Her country had suffered no case of poliomyelitis for 10 years but did not intend to abandon its immunization campaign.

Mr TROSTLE (United States of America) said that Afghanistan, Egypt, India and Pakistan had an opportunity to stop the transmission of poliovirus during 2005. His Government strongly supported

their efforts and urged their national authorities to find the necessary commitment and resources. He congratulated Ghana and Togo on interrupting viral transmission following the re-emergence of poliomyelitis in the region in 2004. The African Union and the Organization of the Islamic Conference had played an important role in mobilizing national commitment to poliomyelitis eradication in Africa. He urged African leaders to work to improve the quality of synchronized immunization campaigns and surveillance.

The final stage of eradication was the most challenging, requiring sustained political and financial commitment, and he urged the G8 countries, the Organization of the Islamic Conference and OECD to increase funding in order to ensure that adequate resources were available. All countries must remain vigilant by maintaining high immunization coverage rates and effective surveillance of acute flaccid paralysis. Surveillance was required in order both to use limited resources judiciously and to provide reliable evidence that poliomyelitis had been eradicated.

The inadequacy of routine immunization programmes in most poliomyelitis-affected countries had made eradication extremely difficult. More support should be provided in order to strengthen all countries' routine immunization programmes not only against poliomyelitis but other vaccine-preventable diseases. Such programmes would also act as a platform for detection of and response to epidemics of severe acute respiratory syndrome or pandemic influenza and to terrorist attacks using agents that cause vaccine-preventable diseases.

He acknowledged the extraordinary role played by Rotary International in the global fight against poliomyelitis. With more than 1.2 million volunteers and raising more than US\$ 600 million in funding for poliomyelitis eradication, Rotary exemplified what was best in public-private partnership.

Dr HASSAN (Chad) said that the situation in his subregion was serious. After the re-emergence of poliomyelitis in his country in 2003, the Government had organized synchronized vaccination days with neighbouring Cameroon, Niger, Nigeria and Sudan. The Government was determined to eradicate poliomyelitis by the end of 2005, or at least to control the spread of wild-type poliovirus. Chad faced particular problems because of its geographical position and large refugee population. His country was grateful for the help of international partners, but more assistance would be needed.

Dr CHAOUKI (Morocco) said that his country had established a surveillance system for acute flaccid paralysis. It had been certified free of poliomyelitis in 2001 but the recent re-emergence of the disease in Africa and the Middle East was a cause for serious concern, owing to the large number of migrants passing through the country. It was essential to consolidate the gains made so far and to continue mass immunization campaigns. Regional and international cooperation was still vital, and WHO and UNICEF should redouble their efforts to raise the level of disease surveillance.

Dr YAN Jun (China) thanked WHO for the support it provided to countries where wild-type poliovirus was still endemic, and endorsed the proposal to phase out the use of oral poliomyelitis vaccine. China had been certified poliomyelitis-free, but considerable effort was needed to maintain that status. Her Government wanted to stop using oral poliomyelitis vaccine but it could not do so until a suitable alternative was available. She hoped that WHO would continue its financial support for countries like her own, in order to strengthen their immunization programmes and maintain their surveillance of acute flaccid paralysis.

Mr ABID (Iraq) said that, despite its difficult circumstances, his country had not recorded a single case of poliomyelitis since 2000, thanks to the assistance it had received from WHO, UNICEF and nongovernmental organizations. A reliable monitoring system had been set up which, according to a WHO evaluation conducted in November 2004, could detect any new case. Routine vaccination coverage against poliomyelitis had increased from 40% in 2003 to 80% in the first quarter of 2005. On the latest national immunization day in late 2004, 95% of children had been immunized.

His country was nevertheless concerned about the possible re-emergence of poliomyelitis, because of low routine immunization coverage in some provinces and an unreliable cold chain, and

owing to recurrent security problems. On account of poliomyelitis cases in Yemen, where some Iraqi citizens lived, the Government had introduced epidemiological measures and set up mobile prevention teams. Observing that a national campaign for oral poliomyelitis immunization had been launched in January 2005, he expressed the hope that WHO would continue to support his country's efforts.

Dr BUHALIGA (United Arab Emirates) said that the report recorded considerable progress, with only six poliomyelitis-endemic countries in the world. He noted, however, the danger of re-emergence of the disease in some African and Asian countries. His country had not recorded a case of poliomyelitis in the past 15 years, but had developed a plan to deal with any new cases, including the maintenance of high vaccination coverage in border areas and creation of a rapid response mechanism. Such precautionary measures were important, and would amply repay the international effort and resources required.

Dr CHITUWO (Zambia) thanked WHO, UNICEF, Rotary International and the Global Alliance for Vaccines and Immunization for their support for the eradication of wild-type poliovirus in his country. Zambia had adopted all the recommended strategies: strengthening routine immunization programmes, providing supplementary immunization where required, maintaining surveillance of acute flaccid paralysis and poliomyelitis, and conducting "mop-up" immunization campaigns in places where wild-type poliovirus had been detected.

Zambia had achieved certification-level surveillance of acute flaccid paralysis in 2003, a standard that would also detect imported polioviruses. A WHO-accredited virology laboratory was based at the University Teaching Hospital in Lusaka. Performance indicators for surveillance of acute flaccid paralysis had improved steadily, reaching 2.67/10 000 for non-poliomyelitis-related paralysis and over 90% for stool adequacy by December 2004. Zambia was to host the annual general meeting of the African Regional Certification Commission in October 2005. He hoped that a verification mission from the Certification Commission would certify his country's surveillance system in August 2005. However, since Zambia had borders with eight other countries and hosted many thousands of refugees, the success of its poliomyelitis campaign would depend on progress in the region as a whole.

Dr ELSAYID (Sudan) thanked WHO and other donors for their technical and material assistance. His country had succeeded in eradicating poliomyelitis for three years but, owing to the premature cessation of the immunization campaign in 2003, the disease had returned. There had been more than 120 cases of poliomyelitis in children in 2004, and 24 cases so far in 2005, the latest occurring in March. The country's geographical position had made it a buffer zone between Africa and the Arab world, and international assistance would be required to prevent the disease from spreading further.

The re-emergence of poliomyelitis in Sudan taught that no country could count itself safe while the disease was prevalent among its neighbours. It was vital to continue immunization campaigns and conduct additional campaigns where necessary, even at times of armed conflict. Routine immunization campaigns were extremely important. Sudan must work with neighbouring countries and even with the rebels in the west of the country to provide immunization for all children. It hoped to interrupt the transmission of poliovirus by the end of 2005, and asked for more assistance from WHO and neighbouring countries in that endeavour.

Mr OMASWA (Uganda), noting that his country had recorded no case of poliomyelitis for more than eight years and that all its surveillance mechanisms were fully operational, applauded headquarters and the Regional Office for Africa for keeping Member States informed of the recent outbreak, with the result that Uganda had received prompt notice of cases in neighbouring Sudan. On that information and working in collaboration with WHO, UNICEF, Rotary International, bilateral partners and civil society, Uganda had urgently undertaken subnational immunization days in 11 border districts. Synchronized with similar days in Sudan and other countries of the region, the immunization days had been successful. Uganda congratulated those countries unfortunately hit by

new infections but which had responded effectively, and was optimistic that, given the degree of national and global response, the target of eradication by the end of 2005 was still attainable.

Mr AL-NOAMI (Yemen) said that his country had been on the point of being declared poliomyelitis-free in the current year, when poliovirus had re-emerged in neighbouring countries. Yemen had restarted immunization campaigns in April, but should have done so in February. That delay had allowed the re-emergence of poliomyelitis in Yemen, with 83 cases confirmed and 23 currently under investigation. Working with Sudan, from which the wild-type virus had come, and other countries, Yemen had designed a new campaign using monovalent vaccine, which would start at the end of May 2005. Yemen lacked resources but needed five or six intensified house-to-house campaigns with full community participation in order to extend coverage. It also needed to increase surveillance. International cooperation in facing the threat of poliomyelitis was essential: the Member States had to help and WHO needed to be able to gather the necessary resources to face the new challenge.

Mr VAN OMMEN (Netherlands) recalled that his country had contributed substantially to the Global Polio Eradication Initiative, both financially and through its National Institute for Public Health, which served as a reference laboratory for wild-type poliovirus. Given current developments, the Netherlands had serious concerns about the feasibility of the eradication strategy in conflict and post-conflict areas, where immunization systems were weak and coverage low; that was where the virus was re-emerging. As national immunization days placed a disproportionate strain on weakened health systems, they should be restricted to areas in which their effectiveness had been scientifically demonstrated. An assessment would be welcome of whether the eradication of poliomyelitis was still feasible in the near future and, if not, what the contingency plan should be.

Mr EL-TAYEB (Egypt) said that, although the rate of infection from poliovirus had been reduced significantly, Egypt was still among the countries unable to be declared poliomyelitis-free. The health ministry had implemented many initiatives to eradicate the disease, supported by the political will expressed by the country's President. A working group comprising local and international experts had been set up in 2003 to track the programme, and a committee established to eradicate poliomyelitis in the provinces. A national three-dose vaccination campaign had been started in December 2004, reaching more than 11 million children and achieving coverage of over 99%. Wide media coverage had resulted in increased awareness. Religious leaders had participated in the campaigns, and some 60 doctors had been sent to the provinces every day to assist with the mission. Surveillance and detection had been intensive, and the necessary steps taken to isolate the virus in the cases detected. There had been no new case between May 2004 and May 2005. Thanking the Secretariat for the assistance it had provided to States in the Eastern Mediterranean Region, he said that Egypt hoped to rid itself of poliomyelitis. However, the re-emergence of the virus in many neighbouring countries meant that a great deal of cooperative effort was still needed.

Dr RAHMAN KHAN (Bangladesh) noted that his country had been poliomyelitis-free for more than four years, the last case dating back to August 2000. The Government had conducted many national immunization days up to 2004, but, as recommended by a technical consultative group, no further such interventions were being undertaken; rather, the emphasis was on strengthening routine immunization and enhancing surveillance for acute flaccid paralysis. However, given Bangladesh's long frontier with India, still a poliomyelitis-endemic country, there was still a threat of imported cases. For that eventuality, an emergency response plan was already in place. In the event of imported cases or detection of circulating vaccine-derived poliovirus, a nationwide mop-up operation would be undertaken within 21 days. Bangladesh intended to continue all necessary activities until it received poliomyelitis-free certification.

Mrs MENGISTU (Ethiopia) said that her country highly appreciated WHO's comprehensive support. Ethiopia had been poliomyelitis-free for four years and preparing for the certification process when the first two cases of imported wild-type poliovirus infection had been reported in December 2004, followed by four more. Her Government had tried to prevent importation of poliomyelitis by planning house-to-house vaccination campaigns, had had a request for funding pending with donors for two years, but had failed to secure that support. Had it been able to sustain its campaign, it would have prevented those importations, but all those years of hard work and investment seemed almost futile. If poliomyelitis were not eradicated from the populous countries of Angola, the Democratic Republic of the Congo, Ethiopia and Nigeria, it would be difficult to eradicate it from sub-Saharan Africa and the rest of the world. Consequently, Ethiopia urged that collaboration among countries be further strengthened and activities more closely synchronized to prevent import of poliovirus and further infection of children. Finally, Ethiopia thanked WHO, UNICEF, Rotary International, the Global Alliance for Vaccines and Immunization and other partners for their help and support.

Dr BRUNET (France) congratulated the Secretariat on its effective action in the Global Polio Eradication Initiative, and applauded the efforts of Member States directly concerned. Identification since 2004 of new foci of the disease in countries from which it had formerly disappeared certainly gave grounds for concern, but also demonstrated the effectiveness of the rapid detection system put in place. All shared the responsibility of ensuring that detection was followed by immediate and large-scale action, in order to eliminate new foci at the outset. France had reacted at the first signs of re-emergence of disease; it had allocated €30 million, over three years, to attaining the common goal of eradication. It had also provided technical assistance to affected countries, initially to Niger and currently to Chad, and had recently allocated €100 000 from its emergency fund for vaccination in the Tigre region in Ethiopia.

Continuing to uphold its responsibilities at national level, France had recently concluded an inventory of French laboratories still holding poliovirus, which since 2001 had been classified as material able to be turned into terrorist weapons, thereby making it possible to enhance traceability and biosecurity.

Ms DEL VALLE MATA LEÓN (Bolivarian Republic of Venezuela) thanked the Director-General and the spearheading partners of the Global Polio Eradication Initiative for their significant contributions towards the eradication of wild-type poliovirus, and urged Member States to upgrade their contributions and to devise more equitable funding strategies channelling support to Africa, Asia or any particular country involved. The appearance of new outbreaks made it necessary to review the strategies and imposed ongoing and sustained maintenance of financial support.

Dr YOOSUF (Maldives) said that his country had been free of indigenous poliomyelitis since 1981, with only one imported case since then. Immunization coverage exceeded 98% and the country had strong surveillance mechanisms for acute flaccid paralysis. It was concerned about the re-emergence of the virus in a country of the South-East Asia Region and equally concerned at the delay, of almost two months after detection, in WHO's sharing of that information. If the delay was due to limitations regarding the technology available, hard work was called for to rectify the situation, as early diagnosis and information-sharing were essential for successful global elimination of poliomyelitis.

Dr PHOOKO (Lesotho) said that, in 1979, the country had established an expanded programme on immunization to focus on vaccine-preventable diseases, including poliomyelitis. Its policy had been reviewed in 2001, with the involvement of all those concerned in child health issues. Further actions had included the development of a five-year immunization plan for 2001-2006, a financial sustainability plan and an injection safety plan. Lesotho's last poliomyelitis case had been in 1986, two years before the Health Assembly had adopted the goal of global poliomyelitis eradication. At regional level, WHO had selected Lesotho as a country for certification in 2005. Activities to that end

included surveillance for acute flaccid paralysis, national immunization days (the last of which had been in August 2004), supplementary immunization activities, middle-management training on the Expanded Programme on Immunization and the setting up of poliomyelitis certification committees. Lesotho thanked WHO and all its partners in those activities, including South Africa and other neighbouring countries, for its continuing support and was determined to remain vigilant in order that poliomyelitis might be eradicated in the region.

Mr OLANGUENA AWONO (Cameroon) said that poliomyelitis, whose resurgence had been observed three years previously, was a health emergency and its global eradication called for massive efforts. Cameroon was unfortunately in the resurgence zone. Since the adoption of the Declaration on Poliomyelitis Eradication in Africa, by the Heads of State and Government of the Organization of African Unity in Yaoundé in 1996, Cameroon had invested more than US\$ 18 million in poliomyelitis eradication and, since 1999, had recorded no further cases, thus attaining the pre-certification state in 2002. The detection of new imported cases had halted the certification process in 2003. Cameroon had therefore relaunched a campaign to combat poliomyelitis, synchronized with other countries in the region and with the support of WHO, UNICEF, Rotary International and other partners, to whom he expressed thanks.

Three of the five rounds in the vaccination campaign for 2005 had already been effectively carried out under high-level national leadership. Given its pivotal position between central and west Africa, Cameroon was determined to fulfil the role of immunological barrier entrusted to it by the international community. He expressed special thanks, in that regard, to the Director-General and his Representative for Poliomyelitis Eradication. Experience had shown, however, that only sustained investment in vaccination and high surveillance standards could provide countries with protection, and that constant strategic action had to be taken at the same level in all the countries concerned.

Dr AHMED (Pakistan) was confident that the goal of poliomyelitis eradication would be achieved, although he shared the concern about being slightly behind schedule. Unfortunately, Pakistan was one of the countries that still had poliovirus transmission, but he was optimistic that zero transmission would soon be achieved – it had been in 100 out of 126 districts in the country, and only seven cases had been reported during the current year. Every effort was being made to ensure that no eligible child was missed in the immunization rounds being carried out. Since Pakistan shared imported cases with Afghanistan, a synchronized mopping-up effort was required to stop transmission of the virus. The many challenges faced included social barriers to the accessibility of infants, areas of conflict, tribal communities and weather restrictions. His Government remained fully dedicated to eradicating poliomyelitis and was grateful to WHO and many other partners for their help.

Dr SINGH (India) said that his country was fully committed to halting poliomyelitis transmission by 2005 and would treat the detection of any poliovirus as a public health emergency. The poliomyelitis eradication programme had achieved remarkable success during 2003 in limiting the spread of poliovirus, since there had been only 225 cases. The Pulse Polio Programme was intensified in 2004, and the virus had been restricted to mainly two areas, Central Bihar and Western Uttar Pradesh, with a total of 134 cases being reported for that year. Two subnational immunization days had already been successfully held in January and February 2005.

Dr ASSI-GBONON (Côte d'Ivoire) said that nine rounds of national poliomyelitis vaccination days had been organized between 1997 and 2005, and no case had been notified up to 2002, when the military and sociopolitical crisis had broken out. The epidemiological situation had worsened progressively from 2003, and in 2004 17 cases of infection with wild-type poliovirus had been notified, thus classifying the country as one of those where poliomyelitis had reappeared.

She thanked WHO, UNICEF and the international community for supporting the organization of five national immunization days in 2005. The results of the first two had been generally satisfactory, with some four million children covered in February and five million in April. Much

work remained to be done with regard to monitoring acute flaccid paralysis. Since the quality of the action taken was of major concern in vaccination campaigns, the marking of children and homes had been instituted and independent evaluators were being used. Immunization activities were monitored by a national coordination committee, including representatives of the various partners, and by local bodies under the administrative authorities. Local recruitment of vaccinators had fostered more widespread acceptance of vaccination by the population. Efforts to promote more social mobilization had been organized in the country's 19 regions, launched and coordinated by the Head of State, the Prime Minister and members of the National Reconciliation Government.

Despite all efforts, however, there remained grounds for concern, particularly with regard to surveillance of acute flaccid paralysis, the attainment of full routine vaccination coverage and the synchronization of vaccination days with those of neighbouring countries. In order to speed up the certification of poliomyelitis eradication, her country requested the international community's support, especially in view of its current crisis. It was grateful to WHO, UNICEF, Rotary International, and other partners for the technical and financial support they had provided.

Dr AYDINLI (Turkey) said that, at the end of the poliomyelitis eradication programme implemented in Turkey since the early 1990s, the last wild-type poliovirus infection had been detected in November 1998, and the European Region (including Turkey) had been certified as free from poliomyelitis on 21 June 2002. However, the importation of poliomyelitis to Turkey would remain a threat unless it was completely eradicated from the world, and WHO was to be thanked for its efforts to attain that goal.

Dr OTTO (Palau) said that his country had had no case of poliomyelitis since the late 1960s. Thanks to the efforts of the Regional Office for the Western Pacific, the Region's Member States and international partners such as UNICEF and Rotary International, the Region had been declared poliomyelitis-free. Those countries remained vigilant, however, and their efforts included strong immunization programmes. In that regard, Palau was grateful for the continued assistance it received from the Government of the United States of America through the Centers for Disease Control and Prevention.

Dr JACKLICK (Marshall Islands) said that his country appreciated WHO's support and assistance in providing poliomyelitis vaccine. Although the health ministry had found no new case of poliomyelitis, he asked WHO to continue to make poliomyelitis vaccine available to the country.

Dr NYIKAL (Kenya) said that Kenya, in partnership with other countries, was striving to achieve the goal of global eradication and was committed to the new deadline of 2008. The strategies adopted to that end included strengthening routine immunization programmes, organizing national immunization days, strengthening surveillance for acute flaccid paralysis and carrying out mopping-up immunization activities. Although no poliomyelitis case had been confirmed since 1984, surveillance had been ongoing since 1996. In the past two years surveillance had met the required targets for certification; national and subnational immunization days for poliomyelitis had taken place between 1996 and 2002, with more than 90% coverage attained; and routine immunization coverage with oral poliomyelitis vaccine had improved. Emergency response campaigns had been conducted in three high-risk districts bordering Sudan, and Kenya was responding to conditions reported in Yemen by means of subnational immunization days in its coastal regions. Kenya faced the risk of importation of wild-type poliovirus because of its extensive air, sea and road links to endemic countries. He thanked WHO for the support it continued to receive.

Dr BELBEISI (Jordan) echoed the emphasis placed by previous speakers on the importance of eradication of poliomyelitis through routine vaccination, heightened surveillance of acute flaccid paralysis and the institution of national immunization days. Jordan had been poliomyelitis-free since 1997, and the country's current vaccination coverage was more than 96%. Constant vigilance was,

nevertheless, required, and national vaccination campaigns were undertaken, with focus on risk areas. Jordan thanked WHO for its constant support and remained deeply committed to the global eradication of poliomyelitis.

Dr GAMBOA PEÑARANDA (Costa Rica) said that, in the interest of saving the Committee's time, he simply endorsed all the views expressed by previous speakers.

Professor JOHNSTONE (United Kingdom of Great Britain and Northern Ireland) said that his country fully supported efforts to eradicate poliomyelitis. The world was close to stopping poliovirus transmission, and the new cases reported were a cause for concern. A major obstacle to achieving a poliomyelitis-free world was the lack of funding, and the current gap of US\$ 50 million must be closed. His country encouraged all Members to do their utmost to raise the necessary funds for 2005 and beyond.

Dr NAVARRO MARÍN (El Salvador) thanked WHO, UNICEF and Member States for enabling his country to succeed in its programme to eradicate poliomyelitis. In 1987 the last wild-type poliovirus had been isolated. Thanks to intensified vaccination programmes and epidemiological vigilance, the country had been free of the disease for 17 years. The national vaccination programme had been maintained, using the Sabin vaccine. Detection of mutation of the vaccine virus in Haiti and the Dominican Republic in August 2001 had prompted house-to-house vaccination campaigns, which had achieved 98% coverage. El Salvador continued its efforts to contribute to the goal of eradicating poliomyelitis in 2005, including surveillance of acute flaccid paralysis, and it was a matter for concern that, in some cases when enteroviruses were isolated, no link with pathology could be determined, which meant strengthening laboratory capacity for identification of enteroviruses.

With regard to the laboratory containment of wild-type poliovirus, 606 private and national laboratories had been surveyed, and no infectious or potentially infectious material had been found.

Dr MUKELABAI (UNICEF) said that his organization firmly believed that children must and could be protected against poliomyelitis and was encouraged by the commitment voiced, particularly by Nigeria on behalf of Member States of the African Region. The effort called for strong leadership in all fields, and commitment of the communities themselves. UNICEF would be present at all steps and would continue to manage the purchase and distribution of oral poliomyelitis vaccines, having recently procured the latest monovalent form, and to focus on children hardest to reach. It was alarming, however, that poliomyelitis was spreading to areas that had been free from the virus for many years. The cause in some areas was low immunization coverage. It was important to raise and sustain routine immunization coverage.

Poliomyelitis eradication was an example of global success and depended on strong partnerships. A lesson learnt from smallpox eradication was that eradication of poliomyelitis would become more difficult as the end was approached. That should sharpen resolve and determination to finish the job, thereby ensuring that all the world's children would be protected from poliomyelitis for ever.

Dr MBIZVO (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that the last remaining poliomyelitis-affected countries would require more aggressive support in the coming months. The strategy of synchronized national immunization days must be intensified, high-quality campaigns must be ensured, and partners must pledge their utmost support. Her Federation was continuing to expand its poliomyelitis eradication efforts, focusing on national societies in the countries most affected and strengthening its collaboration with other partners. Its network of volunteers was working in WHO's poliomyelitis priority countries. It paid serious attention to countries' capacity to mobilize their communities to promote successful immunization programmes, especially the efforts to ensure maximum coverage in difficult population groups. The presence of the Federation's volunteers in such communities, working in partnership with

government agencies and others having responsibilities for immunization, was vital to success and clearly showed how the auxiliary relationship between national societies and public authorities worked effectively at all levels, in every country. The Federation pledged its intensified efforts in the final assault on poliomyelitis.

Mr HÖRNDLER (Rotary International), speaking at the invitation of the CHAIRMAN, pledged the continued commitment of Rotary International's 1.2 million members to working with its partners until poliomyelitis eradication was certified. He paid homage to health leaders' tremendous dedication to the shared goal of a poliomyelitis-free world and to ensuring that every child was protected from a disease that was preventable by use of an effective vaccine. Yet the many obstacles of war, poverty and misinformation remained to be removed. Rotary's global network of community-based volunteers was committed to overcoming those challenges and any unforeseen global events that could impede eradication of the disease.

Rotary International, whose determination had provided the catalyst for the Health Assembly's resolution in 1988 on the eradication of poliomyelitis, remained committed to that target. Poliomyelitis eradication in Africa was feasible, even though the final leg would be the most challenging. The last endemic pockets were proving stubborn; unless they were eradicated the disease would again spread rapidly and cripple hundreds of thousands of children each year.

Countries had cooperated as never before by synchronizing immunization campaigns, and there had been unprecedented cooperation between national governments, United Nations agencies and the private sector. The financial support from donor governments, foundations and private citizens had been staggering, but, tragically, volunteers and health workers had lost their lives in the effort to reach children in areas of conflict.

The initiative to eradicate poliomyelitis had been hailed as the model to follow for other global health endeavours. With so much at stake, the historic opportunity must be grasped and the initiative completed successfully.

Dr HEYMANN (Representative of the Director-General for Polio Eradication) thanked Member States for their strong support and guidance, and for maintaining strong national poliomyelitis surveillance and immunization programmes. He had noted the concerns expressed about vaccine-associated paralytic poliomyelitis and vaccine-derived polioviruses. Fortunately, WHO was able to provide a framework for putting all such risks in perspective, as the move towards cessation of oral poliomyelitis vaccine continued. He was grateful to many of WHO's financial partners for their unprecedented support; the Group of Eight highly industrialized countries, in particular, had made a commitment to the 2005 budget and multiyear pledges to the Global Polio Eradication Initiative budget for 2006-2008. In addition, the African Development Bank would shortly be signing agreements with four African countries to provide emergency grants to combat the continuing poliomyelitis epidemic in sub-Saharan Africa. Member countries of the Organization of the Islamic Conference had also adopted a strong resolution to continue and complete the eradication campaign, following the lead given by Malaysia, Qatar and the United Arab Emirates in providing funding. He welcomed the most recent country partners to join the campaign, including France, Monaco, the Russian Federation, Spain and Sweden. Technical partners included the Centers for Disease Control and Prevention in the United States of America and the United Kingdom's National Institute for Biological Standards and Control; and the Bill and Melinda Gates Foundation had supported development of new diagnostic tests and the complete development of the new monovalent vaccine.

Poliomyelitis must be eradicated; as long as it was present in any one country, it would remain a threat to all. WHO would continue to rely on the advice of its advisory group, which in April had conducted a country-by-country review of progress in eradication. The group was concerned at the high level of risk in countries with high population densities, where transmission was easy. However, it was satisfied that the monovalent vaccine was available to those countries, and it was able to predict that transmission would be interrupted in the course of 2005. The group was reviewing the poliomyelitis situation in countries with ongoing conflicts and had been pleased to note that a meeting

of health ministers from the African continent, held in Geneva in January, had been attended by both the Minister of Health for the north of Sudan and the Director-General of Health for the south. A recent joint mission by WHO, UNICEF and Rotary International to the north of Côte d'Ivoire had enabled poliomyelitis eradication efforts to continue there. Routine immunization was the key to eradication, and must be strengthened through continuing collaboration with the Global Alliance for Vaccines and Immunization. It was encouraging that countries had continued their campaigns to top up routine immunization coverage and he was grateful to the donors who had provided funds in emergencies, including Australia, Canada, France, the United Kingdom of Great Britain and Northern Ireland, the United States of America and Rotary International.

The Committee took note of the report.

Health action in relation to crises and disasters: Item 13.3 of the Agenda (Resolution EB115.R11; Documents A58/6 and A58/6 Add.1) (continued from the second meeting)

The CHAIRMAN drew attention to the revision of resolution EB115.R11 incorporating amendments proposed by the delegations of Cameroon, Canada, India, Spain, Thailand, and the Bolivarian Republic of Venezuela:

The Fifty-eighth World Health Assembly,

Regretting the profound human consequences of the earthquakes and tsunamis that on 26 December 2004 struck many countries, from south-east Asia to east Africa, causing an estimated 280 000 deaths, with thousands more still missing, injuring as many as half a million people, and making at least five million people homeless and/or deprived of adequate access to safe drinking-water, sanitation, food or health services;

Noting that citizens of more than 30 countries were affected by the disaster, and that those who died included many health professionals;

Acknowledging that most relief assistance has initially been, and will continue to be, provided from within affected communities and through local authorities, supported through intense international cooperation, and expecting that these communities will continue to experience serious difficulties as a result of the loss of their means of livelihood, overloading of health and social services, and both immediate and long-term psychological trauma;

Recognizing that action to address the public health aspects of crises should at all times strengthen the ingenuity and resilience of communities, the capacities of local authorities, the preparedness of health systems, and the ability of national authorities and civil society to provide prompt and coordinated back-up geared to the survival of those immediately affected;

Appreciating the generous assistance provided to the affected nations by governments, nongovernmental groups, individuals, and national public-health institutions, including through the Global Outbreak Alert and Response Network;

Acknowledging the difficulties faced by under-resourced local health systems in locating missing persons, identifying those who have died, and managing the bodies of the deceased;

Recognizing the challenges faced by overwhelmed local authorities as they coordinate the relief effort, including personnel and goods generously made available as a result of both national and international solidarity;

Noting that the effectiveness with which affected nations respond to sudden events of this scale reflects their preparedness and readiness for focused and concerted action, particularly in relation to saving life and sustaining survival;

Recalling that more than 30 countries worldwide are currently facing major, often long-standing crises, with as many as 500 million persons at risk because they face a variety of avoidable threats to their survival and well-being, and that around 20 other countries are at high risk of serious natural or man-made events, increasing the number of persons at risk to between 2000 million and 3000 million;

Appreciating that analyses of health needs and performance of health systems, within the context of national policies and internationally agreed development goals, including those contained in the United Nations Millennium Declaration, are essential for the proper rehabilitation and recovery of equitable individual and public health services, and that this task is best undertaken if there are clear synergies between preparedness and response;

Reaffirming the need to build local capacity to assess risks, and to prepare for, and respond to, any future catastrophe, including by providing continuous public education, dispelling myths about health consequences of disasters, and reducing the risk of disaster damage in critical health facilities;

Recognizing that improvement of social and economic circumstances of the most disadvantaged countries is a preventive action that reduces the risk of crises and disasters and their consequences;

Taking into account the outcomes of the World Conference on Disaster Reduction (Kobe, Hyogo, Japan, 18 to 22 January 2005),

1. CALLS UPON the international community to continue, in response to countries' request, its strong and long-term support to areas affected by the tsunamis of 26 December 2004, and to give similar attention to the needs of people affected by other humanitarian crises;

2. URGES Member States:

(1) to provide adequate backing to tsunami-affected countries for the sustainable recovery of their health and social systems;

(2) to pay particular attention to mental health needs and establishment of service-delivery models in their health and social systems;

(3) to make their best efforts to engage actively in the collective measures to establish global and regional preparedness plans that integrate risk-reduction planning into the health sector and build up capacity to respond to health-related crises;

(4) to formulate, on the basis of risk mapping, national emergency-preparedness plans that give due attention to public health, including health infrastructure, and to the roles of the health sector in crises, in order to improve the effectiveness of responses to crises and of contributions to the recovery of health systems;

(5) to ensure that women and men have equal access to both formal and informal education on emergency preparedness and disaster reduction through early warning systems that empower women, as well as men, to react in timely and appropriate ways, and that appropriate education and response options are also made available to all children;

(6) to ensure that – in times of crisis – all affected populations, including displaced persons, have equitable access to essential health care, focusing on saving those whose lives are endangered, and sustaining the lives of those who have survived, and paying particular attention to the specific needs of women and children, older people, and persons with acute physical and psychological trauma, communicable diseases, chronic illnesses, or disability;

(7) to provide support for a review, within the Proposed programme budget 2006-2007, of WHO's actions in relation to crises and disasters, in order to allow for immediate, timely, adequate, sufficient and sustained interventions, and to consider increasing contributions in order to ensure adequate financing of significant WHO actions and interventions before, during and after crises;

(8) to protect national and international personnel involved in improving health of crisis-affected communities, and to ensure that they receive the necessary back-up to undertake urgent and necessary humanitarian action and relief of suffering – to the greatest possible extent – when lives are endangered;

(9) to strengthen information systems and to improve collaboration with national and international media in order to ensure the availability of accurate and up-to-date information;

3. REQUESTS the Director-General:

(1) to intensify WHO support for tsunami-affected Member States as they focus on effective disease-surveillance systems, and improved access to clean water, sanitation, safe foodstuffs, good quality essential medicines and health care, particularly for mental health, providing necessary technical guidance, including that on management of bodies of the deceased and avoidance of communicable diseases, and ensuring prompt and accurate communication of information;

(2) actively, and in a timely manner, to provide accurate information to international and local media to counter rumours in order to prevent public panic, conflicts, and other social and economic impacts;

(3) to pay particular attention to providing support to Member States for establishment of service-delivery models in their health and social systems;

(4) to encourage cooperation of WHO's field activities with those of other international organizations, with the support of donor agencies, so as to help governments of countries affected by the tsunamis to coordinate responses to public health challenges, under the aegis of the United Nations Office for the Coordination of Humanitarian Affairs, and to plan and implement the rapid and sustainable rehabilitation of health systems and services, and to report to the Health Assembly on the progress of such cooperation;

(5) to assist in the design of health aspects of programmes that provide support to persons whose lives and livelihoods have been affected by the tsunamis, and of the services needed to address their physical and mental trauma;

(6) to adapt, redesign where necessary, and secure adequate resources for effective work in the area of emergency preparedness and response, and other areas of work involved in the Organization-wide response to crises;

(7) to enhance WHO's capacity to provide support, within the coordination mechanisms of the United Nations system and of other institutions, particularly the International Red Cross and Red Crescent Movement, for formulating, testing and implementing health-related emergency preparedness plans, responding to the critical health needs of people in crisis conditions, and planning and implementing sustainable recovery after a crisis;

(8) to establish clear lines of command within WHO in order to facilitate rapid and effective responses in the initial stages of an emergency, and to communicate those arrangements clearly to Member States and other partners in the United Nations system;

(9) to mobilize WHO's own health expertise, to increase its ability to locate outside expertise, to facilitate effective collaboration between local and international expertise, to ensure that knowledge and skills are updated and relevant and to make this expertise available in order to provide prompt and appropriate technical support to both international and national health disaster preparedness, response, mitigation and risk-reduction programmes;

(10) to foster WHO's continued and active cooperation with the International Strategy for Disaster Reduction, thereby ensuring adequate emphasis on health-related concerns in the implementation of the outcomes of the World Conference on Disaster Reduction (Kobe, Hyogo, Japan, 18 to 22 January 2005);

(11) to ensure that WHO helps all relevant groups concerned with preparation for, response to, and recovery after, disasters and crises through timely and reliable assessments of suffering and threats to survival, using morbidity and mortality data;

coordination of health-related action in ways that reflect these assessments; identification of, and action to, fill gaps that threaten health outcomes; and building of local and national capacities, including transfer of expertise, experience and technologies, among Member States, with adequate attention to the links between relief and reconstruction;

(12) to strengthen existing logistics services within WHO's mandate, in close coordination with other humanitarian agencies, so that the necessary operational capacity may be available for Member States to receive prompt and timely assistance when faced with public health crises;

(13) to develop models and guidelines for rapid health-impact assessments after crises, in order to assure appropriate, timely and effective response to affected communities;

(14) to inform the Fifty-ninth World Health Assembly, through the Executive Board, of progress made in the fulfilment of this resolution.

Mr LEPPÖ (Finland), noting that gender-based violence was not mentioned in the text of the revised resolution, suggested inclusion of a new subparagraph after paragraph 2(5), to read: "to pay particular attention to gender-based violence as an increasing concern during crises, and to provide appropriate support to those affected;". For the sake of consistency with the title of the draft resolution, he also suggested adding, after the words "tsunami-affected countries" and "tsunami-affected Member States" in subparagraphs 2(1) and 3(1) respectively, the words "and all other Member States affected by disasters and crises".

Dr LARIVIÈRE (Canada) supported that proposal. Violence against women in crises was wholly unacceptable and, while health and social services were being restored, monitoring systems should be set up to prevent it.

Mr FERRER RODRÍGUEZ (Cuba), supported by Mr PERDOMO (Bolivarian Republic of Venezuela), proposed two further subparagraphs in paragraph 2 (subparagraphs 2(11) and 2(12), respectively): "to enhance international solidarity and identify mechanisms for joint cooperation in the development of emergency preparedness and response strategies;" and "to consider possible mechanisms and modalities for the rapid availability of global funds in the event of disasters, so as to allow a prompt and effective response".

Ms VALDEZ (United States of America) suggested substituting the term "resources" for "global funds", because the latter term had different connotations from one country to another.

Dr LARIVIÈRE (Canada) was anxious to ensure that the United Nations Office for the Coordination of Humanitarian Affairs retained its mandate, in the context of United Nations operations, to assess needs and issue consolidated appeals to the international community. Much of the work done in response to disasters and emergencies required funding in both the immediate and longer term. He suggested inserting, before the proposed subparagraph 2(12), the words "in the context of the responsibility of the United Nations Office for the Coordination of Humanitarian Affairs".

Mr FERRER RODRÍGUEZ (Cuba) said that his proposal was not confined to existing mechanisms; it was meant to include bilateral and other donors. The text could perhaps refer to the "availability of resources, including global funds". He would have difficulty in accepting that funding in disaster response should be conditional on action by the Office for the Coordination of Humanitarian Affairs. Various bodies, including WHO and bilateral and regional donors, were directly involved in providing resources of all kinds – human, financial and technical.

Dr LARIVIÈRE (Canada) suggested setting up a small drafting group comprising the delegations concerned to redraft the text of the resolution.

The CHAIRMAN requested that the delegations of the United States of America and Cuba seek agreement on the text.

(For approval of the draft resolution, see summary record of the fourth meeting, section 1.)

Sustainable financing for tuberculosis prevention and control: Item 13.4 of the Agenda (Resolution EB114.R1; Document A58/7)

Mr GUNNARSSON (Iceland, Representative of the Executive Board), introducing the item, said that sustainable financing was a key issue in progress towards the target for 2015 relevant to tuberculosis in the Millennium Development Goals. A global plan to achieve that target would be launched towards the end of 2005. The resolution on sustainable financing for tuberculosis prevention and control was framed by the global plan in the context of strengthening health systems.

At its 114th session, the Executive Board had adopted the relevant resolution, having discussed in particular how to fulfil commitments to ensure sufficient resources to achieve the target for 2015; how to ensure that all tuberculosis patients had access to the universal standard of care consistent with the DOTS strategy; and how to strengthen prevention of and social mobilization against tuberculosis.

A personal visit to a hospital where people with tuberculosis were being treated had clearly shown him the importance of the task, and the Executive Board considered it very important that the Health Assembly should consider the report and adopt the draft resolution contained in resolution EB114.R1.

Dr RUIZ (Mexico) supported the draft resolution, but suggested strengthening it by adding, between paragraphs 1 and 2, a form of words to encourage the financial and social institutions to become involved by setting up Stop TB partnerships in each country.

Dr KAMUGISHA (Uganda), speaking on behalf of the African group, said that tuberculosis, compounded by malnutrition and the close link with HIV infection, remained a major cause of morbidity and mortality, especially in sub-Saharan Africa. Activities aimed at controlling tuberculosis and HIV infection should be coordinated between the two programmes for those diseases. Overall, a special focus on Africa was necessary over the coming few years in order to mobilize resources and improve the quality of efforts. The African group therefore supported the Roadmap for TB Control in Africa that had been endorsed by the Stop TB Partnership Coordinating Board (Addis Ababa, 4 May 2005). Furthermore, in order to have full control of tuberculosis at community level, control programmes needed to provide support to public-private initiatives, so that the highest standards of care could be ensured and high levels of detection and cure achieved in both the public and non-public health systems. The roles of political leadership and ownership, partnerships, community involvement and a strong health system were recognized in effective tuberculosis control. The African group therefore supported the work on capacity building to strengthen human resources and laboratory services and looked forward to receiving the necessary technical assistance.

While noting good progress towards the Health Assembly targets for 2005, with projections of a global case-detection rate of 60% and a global cure rate of 82% by the end of the year, he recommended that a definitive report on achievements in global tuberculosis control should be submitted to the Health Assembly in either 2006 or 2007. The African group also supported the notion that those operational targets should be constantly monitored and achieved in all countries as soon as possible, so as to reach the more important impact targets of reducing incidence, prevalence and mortality, as set out in Millennium Development Goal 6. WHO should work towards incorporating the new elements of tuberculosis control, as defined in the draft resolution, into a comprehensive strategy to enable the Millennium Development Goals to be reached in 2015. Long-term planning for 2006-2015 could best take place through the second Global Plan to Stop TB, underpinned by country-specific plans that were sustainable and clearly budgeted. Member States in the African Region would work towards drawing up such plans. They supported the concept of intensified

resource mobilization to meet programme needs in countries. In that context, he suggested that Member States should set up TB/HIV collaborative programmes, bring tuberculosis prevention and control activities into the mainstream of their health development plans, and form a Stop TB partnership at country level. The African group also urged the Director-General to provide regular reports on progress towards attainment of the targets in the Millennium Development Goals; to ask for tuberculosis to be singled out in Goal 6, rather than being included among other diseases; and to promote research into and development of new tools for tuberculosis control, as part of the Global Plan to Stop TB.

Mr BELOT (South Africa), agreeing with the previous speaker, emphasized the importance of developing better diagnostic tools for tuberculosis and medicines with shortened treatment courses, and only minimal side-effects.

Mr RYAZANTSEV (Russian Federation) acknowledged the importance of international cooperation and the work done by WHO and many other international organizations in combating tuberculosis worldwide, including in his country. He supported the DOTS strategy in general but did not agree with all the positions so far as its implementation in his country was concerned. The current programme would accordingly be supplemented by giving priority to preventive measures; actively identifying individuals with clinical symptoms and/or positive X-ray results; and adopting a comprehensive approach to treatment that included chemotherapy, surgery and immunomodulatory therapy. Treatment success was defined to include not only bacteriological and clinical cure but also restoration of the patient's work capacity and social functioning. He favoured devising a comprehensive strategy for tuberculosis control that, inter alia, dealt with drug resistance and HIV-related tuberculosis.

Dr YUSHARMEN (Indonesia) said that financing was only one aspect of securing the sustainability of tuberculosis control. There should also be effective advocacy to all parties, especially decision-makers, to emphasize the burden of the disease and the cost-benefit ratio of investment in DOTS. There should be stronger partnerships and cooperation with all stakeholders, including hospitals, private practitioners and community-based institutions, to ensure that the DOTS services were accessible, accountable and evenly distributed; they should be an integral part of primary health services. The DOTS strategy should be incorporated into the curricula of health-related educational institutions, and the emphasis of training should be shifted to human resource development covering pre-service education, in-service training and supervision. Minimum service standards (including the DOTS strategy) should be applied and met in all health-care facilities.

(For continuation of the discussion, see summary record of the fifth meeting, section 3.)

The meeting rose at 12:40.

FOURTH MEETING

Wednesday, 18 May 2005, at 15:00

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)

1. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Health action in relation to crises and disasters: Item 13.3 of the Agenda (Resolution EB115.R11; Documents A58/6 and A58/6 Add.1) (continued from the third meeting)

The CHAIRMAN drew attention to an amendment to subparagraph 2(12) of the revision of the draft resolution proposed by the delegations of Canada, Cuba and the United States of America, which read:

“to consider improving existing intergovernmental humanitarian assistance mechanisms and possible additional mechanisms and modalities for the rapid availability of resources in the event of disasters, so as to allow for prompt and effective response.”

The draft resolution, as amended, was approved.¹

2. PROGRAMME BUDGET 2002-2003: PERFORMANCE ASSESSMENT REPORT: Item 11 of the Agenda (Documents PBPA/2002-2003 and PBPA/2002-2003 Corr.1)

Mr GUNNARSSON (Iceland, Representative of the Executive Board) said that the Executive Board had commended the new method of presenting the programme budget and the performance assessment report, which members had found more transparent and comprehensible than the previous format.

An initial draft of the assessment report had been made available to Member States in May 2004. The report had then been revised in the light of comments received, and discussed in depth by the Programme, Budget and Administration Committee before the 115th session of the Executive Board. The Board had supported the principle of performance assessment, since that provided valuable information permitting analysis of the implementation of the budget during the biennium, the extent to which programmes and activities had met expectations and the way in which priorities set by the Health Assembly had been respected. Particular attention had been paid to the sections on lessons learnt and critical impediments, which identified difficulties that needed to be tackled. It had been noted that the report's frank analysis demonstrated the new spirit of transparency and accountability prevailing in WHO and that it had provided useful input for the preparation of the Proposed programme budget 2006-2007.

The Board had reviewed and noted with appreciation the performance assessment report on the programme budget 2002-2003.

Dr NORDSTRÖM (Assistant Director-General) said that the production of the performance assessment report had been an important step towards improving the results-based managerial

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA58.1.

framework and securing increased accountability. Member States' comments had proved useful for revising the report. The Secretariat hoped that it would be possible to present the Fifty-ninth World Health Assembly with a performance assessment report covering the results and expected outcomes of the work of the Organization together with the financial report for 2004-2005. An interim medium-term progress report (2004) had recently been discussed by the Programme, Budget and Administration Committee with a view to providing an up-to-date report on financial matters and results.

The performance assessment report was noted.

3. PROPOSED PROGRAMME BUDGET 2006-2007: Item 12 of the Agenda (Documents PB/2006-2007 and Corr.1, A58/INF.DOC./1 and A58/INF.DOC./3)

Mr GUNNARSSON (Iceland, Representative of the Executive Board) explained that the Director-General's programme budget proposals for 2006-2007 had first been reviewed at the first meeting of the Programme, Budget and Administration Committee, held before the 115th session of the Executive Board. Members of the Board had welcomed the results-based approach and the strategic directions proposed. Nevertheless, some comments had been made and clarifications sought on some points. They considered that goals in some areas of work needed to be revised in order to achieve consistency, to clearly indicate commitments to accepted health goals and to highlight collaboration with other organizations and partners. They had also noted the need to revise some of the expected results, targets and indicators in order to reflect more accurately the current burden of disease and the priorities set by the governing bodies. It had also suggested that some funds should be reallocated to different areas of work within the budget proposals.

The Board had noted with concern the rapid decrease during the previous decade of the proportion of the overall budget constituted by the regular budget and its possible effects on governance, ownership of the Organization, WHO's normative functions and its ability to carry out certain technical activities that were not particularly attractive to donors.

The Director-General's proposal for a 9% increase in the regular budget and its allocation to countries and regions had given rise to concern among some members, some of whom had rejected any increase; others had believed that it was justified. The Director-General had noted the various views expressed and undertaken to present revised proposals for a programme budget to the Health Assembly.

Dr NORDSTRÖM (Assistant Director-General) said that the Director-General was committed to ensuring a participatory process during the preparation of the budget, so that the latter properly reflected Member States' needs and expectations. Consultations had already begun in mid-2004 with briefings of the missions in Geneva. Thorough discussions had taken place in the regional committees, the Programme, Budget and Administration Committee and the Executive Board. An attempt had been made at all times to take account of Member States' suggestions and priorities.

The Board had requested the Director-General to review some text of the budget, strategic directions, and expected results and indicators. That had been done. The Board had also requested some minor reallocations of resources, as indicated on page 2 of document PB/2006-2007. The suggested total programme budget amounted to US\$ 3300 million, an overall increase of 17%, which was to be funded by a 4% rise in assessed contributions to the regular budget. That represented a reversal of the trend in recent years, but the total volume involved was still small. A growth in the budget by that amount would ensure that the Organization's priorities could be maintained, core activities would be adequately financed and savings could be achieved in transaction costs. It was also suggested that funding through voluntary contributions should go up by 23% in order to finance the budget.

A comparison of the Organization's income in 2002 with that in 2004 would show that its income from voluntary contributions had grown by 36%. That was a welcome token of Member States' trust in the Organization and, for that reason, the proposed 23% increase appeared to be realistic.

The CHAIRMAN invited consideration of the general issues in Part I of document PB/2006-2007.

Dr PARIRENYATWA (Zimbabwe), speaking on behalf of the Member States of the African Region, welcomed the fact that the proposed programme budget constituted a marked improvement in the allocation of resources, but regretted that his Region's expectations had not been met. Although the net effect of the proposed increases would be higher contributions for 10 African States, his Region had endorsed the proposed budget and its representatives had actively participated in the deliberations at the 115th session of the Executive Board, at which a general consensus to adopt the budget had been reached.

Africa was still battling with malaria, HIV/AIDS, tuberculosis, problems in the areas of maternal, infant, child and adolescent health, poliomyelitis and viral haemorrhagic fevers. The budget allocations to regions should be commensurate with their disease burden. The appropriations earmarked for HIV/AIDS, malaria and tuberculosis, which reflected marginal increases of 20%, 11% and 9% respectively, clearly fell far short of real requirements.

The programme budget 2006-2007 ought to underpin areas of work conducive to faster progress towards the achievement of the Millennium Development Goals, especially in the fields of sexual and reproductive health, in keeping with resolution WHA57.12, and which would also make it possible to honour the commitments accepted in resolutions WHA55.25, WHA56.20 and WHA56.21 on improving child survival, WHA57.14 and WHA53.1 on tackling the global pandemics of HIV/AIDS, tuberculosis and malaria, WHA57.9 and WHA57.10 on promoting healthy environments and WHA56.27 and WHA55.14 on increasing access to essential medicines. More resources might have been allocated for the effective implementation of those resolutions.

He commended the Director-General's efforts to strengthen health systems at country level by allocating more resources to countries and regions. The African Region also noted with satisfaction the participatory nature of the budgetary process, which should be continued. It took note of the six specific areas of work to which special emphasis would be given in the 2006-2007 biennium, but urged consideration of funding for human resources for health and the strengthening of health systems, including essential medicines. The outbreak of Marburg disease in Angola had underlined the need for the allocation of significant funds to the Region under the epidemic alert and response programme.

While the proposed allocation of resources was generally to be welcomed, the level of programme-specific funds from voluntary contributions was a matter of concern. It would be better if their purpose was not specified, so that the Director-General had greater flexibility and discretion in their disbursement and could finance the two areas of special importance to the African Region. Moreover it was to be hoped that programme-specific funds would not deprive deserving cases of the requisite resources because the latter were tied to conditions determined by political, rather than social and humanitarian considerations. If the targets set in the programme budget were to be achieved, it would be necessary to place the requisite resources at the disposal of the Director-General.

Mr NAKAZAWA (Japan) said that his country was committed to continue providing financial and technical contributions to WHO. In order to respond promptly to health crises at all levels, WHO needed to strengthen and streamline its activities. Improvements were not achieved only through budgetary increases. Proper priority-setting followed by adequate resource allocation, coordinated implementation, monitoring, evaluation and feedback were all key components of better performance.

Japan had some concerns regarding the Proposed programme budget 2006-2007 overall. The efforts to decentralize functions to the regional and country levels did not go far enough and did not meet the expectations for the new administration. While the proportion of resources allocated to headquarters from all sources of financing had declined to 25%, the absolute value remained the same

or was slightly increased, so that there appeared to be no curtailment of activities at headquarters. Moreover, analysis of the information provided in Figure 1 and Annex 2 suggested that the proportion was closer to 30%. The headquarters allocation should be revised with a view to making a reduction in real terms.

The imbalance between the regular budget and voluntary contributions and the specification of use of the latter were cited as justification for an increase in the regular budget. However, the problem lay rather in the lack of basic principles for the allocation of finance from the two different sources across a single organization, which resulted in over-funding of some areas and under-funding of others. In addition, voluntary contributions were often solicited by individual units rather than in a coordinated and strategic manner by the Organization as a whole. The proposed programme budget should be adjusted to redress the situation by allocating the regular budget to areas of high priority and requesting voluntary contributions to areas with insufficient funding, or by allocating the regular budget to areas with insufficient funding in a more strategic way.

The combined increases for the 2006-2007 and the 2004-2005 bienniums amounted to a 41% rise in four years which was large and raised concerns about fiscal discipline. Moreover, project support costs, which were supposed to account for 13% of voluntary contributions, were not always properly collected, with the shortfall having to be met from the regular budget. WHO should strengthen and streamline its activities but not in a way that would necessitate an increase in the regular budget when there remained room for further improvements in efficiency.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) welcomed the report on implementing the normative and statutory functions of WHO (document A58/INF.DOC./3) and endorsed the principles and practices proposed therein. The statutory function of WHO demanded integrity, impartiality and avoidance of potential influence resulting from earmarking of voluntary contributions by donors. The Proposed programme budget 2006-2007, although well prepared, showed the continuing trend towards reliance on extrabudgetary funds, which would represent 72% of the total compared with 69% in 2004-2005. The proposed increase in the regular budget was only 4% compared with a projected 23% for extrabudgetary resources. As a consequence, the Secretariat, whose staff members' salaries were financed from the regular budget, would be required to serve programmes financed by specified voluntary contributions with the potential for activities to be dictated by the donors and not by Member States. How could that trend be addressed in the course of the General Programme of Work 2006-2015?

The programme budget was an important tool for ensuring that the priorities set by Member States through Health Assembly resolutions and decisions were respected. Analysis indicated, however, that not all the priorities had been adequately reflected in the Proposed programme budget 2006-2007. It was disappointing that the greatest reductions in regular budget allocations were for Human resources for health, Health system policies and service delivery, and Policy-making for health in development (26%, 25% and 19%, respectively). Resolution WHA57.19, International migration of health personnel: a challenge for health systems in developing countries, had been the result of intensive negotiation and had specifically requested the Director-General to include human resources for health development as a top priority programme area in the General Programme of Work 2006-2015, yet it had been allocated only 2.41% of the total WHO budget compared with 2.66% in 2004-2005. International migration of health workers was a continuing problem for developing countries, and it was a global inequity that staff trained at the expense of such countries were serving patients in developed countries. Why was there such a discrepancy between the Health Assembly resolution and the proposed programme budget allocation, and how could the problem be overcome? The Director-General was accountable for the implementation of Health Assembly resolutions, and measures should be instituted to prevent such discrepancies in the future.

Dr GØTRIK (Denmark), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, expressed strong support for an increase in the overall level of the proposed programme budget in order to meet global health needs. Attainment of the Millennium Development Goals demanded an empowered WHO with adequate budgetary resources. The

increasing imbalance between the regular budget and voluntary contributions and the potential for a decreasing influence on the direction and priorities of WHO's work by the governing bodies were a major concern.

Noting the need for burden-sharing, predictability and stability, he supported an increase in the regular budget together with increased efforts to make reallocations, set priorities and find efficiency savings. The projected 23% increase in voluntary contributions might, however, prove optimistic, and he requested information on the budgetary consequences and adjustment mechanisms needed in the case of a shortfall. He urged donors to avoid, as far as possible, specifying the use of voluntary contributions to allow for expenditures in line with the core priorities set by WHO's global and regional governing bodies.

He endorsed the Director-General's objectives of achieving transfers of resources from headquarters to the regional and country levels of 70% of total resources in 2004-2005 and 75% in 2006-2007. Recent figures showed, however, that for 2004 the level had reached only 58%, and additional measures were needed to accelerate the process. He requested the Director-General to report to the Executive Board and the regional committees on progress towards the attainment of the targets. Programme budget performance assessment should be developed further to enhance its effectiveness in identifying and rectifying under- or over-funding of priority areas of work and the over-dependency of any one area on voluntary contributions. The Director-General should use his reallocation authority to prevent gross imbalances and to secure adequate resourcing of WHO's follow-up of the Millennium Development Goals.

He endorsed the six areas of work designated to receive greater emphasis and additional resources, in particular at the country level. Making pregnancy safer and Child and adolescent health were of particular importance for the attainment of the health-related Millennium Development Goals. Efforts to improve management were to be welcomed. The new global results-based management system should serve the governing bodies well as a tool for good governance.

The budgetary implications of new governing body resolutions should be presented, in conformity with the Financial Regulations, to ensure greater alignment between the programme budget and General Programme of Work on one hand and the available resources on the other. Such an approach would facilitate the setting of priorities for allocating resources in line with the principles of results-based management and health needs. It would also benefit the moves to harmonize the activities of other United Nations organizations and donors.

The Nordic countries looked forward to the Board's forthcoming discussion of the revised set of guiding principles, based on objective criteria, to be applied in the allocation of funds from all sources. The introduction of a validation mechanism and a needs-based index to ensure that resources were allocated to countries in greatest need on the basis of national health and socioeconomic indicators was to be welcomed.

Dr VIOLAKI-PARASKEVA (Greece) said that the format of the Proposed programme budget 2006-2007 was a considerable improvement over that for 2004-2005 and resulted in a more coherent policy and budget for a single uniform WHO. Any attempt to simplify and shorten the document was to be welcomed. However, while the programmes for all areas of work had been prepared in a way that allowed evaluation and a clear perspective on responsibilities, further work was needed to refine goals, objectives and expected resources. It was also essential to maintain links with the Programme budget 2004-2005 in order to preserve continuity and to show the progress made over the two bienniums. It might be useful to provide an executive summary giving qualitative indicators and a review of the results achieved. There should also be a link between resources and expected results. She welcomed the incorporation of voluntary contributions in the figures provided and noted the projected increase in such funds. The proposed programme budget showed a strong commitment to effective and efficient implementation.

Mr LOZINSKIY (Russian Federation) welcomed the principle of preparing a budget oriented towards the achievement of the Millennium Development Goals, and the proposed additional resources for six specific areas of work. Attempts to redress the balance between assessed and

voluntary contributions were welcome, although that goal was unlikely to be achieved in the short term. Given the difficulties associated with the use of voluntary contributions, the Secretariat should, to the extent possible, coordinate the process for the allocation of such contributions among priority areas of work.

The Russian Federation had no objection in principle to a slight increase in the regular budget to reflect increasing costs and inflation, detailed information about which had regrettably not been provided. It also welcomed results-based budgeting. However, while the format of the budget had improved significantly, further improvements could be made. Many indicators were difficult to assess, and more quantitative indicators reflecting qualitative changes should be used. For example, the naming of countries in which activities were being undertaken would enable Member States to evaluate budget implementation in the future and to monitor the strategic distribution of resources region by region.

A major shortcoming was the absence of any correlation between expected results and funding. Some activities did not appear to have been greatly affected by the cutbacks made since the first draft of the budget, and he wondered why additional resources needed to be allocated if no additional outputs were expected. The task indicators, not the expected results, should change in each financial period, showing whether progress had been made.

Ms BLACKWOOD (United States of America) commended the clear presentation and results-based focus of the Proposed programme budget 2006-2007 and welcomed the progress made in setting more effective indicators and making evaluations and programme assessments to bring about increased performance and accountability. The new global management system to become effective in 2006 would undoubtedly result in more efficient working methods through effective management of human, physical and financial resources, and it was to be hoped that its progressive implementation would yield real savings in the longer term.

With regard to the strategic directions and priorities, she noted the emphasis on accelerating progress towards achieving the internationally agreed development goals of the Millennium Declaration, which encompassed the Making pregnancy safer, Child and adolescent health, HIV/AIDS, Tuberculosis, Malaria, Health and environment and Essential medicines areas of work. Efforts to achieve the goals of reducing infant and maternal mortality were not on track, and their attainment would require additional resources and leadership.

She strongly supported the increased emphasis on and resources for the areas of work concerned with epidemic alert and response and noncommunicable diseases – core activities in the light of the shifting disease burden. Nevertheless, hard choices would continue to have to be made in respect of the activities that had lower priority for WHO. The United States continued to advocate budget discipline, accountability and efficiency at all levels of implementation and prioritization and urged WHO to improve transparency in future budgets and provide information about the extent to which proposed increases were the result of programme changes rather than economic factors. She endorsed the previous comment that the governing bodies should receive, as standard practice, full information on the resource implications of new resolutions, in accordance with the Financial Regulations.

The proposed programme budget reflected a move towards the integration of the work carried out under the total resources available, and would enable Member States to provide better governance of expenditures in line with the priorities set by the Health Assembly. Her Government was prepared to join consensus on the proposed 4% increase in the regular budget, and was pleased to note that the Secretariat had revised its budget proposal in the light of the views expressed by Member States.

Dr QI Qingdong (China) said that China recognized that the six specified areas of work required additional resources, but trusted that the resources available for HIV/AIDS, tuberculosis, malaria and other major diseases would still be adequate. Although any increase in the overall budget level would improve the chances of attaining the Millennium Development Goals, the amount of the increase should be discussed with Member States. China supported the Director-General's initiative to promote decentralization of resources, but was concerned that the resources allocated to the Western Pacific Region had increased by only 0.3%. The work of country offices should be evaluated to ensure that

the resources were being spent on improving health capacities and situations, and meeting the demands of States, rather than administrative tasks.

Mr MCKERNAN (New Zealand) said that the overall budget increase of 17.4%, a significant increase on previous years, might pose a challenge for WHO. Robust programme planning, implementation, monitoring and accountability must be in place across all programme areas to ensure that resources were not wasted. The Director-General should therefore establish clearly-defined targets at individual programme level to ensure increased programme activity commensurate with such an increase.

The heavy reliance on voluntary contributions was a matter of concern and required further debate as, based on current trends, only 17% of total funding for WHO would come from regular budget financing by 2015. WHO existed for its Member States, a fact that should be reflected in its overall financing mix. Furthermore, little consideration was given in the proposed programme budget to the action to be taken in the event of a lower than expected level of voluntary contributions. A clear and transparent mechanism should exist to deal with such a situation, and its implications should be understood at a programme level.

The reduction in the percentage expenditure at headquarters to previously established target levels had, to a large extent, been achieved by means of significant revenue increases applied at a regional level; in real terms, however, expenditure at headquarters had not decreased. The efficiency measures outlined in the proposed programme budget and the recommendations included in the audit reports should therefore be implemented promptly.

Mr KESSLER (Switzerland) said that, although the balance between regular budget and voluntary contributions was not entirely satisfactory, it was not realistic to expect to be able to increase assessed contributions. The budget was a global one, set out in a transparent and detailed document. To make it more transparent, information on the financial implications of the resolutions to be adopted by the Health Assembly and on the consequences of a fall in voluntary contributions below expected levels might be provided.

Dr BRUNET (France) recalled that, at the 115th session of the Executive Board, the member for France had supported the proposed budget despite the size of the proposed increase, as it sought to redress the imbalance between regular budget and voluntary contributions. However, the proposed programme budget before the Health Assembly was not the same as the one submitted to the Executive Board either in terms of structure or proposed increase. France continued to support the general direction of the budget, but was concerned about the risks being taken by WHO and the increasing imbalance that would result.

He endorsed the comment of a previous speaker on the need for an adjustment mechanism in the event of lower than expected levels of voluntary contributions, but questioned the likelihood of a significant proportion of voluntary contributions being unearmarked by donors. For that to be the case, there would have to be a greater exchange of information on priorities in order to define the areas in which WHO was competent to act, highly effective, and more likely than other institutions to make a difference. Considerable responsibility on the part of Member States and work on the financial implications of resolutions before the Health Assembly would also be required.

The efforts to establish a resource allocation mechanism for the long term were commendable, but more work was required to establish priorities. The discussion on the different components of the budget should also include the detailed exchange of information necessary if the budget were to be approved.

Dr AL KHARABSEH (Jordan) endorsed the proposed budget increase, but emphasized the fact that some countries in the Eastern Mediterranean Region were in great need of financial resources. Those countries were in conflict or post-conflict situations, under occupation, or indirectly affected by such situations. The Region also faced a huge burden in terms of communicable and noncommunicable diseases; resources should be allocated to complement national efforts in those

areas. The Director-General's efforts to promote decentralization of funds to countries and regions were commendable.

There appeared to be no resource allocation for the prevention and control of genetically-transmitted diseases or support to countries in preparing for the implementation of the revised International Health Regulations, and the question should be given further consideration.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) commended the ongoing efforts to refine the biennial budget. The documents before the Health Assembly sought to identify resource streams associated with priority areas and markers against which performance could be measured. The performance assessment report on the Programme budget 2002-2003 and results-based management had made an important contribution to that process. WHO led the way in seeking to make explicit connections between resources and outputs, some of which were inevitably broadly defined. However, attempts to provide better information and improved transparency could leave the budget open to more questions. The budget development process had been extensive and complex, but the output from the regional consultations could have been reflected in the documentation submitted to the Executive Board at its 115th session. The revisions that had been made in the light of the Board's discussions were nevertheless welcome.

His Government fully supported the strategic directions and priorities, the process for their ongoing review and efforts to seek greater efficiency. Efforts should continue to be made to ensure that voluntary donations, received at whatever level, were used for priorities agreed by the governing bodies; to clarify contingency planning to deal with any shortfall in projected levels of funding; to ensure that, in the event of an emergency, such as an outbreak of pandemic influenza, extra demands on WHO were met, to the extent possible, from within existing budgetary resources; to elaborate the work further at country level; and to continue to seek new ways of operating at country level. The United Kingdom had made a long-term commitment to make available unearmarked voluntary funds. It urged the Director-General to continue to explore ways of attracting such donations, to further efforts to ensure a more equitable distribution of resources between regions based on need, and to establish annual efficiency targets.

Mr VAN DER HOEVEN (Netherlands) said that budget discipline remained the most important guideline for resource requirements. However, in view of the relevance of WHO's activities and good management, his country would support a modest increase in the budget. WHO's activities benefited all countries, and should not depend on increased voluntary contributions. The proposed budget increase should therefore be financed from assessed contributions.

Ms DE HOZ (Argentina) welcomed the participatory process for drawing up the proposed programme budget. She endorsed the statement made by the African group on essential medicines. Access to those medicines should be a priority area of work and, accordingly, should be included among the strategic directions and priorities in the programme budget.

Mr MACPHEE (Canada) reiterated Canada's support for the proposed programme budget. He was aware of the challenges facing WHO in responding to requests to undertake more work in response to, for example, the requirements stemming from the revised International Health Regulations and the urgent needs represented by the Millennium Development Goals. The substantial increase in Canada's provision of extrabudgetary resources to WHO was evidence of its resolve to help the Organization meet those challenges. He, like other delegates, was, however, disturbed about the amount of critical work that was to be funded by voluntary contributions, as such resources were by nature vulnerable. Issues of global importance, such as disease surveillance and response, must be safeguarded. Canada remained committed to a policy of budgetary discipline and to continued close attention to priority-setting. The considerable progress made by WHO in results-based budgeting was apparent in the 2006-2007 budget proposal, but there was need for further effort. Canada would be pleased to work closely with the Secretariat and with other Member States in refining the programme budget process and in full implementation of results-based management at WHO.

Dr TANGI (Tonga) acknowledged the difficulty of preparing a budget that would satisfy all Member States and regions; however, the Western Pacific Region had reason to be disappointed and dissatisfied. It had been expecting some share of the 17.3% increase in the overall budget, but in percentage terms it had received none, despite the fact that it was the most populous region in the world and the steps that had been taken to enhance performance through the years. A positive trend was the increased attention to noncommunicable diseases and health promotion. He remained puzzled about a matter he had raised during the 115th session of the Executive Board: the Organization had made it a priority to improve maternal health and make pregnancy safer, and the Proposed programme budget allocated US\$ 10.866 million at headquarters for that purpose. Why was such a large amount being retained at headquarters, whereas it was in countries, where more than half a million mothers a year were dying from pregnancy-related causes, that they were really needed? All the knowledge necessary to make pregnancy safer already existed.

Dr AL-MAZROU (Saudi Arabia) welcomed the Proposed programme budget 2006-2007 and the increased attention paid to important issues such as noncommunicable diseases and maternal health. Nevertheless, he shared the concern of other delegates about the large increase in funding from voluntary contributions and asked for clarification of the reasons for that trend.

Mr SPEZIA (Brazil) commended the transparency of the Proposed programme budget. He supported the proposal, including the 4% increase in assessed contributions of Member States, but asked for greater transfer of resources from headquarters to regions and countries for some areas of work, especially essential health interventions.

Dr ABDUL WAHAB (Bahrain) said that Bahrain welcomed the increase of 17.3% in the overall budget due to voluntary contributions and applauded the greater country allocations. Drawing attention to the recent resurgence of poliomyelitis in several countries of the Eastern Mediterranean Region, he urged the Organization to ensure that both the present and future budgets contained sufficient funding to enable countries to carry out the necessary immunization programmes and implement the other activities required to interrupt transmission and eradicate the disease.

Mr BELOT (South Africa) said that South Africa applauded the Director-General's efforts to improve results in countries and welcomed the proposed increases in epidemic alert and response, maternal and child health, noncommunicable diseases, tobacco control and emergency response. It also commended the increase in funding aimed at meeting the Millennium Development Goals. He remained concerned, however, about the significant decrease in the allocations for immunization and vaccine development and for communicable disease research. South Africa appealed to donors to refrain, as much as possible, from earmarking their voluntary contributions.

Dr MOOSA (Maldives) supported the Proposed programme budget 2006-2007 and welcomed the proposed increase, while expressing concern about the disproportionate increase in funding from voluntary contributions. She encouraged the Director-General to make every effort to obtain contributions that were not earmarked. Management of that large proportion of WHO's total resources should be more transparent, and information regarding the use of voluntary contributions should be available to Member States.

Dr CICOONA (Italy) welcomed the clear, transparent, well-balanced proposed programme budget. He reiterated that Italy supported the proposed increase in the programme budget, which was necessary to meet the growing needs and expectations of Member States and the targets and objectives of the Organization. He stressed, however, that the increase should be accompanied by a well-planned strategy for savings, efficiency, effectiveness and better-coordinated work within the United Nations system at country level.

Mr KRANEN (Germany) welcomed the comprehensive consultation with Member States that had been held on the budget and which should be repeated in preparing future budgets. The overall increase of 17.3% was exceptionally high in comparison with those sought by other specialized agencies. Germany was one of the Organization's largest contributors, accounting for almost 10% of total assessed contributions. National budget constraints would have made it very difficult to accept a 9% rise in assessments, and Germany therefore commended the reduction in the proposed increase to 4%. His country was also pleased that additional funds were not being sought from Member States to compensate for cost increases and exchange rate fluctuations. He too expressed concern about the steady growth in the proportion of the budget funded by voluntary contributions and about the validity of projections regarding those resources. Germany remained committed to the work of WHO; joining the emerging consensus on the budget proposal would not be easy, but his country was prepared to do so.

Dr AL-SAIF (Kuwait) echoed the concerns of other delegates regarding the upward trend in the proportion of the Organization's budget that was funded by voluntary contributions. It was important to know the source of those contributions and to ensure that they were allocated in a way that would not affect the policies of WHO and that would benefit all countries. The efficiency measures described in the programme budget proposal were a positive step; however, the proposed reductions in staff should not be undertaken without adequate study, so as to ensure that WHO headquarters and the regions did not lose needed competencies.

Dr DE URIOSTE BLANCO (Bolivia), speaking on behalf of the five countries of the Andean Community, stressed the importance of including access to essential drugs as an explicit strategic direction and priority for the Organization. Access to essential drugs was a priority for the Andean countries and MERCOSUR, and she urged WHO to maintain the priority that it had accorded to that area for the past 15 years.

Dr AL-LAWATI (Oman) said that his Government endorsed the Proposed programme budget 2006-2007. He supported the delegate of Jordan in arguing that a larger amount should be devoted to genetically transmitted diseases. He also supported the statement made by the delegate of Maldives that a larger proportion of the budget should be allocated to specific countries rather than regions.

Ms DEL VALLE MATA LEÓN (Bolivarian Republic of Venezuela) supported the statements made by Argentina and Bolivia regarding inclusion of access to essential medicines as a priority in the Proposed programme budget.

Dr NORDSTRÖM (Assistant Director-General) thanked the Committee for its support and useful observations. He said that the increase in the Proposed programme budget 2006-2007 reflected the increased expectations and demands of Member States and partners over recent years.

With regard to a point raised by the delegate of Zimbabwe he recalled that funding for HIV/AIDS, tuberculosis and malaria had increased over the previous two years and would continue to do so. The budget target for HIV/AIDS for the 2002-2003 biennium had been US\$ 130 million, but only US\$ 55 million had been forthcoming. The target for the 2004-2005 biennium was US\$ 218 million, and it was hoped that even more could be raised. He expressed gratitude for the support that made that possible, as HIV/AIDS continued to be one of WHO's top priorities, as evidenced by the target of raising US\$ 260 million for the 2006-2007 biennium.

He agreed that it would be preferable for WHO to receive a large part of its financial resources from its regular budget rather than from voluntary contributions, in order to ensure good governance, integrity and low transaction costs. There was room for more dialogue with Member States about the future funding of the Organization from both sources, and the Executive Board would discuss the possible introduction of a six-year strategic plan with an associated expenditure framework at its 116th session. A longer-term approach to funding would enable more work to be done using various financial resources. Attention should also be paid to the mobilization of resources, to ensure that funds

reached the right areas of the Organization so that its programmes could be implemented effectively. Another major task being undertaken was the management of relations with key partners and donors, to improve the way in which voluntary contributions were administered by both sides.

He considered that the process was already fairly transparent, as the departure point for mobilizing resources was the programme budget document being discussed. Furthermore, the Secretariat reported back to Member States in performance assessment reports and financial reports, providing continuous information on implementation of the budget as a whole, including voluntary contributions. Increased use of information technology would improve the provision of information even further.

Many speakers had mentioned the advisability of obtaining unspecified funding and avoiding the earmarking of resources. Discussions were under way with WHO's key partners to find ways to enable the Organization to work more effectively and improve the management of its resources.

On the issue of whether maintaining the budget for headquarters at the same level as in 2004-2005 represented real decentralization, he reiterated the Director-General's view that a strong headquarters was essential for WHO to be effective. The Organization needed to function well at global level, since much of its normative work was done on a global basis. Zero growth in the budget for headquarters in fact represented a decrease in real terms, especially since costs stemming from, for instance, currency fluctuations were absorbed into the budget. Such costs principally affected the Regional Office for Europe and headquarters, where the number of staff would decrease by up to around 20% in line with an approximate 20% increase in staff costs.

In response to the query regarding an apparent discrepancy in the figures for the overall allocation of resources to headquarters, he explained that certain special programmes had been excluded from some of the calculations, as detailed in Figure 1, footnote (a) of document PB/2006-2007, since, although they would be implemented throughout the world, it was as yet unclear exactly where activities would be carried out, because of the nature of those programmes.

With regard to the comments made by the delegates of Greece and the Russian Federation on expected results, he said that more work was needed to improve and fine-tune the system, not only to obtain better costing of expected results but also to introduce longer delays for achieving them, as most could not be accomplished within two years. Specific indicators would nevertheless still need to be linked to shorter timescales.

Naming of countries that would benefit from activities, as proposed by the Russian Federation, would prove difficult in many cases, as it was not always clear at the outset which countries would ultimately benefit and how best to respond to country strategies. In terms of reporting back on expenditure, the Secretariat was committed to providing a clearer breakdown of expenditure by country, as well as by region.

The delegate of the United States of America had suggested that distinctions be drawn between cost increases for programme expansion and those proposed for other reasons. In reality, cost increases usually occurred for a variety of reasons, although he accepted that information on input costs could be improved. WHO was not a static organization, and most increases were due to programme changes.

The issues raised by the delegate of China about the evaluation of WHO's work in countries could be discussed further when that area was addressed. The work was already being evaluated, and the methods for country strategies, an important instrument for national strategic planning, had been reviewed.

Several speakers had said that robust systems were needed to ensure that resources were managed, planned for, monitored and accounted for effectively so as to avoid the possibility of fraud or misuse of resources. The Secretariat took the matter extremely seriously, and robust systems were already in place for planning and performance monitoring, for both the Organization as a whole and individual staff members. A zero-tolerance policy on fraud was being applied, and resources were being increased to allow investigation of suspected instances of fraud or misuse of resources. A new fraud policy had been launched, and training sessions were being held throughout the Organization to raise awareness and mitigate risks.

He underlined the importance of contingency planning, as referred to by the delegate of the United Kingdom of Great Britain and Northern Ireland. Continuous dialogue between the Secretariat

and the Executive Board, in particular, was important, to enable the Secretariat to report back on implementation of the programme budget and to take any necessary measures to overcome difficulties. Dialogue was also needed between the Director-General and the members of the Executive Board to address emerging needs, such as new outbreaks of disease, even though taking action fell within the authority of the Director-General.

Annual efficiency targets would be useful as WHO moved closer to a modern business structure, with the introduction of the Global Management System. The operations of the Organization would be examined to ensure efficiency, and potential gains from that System would be evaluated.

In response to the comment made by the delegate of Tonga, he confirmed that the share of resources allocated to the Western Pacific Region would remain the same as for 2004-2005 but added that the actual amount of funding would increase by US\$ 40 million, including a US\$ 4.5 million increase in funds from the regular budget. The prevalence of noncommunicable diseases in the Western Pacific Region had increased by 200%, and they were one of that Region's key priorities. With regard to the programme on making pregnancy safer, the balance in the allocation of funds for global action and for country or regional action had shifted from US\$ 12 million and US\$ 38 million to US\$ 10 million and US\$ 64 million, respectively. The issue of what was to be achieved within the global part of that programme would be discussed later, but most funds were allocated to countries and regions.

Several speakers had highlighted the issue of essential medicines. He stressed that the decision to focus on certain areas during the 2006-2007 biennium did not mean that other areas were not important. Furthermore, work on essential medicines was crucial to successful implementation of at least five of the priority areas for 2006-2007 listed in paragraph 11 of document PB/2006-2007.

Part II: Orientations 2006-2007 by area of work

Communicable disease prevention and control; Communicable disease research; Epidemic alert and response; Malaria; Tuberculosis; HIV/AIDS

Dr VIROJ TANGCHAROENSATHIEN (Thailand), welcoming the proposed programme budget, stressed the importance of the five most-highly funded programmes, which accounted for 37.4% of the total biennium budget of US\$ 3310 million. A total of 57% of the biennium budget had been allocated to the 10 main programmes, which were, broadly speaking, the same as those for 2004-2005, indicating a conservative outlook in the programme budget for 2006-2007. He noted with satisfaction that most of those programmes supported achievement of the Millennium Development Goals. As those priority programmes accounted for most of the Organization's resources, the Secretariat should ensure the highest effectiveness and efficiency in their implementation. Together with country programmes, it should also ensure equitable access for poorer countries to achieve the Millennium Development Goals. The capacity of the programmes to use the allocated resources at country level should be monitored closely. As several of the programmes relied on extrabudgetary funding, it was essential to ensure that the activities were not interrupted. As WHO's core presence in countries was the third largest programme area, accounting for 5.7% of total resources, the effectiveness of WHO country offices should be improved.

Dr AL-SALEH (Kuwait) noted the emphasis on malaria, tuberculosis and HIV/AIDS but said that tuberculosis did not receive its full share of resources in comparison with the other diseases. Allocations at national and regional levels were considerable for malaria and HIV/AIDS but not for tuberculosis, which was closely associated with AIDS. Resources allocated at regional and national levels to tuberculosis control should be increased, especially in view of the high cost of new drugs and the resistance of the disease to many treatments.

Dr LARUELLE (Belgium) commended the participative process used in drawing up the Proposed programme budget, with the new results-based presentation. Nevertheless, he regretted the imbalance in budgetary allocations for activities considered as priorities. Without an effective health

system, for example, countries with a heavy disease burden were unable to consider long-term action. More resources should be allocated to strengthening health systems, namely human resources, mechanisms to ensure adequate funding for health, social and health policies, health information and health services. More resources should also be provided for research, not only on tropical diseases but also on human reproduction and health systems. Currently, more than US\$ 1150 million were allocated to the fight against communicable diseases, while only about US\$ 350 000 were proposed for all activities related to strengthening health systems. That trend was neither desirable nor in line with WHO's objective of strengthening health systems in countries with major problems of access to effective health services. He supported other speakers in calling for a clear policy that took account of foreseeable deficits by area of activity.

Dr ASAMOA-BAAH (Assistant Director-General) affirmed that allocations to the areas of work under consideration represented nearly 30% of WHO's total budget; great care must be taken to use those resources carefully. He took note of the comment by the delegate of Kuwait that certain areas remained underfunded, and thanked the delegate of Belgium for emphasizing the importance of research, especially in the ensuing biennium.

Dr CHOW (Assistant Director-General) said that the Secretariat greatly appreciated the support given by Member States to the programmes on HIV/AIDS, tuberculosis and malaria. In reply to the delegate of Kuwait, he said that work on tuberculosis and HIV/AIDS had been given greater prominence at national and community levels. In line with WHO's decentralization policy, the regional and country allocation for tuberculosis was 79% of all financing. The Global TB Drug Facility was partly financed from the headquarters budget but the medicines were sent directly to the countries concerned. The Secretariat was continuing to link work on tuberculosis and HIV/AIDS to the development of health systems, in particular by training of health personnel, as part of its commitment to strengthening national capacity.

Surveillance, prevention and management of chronic, noncommunicable diseases; Health promotion; Mental health and substance abuse; Tobacco; Nutrition; Health and environment; Food safety; Violence, injuries and disabilities

Ms BLACKWOOD (United States of America), referring to Food safety, noted that WHO and FAO collaborated on the food standards programme and that through its regular budget WHO supported the work of the Codex Alimentarius Commission. How much funding went to those important standard-setting activities of WHO and its support for the relevant scientific expert committees?

Dr LEITNER (Assistant Director-General) said that the proposed regular budget allocation for the food safety area of work had declined slightly from the figure for the 2004-2005 biennium, but the regular budget allocation at headquarters of US\$ 3.2 million would be augmented by US\$ 3.6 million in voluntary contributions. In the present biennium, US\$ 1.2 million had been allocated to the work of the Codex Alimentarius Commission with a similar sum included in the regular budget for 2006-2007. Also for 2006-2007 the Organization would earmark about US\$ 1.0 million for scientific advisory work to support the Commission, leaving US\$ 4.5 million for staff costs and other activities.

Reproductive health; Making pregnancy safer; Gender, women and health; Child and adolescent health; Immunization and vaccine development

Ms BLACKWOOD (United States of America) drew attention to the fifth indicator for Reproductive health in document PB/2006-2007 which mentioned "reproductive and sexual health and rights". Sexual rights had never been agreed to or defined by the United Nations. The member for her country had raised the issue at the 115th session of the Executive Board in January 2005. She requested that a corrigendum be issued, with deletion of the words "and rights".

Mr KOCHETKOV (Russian Federation) reiterated the request made by the member for his country at the Board session in January 2005 for clarification of the indicators relating to eradication of poliomyelitis, as there was a discrepancy in the text concerning the number of countries in which the disease was endemic.

Mrs PHUMAPHI (Assistant Director-General) welcomed the emphasis on research in human reproduction expressed by the delegate of Belgium earlier in the meeting. Responding to the delegate of the United States of America, she said that the necessary correction would be made. In response to the delegate of the Russian Federation, she said that poliomyelitis was endemic in six countries, and the virus had been imported into seven others.

Essential medicines; Essential health technologies; Policy-making for health in development; Health system policies and service delivery; Human resources for health; Health financing and social protection; Health information, evidence and research policy

Dr BRANDRUP-LUKANOW (Germany) commended WHO's work on human resources in the health sector. Germany would support the collection of data for the next *World health report* and would support partner countries in the development of national and regional strategies for strengthening human resources and capacity in health services.

Dr SANGALA (Malawi), referring to the subject of human resources, said that low salaries were a major cause of the migration of health workers towards developed countries. Retention strategies should include salary enhancement in some form or other.

Dr LARUELLE (Belgium) reiterated that the fight against both communicable and noncommunicable diseases was inconceivable in the long term without strengthening health systems. He also welcomed the earlier emphasis on the issue of research.

Dr AL-SALEH (Kuwait) said that the resources allocated to knowledge management and information technology at regional level were limited in comparison with those at headquarters and would not meet regional needs for making scientific resources available to Member States in the form of translations and web sites.

Dr NORDSTRÖM (Assistant Director-General) said that it was not fully possible to compare the current and future budgets for human resources and health systems development, as the previous two areas of work had become four. Some areas had received major increases and others slight decreases, but the overall budget for health systems development had been increased by 28%. Moreover, a further US\$ 2.5 million had been added in response to comments made in the 115th session of the Executive Board on the subject of human resources. The next *World health report* would focus on human resources broadly, including the factors that hampered effective access to services at country level, motivation and salaries.

In regard to knowledge management and information technology, the trend was towards decentralization, which would be reinforced within the new Global Management System.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) reiterated his earlier comment with regard to WHO's core presence in countries, and asked whether WHO was planning to evaluate the effectiveness and performance of its country offices.

Dr LEITNER (Assistant Director-General) said that allocation of more resources to the regional and country levels represented a major change, which would be made step by step. The Secretariat was still defining guiding principles for strategic resource allocation. Nevertheless, there was a clear understanding that the country cooperation strategies would be crucial for determining the purposes for which funds would be allocated in the 2006-2007 biennium at the country level.

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

The meeting rose at 18:05.

FIFTH MEETING

Thursday, 19 May 2005, at 09:15

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)

1. FIRST REPORT OF COMMITTEE A (Document A58/49)

Dr BUSUTTIL (Malta), Rapporteur, read out the draft first report of Committee A.

The report was adopted.¹

2. PROPOSED PROGRAMME BUDGET 2006-2007: Item 12 of the Agenda (Documents PB/2006-2007 and Corr.1, A58/INF.DOC./1 and A58/INF.DOC./3) (continued from the fourth meeting, section 3)

Emergency preparedness and response; WHO's core presence in countries

Dr DE URIOSTE BLANCO (Bolivia), supported by Mr BENTO ALCÁZAR (Brazil), welcomed the proposed increase in allocations for the area of emergency preparedness and response, but said that more emphasis should be placed on the supply of essential medicines. There was no need to change the proposed budget, but any additional funds that became available should be allocated to essential medicines.

Mr KOCHETKOV (Russian Federation) noted that the proposed allocations to finance WHO's core presence in countries had been reduced from those quoted in the original draft of the proposed programme budget. He had attempted to estimate what effect that reduction would have on the expected results, but those, too, had changed considerably between the first draft and the second. Moreover, the first draft had stated that only 25% of Member States had a WHO Representative, with a target of 75% of Member States, while the second draft gave 143 Member States, or 75%, as the baseline figure. While he was glad to see figures more closely reflecting the real situation, such a discrepancy made comparisons harder. He was also concerned about the frequent changes in expected results, which made it difficult to evaluate the related financial issues.

Dr PRESERN (United Kingdom of Great Britain and Northern Ireland) said that her country no longer earmarked core voluntary contributions for specific programmes, in order to increase WHO's flexibility in the allocation of resources. However, she was concerned that key areas were underfunded, and called on the Secretariat to reallocate resources where necessary and warn Member States of potential financing shortfalls; reproductive health, human resources, health systems and attainment of the Millennium Development Goals, for instance, had not been cited as priorities of the Organization in the proposed programme budget.

¹ See page 352.

Dr MOSA (Madagascar) said that his country had suffered two cyclones and a number of floods so far in 2005, which had cost lives and devastated crops and the country's infrastructure, including health facilities. He thanked all the countries that had expressed sympathy with Madagascar's plight, and supported Bolivia's call for sufficient resources to be allocated to the provision of essential medicines.

Dr LEITNER (Assistant Director-General), replying to the delegate of the Russian Federation, confirmed that the baseline figure for WHO's presence in countries was 143 – the number of countries with a country office. The baseline figure of 133 for the third expected result referred to the number of country cooperation strategies that had been prepared or were close to completion during the current biennium. The Secretariat expected to prepare country cooperation strategies for the remaining countries with a WHO country office during the 2006-2007 biennium. The country cooperation strategy would be updated or reviewed for about 25% of countries.

Dr NABARRO (Representative of the Director-General for Health Action in Crises) stressed that essential medicines were a priority of the emergency preparedness and response programme.

Dr LEPAKHIN (Assistant Director-General) affirmed that essential medicines were an important part of many WHO programmes, including the emergency preparedness and response programme. It was important, however, to ensure that they were of high quality and used rationally. He had noted the request of the delegate of Bolivia that any additional funds becoming available should be used to provide essential medicines.

Dr NORDSTRÖM (Assistant Director-General) said in reply to the delegate of the United Kingdom of Great Britain and Northern Ireland that effective internal mechanisms were important if resources were to be allocated optimally. The Secretariat was keen to maintain a dialogue with Member States and highlight any potential gaps in financing.

Essential medicines were indeed a priority of the Organization, in the area of emergency preparedness and response as elsewhere. A specific reference might be included in the introduction to the Proposed programme budget.

For WHO's core presence in countries, one of the indicators cited was the reprofiling of the WHO country offices to ensure an optimum range of skills among staff. Considerable effort was currently being given to operational planning, to ensure appropriate skills and strategic directions throughout the Organization. Some country evaluations had already begun.

Knowledge management and information technology; Planning, resource coordination and oversight; Human resources management in WHO; Budget and financial management; Infrastructure and logistics; Governing bodies; External relations; Direction; Other

Mr KOCHETKOV (Russian Federation) noted that the Security Fund, which had been set up to finance WHO's share of the costs of security arrangements in the United Nations system, had increased considerably compared with the previous biennium. He asked what target indicators might be used for that section of the budget: for instance, it might be possible to use the number of country and regional offices that complied with minimum operating security standards. He asked why the entire budget had been allocated to headquarters, when it was, in fact, to be used for security at country level.

Dr NORDSTRÖM (Assistant Director-General) said that the United Nations General Assembly had increased the budget for security measures in the field for the entire United Nations system without, however, increasing the allocation from its regular budget. WHO was responsible for about 10% of that figure. The funds were budgeted globally into a central security fund, but were used for security measures in the field. One possible indicator for assessing progress under that budget heading

was shown on page 146 of the Proposed programme budget, namely number of WHO sites that comply with minimum operating security standards. An inventory of security standards and a risk assessment were being conducted at various WHO sites to determine how best to balance security priorities with the available financing.

The CHAIRMAN, observing that the Committee had completed its discussion of the programmatic aspects of the Proposed programme budget, suggested that the agenda item should be kept open until the relevant appropriation resolution was ready for consideration.

It was so agreed.

(For approval of the draft resolution, see summary record of the seventh meeting, section 3.)

3. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Sustainable financing for tuberculosis prevention and control: Item 13.4 of the Agenda (Resolution EB114.R1; Document A58/7) (continued from the third meeting)

Dr SANGALA (Malawi) said that the tuberculosis programme in his country was still a vertical programme, although it worked closely with the health ministry's HIV/AIDS unit. However, the health system was currently being reformed. An essential health package had been defined and costed to cover the most significant diseases, including HIV/AIDS and tuberculosis. Tuberculosis control would gradually be integrated into district health plans, and district-level tuberculosis control officers would work closely with zonal supervisory officers and the district health management teams.

At present, the Government provided 41% of the resources of the programme, covering salaries, equipment and the supply chain for treatment centres. That share would increase as the country's economy improved. The rest of the programme – principally the purchase of medicines – was financed by WHO and bilateral donors. His country's programme was a sustainable one which would continue to grow.

Dr VIOLAKI-PARASKEVA (Greece), observing that the report highlighted the continued difficulty of mobilizing resources for tuberculosis control, despite the significant role tuberculosis played in the HIV/AIDS pandemic, emphasized that tuberculosis control should be integrated into primary health care. After asking what the current thinking was concerning the continuation or otherwise of vaccination with BCG vaccine, she expressed support for the draft resolution contained in resolution EB114.R1.

Dr BRANDRUP-LUKANOW (Germany) commended the report and the work being done towards sustainable financing and resource mobilization for tuberculosis prevention and control. Germany was a member of the global Stop TB Partnership and supported national Stop TB Partnerships. It was contributing US\$ 300 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria and, through the GTZ BACKUP Initiative, partner countries were receiving technical assistance in preparing proposals to the Global Fund to strengthen national tuberculosis programmes and linked HIV/AIDS and tuberculosis interventions, particularly in the African and European regions. Recognizing the role of WHO in the efforts to control tuberculosis, Germany was strengthening the capacity of the Organization through secondments to global and regional programmes. The emphasis of the support lay in: strengthening health systems overall; capacity building at central and district levels; quality management in laboratories, in particular with respect to drug-resistance issues; building systems of sustainable financing of health care; and examining the feasibility of local drug

production. Within that framework, Germany supported the draft resolution in the hope that it would contribute to effective tuberculosis control globally.

Mr DE SOUSA CARVALHO (Cape Verde) said that tuberculosis continued to be a serious public health problem for Cape Verde, which had just made a new strategic plan for tuberculosis control in accordance with the Millennium Development Goals. It counted on WHO's support, be it for training technicians to improve the management capacity of the tuberculosis programme or guaranteed provision of anti-tuberculosis medicines. He supported the draft resolution contained in resolution EB114.R1.

Dr AL-OWEIDI (Oman), expressing appreciation of WHO's efforts to diminish the global burden of tuberculosis and so contribute to achieving the Millennium Development Goals, said that the financial sustainability of programmes was crucial to sustaining and achieving tuberculosis prevention, control and goals. There was also a need to extend the scope of DOTS ALL OVER to other emerging issues not included in earlier strategies, such as HIV-related tuberculosis, multidrug-resistant tuberculosis, community mobilization for advocacy, and patient support. Ignoring any of those issues would make it difficult to progress towards achieving WHO's global targets. He was also aware that WHO was preparing a package that included new approaches and strategies for further accelerating tuberculosis control programmes. He therefore strongly supported adoption of the draft resolution.

Mrs WALAIPORN PATCHARANARUMOL (Thailand) commented that adequate financing was not the only issue for an effective tuberculosis programme, other important determinants being health system capacity, adequacy of human resources to deliver services, quality laboratory services, and supply of anti-tuberculosis medicines. Effective integration of tuberculosis and HIV programmes was essential for successful tuberculosis control. To ensure sustainable financing of the tuberculosis programme, resource tracking was essential in order to determine what proportions came from the government, from households and from donors. A medium-term economic framework was required for estimating the total resource requirement and the programme's resource gap.

She proposed amending the draft resolution by inserting a new subparagraph 1(1), reading "to estimate the total resource requirement for their tuberculosis prevention and control programme including tuberculosis, HIV-related tuberculosis and multidrug-resistant tuberculosis case management in the medium term, and the resources available from domestic and international sources, in order to identify any gap in programme resources".

Dr EGAMI (Japan), commending the high priority given to tuberculosis, said that several factors hampered achievement of the target of stopping tuberculosis by the end of 2005. It was to be hoped that WHO's initiative, together with even greater efforts from Member States, would improve the case detection rate. It was important not only to increase financing from Member States, but also to improve the efficiency of use of funds by recipient countries. Tuberculosis control had long been a priority in Japan, which had created its own DOTS strategy, providing support for patients through home visits and telephone follow-up. Human resource development was the core issue for expanding DOTS. Japan had been developing those resources through the training programme of the Tuberculosis Research Institute and the Japan International Cooperation Agency for more than 40 years. Japan supported tuberculosis control through bilateral channels and through WHO, and intended to continue both forms of support.

Mr KAMWI (Namibia) said that in recent years Namibia had seen a steady increase in the number of cases of tuberculosis, which claimed hundreds of lives each year, particularly among the young and productive population. The Government had launched a five-year strategic plan, the implementation of which would need human, technical and financial support. Namibia fully supported the draft resolution.

Mr SHONGWE (Swaziland) said that the incidence of tuberculosis, including multidrug-resistant disease, in Swaziland had been increasing owing to the escalating HIV/AIDS epidemic. The high coinfection rate, about 75%, between HIV and tuberculosis had complicated the management of both diseases. Concerned that the discussion on sustainable financing for tuberculosis prevention and control made no mention of the role of nutrition, he called on WHO to advocate with relevant United Nations agencies and other partners provision of nutritional support to HIV-positive individuals receiving anti-tuberculosis therapy. To date, financing of tuberculosis control had been provided by his Government with support from the Japan International Cooperation Agency, but he looked forward to receiving additional funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. He suggested inserting a new preambular paragraph in the draft resolution: "Noting with concern the increase in the number of cases of multidrug-resistant tuberculosis, and the worsening morbidity and mortality among HIV-positive tuberculosis patients, especially in the African Region,"; strengthening paragraph 4 as follows: "to take the lead under national health authorities in working with partners to mobilize sufficient resources in order to ensure sustainable financing of tuberculosis control;" and adding a new paragraph 6: "REQUESTS the Director-General to engage the international pharmaceutical industry with a view to increasing their investment in research and development of new and more effective anti-tuberculosis drugs".

Professor MAJORI (Italy) suggested that the various approaches which were part of modern tuberculosis control needed to respect national and regional priorities while focusing on the key DOTS strategy and the training of human resources. He was concerned about the extent of the combined tuberculosis and HIV/AIDS epidemic in Africa. Activities aimed at controlling tuberculosis and HIV had to be coordinated. Concerned about the extent of the multidrug resistance, especially in countries of the former Soviet Union and in China, he supported efforts to control multidrug-resistant tuberculosis. He called for constant monitoring of progress towards the operational targets in all countries and, noting that for 2005 it was virtually on track, suggested that a final report on achievements in global tuberculosis control should be made at the Fifty-ninth or Sixtieth World Health Assembly. He fully supported the draft resolution.

Dr PARIRENYATWA (Zimbabwe) said that in Zimbabwe tuberculosis remained a major public health challenge, exacerbated by the prevalence of HIV and AIDS. As it was the leading cause of death among HIV-positive patients, HIV and tuberculosis coinfections demanded coordinated management. All patients living with HIV were routinely offered tuberculosis screening, free of charge, and those with tuberculosis were offered counselling and testing for HIV. While appreciating WHO's technical support, Zimbabwe was disturbed that the Global Fund to Fight AIDS, Tuberculosis and Malaria had from the outset denied Zimbabwe any funds. The country had therefore used its national AIDS levy to fund prevention, counselling and testing. Although Zimbabwe had a well-equipped reference laboratory for tuberculosis, he emphasized the need to strengthen diagnostic systems.

Mr JANG Il Hun (Democratic People's Republic of Korea) noted that tuberculosis, as the communicable disease accounting for the major share of the global disease burden, was receiving priority attention in his country. The disease had resurged in the mid-1990s when the country had been struck by natural disasters that caused economic difficulties and a steady rise in the number of tuberculosis cases. A strong control programme had been implemented, through increased government investment including increased production of anti-tuberculosis medicines and with close collaboration and support from WHO and the Global TB Drug Facility. His was the first country in the South-East Asia Region to achieve full DOTS coverage, but more time and a continued supply of anti-tuberculosis drugs would be needed before the disease could be eradicated. His country looked forward to close cooperation with WHO and the Drug Facility, and supported the draft resolution. It also hoped that sufficient funding would be secured for WHO's Stop TB programme to continue its excellent work.

Dr ANZI (Côte d'Ivoire) said that his Government had taken measures aimed at detection and treatment of tuberculosis, with the number of cases detected increasing by 10% every year. Management of tuberculosis and HIV coinfecting patients had started in 1989, with the introduction of HIV screening of tuberculosis patients. That activity had in 2003 been absorbed into the national anti-tuberculosis programme. Some innovative experiences such as the implementation of a community DOTS strategy in two sections of the capital had increased the treatment success rate above the national average. Implementation of the enhanced DOTS strategy, financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria with support from the United Nations Development Programme, had improved management capabilities in the national anti-tuberculosis programme, which, however, was encountering financing difficulties in the areas of drug supply, provision of management tools, purchase of laboratory reagents and consumables, ongoing personnel training, mobilization and awareness-raising.

Mr HARTOG (Netherlands) said that reinforcing weak general health systems was a key priority for successful tuberculosis control programmes. Practical problems such as lack of human resource capacity, called for special emphasis. The tuberculosis epidemic was worsening in Africa, and the disastrous effect of tuberculosis and HIV coinfection required faster and more intense action. Specific attention should be given to an integrated approach for joint tuberculosis-HIV programming. WHO's role in the Stop TB Partnership could be expanded for the sake of further synergy in the wide spectrum of technical and financial partners and stakeholders, including countries with a high burden of tuberculosis and HIV/AIDS. In eastern Europe, multidrug-resistant tuberculosis was a major problem, needing faster and effective action to prevent its further spread. In particular, the efficacy of first-line treatment needed to be enhanced, in combination with increased access to second- and third-line drugs. He urged WHO to reinforce the written framing of its recommended approach to tuberculosis control as set out in the draft resolution, to demonstrate that it represented a comprehensive strategy for achieving the Millennium Development Goals. Within that strategy, the Netherlands supported the increased focus on the urgent need for research and development of new diagnostics, drugs and vaccines. Securing the operations of the Green Light Committee through sufficient and sustained funding and access to human resources would be critical. The Netherlands fully supported the draft resolution and called for sustainable, well-planned funding of tuberculosis control.

Dr ABEBE (Nigeria) said that in Nigeria, one of the 22 high-burden countries, DOTS coverage reached only 55% of the local government areas: a large portion of the population lacked access to treatment. The case detection rate was 23%, a far cry from the 70% global target set for 2005. The Government had earmarked a substantial amount for tuberculosis control in its 2005 budget, but there was still a huge funding gap. Nigeria's tuberculosis control programme had not received support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Without access to such funds, attainment of the tuberculosis-related Millennium Development Goal would be a mirage, especially given a high coinfection rate with HIV and possible spread of multidrug-resistant tuberculosis. Nigeria was hopeful of success in round 5, and appreciated the help of its partners in ensuring that its proposals were well written and met the expectations of the Global Fund.

Dr PARK Ki-dong (Republic of Korea) suggested that, given the gravity of tuberculosis as a global health problem, countries with sufficient resources needed to expand their assistance to less privileged Member States through international agencies or bilateral cooperation. The increasing spread of multidrug-resistant tuberculosis was an emerging health issue that deserved urgent global attention but, unfortunately, little progress had been made in developing new anti-tuberculosis agents. His Government, in collaboration with the United States of America, intended to build an international tuberculosis research centre with the aim of both solving the problem at home and contributing to the global anti-tuberculosis effort. That centre would conduct research to develop new drugs for multidrug-resistant tuberculosis and the next generation of vaccines, and would serve as a training

ground for health workers responsible for tuberculosis control in the developing countries. He supported the draft resolution, as amended by Thailand, and thanked the United States and WHO for their technical assistance in the initial stages of tuberculosis control in his country.

Dr AL-SALEH (Kuwait) said that the problem of tuberculosis presented many challenges, including lack of human resources and laboratory facilities, and insufficient political will. Treatment was becoming less successful and the number of cases was increasing: tuberculosis was a re-emerging disease. A sustainable campaign against tuberculosis (including preventive measures) had to be mounted in order to attain the Millennium Development Goals. All countries needed to make a lasting political commitment to the campaign. There should be close coordination between the various programmes concerned, especially those against tuberculosis and HIV/AIDS, and local communities should be involved on a sustainable basis. The constraints on the financing of drugs and other means of treatment meant that resources should be rallied at international level in a durable way, not on a temporary basis. Sustainable financing was also needed at the level of WHO's regions, so that Member States could benefit from such resources.

Dr MOSA (Madagascar) said that tuberculosis remained one of Madagascar's major public health problems. In 2004, 17 841 cases had been notified, including more than 12 000 new cases. The prevalence rate was 111 cases per 100 000 inhabitants. DOTS was the national strategy for treatment and fixed-dose combination therapy was being introduced, with financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, the follow-up failure rate of 17% represented a potential source of multi-drug resistance, so the prospect of applying the DOTS-Plus strategy was welcome. Madagascar therefore fully supported the draft resolution.

Dr NABLI (Tunisia) said that, in the context of Goal 6 of the Millennium Development Goals, a case detection rate of 70% and a treatment success rate of 85% had been achieved in the past four years through implementation of the DOTS strategy throughout the country. The budget covered all anti-tuberculosis drugs and screening but drug resistance remained a problem, which it was hoped countries would be able to deal with more effectively through the DOTS-Plus strategy.

Dr SINGH (India) supported the draft resolution but suggested that, in subparagraph 2(4) the phrase "to strengthen and support" should be expanded to read "to devise, strengthen and support". India was committed to nationwide expansion of the DOTS strategy by 2005 and was on course to achieve global targets, the case detection rate and treatment success rate being close to or above global targets. To achieve the desired epidemiological impact, a long-term tuberculosis programme would be required even after full coverage was achieved; sustained efforts would have to continue, therefore, far beyond 2005.

Most high-burden countries were implementing the DOTS strategy with technical support from WHO and financial assistance from various partners. But funding agencies' differing mechanisms and commitment terms created uncertainties for long-term planning. Even donor coordination meetings, which India had used in an effort to solve the problem, had limitations. He therefore urged WHO to take the lead in devising a suitable mechanism.

Mr ABDOO (United States of America) said that his country was strongly committed to working with the international community in the efforts to combat tuberculosis, which should involve continued emphasis on the DOTS strategy. Ongoing collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria was crucial to securing sustainable financing for making further progress towards the internationally agreed health-related goals of the Millennium Declaration. The Stop TB Partnership was a further contributing factor; the United States, a founding member of it, provided technical and financial support to numerous countries towards attainment of global tuberculosis targets. In order to achieve significant reductions in tuberculosis, there must be expanded access to tuberculosis treatment for HIV-infected persons, and the DOTS Plus programmes must be

implemented so that persons with multidrug-resistant tuberculosis could be treated through affordable second-line medicines. The basic DOTS strategy should be simultaneously strengthened to prevent additional drug resistance. He supported the draft resolution contained in resolution EB114.R1.

Dr CHAOUKI (Morocco) said that his country had been working hard to achieve the goals set, and its national programme had been awarded a medal by the Stop TB Partnership at a ceremony held in New Delhi in 2004. The achievements were due to the political will and commitment of the Government, which considered that the anti-tuberculosis campaign must be based on advocacy and social mobilization to increase awareness at regional and national levels. The DOTS strategy should be reinforced by a respiratory health programme and be linked more closely with the campaign against AIDS. He supported the draft resolution contained in resolution EB114.R1 because of its approach to the issue of sustainable finance, but success would be achieved only through partnership of the health sector with other sectors, public authorities and civil society at large.

Dr REN Minghui (China) agreed in principle with WHO's analysis of current global progress in tuberculosis control and of existing obstacles, and with its guidelines for future actions, including models of sustainable financing. WHO's efforts, including its support for his own country, were greatly appreciated. The Chinese Government had always placed great emphasis on tuberculosis control. By 2004, coverage under the DOTS strategy expansion had reached 95%, the case detection rate being 64.1% and the treatment success rate more than 85%. The country hoped to reach the WHO prevention goal by the end of 2005.

WHO should attach greater importance to expansion of the DOTS-Plus strategy, to joint control of tuberculosis and HIV, and to tuberculosis control among poorer people, assisting in the mobilization of financial resources for countries with a heavy tuberculosis burden. It should enhance capacity-building, including human resources development, in those countries, and strengthen practical research in areas such as smear-negative diagnostic measures and the use of anti-tuberculosis drugs. He supported the draft resolution.

Dr ZAHER (Egypt) acknowledged WHO's pioneering role and assistance. Egypt had a good tuberculosis control programme, using the DOTS strategy; the current case detection rate was 54% and the treatment success rate 89%, thanks to constant surveillance and continuous case management. There was also a treatment centre which was playing a pioneer role, in contact with 24 laboratories around the world. Tuberculosis research was ongoing, as was the search for better drugs.

Professor IVANOV (Bulgaria) said that the draft resolution would be an efficient instrument for reducing the incidence rate of tuberculosis, which Bulgaria expected to halve from 2003 to below 20 per 100 000 population by 2015. Implementation of the DOTS strategy was an important factor; it had been applied throughout Bulgaria since April 2003, but the quality of DOTS work needed to be further improved in order to maximize treatment success rates and reduce the frequency of relapses. Complete and timely case registration would be ensured by introducing WHO-accepted case definitions and diagnostic criteria. One problem was involving physicians in remote regions, far from dispensaries, in the second, prolonged stage of DOTS treatment. Funding came from the national control programme, with additional financing from the Swiss Agency for Development and Cooperation.

WHO technical assistance was desirable for the following universally important measures for tuberculosis control: training of regional managers; purchase of equipment for interregional microbiological laboratories; preparation of guidance for determining and updating the categories and current instructions for early diagnosis and treatment; production of printed forms for hospitals and dispensaries; strengthening of tuberculosis control measures among prisoners; and enhanced public awareness of the tuberculosis problem, in order to attract funding from private and nongovernmental sources. He supported the draft resolution contained in resolution EB114.R1.

Dr AHMED (Pakistan) said that Pakistan was a high-prevalence country, having an incidence rate of 177 per 100 000 population, which represented 43% of the tuberculosis disease burden for the Eastern Mediterranean Region. The DOTS implementation rate had been accelerated; it was expected that 100% coverage would be achieved by June 2005. But such an achievement, for a population of more than 150 million people, required a huge resource commitment. The Government was the main provider of finance but the country depended on many other partners, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria. Scarcity of resources called for a sound strategy in order to ensure the sustainable financing essential to achieve the global and regional targets. He therefore strongly supported the draft resolution.

Dr AL MUTAWAA (United Arab Emirates) commended the work of headquarters and the Regional Office for the Eastern Mediterranean to control and prevent tuberculosis in line with the Millennium Development Goals. His country had succeeded in controlling tuberculosis through implementation of the DOTS strategy, reliable screening, trained health workers and the compilation of statistics, which were available to all countries. Good surveillance, which was essential in view of the country's many migrant workers from tuberculosis-prevalent countries, demanded sustainable financing.

Dr MBONEKO (Burundi) said that tuberculosis was a major problem in Burundi, and sustainable financing was essential for its prevention and control. For that reason, he particularly welcomed the emphasis in the report on political will, the strengthening of health systems and the mobilization of funds from all sources, including the international community and the private sector. With regard to the draft resolution contained in resolution EB114.R1, he supported the amendments proposed by previous speakers and, with reference to subparagraph 2(2), stressed the importance of cooperation with Member States with a view to improving collaboration between tuberculosis programmes and those against HIV.

Dr CHITUWO (Zambia) acknowledged the assistance given through the Stop TB Partnership, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Japan International Cooperation Agency and other partners. Although Zambia had a high HIV prevalence rate and a tuberculosis incidence rate that had risen almost five-fold, the anti-tuberculosis programme was progressively improving, using the DOTS strategy. The cure rate achieved in 2003 was more than 70% and the case detection rate had increased to 81%. Nutrition, too, was a key issue, and Zambia was grateful for WFP's efforts in that regard. Overall tuberculosis control in the African Region depended on effective HIV/AIDS programmes which called, inter alia, for the mobilization of local partners, including faith-based organizations, community bodies and civil society in general. He supported the draft resolution.

Dr INSANOV (Azerbaijan) also supported the draft resolution. The DOTS strategy was applied throughout the country, but the methods for detection and treatment of chronic cases needed improvement. The role of the Global Fund to Fight AIDS, Tuberculosis and Malaria was important, and Azerbaijan thanked the American researchers who had been developing more effective drugs using some of the work begun by Azerbaijan in the 1990s. New types of vaccine were essential because BCG vaccination was not only ineffective but risky in areas of high HIV prevalence. The financing of individual groups of researchers into new drugs and vaccine types was extremely important.

Mr EDWARDS (Marshall Islands) acknowledged the assistance his country had received from WHO. Despite a high prevalence rate of tuberculosis, the Marshall Islands continued to apply the public health measures suggested by WHO and the Centers for Disease Control and Prevention (Atlanta, Georgia, United States of America) and to implement its own intervention initiatives such as health promotion and surveillance, as well as the DOTS strategy. Although a small country, it was making every effort to prevent the further spread of tuberculosis. He supported the draft resolution.

Mrs LE THI THU HA (Viet Nam) said that her country's tuberculosis control programme had achieved good results since 1997 in terms of DOTS expansion – the strategy covered the whole population – and of case detection and cure rates. In 2004, Viet Nam had been one of the six countries to be presented with an award by the global Stop TB Partnership. The achievement owed to the support of various partners and her Government's commitment to controlling the disease through increased investment. However, the tuberculosis control programme also faced many challenges, including increased coinfection with HIV and tuberculosis and funding constraints. Sustainable financing for tuberculosis control would help countries continue to fight tuberculosis, and she therefore fully supported the draft resolution.

Dr NAVARRO MARÍN (El Salvador) supported the draft resolution. Thanks to support for the national tuberculosis control programme from various international organizations, such as PAHO, and the Global Fund to Fight AIDS, Tuberculosis and Malaria, it had been able to attain the targets set for tuberculosis control. The Ministry of Health was responsible for supplying the tuberculosis control programme with human resources and first-line medicines. Through a cooperation agreement with PAHO, his country was able to obtain high-quality medicines at low prices, thus enabling it to maintain a cure rate of 85%. Recently, the combined HIV/AIDS and tuberculosis treatment had been successfully incorporated into its tuberculosis control programme.

Innovative strategies were needed to attract further and sustainable financial and technical support from international organizations for tuberculosis control. It was also incumbent upon Member States to fulfil their commitment to ensure the availability of sufficient domestic resources.

Dr DA COSTA SEMEDO (Guinea-Bissau) said that, despite the efforts of countries and various partners, much remained to be done in fighting tuberculosis because the number of infected persons was increasing daily. The lack of resources was one of the obstacles to attaining the Millennium Development Goals relevant to tuberculosis. His country had implemented the DOTS strategy and received support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. WHO was a strategic partner in the technical field. Tuberculosis was a public health problem in Guinea-Bissau and he supported the draft resolution.

Mrs ANGHELUTĂ (Romania) fully supported the objectives of the Stop TB Partnership and said that Romania's tuberculosis control programme was based on those objectives. Despite a high incidence of tuberculosis in Romania, compared with other European countries, its control programme had brought about significant improvements. Incidence had been declining since 2003. By 2004, the DOTS strategy had been fully implemented, the detection rate had reached more than 70% and the treatment success rate had been more than 82%, which was close to the target of 85% by 2005. The objectives set for 2006-2010 included improving the quality of the laboratory network and establishing regional reference centres, ensuring the appropriate treatment and care of multidrug-resistant tuberculosis patients, increasing the capacity of preventive and treatment programmes and obtaining low prices for drugs. The Global Fund to Fight AIDS, Tuberculosis and Malaria provided significant financial support for Romania's tuberculosis control programme.

Dr CHOW (Assistant Director-General) acknowledged the support for the draft resolution and welcomed the participation of the Stop TB Partnership. Good progress had been made towards attaining the 2005 targets, but sustained efforts were necessary if the Partnership's global targets for 2015, which were linked to the Millennium Development Goals, were to be attained. The second Global Plan to Stop Tuberculosis (2006-2015), by providing a blueprint for tuberculosis control and setting out the activities and the costs required for all regions, would provide a powerful argument for resource mobilization and support country needs for long-term planning and financial sustainability. In support of that Plan, the forthcoming global strategy to stop tuberculosis set out the various elements that were essential to successful implementation of the DOTS strategy and which facilitated the involvement of all health-care providers.

The global achievement of the 2015 targets depended on their achievement in Africa and other high HIV-prevalent settings. Tuberculosis control in Africa called for intensified action and an unprecedented level of political commitment and multisectoral involvement; the road map set out the key areas of activity and the financial resources needed to place tuberculosis on the development agendas of all African states. It proposed best mechanisms for concerted efforts by donors, technical agencies and African governments to accelerate implementation of the health strategy under the New Partnership for Africa's Development.

The Global Drug Facility, established in 2001, was a key initiative of the Stop TB Partnership that provided high-quality, low-cost medicines through its grants and direct procurement service lines. The work of WHO's Green Light Committee aimed to link access to quality-assured medicines to treat multidrug-resistant tuberculosis with the rational use of those drugs. The Organization's partnership with the World Bank in the provision of technical assistance and with the Global Fund to Fight AIDS, Tuberculosis and Malaria had also greatly contributed to its tuberculosis control efforts.

In reply to the point raised by the delegate of the Russian Federation, he said that all countries were encouraged to adapt, rather than rigidly adopt, the DOTS strategy, taking into account relevant social and patient factors. Referring to the question raised by the delegate of Greece, he said that WHO supported use of BCG vaccine, especially in the prevention of severe tuberculosis among children. The suggestion by the delegate of Oman that the new approaches should be incorporated in the global strategy deserved serious consideration. In reply to the comments made by Swaziland and Zambia on nutrition, he said that the DOTS strategy encouraged the use of standardized short-course chemotherapy in proper case-management conditions, one aspect of which was proper nutrition.

The Secretariat would report in 2006 or 2007 on the progress made towards attaining the 2005 targets. It had already published a guide addressing poverty and tuberculosis control; the Commission on the Social Determinants of Health would also address that issue.

The CHAIRMAN suggested that, in order to reflect the proposed amendments, the Secretariat should prepare a revised version of the draft resolution contained in resolution EB114.R1 for circulation and consideration at a later stage, the subitem remaining open.

It was so agreed.

(For continuation of the discussion, see summary record of the seventh meeting, section 4.)

Malaria: Item 13.5 of the Agenda (Resolution EB115.R14; Document A58/8)

Mr GUNNARSSON (Iceland, Representative of the Executive Board) said that, in the discussion of the subject by the Board at its 115th session, several members had emphasized that malaria affected not only Africa but also Asia, the Americas and the Pacific. The Board had stressed the important role of the Global Fund to Fight AIDS, Tuberculosis and Malaria in increasing malaria control, and the need for technology transfer and local production to ensure necessary supplies, inexpensive diagnostic tests and strictly controlled distribution systems for antimalarial medicines. It had noted that indoor residual spraying remained an important vector-control method for malaria.

He urged the Committee to bear in mind the belief expressed by Mr Bill Gates in his address to the Health Assembly that, if malaria were a disease prevalent in the rich countries of the world, a vaccine or inexpensive medicine would have been found a long time ago.

Dr CHITUWO (Zambia), speaking on behalf of the African group, said that Member States in the African Region were concerned by the high rates of malaria morbidity and mortality there. Few countries endemic for malaria were likely to reach the target set in the Abuja Declaration on Roll Back Malaria in Africa (25 April 2000) of ensuring that at least 60% of those at risk of, or suffering from, malaria benefited from suitable and affordable preventive and curative interventions by 2005. However, malaria control interventions in Africa were expanding. Members in the Region supported

the various strategies to tackle malaria that were outlined in the draft resolution contained in resolution EB115.R14, for they reflected the diversity of the needs of the various countries and subregions. They also supported the request that the Director-General should take measures to scale up activities against malaria. They called on him to intensify research into the sterile-insect technique, which was environmentally safe and could be applied to wide areas for malaria control, to report on the progress made in the African Region towards attaining the Abuja Declaration targets and the Millennium Development Goals, and to mobilize resources to facilitate implementation of the resolution. The African group also called on the Region's Members to provide leadership and to ensure that the resolution was implemented at country level and the crisis in human resources was resolved. The Member States in the African Region endorsed the draft resolution.

Dr DAYRIT (Philippines) said that malaria continued to pose a serious challenge in Asia, the Americas and the Pacific region. In his country, malaria-control activities had made great strides. For example, the deployment of low-cost strategies in two provinces endemic for malaria had reduced malaria incidence by more than 80% in two years. Such successes were proof that the right strategy, effectively implemented and closely monitored, could yield verifiable health gains through the efficient use of scarce resources. His Government was aware that further success in malaria control depended on the sustained flow of resources. He acknowledged the role played by the Regional Office for the Western Pacific and headquarters in his country's past successes and looked forward to continued support and technical assistance. He supported the draft resolution.

Mr RYAZANTSEV (Russian Federation) said that Russian specialists were working with the Regional Office for Europe to assess the risk of the re-establishment of malaria transmission in the Commonwealth of Independent States as a result of importation from endemic countries. The success of current malaria-control activities depended on the widespread use of antimalarial medicines and insecticides. As those had been used over many years it was particularly important to strengthen surveillance of vector and pathogen sensitivity. The range of laboratory approaches should be expanded by including assessment of intraspecies differences in plasmodia and the use of molecular diagnostic techniques to study the cytogenetics of mosquito vectors. Russian experts were prepared to participate in all aspects of that important work, including the training of staff for epidemiological surveillance and prevention of malaria.

Dr TSHABALALA-MSIMANG (South Africa) supported the statement on behalf of the African group. She expressed her concern that, despite initiatives and commitments to roll back malaria, most countries endemic for the disease would not be able to reach the targets set. The persistence of malaria in Africa was attributable to multiple factors, not least the survival of the vector and parasite in a favourable environment and their resistance to the agents used. Integrated vector management was therefore an appropriate approach to malaria control, and support was required from national and international partners to help affected countries to apply the vector-control methods of their choice. South Africa continued to use DDT for indoor residual spraying, as it had been found to be effective and sustainable.

The high cost of effective interventions remained an obstacle; proposals for global subsidies were to be welcomed. Support for monitoring and evaluation, including the development and implementation of appropriate pharmacovigilance systems, was also urgently needed, to ensure appropriate case management. Health systems as a whole needed to be strengthened, as the number of deaths that resulted from malaria reflected inadequacies in, for instance, referral systems, transport of emergency cases and inadequate drug supplies.

Expressing her support for the draft resolution, she stressed the importance of sustained support from international partners for country-specific malaria prevention and control strategies; strengthening cross-border and inter-country collaboration on malaria control; the development of insecticides with long-lasting residual effects; stepping up vector-control programmes; and exploring new methods of vector control.

Professor IVANOV (Bulgaria) said that, although his country had been certified as malaria-free in 1965, migration had become a constant source of imported cases and, in the mid-1990s, had led to a total of 18 indigenous cases being registered. Bulgaria was currently at the stage of sustainable malaria elimination, directing its efforts to epidemiological surveillance and preventive measures to hinder transmission from imported cases. In recent years, it had cooperated closely with WHO in the context of malaria control. A cross-border project with Greece was in preparation, one facet of which concerned the updating of an existing database of *Anopheles* populations in some border areas. He supported the draft resolution.

Dr HAMADI (Morocco) expressed his support for the draft resolution contained in EB115.R14, adding that his country was willing to support the efforts of other countries endemic for malaria within South-South partnerships. Morocco was crossed by significant migratory flows, and it had therefore maintained epidemiological surveillance for the disease and would take all the steps necessary to prevent the introduction of imported cases.

Dr KAMUGISHA (Uganda), associating himself with the statement on behalf of the African group, said that malaria remained a major problem in Uganda, especially since the onset of HIV/AIDS, as many people with AIDS eventually died of malaria. In the draft resolution contained in EB115.R14, he asked for clarification of the term “local conditions” in paragraph 1(6) in reference to indoor residual spraying. Some countries that had attempted to apply that measure had met with strong resistance from sections of the international community, particularly to the use of DDT, and some Ugandan exporters had been threatened with a boycott of commodities treated with DDT on the grounds that it contaminated the food chain. He understood that DDT had been banned for agricultural use but not for vector control, and he requested a categorical statement on whether the use of DDT for indoor residual spraying was associated in any way with contamination of the food chain. As a previous speaker had observed, without vector control, countries heavily infested with mosquitoes would never be able to eradicate malaria. Subject to those remarks, he supported the draft resolution.

Dr PARK Ki-dong (Republic of Korea) said that malaria had been eradicated from his country by the late 1970s, thanks to the efforts of the Government in collaboration with WHO; however, it had re-emerged in the mid-1990s on the Korean peninsula and in other countries of East Asia. As the main occurrences were along his country's borders and as malaria had also re-emerged in the Democratic People's Republic of Korea, his Government had supported the malaria-control programme of that country since 2001, with help from WHO. It had also helped to strengthen collective response measures, working closely with WHO and other Member States in the South-East Asia Region. As a result, the incidence of the disease had dropped dramatically, although full eradication would take several more years. His Government intended to strengthen further its international collaboration. It expected WHO to step up its efforts to combat malaria, and to do so in close collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria, so as to further expand support to economically deprived Member States. He supported the draft resolution.

Dr DE LIMA (Sao Tome and Principe) said that, notwithstanding progress in rolling back malaria, the disease remained one of the main causes of morbidity and mortality, especially in poor countries; indeed it was itself a cause of poverty. If real progress was to be made in combating the disease, the international community would have to increase its funding for research into new medicines, effective vaccines and new insecticides; affected countries, for their part, must ensure that the most vulnerable groups of the population had access to medicines and insecticide-treated nets, albeit in the knowledge that the new agents were less affordable than chloroquine.

Cooperation and partnership were important elements in combating malaria. He thanked WHO and partner countries for their support for a malaria-control project in his country which was taking a three-pronged approach: patient care, vector control and epidemiological surveillance. Funds recently approved by the Global Fund to Fight AIDS, Tuberculosis and Malaria should become available

during the current year. He endorsed the statement by the delegate of Zambia and fully supported the draft resolution.

Professor KORTE (Germany) said that his country was strongly committed to supporting international efforts to combat malaria, particularly through the Global Fund to Fight AIDS, Tuberculosis and Malaria. Areas such as management and implementation, however, required technical support from WHO and other agencies, including bilateral technical agencies, and he gave an assurance that Germany would continue to help countries to build the management capacity they needed in order to make optimal use of available resources. Collaboration with the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases on research into implementation and biomedical aspects would also benefit from strengthened cooperation. He welcomed the “quick win” initiative, which Germany would support through development cooperation. He strongly supported the draft resolution.

Dr NLOME NZE (Gabon), endorsing the statement by the delegate of Zambia, said that malaria was a serious public health problem in Gabon as it was still not possible to meet the needs of all sectors of the population, especially pregnant women and children. Few pregnant women received intermittent preventive treatment, and only 1% of Gabonese children benefited from the use of insecticide-treated mosquito nets. Resistance to established antimalarial medicines was also a major obstacle. He acknowledged WHO’s support in obtaining additional resources for malaria control from the Global Fund to Fight AIDS, Tuberculosis and Malaria. He supported the draft resolution.

Dr VIOLAKI-PARASKEVA (Greece) observed that malaria control should be an integral part of primary health care in any existing health-care system. Greece had formerly had the highest incidence of malaria in Europe, with two million cases annually, but, thanks to an effective control programme, eradication had been certified in 1974. The possibility of autochthonous malaria transmission nevertheless remained a concern because of the frequency of international travel and immigration, the presence of competent mosquito vectors and environmental conditions that favoured transmission. A committee had been set up within the Greek Ministry of Health to deal with malaria and other tropical diseases; its mandate included authorizing mosquito control, training for medical and technical personnel, and improving early diagnosis and treatment. She asked whether any progress had been made on vaccine preparation. She supported the draft resolution but suggested that its title should be changed from “Malaria” to “Malaria control”.

Dr RUIZ (Mexico) said that, after years of combating malaria, Mexico had managed to reduce its malarial areas significantly through a strong, highly innovative programme based on active epidemiological surveillance, early diagnosis and treatment and, above all, vector control with ecologically-friendly pesticides and broad community participation. Currently, it had the lowest number of malaria cases in its history and also the lowest level of insecticide use. It had ceased using DDT some years previously.

He supported the draft resolution but proposed insertion of a new subparagraph after subparagraph 1(6) urging Member States to promote community participation in vector-control programmes. As migratory movements were also a risk factor, he proposed that subparagraph 1(7) should be amended to read “to develop or strengthen intercountry cooperation to combat the spread of malaria across shared borders and along migration routes;”.

Dr NABLI (Tunisia), noting the very slow progress towards the targets set for malaria control in Africa, supported the draft resolution. Member States should cooperate in controlling an epidemic that was threatening to make a comeback, even in countries in which the disease had been eradicated. It was necessary to increase awareness and to make available human and financial resources, which had fallen below targets and expectations. Preparedness had to be increased at all levels to make malaria control a priority, economically and socially, especially in endemic areas. Primary health care systems

must be improved, especially in front-line countries, so that they could play an effective role in implementing programmes and providing services. Civil society and the private sector also had a part to play in malaria control.

Professor KINDE-GAZARD (Benin) said that the Committee's work was vital for her country, in that it dealt with most of the endemics that were ravaging Benin and holding back the development of Africa as a whole. She supported the African group's statement on malaria control. She thanked the Roll Back Malaria partnership for making resources available, particularly the Global Fund to Fight AIDS, Tuberculosis and Malaria. Her country had received funding for malaria control under round 1 and achieved an implementation rate of more than 90% in Phase One. Nevertheless, children under five continued to die because of growing resistance to most of the available antimalarial medicines. Benin had changed its policy, in favour of artemisinin-based combination therapies; it wanted the Global Fund to take account of her country's performance and resource-management capacities and accept its submission for round 5, enabling it to obtain those therapies. Malaria control was strategic for Benin and would enable it to progress towards achieving the Millennium Development Goals.

Dr SANGALA (Malawi) endorsed the position of the African group. Under its national malaria control policy, and in line with the theme of World Health Day 2005, "Making every mother and child count", Malawi was implementing the Integrated Management of Childhood Illness programme, together with a new paediatric triage programme at district hospitals designed to identify children suffering from malaria and to offer them appropriate and timely emergency care. Pregnant women were offered intermittent preventive treatment. Mothers attending antenatal clinics or clinics for children under five were provided with heavily-subsidized insecticide-treated mosquito nets costing only US\$ 0.50. In rural communities, the nets were made available for US\$ 1 each, and 2.5 million had been distributed. Each year, during the Southern African Development Community's Malaria Week, mosquito nets could be re-treated free of charge, and the rate of re-treatment had increased from 7% in 2002 to 61% in 2004. Use of mosquito nets was still too low, however, at 35% for children under five and 31% for pregnant women; a study was to be conducted of the impact of the present level of net distribution on overall rates of morbidity and mortality from malaria. Malawi had made an application to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Funds received from any grant would be pooled in its sector-wide approach. He supported the draft resolution.

Dr XIAO Donglong (China) supported the draft resolution. He also endorsed the appeal in the report for Member States to step up national surveillance and evaluation programmes, in order to achieve the target of enabling 80% of persons at high risk from malaria to benefit from existing interventions by 2010. More attention should be paid to the increase in outbreaks of tertian malaria in Asia, with development of an effective control strategy and cooperation between regions and countries. A strategy should be formulated to prevent the re-emergence of malaria in certain areas, and WHO should expand the study of artemisinin-based therapies in order to broaden the range of treatments available. China was preparing a national medium- and long-term plans to bring malaria transmission under control by 2010 and to eradicate it entirely by 2015.

Dr MOSA (Madagascar) said the burden of malaria in his country was heavy: in 2003, there had been 2 250 000 reported cases, of which 35% had been among children under the age of five. In that year, around three million school days and more than four million working days had been lost owing to the disease, with more than US\$ 5 million of direct financial loss. The national malaria-control programme emphasized early treatment and indoor residual insecticide spraying. Insecticide-treated mosquito nets were distributed to vulnerable groups either free of charge or at a modest price. Madagascar had decided to introduce artemisinin-based combination therapy, but was aware of the relatively high cost involved. He therefore welcomed the draft resolution, which sought to broaden access to that therapy.

Dr CONOMBO-KAFONDO (Burkina Faso) said that, in her country, malaria remained one of the major causes of death among children under five years of age, with a case-fatality rate of 43%. Some strategies had been adopted, including use of artemisinin-based combination therapies in simple cases and quinine salts in more serious cases. In addition, sanitation and use of insecticide-treated nets were encouraged, although the rate of use of nets was only 8%. A malaria vaccine was currently being tested in a Phase Ib trial financed by the African Malaria Network Trust.

Burkina Faso had received support from the Global Fund to Fight AIDS, Tuberculosis and Malaria and had established partnerships with nongovernmental organizations. She supported the draft resolution, in particular subparagraphs 1(2) and 1(9). Although Burkina Faso had adopted a new treatment scheme involving artemisinin-based combination therapies, it had yet to receive supplies. The cost was higher than that of chloroquine, and personnel would have to be trained to deliver it. She endorsed the statement made on behalf of the African group.

Dr NAKASHIMA (Japan) said that his country was strongly committed to global malaria-control activities, noting in particular its support to the Global Fund to Fight AIDS, Tuberculosis and Malaria and to international control initiatives, its development of new antimalarial agents, and its provision of bilateral technical support through the Japan International Cooperation Agency. His Government was disappointed that, despite the enhanced financial support provided through the Global Fund, less progress than expected had been made towards the targets set out in the Abuja Declaration. Malaria remained a global public health concern, and further efforts were required from countries and stakeholders. Moreover, strategies to increase use of insecticide-treated nets should be developed.

The draft resolution did not touch upon cooperation in the public sector, and he suggested that subparagraph 1(8) be amended to read: "to encourage intersectoral collaboration, both public and private, at all levels, especially in education;".

With regard to the enhancement of financial support, he said that more long-term strategic plans making better use of limited budgets should be developed to meet the targets of the Roll Back Malaria initiative. The cost-effectiveness of action plans should be evaluated, together with progress.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) commented that, despite global efforts, malaria remained a principal cause of death of children under five; it constituted a major burden for health-care services, both in terms of outpatient services and admissions; the prevention rate was low, with only 2% of children under five sleeping under insecticide-treated mosquito nets; and pregnant women were not receiving adequate intermittent preventive treatment.

The Global Fund to Fight AIDS, Tuberculosis and Malaria provided a short-term source of finance, but Thailand remained concerned about the funding of activities in the longer term. Strong health systems were required to deliver effective programme activities; however, the migration of health workers, particularly from developing to developed countries, was seriously undermining the performance of malaria programmes in many countries.

Thailand welcomed the initiative for a global subsidy of artemisinin-based combination therapy proposed by the Institute of Medicine in the United States of America and the UNICEF multi-indicator cluster survey to be conducted in 2005-2006 to assess the impact of efforts to control malaria at the household level. Thailand supported the draft resolution, but in the light of its concerns about long-term financing, he suggested the addition of the words "to ensure financial sustainability and" at the beginning of subparagraph 1(4).

Dr SINGH (India) fully supported the draft resolution. Focused field studies should be encouraged to control the transmission of infection, and networks should be established for technology transfer on a national and international basis, as no vaccine existed for large-scale application. Research into a malaria vaccine should therefore be supported with a view to developing a product with the potential to reduce morbidity and mortality and the spread of infection.

Dr ASSI GBONON (Côte d'Ivoire) endorsed the statement made on behalf of the African group but stressed that emphasis should be given to vector control. She would welcome an environmental policy for destroying malaria-vector breeding grounds, particularly open gutters. It was essential to raise awareness, and she called on international organizations to provide assistance for environmental vector control. She welcomed the partnerships that had been forged between WHO and some pharmaceutical companies to provide cheaper antimalarial medicines to African countries and called for the development of pharmacovigilance systems. Efforts in the area of vaccine development should be intensified. She fully supported the draft resolution, as amended by Thailand.

Dr WINT (Jamaica) said that his country, like many others in the Caribbean, had eradicated malaria in the 1960s. It had, however, remained vigilant with regard to the surveillance and control of imported cases of malaria, the number of which had increased significantly in recent years. In 2004, 141 such cases had been recorded in Jamaica, mainly as a result of a sudden influx of refugees from a neighbouring country where the disease was highly endemic. Jamaica's diagnostic and treatment capacities had been severely tested, and he was grateful to WHO for having responded to his country's request for assistance to review and update its treatment protocols and retrain laboratory staff. He suggested that future documentation on malaria should take into account the issue of re-emergent malaria. In the draft resolution, therefore, he proposed that the words "as well as malaria-free countries facing a real risk of re-emergence" be inserted after "Roll Back Malaria partners" in subparagraph 2(2). He expressed support for the Mexican amendment.

Professor MAJORI (Italy) said that, although full access to diagnosis and treatment of malaria was still a critical problem in many areas, in particular sub-Saharan Africa, he remained optimistic about future progress in malaria control. Effective tools existed, such as the recently available artemisinin-based combination therapies and long-lasting insecticide-impregnated nets. Local partnerships should be strengthened and well-trained human resources deployed in the field if malaria control programmes based on the Roll Back Malaria strategy were to be implemented on a large scale. Italy supported the draft resolution and confirmed its commitment to global malaria control.

Dr NYIKAL (Kenya), having endorsed the statement made on behalf of the African group, said that malaria remained an important public health problem in Kenya; about 20 million people in the country were regularly exposed to the risk of malaria. Malaria alone accounted for 30% to 50% of outpatient attendances and 19% of all admissions, with children under five and pregnant women the most affected. Each year, about 34 000 children under five died from malaria-related complications. The emergence of drug-resistant strains of *Plasmodium falciparum* had exacerbated the problem and epidemics of malaria had been increasingly frequent since the 1990s. Over the previous three years, strategies had been adopted to ensure access to prompt and effective treatment, provide prevention and treatment in pregnancy, promote the use of insecticide-treated nets and vector-control methods such as indoor spraying with pyrethroids, and ensure epidemic preparedness and rapid response in areas prone to epidemics. Three challenges remained: first, vector control – and he urged WHO to adopt a clear position on the use of DDT; secondly, the cost of artemisinin-based combination therapies, particularly when financing from the Global Fund to Fight AIDS, Tuberculosis and Malaria was no longer forthcoming, and he called for international support and advocacy to keep costs down; and, thirdly, the absence of an effective vaccine, and he called for international investment in vaccine research. He supported the draft resolution.

Mr PAK Jong Min (Democratic People's Republic of Korea) said that, although his country had been free of malaria until 1970, 300 000 cases had been recorded in 2000 and it was one of the major communicable diseases. With the assistance of WHO, it had implemented activities to stop the spread of malaria and eliminate the disease. Its control strategy was country-specific and based on the fact that vivax malaria was prevalent in the country. Mass chemoprophylaxis was provided for communities in high-risk areas, and vector-control activities had been conducted on a national scale.

As a result, there had been a substantial reduction in the number of malaria cases, and it was hoped that the disease could be eliminated completely within one to two years. He thanked WHO and donors for their support and welcomed the draft resolution.

Professor BOUPHA (Lao People's Democratic Republic) said that, although the prevalence of the disease in his country had decreased in recent years, malaria was still to be found, in particular in disadvantaged areas, and it remained a public health concern. As a result of assistance from the Global Fund to Fight AIDS, Tuberculosis and Malaria and bilateral and multilateral cooperation, and with technical support from WHO, the malaria-control programme in his country was progressing satisfactorily. Nevertheless, activities still needed to be strengthened. He expressed strong support for the draft resolution.

The meeting rose at 12:45.

SIXTH MEETING

Thursday, 19 May 2005, at 15:00

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Malaria: Item 13.5 of the Agenda (Resolution EB115.R14; Document A58/8) (continued)

Mr KAMWI (Namibia), endorsing the statement made by Zambia, said that, with more than 600 000 cases a year, a third of the population, malaria control was a national priority. The country faced the emergence of resistance to chloroquine and, to a lesser extent, sulfadoxine-pyrimethamine, with efficacy of treatment having declined to less than 75% and 80% to 90%, respectively. The Ministry of Health and Social Services had launched a revised national malaria-control policy in April 2005, encompassing the four basic elements of the global malaria-control strategy, in particular provision of early diagnosis and prompt treatment and implementation of selective and sustainable preventive measures, including vector control through indoor residual spraying with insecticides. Namibia continued to use DDT for control of vector mosquitoes, especially *Anopheles funestus*, after their density had been reduced. He supported the draft resolution contained in resolution EB115.R14.

Mrs BELLA ASSUMPTA (Cameroon), noting that malaria remained highly endemic in Cameroon, said that her country was fully committed to achieving the targets of the Roll Back Malaria initiative. Community awareness, free distribution of insecticide-treated bednets for pregnant women and children under five, use of WHO-recommended combination therapies, intermittent treatment of pregnant women and home treatment of uncomplicated cases of malaria were among the strategies being applied, together with vector control and operations research.

She associated herself with the statement made by Zambia and proposed two amendments to the draft resolution. In subparagraph 2(3), following the words "studying the possibility of WHO undertaking bulk purchases on behalf of Member States", the words "who so desire" should be added. As technology transfer was an essential element in the fight against malaria, she asked that subparagraph 2(5) should incorporate the idea of encouraging local manufacture of malaria-control products.

Two international events would be held in Yaoundé at the end of 2005: the fifth Roll Back Malaria Global Partners' Forum and the fourth Multilateral Initiative on Malaria, Pan-African Malaria Conference. With the commitment of the Secretariat, Member States, private partners, civil society and the scientific community, those two events would give renewed impetus to rolling back malaria and to progress towards the malaria-control target contained in the Millennium Development Goals.

Dr DIALLO (France) observed that, despite the progress of the Roll Back Malaria initiative, malaria continued to kill more than one million people a year and that in many countries child morbidity and mortality rates were on the rise. Given that one of the main causes underlying this trend was the emergence of chloroquine resistance, it was important to stress prevention and accelerate access to artemisinin-based therapies. France was providing substantial funding to malaria control through the Global Fund to Fight AIDS, Tuberculosis and Malaria, to which it was the second largest contributor, and providing direct support for the Roll Back Malaria initiative through a project under way in seven countries of the Sahel. It was also supporting control efforts in several countries through bilateral cooperation. Aware of the challenge that malaria posed to achievement of the Millennium Development Goals relating to child mortality, France fully supported the draft resolution.

Dr MAMADOU-YAYA (Central African Republic) endorsed the statement made by Zambia and supported the draft resolution. Malaria, a major endemic disease in his country, accounted for 40% of health-care visits for children under five and was a leading cause of infant, child and maternal mortality. The Central African Republic was striving to implement regional malaria-control strategies. Its success in doing so was being limited, however, by lack of capacity to mobilize resources nationally and inadequate financing from external sources to meet the high costs of combined therapies. Other problems were insufficient health-care personnel, particularly in rural areas, the weakness of the surveillance system, frequent shortages of insecticide-treated bednets and the delay in calling for the fourth round of proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Expressing gratitude to WHO for its continuous support and to other partners, he asked the Organization to appeal to other bodies and organizations of the United Nations system, within their mandates, and other donors to support his country's efforts to step up its malaria-control programme and, in particular, meet the needs of pregnant women and children under five.

Dr PARIRENYATWA (Zimbabwe) said that his country fully supported the statement made by Zambia and the draft resolution on malaria. His country was a signatory to the Abuja Declaration on rolling back malaria in Africa. The goals of its strategy were to prevent mortality, reduce morbidity and lessen the social and economic losses caused by malaria; the means used were, in order of priority: vector control through indoor residual spraying with DDT and pyrethroids in a mosaic pattern; personal protection, particularly through use of insecticide-treated bednets; protection of children under-five and pregnant women; early case detection and case management; monitoring and evaluation; disease surveillance; advocacy; and research. Although Zimbabwe supported the use of all available tools, its first line of defence remained indoor residual spraying with insecticides, particularly DDT. Countries in North America and Europe had eradicated malaria decades earlier by killing mosquitoes with DDT, and it was by vector control that Zimbabwe and its neighbouring states in southern Africa had recorded successes in the fight against malaria. He encouraged the Director-General to continue recommending that Member States should adopt indoor residual spraying, which was a proven and effective tool.

Zimbabwe had decided to use artemisinin-based combination therapies, but it was hampered in doing so by their high price and lack of financing of their procurement by the Global Fund to Fight AIDS, Tuberculosis and Malaria. He urged the Director-General to persuade the Global Fund to change its position.

Mr ABID (Iraq) said that his country was proud of its Government-funded malaria-control programme, which also benefited from WHO's support. It had reduced the number of cases from 2000 in 2003 to 155 in 2005, all of which had occurred in the north of the country. The integrated programme included the control and monitoring of disease vectors, early diagnosis, treatment, health education, and the use of mosquito nets, although it would be preferable for the latter to be insecticide-treated. The main intervention was indoor spraying with insecticides, and his Government was concerned about their secondary effects on the environment and public health. He suggested a minor amendment to subparagraph 2(5) of the draft resolution: the addition of the words "to promote research to create and use environment-friendly means of controlling the vectors of the disease".

Ms VALDEZ (United States of America) fully recognized the importance of global malaria control especially for children and pregnant women in malaria-endemic settings, and for economic development. Mortality and morbidity rates continued to be devastatingly high owing to insufficient application of effective tools. Artemisinin-based combination therapy had become an important element in malaria control, but vigilance was needed to cope with shortages in the supply of artemisinin, and careful attention had to be paid to short- and long-term planning and implementation. She encouraged further discussion on the regulatory and quality-control issues relating to the formulation of fixed-dose combination therapies to include antimalarial drugs. Adequate funding would have the desired impact only if used for procuring drugs of established safety and efficacy that were approved by national regulatory authorities. Fixed-dose combinations could simplify regimens

and thus improve patient adherence, facilitate interventions and prevent the development of drug resistance. Funds for the Global Fund to Fight AIDS, Tuberculosis and Malaria represented her Government's largest investment in malaria control, and she encouraged all countries to support it. The report mentioned a rapid increase in the number of treatment courses of artemisinin-based combination therapy supported by the Global Fund, but that commendable effort should be accompanied by strengthened pharmacovigilance. The imbalance between the global supply of bulk artemisinin and the demand for its antimalarial derivatives called for international cooperation between the public and private sectors. The governments of producer nations should ensure that the price of artemisinin was not inflated as a result of production shortages. She commended the progress being made by the Medicines for Malaria Venture towards bringing a new antimalarial drug to market every five years. Her country recognized the effectiveness of indoor residual insecticide spraying for prevention and supported its increased use, particularly in Africa. She strongly supported the draft resolution as it stood.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) drew attention to the disturbing observation in the report that the global burden of malaria in terms of morbidity and mortality had not changed significantly since 2000. It was improbable that the goals of the Abuja Declaration would be attained in 2005, and he expressed concern that meeting the targets for 2010 would require some US\$ 3200 million per year, including US\$ 1900 million for Africa. In Cuba, the last case of malaria had been recorded in 1967. In 1973, the country had been certified as malaria-free and that status had been maintained, thanks to efficient epidemiological surveillance. Intercountry cooperation in antimalarial programmes was crucial to avoid cross-border contamination and to increase effectiveness. The fight against malaria depended largely on the available medicines and insecticides, and more research was needed to develop effective vaccines, drugs and insecticides. He supported the draft resolution as amended by Mexico but proposed that paragraph 1 should urge Member States to "ensure multisectoral and community participation for vector control and other preventive actions". Vectors could not be controlled without the active participation of the community and other sectors besides the public health sector. For instance, insecticide-treated bednets were not properly used owing to the lack of both community participation and information on the benefits of such preventive measures.

Mr SHONGWE (Swaziland) said that malaria continued to be a major public health problem in Swaziland, especially for pregnant women and children under five years of age. Support from WHO and other partners had helped his country's efforts to reach the targets set out in the Abuja Declaration and Millennium Development Goal 6. Swaziland's malaria-control programme covered continued indoor residual insecticide spraying, effective treatment of infected persons, surveillance, use of insecticide-treated bednets by pregnant women and children under five, and cooperation with Mozambique and South Africa. He thanked the Secretariat for its technical support and the Global Fund to Fight AIDS, Tuberculosis and Malaria for backing the national malaria-control programme. Swaziland fully supported the draft resolution and the comments made by Zambia.

Dr KAMANA (Burundi) said that his Government had examined the draft resolution closely. Countries affected by malaria should be encouraged to destroy mosquito-breeding sites by taking energetic measures in urban areas and to clean the environment in general. Funding agencies should be more willing to finance such basic activities, as countries that had succeeded in eliminating malaria had invested considerably in improving the environment. In Burundi, where malaria was endemic, artemisinin and amodiaquine had been introduced after resistance to sulfadoxine-pyrimethamine had been demonstrated. WHO should step up research in cooperation with other partners to arrive at a consensus on an intermittent treatment strategy for pregnant women, in areas where sulfadoxine-pyrimethamine was no longer operational. Burundi, a poor post-conflict country, should receive more support from WHO and its partners to subsidize treatment with new drugs and laboratory analyses. Pharmaceutical preparations for children should be given priority, and any pre-qualification process should be accelerated. Pharmacovigilance and stock-building activities should also be supported.

Professor JOHNSTONE (United Kingdom of Great Britain and Northern Ireland) welcomed the draft resolution, as strong, concerted action was needed to end the situation in which 800 000 children under five in Africa died each year from the disease despite the existence of effective prevention and treatment. Access to artemisinin-based therapies should be ensured for Member States that had included them in their medicines policies. Innovative and more effective mechanisms were needed to coordinate and secure procurement and distribution, with the necessary financing. The use of insecticide-treated bednets should be extended. Clearly, Member States were best placed to identify the most appropriate approaches, including free and subsidized delivery and support to local markets. Such measures should be implemented speedily.

Dr AHMED (Pakistan) said that malaria remained a major public health problem in Pakistan. Although WHO had given priority to its control, he shared the concern of others that the Roll Back Malaria partnership had had to reschedule its targets. With renewed commitment and additional resources, the regional and global objectives of the campaign could be achieved. Pakistan's national malaria-control programme was progressing at a reasonable pace towards those targets, and new interventions, such as artemisinin-based combination therapies and insecticide-treated bednets, should benefit. A breakthrough on a malaria vaccine and new antimalarial agents were awaited. He supported the draft resolution.

Dr AL-OWEIDI (Oman) thanked WHO for its continued support to countries suffering from malaria, especially those in Africa. Until 1990, when an antimalarial programme had been introduced, Oman had had some 40 000 cases per year. Since then, as a result of intensive control measures, the number of cases had fallen to about 10 per year, all imported, with no indigenous case during the previous five years. About one million incoming air passengers from malaria-endemic regions were screened each year. In 2004, WHO and regional organizations had paid tribute to Oman's programme and had examined its results with a view to its application in other countries. WHO should adopt precise indicators similar to those used for poliomyelitis and he asked that the resources earmarked for malaria control should be increased, especially for the most disadvantaged countries. Oman supported the draft resolution.

Dr ZAHER (Egypt) said that Egypt had recorded no endemic case of malaria since 1998, thanks to integrated, comprehensive action taken under the country's malaria-control campaign, which included biological and mechanical control methods and the use of environmentally friendly insecticides. The various ministries concerned had worked in a coordinated manner since 1996, before the adoption of the Abuja Declaration on Roll Back Malaria in 2000. Under the current programme, the Ministry of Health and Population supplied the necessary medicines: chloroquine as first-line treatment and sulfadoxine-pyrimethamine and mefloquine as second-line treatment. There was also a joint protocol for cooperation with Sudan to control *Anopheles gambiae*, as a result of which all malaria vectors had been eliminated from a 650-kilometre zone in the north of Sudan. The protocol was a good example of bilateral cooperation on disease control between neighbouring countries.

Dr GAMBOA PEÑARANDA (Costa Rica), recalling the concern expressed at the 115th session of the Executive Board that the Secretariat's report had contained no information on malaria in the Americas,¹ emphasized the need to highlight the efforts being made there to eradicate the disease. Some 36% of the population was living in areas at risk for malaria with 57% in the 21 countries where malaria was transmitted: 293 million people in areas where the socioeconomic and environmental conditions were conducive to transmission. It was to be hoped that WHO would continue to back endeavours to fight malaria in the Region of the Americas. He fully supported the draft resolution, but

¹ Document EB115/10.

agreed that the amendments presented by Cuba, Jamaica and Mexico should be taken into consideration in order to make the text more comprehensive.

Mr SILBERSCHMIDT (Switzerland) expressed concern about the slow progress towards achieving the targets agreed at the African Summit on Roll Back Malaria in Abuja in 2000, notwithstanding the large-scale distribution of antimalarial medicines, insecticides and insecticide-treated bednets. Through its bilateral aid programme, Switzerland contributed to several national malaria-control programmes and, in collaboration with the countries concerned, was devising new models for health financing and fostering scientific and managerial capacity building. It also supported research to develop new tools and delivery modes for control measures. In the Roll Back Malaria initiative, close collaboration with a variety of entities and global programmes was vital.

He supported the draft resolution and the amendments proposed by Thailand.

Dr DUALE (Somalia) said that, although WHO had played a major role in efforts to prevent and treat malaria through the provision of skilled personnel and insecticide-treated bednets, his country continued to have the highest rate of prevalence in eastern Africa. As there had been no central government in Somalia for more than 14 years, the country was in dire need of resources – particularly health personnel, equipment and essential medicines – and it appealed urgently for assistance.

Dr GARCÍA (Bolivarian Republic of Venezuela) expressed support for the draft resolution and the proposal made by Mexico to include a reference to “community participation”, which was crucial in combating malaria. The text might also reflect evidence that migratory movements could increase the incidence of malaria, and the important role of pharmacovigilance in monitoring drug resistance and in plans for controlling malaria.

Mrs AHO (Togo) said that, thanks to the support of her country’s partners, it had been possible in 2004 to protect 46% of children under the age of five and 36% of pregnant women through the distribution of treated bednets, and to use insecticidal spray in prisons, police stations and youth detention centres. In March 2005, sulfadoxine-pyrimethamine treatment had been provided in all 35 districts of the country. Public awareness campaigns about malaria and lymphatic filariasis had also continued. The current major challenges were treating cases at community level with artemisinin-based combination therapy and monitoring the use of insecticide-treated bednets in households.

She urged WHO and her country’s partners to continue their support with the supply of treated bednets and the new combination therapies. Her Government supported the draft resolution and the statement by the delegate of Zambia.

Dr RAMSAMMY (Guyana) said that malaria was a serious public health problem in his country, causing the loss of more than 150 000 person-days in 2004. Until that time, malaria had been due to infection with *Plasmodium falciparum* and *P. vivax*, but subsequently cases of infection with *P. malariae* had been seen. His Government had introduced fixed-dose combination therapy for falciparum malaria in 2004. It had started to provide every household with insecticide-impregnated bednets and had begun residual spraying of every household in malarious areas. Testing of all pregnant women attending antenatal clinics had also been initiated, but cross-border infection was still a matter of concern. Guyana had requested PAHO to include malaria on the agenda of the Pan American Sanitary Conference and had proposed that 6 November should be designated Malaria Day of the Americas and the week around that date Malaria Week of the Americas. If those proposals were accepted, the Region of the Americas would observe its first Malaria Day in 2005. Given that the African States also observed a Malaria Day, he wondered whether a proposal to designate a common World Malaria Day might be included in the draft resolution. He endorsed the amendments proposed by Cuba, Jamaica and Mexico.

Dr TENNAKOON (Sri Lanka) said that in his country malaria had long been recognized as a major public health problem that had a negative impact on the economy by reducing productivity. However, a successful screening programme, the use of insecticide-treated bednets and community awareness schemes had resulted in a sharp drop in the number of cases diagnosed between 2002 and 2005. Mortality due to malaria was very low. His Government appreciated WHO's support with the supply of critical items, logistics and training, and for intersectoral collaboration and community participation in malaria-control work. The support of the International Development Association and the Global Fund to Fight AIDS, Tuberculosis and Malaria was also much appreciated. However, capacity building, human resources development and better monitoring and evaluation efforts were still badly needed in Sri Lanka. There was also a need for further research into, and development of, new kinds of insecticides and vaccines. Moreover, WHO support was still required for the supply of insecticide-treated bednets and for community participation activities.

Dr KYAW NYUNT SEIN (Myanmar) said that, if the Millennium Development Goals were to be attained, there was an urgent need to accelerate malaria control activities, especially the coverage of insecticide-treated bednets and social mobilization to increase public awareness regarding their use. National and regional collaboration was needed to monitor and control counterfeit antimalarial medicines. Effective and efficient control of malaria required comprehensive multisectoral approaches integrated with strong district health systems. Capacity would therefore need to be strengthened in all areas concerned, including entomology. The Global Fund to Fight AIDS, Tuberculosis and Malaria was a good example of the type of collaboration and support needed. The successful functioning of global financing mechanisms was vital. In addition, WHO and other partners should provide technical and financial support to fill gaps in national plans. He supported the amendment proposed by the delegate of Thailand concerning sustainable financing.

Dr MUKELABAI (UNICEF) said that, as a founding member of the Roll Back Malaria Partnership, UNICEF supported the draft resolution. The Millennium Development Goal to reduce the under-five mortality rate by two thirds would not be reached by many African countries unless malaria was effectively prevented and controlled. Cost-effective interventions were available. UNICEF was working closely with countries endemic for malaria to increase the supply of treated bednets, especially those treated with new long-lasting insecticides, and would increase its own stocks in order to be able to make them available at short notice. Treated bednets were best distributed in conjunction with routine or measles immunization campaigns, thereby rapidly increasing the number of people with access to bednets, or through antenatal clinics; both immunization coverage and antenatal attendance could thus be increased. UNICEF was also giving support to countries for the procurement of the new artemisinin-based combination therapy.

The current major challenges for malaria control were: the high cost of insecticide-treated bednets and artemisinin-based combination therapy; the limited availability of both those commodities; and lack of access to preventive measures and early treatment. He urged all Roll Back Malaria partners to encourage the commercial sector to improve the availability of all malaria commodities, especially long-lasting insecticide-treated bednets and the new artemisinin-based combination medicines. He also urged countries in which malaria was endemic to reduce taxes and tariffs on treated bednets to make them more affordable for children and their families, and to encourage local commercial production. UNICEF strongly recommended free distribution of insecticide-treated bednets to children under five and pregnant women. No child or pregnant woman should be denied access to insecticide-treated bednets or to treatment on the basis of cost alone.

Dr MBIZVO (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, pledged the continuing support of her organization as a major partner in rolling back malaria and contributing to the attainment of the Millennium Development Goals and the targets set in the Abuja Declaration on Roll Back Malaria in Africa (April 2000).

Since 2002, the International Federation, through a measles partnership initiative, had promoted an integrated approach to the wide-scale distribution of long-lasting insecticide-treated bednets in

order to achieve high coverage rapidly at low cost, for example, in Ghana and Zambia. In Togo, a nationwide integrated campaign, which combined measles and poliomyelitis immunization with distribution of mebendazole and bednets treated with long-lasting insecticide, had reached more than 850 000 children in late 2004, and a similar campaign, with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, would be conducted in Niger in late 2005.

Such large-scale efforts were possible if three conditions were met: a pooling of resources and technology through effective partnering; transparent joint planning and implementation involving all interested parties; and an unprecedented emphasis on community mobilization to ensure that bednets were properly used.

Dr ISLAM (Secretary) read out the proposed amendments to the draft resolution. Greece had suggested that the title should be “Malaria control”, rather than “Malaria”; Thailand had proposed that the words “to ensure financial sustainability” should be inserted at the beginning of subparagraph 1(4); Cuba and Mexico had requested that subparagraph 1(6) should read: “to support indoor residual insecticide spraying where this intervention is indicated by local conditions, and to achieve community participation and multisectoral collaboration in vector control and other preventive actions”. Mexico had further proposed that the words “and along migration routes” should be added at the end of subparagraph 1(7); Japan had proposed that subparagraph 1(8) should be amended to read: “to encourage intersectoral collaboration, both public and private, at all levels, especially in education”. Jamaica had requested that the words “as well as malaria-free countries facing a real risk of re-emergence” should be inserted between the words “partners” and “to ensure” in subparagraph 2(2); Cameroon had proposed that “Member States” in subparagraph 2(3) should be amended to “Member States, who so desire, ...”; and Iraq had requested that the words “and environmentally friendly” should be inserted between the words “new” and “insecticides” in subparagraph 2(5).

Dr RUIZ (Mexico) said that his delegation had proposed the addition of a new paragraph between subparagraphs 1(6) and 1(7) urging Member States to achieve community participation in vector control activities, rather than amending subparagraph 1(6).

The CHAIRMAN, confirming that that suggestion would be incorporated, invited the Committee to consider the draft resolution contained in resolution EB115.R14, as amended.

The resolution, as amended, was approved.¹

Smallpox: Item 13.6 of the Agenda (Documents A58/9 and A58/10)

Professor FURGAL (Russian Federation) expressed support for the recommendation by the WHO Ad Hoc Committee on Orthopoxvirus Infections and the proposal to establish a global reserve of smallpox vaccine as described in document A58/9. The Secretariat’s concerns were fully justified, since nobody under the age of 25 was protected against the risk of infection, either from natural sources or as a result of bioterrorism. Furthermore, the previous vaccine was unsuitable for mass immunization. Although the only correct decision in the circumstances was to establish and maintain a strategic reserve of at least 205 million doses of vaccine, it did not lessen the strategic necessity of continuing research into new-generation vaccines, which could gradually replace existing stocks.

He endorsed the conclusions and recommendations of the WHO Advisory Committee on Variola Virus Research at its sixth meeting. That Committee had been satisfied that stocks of the virus were maintained with appropriate safeguards in place, and had clearly recommended that research continue into the development of new antiviral agents. In accordance with resolutions WHA52.10 and WHA55.15, research was continuing in the Russian Federation into new-generation diagnostic,

¹ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA58.2.

prophylactic and therapeutic measures against smallpox at the WHO Collaborating Centre for Orthopoxvirus Diagnosis and Repository for Variola Virus Strains and DNA within the State Centre for Research on Virology and Biotechnology, in strict accordance with the recommendations and requirements of the Advisory Committee and under the control and with the participation of the Secretariat. The conclusions and results obtained were available to all interested Member States.

Over the past year, a review of the methods of accounting for virus stocks had been undertaken in order to bring the different practices into line, and a WHO inspection mission was due to visit the country later in the year to evaluate the activities of the Collaborating Centre. The results of the review had been discussed at the Advisory Committee's meeting in November 2004 and considered positive.

Russian scientists, convinced that research using live variola virus should continue, in order, among other things, to allow for the identification of any strain in the event of a deliberate release of variola virus, had been unable to accept the conclusion of the Advisory Committee given in paragraph 3 of document A58/10. He therefore suggested that the matter should be discussed further at the seventh meeting of the Advisory Committee or at a special session.

Dr REN Minghui (China) said that the world should be prepared for smallpox control and prevention of bioterrorism, and therefore agreed in principle with the proposal to establish a global smallpox vaccine reserve. However, mechanisms should be put in place to ensure that countries without the capacity to produce or stockpile vaccines would have access to vaccines in a timely manner, if required. WHO should convene a meeting of experts to establish standards and norms for smallpox vaccine production, which should be published and Member States should be kept informed of progress in that area.

All necessary measures must be taken to prevent any accidental release of variola virus. WHO must establish rules to ensure strict management of existing virus stocks and to improve laboratory oversight mechanisms, and report regularly on the situation to WHO's governing bodies. As long as live variola virus continued to be used for research, there was a biosecurity risk, with a threat to human health. Existing smallpox control methods had proven to be effective; the benefits resulting from the development of effective antiviral agents to treat a small number of patients were outweighed by the risk associated with lengthy retention of live virus stocks. Use of the live virus in research should therefore cease as soon as possible; once work on the sequence analysis of variola virus DNA and rapid diagnostic tests had been completed, WHO should set a target date for destruction of the remaining variola virus stocks.

Dr SINGH (India) endorsed the maintenance of stocks of smallpox vaccine, diluent and bifurcated needles by the Secretariat in Geneva but called for transparent procedures for the management of such a reserve. India had the potential to manufacture smallpox vaccine but would require supplies of the seed virus currently used for manufacture, together with transfer of the necessary advanced technology for the production of safe and potent vaccine. Further consideration should be given to those requirements.

Dr AKBARI (Islamic Republic of Iran) said that the destruction of the two remaining stocks of live variola virus would finally mark the end of smallpox. Continued research using the live virus would only extend the risk of accidental release or accidental infection of laboratory personnel, as had happened during research on severe acute respiratory syndrome and tularemia. The potential for bioterrorism demanded strong countermeasures. He therefore endorsed resolution WHA55.15 and supported the destruction of the stocks as soon as possible.

Ms PODESTA (Australia) agreed that there was a continued need for research using live variola virus in order to develop a safe vaccine and effective antiviral agents, and that such research required clear guidelines, careful monitoring and sharing of information. She welcomed the progress made in the development of smallpox diagnostic capacity and supported the need for continued research to evaluate diagnostic tests using authentic smallpox lesions in infected non-human primates or historic samples. The progress made in DNA sequence analysis and primate modelling to facilitate

development of candidate vaccines and antiviral agents was also to be commended. The report presented a considered approach to continued research, and Australia endorsed the request that the WHO Advisory Committee on Variola Virus Research should reconsider the matter further at its next meeting.

Dr VIOLAKI-PARASKEVA (Greece), referring to the establishment of a global smallpox vaccine reserve, said that many countries, including her own, had stocks of freeze-dried smallpox vaccine that were nearing their expiry date. She asked how long after the expiry date it was possible to use such vaccines, and asked what the next steps in establishing the global reserve would be.

Dr NISHIJIMA (Japan) welcomed the recommendations of the WHO Advisory Committee on Variola Virus Research at its sixth meeting and the significant progress made in the research. Research outcomes should be shared with all nations and peoples and used in the attainment of global objectives; they should not remain the property of individual countries or companies. The recommendations made by the Advisory Committee were crucial and should all be implemented. It was important to maintain careful records following the destruction of variola virus isolates. Japan supported the continued DNA sequence analysis with a view to ensuring traceability.

Japan had started domestic storage in 2001 and stocks in the amounts necessary were being maintained. It was willing to provide technical support in that area through WHO, given the excellent quality of its smallpox vaccine.

(For continuation of the discussion, see summary record of the seventh meeting, section 4.)

The meeting rose at 17:45.

SEVENTH MEETING

Friday, 20 May 2005, at 09:30

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)

1. DRAFT SECOND REPORT OF COMMITTEE A (Document A58/54)

Dr BUSUTTIL (Malta), Rapporteur, read out the draft second report of Committee A.

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Revision of the International Health Regulations: Item 13.1 of the Agenda (Documents A58/4, A58/41, A58/41 Add.1 and A58/41 Add.2) (continued from the first meeting, section 3)

Mr SILBERSCHMIDT (Switzerland), speaking as the chairman of the drafting group, reported that the group had met four times, with broad participation from all regions. Delegates had shown a willingness to compromise, and full consensus had been found for the following draft resolution:

The Fifty-eighth World Health Assembly,
Having considered the draft revised International Health Regulations;²
Having regard to articles 2(*k*), 21(*a*) and 22 of the Constitution of WHO;

Recalling references to the need for revising and updating the International Health Regulations in resolutions WHA48.7 on revision and updating of the International Health Regulations, WHA54.14 on global health security: epidemic alert and response, WHA55.16 on global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health, WHA56.28 on revision of the International Health Regulations, and WHA56.29 on severe acute respiratory syndrome (SARS), with a view to responding to the need to ensure global public health;

Welcoming resolution 58/3 of the United Nations General Assembly on enhancing capacity building in global public health, which underscores the importance of the International Health Regulations and urges that high priority should be given to their revision;

Affirming the continuing importance of WHO's role in global outbreak alert and response to public health events, in accordance with its mandate;

Underscoring the continued importance of the International Health Regulations as the key global instrument for protection against the international spread of disease;

Commending the successful conclusion of the work of the Intergovernmental Working Group on Revision of the International Health Regulations,

¹ See page 353.

² See document A58/4.

1. ADOPTS the revised International Health Regulations attached to this resolution,¹ to be referred to as the “International Health Regulations (2005)”;
2. CALLS UPON Member States and the Director-General to implement fully the International Health Regulations (2005), in accordance with the purpose and scope set out in Article 2 and the principles embodied in Article 3;
3. DECIDES, for the purposes of paragraph 1 of Article 54 of the International Health Regulations (2005), that States Parties and the Director-General shall submit their first report to the Sixty-first World Health Assembly, and that the Health Assembly shall on that occasion consider the schedule for the submission of further such reports and the first review on the functioning of the Regulations pursuant to paragraph 2 of Article 54;
4. FURTHER DECIDES that, for the purposes of paragraph 1 of Article 14 of the International Health Regulations (2005), the other competent intergovernmental organizations or international bodies with which WHO is expected to cooperate and coordinate its activities, as appropriate, include the following: United Nations, International Labour Organization, Food and Agriculture Organization, International Atomic Energy Agency, International Civil Aviation Organization, International Maritime Organization, International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies, International Air Transport Association, International Shipping Federation, and *Office International des Epizooties*;
5. URGES Member States:
 - (1) to build, strengthen and maintain the capacities required under the International Health Regulations (2005), and to mobilize the resources necessary for that purpose;
 - (2) to collaborate actively with each other and WHO in accordance with the relevant provisions of the International Health Regulations (2005), so as to ensure their effective implementation;
 - (3) to provide support to developing countries and countries with economies in transition if they so request in the building, strengthening and maintenance of the public health capacities required under the International Health Regulations (2005);
 - (4) to take all appropriate measures, pending entry into force of the International Health Regulations (2005), for furthering their purpose and eventual implementation, including development of the necessary public health capacities and legal and administrative provisions, and, in particular, to initiate the process for introducing use of the decision instrument contained in Annex 2;
6. REQUESTS the Director-General:
 - (1) to give prompt notification of the adoption of the International Health Regulations (2005) in accordance with paragraph 1 of Article 65 thereof;
 - (2) to inform other competent intergovernmental organizations or international bodies of the adoption of the International Health Regulations (2005) and, as appropriate, to cooperate with them in the updating of their norms and standards and to coordinate with them the activities of WHO under the International Health Regulations (2005) with a view to ensuring the application of adequate measures for the protection of public health

¹ In the version of this draft resolution to be transmitted by Committee A to the Health Assembly, the draft International Health Regulations annexed to document A58/4 will be attached with the title “International Health Regulations (2005)”.

and strengthening of the global public-health response to the international spread of disease;

(3) to transmit to the International Civil Aviation Organization (ICAO) the recommended changes to the Health Part of the Aircraft General Declaration,¹ and, after completion by ICAO of its revision of the Aircraft General Declaration, to inform the Health Assembly and replace Annex 9 of the International Health Regulations (2005) with the Health Part of the Aircraft General Declaration as revised by ICAO;

(4) to build and strengthen the capacities of WHO to perform fully and effectively the functions entrusted to it under the International Health Regulations (2005), in particular through strategic health operations that provide support to countries in detection and assessment of, and response to, public health emergencies;

(5) to collaborate with States Parties to the International Health Regulations (2005), as appropriate, including through the provision or facilitation of technical cooperation and logistical support;

(6) to collaborate with States Parties to the extent possible in the mobilization of financial resources to provide support to developing countries in building, strengthening and maintaining the capacities required under the International Health Regulations (2005);

(7) to draw up, in consultation with Member States, guidelines for the application of health measures at ground crossings in accordance with Article 29 of the International Health Regulations (2005);

(8) to establish the Review Committee of the International Health Regulations (2005) in accordance with Article 50 of these Regulations;

(9) to take steps immediately to prepare guidelines for the implementation and evaluation of the decision instrument contained in the International Health Regulations (2005), including elaboration of a procedure for the review of its functioning, which shall be submitted to the Health Assembly for its consideration pursuant to paragraph 3 of Article 54 of these Regulations;

(10) to take steps to establish an IHR Roster of Experts and to invite proposals for its membership, pursuant to Article 47 of the International Health Regulations (2005).

The draft resolution was approved by acclamation.²

The CHAIRMAN expressed thanks to Mrs Mary Whelan (Ireland) as Chair of the Intergovernmental Working Group, to Mr Silberschmidt (Switzerland) as chairman of the drafting group, and to the delegates for their hard work.

3. PROPOSED PROGRAMME BUDGET 2006-2007: Item 12 of the Agenda (Documents PB/2006-2007, PB/2006-2007 Corr.1, A58/INF.DOC./1 and A58/INF.DOC./3 (continued from the fifth meeting, section 2))

The CHAIRMAN drew attention to the draft resolution on the appropriation for the financial period 2006-2007, which read:

¹ Document A58/41 Add.2.

² Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA58.3.

The Fifty-eighth World Health Assembly,

1. RESOLVES to appropriate for the financial period 2006-2007 an amount of US\$ 995 315 000 under the regular budget as follows:

Appropriation section	Purpose of appropriation	Amount
		US\$
1.	Essential health interventions	238 343 000
2.	Health policies, systems and products	164 913 000
3.	Determinants of health	96 156 000
4.	Enabling programme delivery	251 770 000
5.	WHO's core presence in countries	128 624 000
6.	Other	35 509 000
	Effective working budget	915 315 000
7.	Transfer to Tax Equalization Fund	80 000 000
	Total	995 315 000

2. RESOLVES to finance the regular budget for the financial period 2006-2007 as follows:

Source of financing	Amount
	US\$
Estimated Miscellaneous Income	22 200 000
Regular budget net assessments on Members (see also paragraph 3(3) below)	893 115 000
Transfer to Tax Equalization Fund	80 000 000
Total	995 315 000

3. FURTHER RESOLVES that:

(1) notwithstanding the provisions of Financial Regulation 4.3, the Director-General is authorized to make transfers between the appropriation sections of the effective working budget up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made; all such transfers shall be reported in the financial report for the financial period 2006-2007; any other transfers required shall be made and reported in accordance with the provisions of Financial Regulation 4.3;

(2) amounts not exceeding the appropriations voted under paragraph 1 shall be available for the payment of obligations incurred during the financial period 1 January 2006 to 31 December 2007 in accordance with the provisions of the Financial Regulations; notwithstanding the provisions of the present paragraph, the Director-

General shall limit the obligations to be incurred during the financial period 2006-2007 to sections 1 to 6;

(3) the amount of the contribution to be paid by individual Members shall be reduced by the sum standing to their credit in the Tax Equalization Fund; that reduction shall be adjusted in the case of those Members that require staff members to pay income taxes on their WHO emoluments, taxes which the Organization reimburses to said staff members; the amount of such reimbursements is estimated at US\$ 9 114 080, resulting in a total assessment on Members of US\$ 902 229 080;

4. DECIDES:

(1) that with reference to resolution WHA56.34 and notwithstanding the provisions of Financial Regulation 5.1, an amount of US\$ 8 655 000 shall be financed directly by the Miscellaneous Income account to provide an adjustment mechanism for the benefit of those Member States that will experience an increase in the rate of assessment between that applicable for the 2000-2001 financial period and for the 2006-2007 financial period and notify the Organization that they wish to benefit from the adjustment mechanism;

(2) that the amount required to meet payments under the financial incentive scheme for 2006 and for 2007 in accordance with Financial Regulation 6.5, estimated at US\$ 1 000 000, shall be financed directly by the Miscellaneous Income account;

(3) that the level of the Working Capital Fund shall remain at the level of US\$ 31 000 000 as decided earlier under resolution WHA56.32;

5. NOTES that the expenditure in the programme budget for 2006-2007 to be financed by voluntary contributions is estimated at US\$ 2 398 126 000, leading to a total effective budget under all sources of funds of US\$ 3 313 441 000;

6. COMMENDS the Director-General on the further progress in implementing a results-based management framework, and supports the systematic review of all WHO core managerial and administrative policies and processes with the aim of simplifying and changing the way WHO works to achieve greater impact while maintaining operations of lower cost;

7. REQUESTS the Director-General:

(1) to provide as from the 116th session of the Executive Board, bearing in mind Financial Regulation XV – Resolutions involving Expenditures and Rule 13 of the Rules of Procedure of the Health Assembly, a report on the administrative and financial implications of any resolution proposed for adoption by the Executive Board or Health Assembly and to ensure that this report is provided prior to consideration of adoption of the resolution being introduced;

(2) to continue to pursue rigorous financial discipline through transparency of resource allocations to headquarters, global activities, regions and countries, and elimination of any overlapping functions within the Organization;

(3) to implement the planned efficiency projects described in the Programme budget 2006-2007, and to set clear and measurable efficiency targets for this, and future, budgets;

(4) to ensure early implementation of the outstanding audit recommendations, and to propose to the Executive Board at its 117th session a tracking programme for external and internal audit recommendations which include timeframes for implementation;

(5) to carry through his strong commitment to further strengthen the performance of the Organization, in particular at the regional and country levels;

(6) to provide guidance regarding WHO's relative priorities when requesting voluntary contributions;

(7) to report to the Sixtieth World Health Assembly, through the Executive Board, on progress made in the implementation of this resolution.

Mr AITKEN (Office of the Director-General) explained that the revised version of the draft resolution reflected a number of points and comments made earlier by delegates.

Mr NAKAZAWA (Japan), recalling that his delegation had earlier expressed some concerns, thanked other delegates for their cooperative attitude to revising the draft resolution and said that Japan was ready to join the consensus.

The draft resolution was approved.¹

4. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (resumed)

Sustainable financing for tuberculosis prevention and control: Item 13.4 of the Agenda (Resolution EB114.R1; Document A58/7) (continued from the fifth meeting, section 3)

The CHAIRMAN drew attention to a revised text of the draft resolution on sustainable financing for tuberculosis prevention and control recommended by the Executive Board in resolution EB114.R1, which incorporated amendments proposed by the delegates of India, Mexico, Swaziland, Thailand and Uganda and which read:

The Fifty-eighth World Health Assembly,

Having considered the report on sustainable financing and tuberculosis control;

Aware of the need to diminish the global burden of tuberculosis and thereby lower this barrier to socioeconomic development;

Noting with concern the increasing number of cases of multidrug-resistant tuberculosis, and worsening morbidity and mortality among HIV-positive tuberculosis patients, especially in the African Region;

Welcoming the progress made towards achieving the global tuberculosis-control targets for 2005 following the establishment, in response to resolution WHA51.13, of the Stop Tuberculosis Initiative;²

Noting the need to strengthen health systems development for the successful delivery of tuberculosis-control activities;

Stressing the importance of engagement of the full range of health providers in delivering the international standard of tuberculosis care in line with the strategy of directly observed treatment, short-course (DOTS);

Concerned that lack of commitment to sustained financing for tuberculosis control will impede the sound long-term planning necessary to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

Encouraging the development of a global plan for the period 2006-2015, which will address the need for sustained financing in order to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration,

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA58.4.

² Now known as the Stop TB Partnership.

1. ENCOURAGES all Member States:
 - (1) to estimate the total resources required for prevention and control of tuberculosis, including HIV-related tuberculosis and multidrug-resistant tuberculosis, in the medium term, and the resources available from domestic and international sources in order to identify the funding gap;
 - (2) to fulfil the commitments made in endorsing resolution WHA53.1 and hence the Amsterdam Declaration to Stop Tuberculosis, including their commitment to ensure the availability of sufficient domestic resources and of sufficient external resources to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;
 - (3) to strengthen integration between financial, operational and social partners by setting up Stop TB partnerships in each country;
 - (4) to ensure that all tuberculosis patients have access to the universal standard of care based on proper diagnosis, treatment and reporting consistent with the DOTS strategy by promoting both supply and demand;
 - (5) to strengthen prevention of, and social mobilization against, tuberculosis;
 - (6) to set up collaboration between tuberculosis and HIV programmes, in order to address more effectively the dual tuberculosis/HIV epidemic;
 - (7) to integrate the prevention and control of tuberculosis in the mainstream of their health development plans;
 - (8) to form Stop TB partnerships at country level in order to provide a vehicle to support the implementation of long-term plans for expansion of DOTS through national interagency coordination committees;
2. REQUESTS the Director-General:
 - (1) to intensify support to Member States in developing capacity and improving the performance of national tuberculosis-control programmes within the broad context of strengthening health systems in order:
 - (a) to accelerate progress towards reaching the global target of detecting 70% of new infectious cases and successfully treating 85% of those detected;
 - (b) to sustain achievement of that target in order to reach the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;
 - (2) to strengthen cooperation with Member States with a view to improving collaboration between tuberculosis programmes and HIV programmes, in order:
 - (a) to implement the expanded strategy to control HIV-related tuberculosis;
 - (b) to enhance HIV/AIDS programmes, including delivery of antiretroviral treatment for patients with tuberculosis who are also infected with HIV;
 - (3) to implement and strengthen strategies for the effective control of, and management of persons with, drug-resistant tuberculosis;
 - (4) to take the lead under national health authorities in working with partners to devise, strengthen and support mechanisms to facilitate sustainable financing of tuberculosis control;
 - (5) to enhance WHO's support to the Stop TB Partnership in its efforts to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;
 - (6) at the United Nations General Assembly's next review of the Millennium Development Goals, to have tuberculosis named in Goal 6, Target 8, instead of being included in other diseases;
 - (7) to promote research and development for new control tools as part of the global plan to stop tuberculosis.

Mr HOHMAN (United States of America) requested some time for further study of the revised draft resolution.

It was so agreed.

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

Smallpox: Item 13.6 of the Agenda (Documents A58/9 and A58/10) (continued from the sixth meeting)

Dr TSHABALALA-MSIMANG (South Africa) recalled that in 1999 the Health Assembly had reaffirmed that all remaining stocks of variola virus should be destroyed. In consequence, South Africa proposed that research on the virus should be stopped immediately, and that the Health Assembly should establish an expanded team to evaluate any such work being carried out by either developed or developing countries. South Africa was prepared to serve on such a team, whose review would also cover the concerns raised by the Director-General, and which should report to the next Health Assembly.

Mr VOIGTLÄNDER (Germany) recalled that the proposal for the vaccine reserve was to establish a strategic stock of five million doses to be held at WHO headquarters and an additional pledged stock of 200 million doses to remain under the control of donor countries until needed. In addition, countries with vaccine production capacity would be requested to reserve standby capacity. Those numbers fell far short of the plan for a reserve of 25 million doses at WHO headquarters and a pledged stockpile of 475 million doses. Germany welcomed WHO's initiative to help countries in an emergency that were not in a position to acquire their own supplies of vaccine, and had pledged to place two million doses at the disposal of WHO for use in the event of a smallpox outbreak.

Mr VAN DER HEIDEN (Netherlands) observed that, after the successful eradication of smallpox, the world faced a new era in which bioterrorism had become a public health threat and in which variola virus was one of the most feared agents. Many countries, including his own, had decided to be prepared for a new outbreak. Producing vaccine was one of the measures taken, and the proposal to increase the global smallpox vaccine reserve was a rational next step, which the Netherlands wholeheartedly supported. It also welcomed the proposal to retain the variola virus stocks for public health-related research. The Netherlands was concerned, however, about the potential dangers of the proposed plans for genetic engineering of the virus, and document A58/10 did not give adequate assurance that the risk of inadvertent proliferation could be negated. Research on variola virus should be kept to an absolute minimum and thoroughly scrutinized by an independent body. For that reason, he strongly supported the requirement that the WHO Advisory Committee on Variola Virus Research should report to the Fifty-ninth World Health Assembly on the outcome of its further consideration of the issue.

Dr MASSÉ (Canada) strongly supported WHO's efforts to increase international capacity to respond to a smallpox outbreak. Canada was also establishing a reserve of smallpox vaccine, under the aegis of the Global Health Security Initiative. In line with the discussions during the last meeting of the Ad Hoc Committee on Orthopoxvirus Infections, Canada called for particular attention to be paid to monitoring the quality of the various vaccine reserve stocks. It also supported the establishment of a strategic group dealing specifically with smallpox, within the Global Outbreak Alert and Response Network, and the development of an operational framework and an emergency response plan as proposed in document A58/9.

Although Canada recognized the importance of the work undertaken to develop rapid diagnostic tests and to analyse the genomic sequence of variola virus, resolution WHA55.15 specifically stated that such research must remain outcome-oriented and time-limited, and the Executive Board had reiterated in 2003 and 2004 that such research had to be deemed essential to public health. The current

research programme, however, was still directed towards the development of antiviral medicines, which Canada feared would be a costly and long-term effort; he asked whether it was really an essential part of the public health response to an outbreak of smallpox. The proposed research programme entailed a risk of transmission of variola virus due to a laboratory accident or even the creation of a recombinant virus. Canada endorsed the Director-General's recommendation that the issue of expression of individual variola virus genes in a recombinant orthopoxvirus should be reconsidered by the Advisory Committee at its next meeting, and argued strongly that the stocks should be destroyed as soon as there was no further health benefit in research on live virus.

Dr TANGI (Tonga) expressed relief at knowing that there was a stock of smallpox vaccine that in the event of an outbreak would be available to countries like his own without such reserves. Yet the possibility of bioterrorism and biological attack was a matter for concern. Officially, stocks of smallpox virus were held in only two places, but it was possible that other countries had unofficial stocks, and, while attention was focused on official stocks, there was no way of knowing what they might be doing with such unofficial stocks. It should be made a crime against humanity for anyone outside the two official repositories to keep stocks of variola virus.

His second concern related to research using variola virus DNA. Document A58/10 stated that five such areas of research were recommended, to be carried out under the supervision of the WHO Advisory Committee on Variola Virus Research, which would report annually to the Health Assembly through the Executive Board. With regard to the distribution of small pieces of the DNA to different laboratories worldwide, it would take just one irresponsible scientist to use those fragments to reconstruct the virus itself, thereby entailing the risk of its falling into the hands of terrorists, with potentially very grave consequences. Paragraph 8 of document A58/10 did state that attempts to synthesize full-length variola virus genomes from smaller DNA fragments remained strictly prohibited, but he was not convinced that that provision was strong enough. He supported the concept that the stocks of live virus should be scheduled for destruction sooner rather than later.

Dr STEIGER (United States of America) expressed appreciation of the development of the operational framework for a global smallpox vaccine reserve, but added that much work remained to be done, including drawing up the protocols for distribution and use of vaccines in emergencies. His country was proud to have been able to contribute to the critical first line of defence against a smallpox attack anywhere in the world, by pledging 20 million doses of vaccine from its national stockpile, and urged other Member States to make similar pledges or donations; it also encouraged them to develop national plans for preparedness against a smallpox outbreak or a bioterrorist attack. He agreed with the delegate of Tonga regarding the risks of stocks held outside the two official repositories. It was precisely because of the dangers inherent in such a situation that the United States had pushed hard for WHO to establish the stockpile.

With regard to the research agenda, he associated himself completely with the comments made by the delegate of the Russian Federation. An established review process was in place for the agenda already agreed to, although it needed to be stressed that that agenda was not yet finished. There was a need for further work on antiviral agents. There was clear guidance on the research parameters, and the United States did not believe that setting an arbitrary date for destruction of the virus stocks was warranted. The two repositories operated to the highest standards of biosafety and biosecurity, and the risk of an accident or release was incredibly small. The United States generally supported the recommendations of the WHO Advisory Committee on Variola Virus Research, but disagreed with paragraph 3 of document A58/10, believing that further research was necessary on sequencing viral DNA for the purpose of creating better diagnostic tools. There were differences in the American and Russian virus isolate collections, and more sequencing of the Russian strains was necessary. It was understood that WHO was willing to facilitate access to such new diagnostic devices and techniques, once developed, through the established international laboratory networks.

Ms SICARD (France) said that the re-emergence of smallpox, particularly in a country lacking easy access to the vaccine, would expose the world to a major public health threat. Therefore, as the

member for France had said during the Executive Board's 115th session, the establishment of a smallpox vaccine reserve under WHO auspices would be a welcome means of providing an immediate response to an epidemic anywhere in the world. That step had been supported by the ministers participating in Fifth Ministerial Meeting on the Global Health Security Initiative (Paris, 10 December 2004). France was making available to WHO five million doses of smallpox vaccine from its national strategic stock and, through its Health Products Safety Agency, had set up a periodic inspection mechanism for that stock so as to ensure the maintenance of batch quality. The report stressed the need to consider the practical means for giving effect to those commitments in emergencies. There were still many questions to discuss concerning the packaging, transport and distribution of vaccines. France was ready to work closely with WHO on drawing up protocols and operational plans, so as to make the most efficient use of that global reserve in an emergency.

Dr ESTÉVEZ TORRES (Cuba) said that, although some Member States feared the possible reintroduction of smallpox as a result of a laboratory accident or deliberate terrorist act, such incidents could not occur if control of viral stocks was adequate. That being so, a deadline should be fixed for the destruction of variola virus stocks. There was, however, a risk of producing genetic mutations of the viruses for which no vaccines existed.

The Committee on Orthopoxvirus Infections had proposed the creation of vaccine reserves, of which WHO would be one of the holders for distribution to countries where needed. He proposed that the Secretariat and Executive Board members should prepare a draft resolution accordingly for the Health Assembly to consider.

Dr ZAHER (Egypt) agreed with the Ad Hoc Committee's views on the need to maintain a vaccine reserve and the holding of a strategic reserve at WHO headquarters. Current stocks should be maintained in order to have at least five million doses available. Countries able to hold a reserve should do so and should be urged to maintain reserve capacity to meet any emergency. She agreed with the observations of the WHO Advisory Committee on Variola Virus Research on safety and scientific value, and extension of the use of DNA and related authorized research in the five areas mentioned in the report.

Dr AL-MAZROU (Saudi Arabia) welcomed the plan to hold an international reserve of vaccine. With regard to DNA sequence analysis and research into diagnostics, that work had already been done and the objectives had been achieved; therefore, all research and manipulation of live viruses should end, or at least a deadline should be set for the destruction of stocks, on the basis of the resolution already adopted by the Health Assembly.

Dr AHMED (Pakistan) said that he shared the concern about the possible reintroduction of smallpox through a laboratory accident or bioterrorist act, and therefore fully supported WHO's plan to create a global smallpox vaccine reserve. Every Member State should have free and equitable access to it in time of need. He agreed with the retention of variola virus stocks for a limited period, understanding that the research work of the two repositories would be open to full inspection by WHO and that a comprehensive inventory system for research material would be in place; the research results should be published.

Mr BARBOSA DA SILVA JR (Brazil) supported the recommendations on variola virus research and welcomed the clear statement on the development of new diagnostic techniques and DNA sequencing. He agreed that viral isolates should be destroyed, since their maintenance was not scientifically justified. The need remained to disseminate among the Member States the findings from research that had used existing virus stocks and to provide detailed information on new diagnostic methods developed by authorized research programmes. Studies to evaluate the quality, safety and efficiency of new-generation vaccines were necessary and must be stimulated and coordinated by WHO. He supported the proposal to establish a new global smallpox vaccine reserve.

Dr HARPER (United Kingdom of Great Britain and Northern Ireland) said that his country supported the establishment of a global stockpile of smallpox vaccine and had contributed substantially to it. It wished to remain closely involved in future international discussions on that vitally important issue. He was pleased to note the progress made in research and supported the views of the Ad Hoc Committee on Orthopoxvirus Infections and the Advisory Committee on Variola Virus Research that access to live variola virus stock should be maintained to facilitate the development and testing of new vaccines and antiviral agents. All such research should be outcome-oriented and, most importantly, time-limited. The proposals relating to further permissible research had wide implications for the security of Member States, and he shared the Director-General's concerns about biosafety and biosecurity. He sought assurance that the utmost attention was being paid to ensuring that all variola virus research remained under WHO's control and that all adequate safeguards were in place to prevent the risk of creating more virulent strains and obviate the risk of potential proliferation.

Dr PARIRENYATWA (Zimbabwe) endorsed the statement made by the delegate of South Africa. He urged the Health Assembly to facilitate the expansion of the task team and to include members from developing countries. The work on variola virus was critical, and the Health Assembly should be kept well informed of developments.

Dr SUWIT WIBULPOLPRASERT (Thailand) welcomed the Advisory Committee's recommendations. At previous Health Assemblies his delegation had voiced its concern about commitment to resolution WHA55.15 on the destruction of virus stocks, and in that regard supported the relevant recommendation. With regard to paragraphs 7 and 8 of document A58/10 in particular, he proposed that the Advisory Committee should consider the granting of limited permission for virus research and distribution, on a case-by-case basis, instead of open-ended permission.

Dr AL MUTAWAA (United Arab Emirates) commended WHO's work relating to smallpox, and supported the decision to increase the vaccine reserve and the steps taken to prevent any escape of virus. Countries able to produce vaccine should be enabled to build up stocks, and ways should be found of distributing doses whenever needed. There was no absolute guarantee that the international repositories' variola virus stocks could be perfectly guarded; in any case, to prevent the spread of the virus, there should be no other such repositories.

Dr ASAMOA-BAAH (Assistant Director-General) said that he had noted the proposal that the Advisory Committee should be asked to review its recommendations. It was encouraging to note the overwhelming support for an expanded smallpox vaccine reserve, and he was grateful for the reminder that the issue was the world's preparedness to prevent, contain and respond to any smallpox outbreak; the establishment of a vaccine stock was just one important step towards that goal. A smallpox outbreak would be a public health emergency of international concern. WHO looked forward to further support from Member States on expanding national and international capacity and drawing up protocols.

In reply to the delegate of Greece, he said that consideration would have to be given to the circumstances and the prevailing risks and options before use of expired vaccines.

The Committee noted the reports.

Draft global immunization strategy: Item 13.8 of the Agenda (Documents A58/12 and A58/12 Add.1)

Mr GUNNARSSON (Iceland, Representative of the Executive Board), introducing the item, drew attention to the draft resolution contained in document A58/12. The draft global immunization strategy was probably one of the most important items to come before the governing bodies. Thanks to vaccination, smallpox had been successfully eradicated, and it was hoped that increased coverage with other vaccines would lead to the same success against other communicable diseases. The Board had

considered, at its 115th session, a draft version of the global immunization vision and strategy, jointly developed by WHO and UNICEF to serve as a framework for planning and collaboration by Member States, international organizations and other partners. Since early 2004 the document had been subject to wide consultation and discussion at WHO and UNICEF meetings at global, regional and country levels, and at meetings of Member States and the Global Alliance for Vaccines and Immunization.

Dr RUIZ (Mexico) said that the immunization programme had added significant value to the delivery of health care throughout the world. Mexico had a well-established tradition of that type of programme, which involved the participation of the public services, civil society, the private sector and, significantly, local communities. An independent regulatory body ensured that vaccines were safe and effective. The programme covered more than 95% of one-year-old children and more than 98% of those aged from 1 to 4 years; it had also incorporated, the previous winter, administration of influenza vaccine for children aged from 6 to 26 weeks and for the most vulnerable sectors of the adult population.

The draft strategy included a welcome reference to immunization against other diseases such as hepatitis B and *Haemophilus influenzae* type b infection, but new inclusions could be expensive. Therefore, the strategy should incorporate support for countries at an intermediate level of development and those with emerging economies, which were currently exempt from the benefits available to the poorest countries from such sources as the Global Alliance for Vaccines and Immunization. Otherwise, the principle of health equity could be compromised. The draft resolution should therefore request the Director-General to seek options and alternatives for financing.

In 2004 Mexico had been unable to buy sufficient BCG vaccine because of a worldwide shortage. Although the problems had been overcome, he drew attention to the sort of situation that could arise. He supported the draft global immunization strategy.

Dr DAHL-REGIS (Bahamas), speaking on behalf of the 14 member countries of the Caribbean Community, welcomed the draft global immunization strategy and was pleased to note the attention paid to the goal of sustaining immunization coverage. Achievement of the goal, however, would require maintenance of the infrastructure and adequate financial resources. In that regard, it was seen from the Programme budget 2006-2007 that most of the relevant funding came from voluntary contributions, for encouraging which the Director-General was to be commended on his leadership. At the same time, she agreed with the delegate of Mexico that some funds should be allotted to countries that did not qualify for support through the Global Alliance for Vaccines and Immunization. The countries of the Caribbean Community were also concerned that they would not have equal access to new vaccines and technologies as they became available. She endorsed the draft strategy but would like the report to the next Health Assembly to outline measures to meet the cost of achieving the immunization targets described in the document.

Dr GØTRIK (Denmark), speaking also on behalf of Finland, Iceland, Norway and Sweden, welcomed the draft global immunization strategy and strongly supported WHO in continuing to take a leading role in the prevention of communicable diseases. The strategy would be a valuable tool for use among partners, including the Global Alliance for Vaccines and Immunization. National immunization programmes, too, were crucial to the strengthening of health systems and a step towards attainment of the Millennium Development Goals. Sadly, many countries still lacked provisions for adequate immunization coverage while others, even in the European Region, which did have such provisions, were seeing an increase in certain preventable diseases because of insufficient coverage arising, inter alia, from unfounded distrust of vaccination. WHO must take the lead, therefore, in providing Member States with updated evidence to counter the alarming consequences of misinformation. Other tasks facing WHO included the development of new and better vaccines. He fully supported the draft strategy and the draft resolution.

Dr NAKASHIMA (Japan) commended the immunization-related goals set by the United Nations General Assembly at its special session on children in 2002 and supported the draft global

immunization strategy. In recent years, the Japanese Ministry of Health, Labour and Welfare had been discussing the prevention and control of vaccine-preventable diseases, including the introduction of second opportunities for measles and rubella vaccination into routine childhood immunization programmes. With regard to the interdependence of vaccines and immunization, the Government had long been promoting the activities of the global Expanded Programme on Immunization through funding to international organizations, including WHO and UNICEF, bilateral support, and technology transfer for vaccination production and quality control, especially to nations with a sustainable capacity to manufacture vaccines themselves. Such cooperation was also beneficial in terms of global health security.

Dr NLOME NZE (Gabon), speaking on behalf of the African group, warmly welcomed the draft global immunization strategy. The relevance of the draft resolution and the report to the Executive Board at its 115th session¹ had led the African countries to support the proposed strategy, which would encourage Member States to make immunization a high priority in their national health programmes and the driving force of health system renewal, enabling targets to be met, the delays in routine vaccination to be overcome and the burden of communicable disease to be reduced. The strategies chosen, in particular integrating immunization, other linked health interventions and surveillance in the health systems' context, building human resource capacity, improving logistics, and securing financial resources, would make health systems more responsive and effective. The introduction and provision of new vaccines and technologies for diseases for which no vaccines were currently available would enable countries to come significantly closer to attaining the recommended immunization coverage. Not only vaccines, but all the other consumables for immunization had to be available. He looked forward to a strengthened commitment from governments and an intensified international partnership to meet the challenges ahead, especially to secure the necessary funding and thereby ensure the success of the strategy; in that way, by 2010 the mortality rate from measles would be 90% lower than the 2000 rate, and national immunization coverage would be at least 90% in all the countries that had fallen behind.

Dr REN Minghui (China) expressed full agreement with the four strategic areas of the draft global immunization strategy. The fourth area in particular (immunizing in the context of global interdependence) would help to ensure that all countries had access to immunization. Strategic area 3 (integrating immunization, other linked health interventions and surveillance in the health systems' context) could serve as a basis for surveillance systems, more efficient networks and emergency preparedness. In 2003, at the time of the outbreak of severe acute respiratory syndrome, China's immunization systems had helped with emergency control. Since most vulnerable groups with few or no immunization services were evidently located in developing countries, special attention should be given in strategy implementation to developing countries and regions, in order to secure the support and resources they needed to attain the targets. There should also be a focus on research into new outbreaks of epidemics. He supported the draft resolution.

Dr ZAHER (Egypt) agreed with the draft global immunization strategy and supported the draft resolution. Under Egypt's national immunization strategy, coverage had reached 98%. Children were immunized against nine diseases during the first year of life and given a follow-up dose 12 months later. A new syringe was used for each child, making a total of around 40 million syringes per year. Mass immunization campaigns were conducted against poliomyelitis and neonatal tetanus, and special attention was given to vulnerable groups for selected diseases. Vaccination was done in schools, military camps and prisons, and was offered to persons travelling to countries endemic for diseases such as yellow fever. A cold chain ensured that the vaccines remained effective until use.

¹ Document EB115/13.

Dr NABLI (Tunisia) commended the draft global immunization strategy, stressing in particular the importance of consultation, partnership and cooperation, not least between the public and private sectors. The success of the strategy would depend above all on finding a solution to the funding problem, so that all countries had access to vaccines and the resources necessary to conduct immunization campaigns.

Dr ZOMBRE (Burkina Faso) said that immunization undoubtedly had one of the best cost-benefit ratios as a way of saving life, which was why his country had launched an expanded immunization programme in 1985 to reduce morbidity and mortality from vaccine-preventable diseases. In 2001, with support from the Global Alliance for Vaccines and Immunization, WHO and UNICEF, the programme had been expanded, with encouraging results. There were plans to introduce new vaccines, against hepatitis B and *Haemophilus influenzae* type b infection, from January 2006. He expressed his support for the draft global immunization strategy, stressing the urgency of finding ways to make new vaccines affordable, and the draft resolution. He endorsed the statement by the delegate of Gabon.

Dr HAMADI (Morocco) also supported the draft global immunization strategy. In Morocco, the vaccination coverage rate had been in excess of 90% since 1995 and up to 94% in 2004. The success and sustainability of the proposed new strategy would depend on several factors including ensuring that all countries had the requisite technical and financial support to maintain optimal immunization coverage and active epidemiological surveillance; improving intraregional and interregional collaboration and coordination; and ensuring that all developing countries had access to a regular and sustainable supply of vaccines.

Dr NSENGIYUMVA (Burundi) associated himself with the statement by the delegate of Gabon and commended the draft global immunization strategy. He favoured giving priority to the most vulnerable groups with limited resources. As far as strategic area 2 of the proposed strategy was concerned, in February 2004 Burundi had started introducing new vaccines, against viral hepatitis B and *Haemophilus influenzae* type b infection, as part of routine immunization. Burundi had also started integrating vitamin A supplementation for children into routine immunization programmes in 2002, and the distribution of insecticide-treated bednets was to become part of the expanded immunization programme, beginning in the current year.

Mr ADAMCZEWSKI (Poland) said that the draft global immunization strategy drew attention to weak points in the system of funding national immunization programmes and the need to make changes, for example to base the purchase of vaccines on epidemiological analysis and assessment of the population targeted for immunization. In view of the limitations on funds in many countries and the need to implement WHO's recommendations, consideration might be given to funding immunization programmes from different budgets, for example joint funding of certain scientific research on vaccines by vaccine producers. Regarding new vaccines and technologies, it seemed justifiable, in line with modern immunology, to develop vaccines obtained by genetic recombination, to improve their potency and safety. He favoured the targeting of risk groups for immunization against vaccine-preventable diseases.

Dr AHMED (Pakistan) observed that immunization was one of the most cost-effective public health interventions. At current levels of coverage, immunization averted the death of between two and three million children annually. A further one to two million deaths could be prevented annually by 2015, provided that countries increased coverage substantially with both current and new vaccines, such as pneumococcal and rotavirus vaccines. There was certainly a need for a well thought-out global immunization strategy that took account of new vaccines and technologies. He endorsed the draft global immunization strategy and supported the draft resolution. Vaccines were expensive, however, and their maintenance and delivery also required substantial resources. Therefore unless and until developing countries were enabled, through international support, to have access to vaccines of

assured quality, with the requisite delivery system, the strategy might not achieve the desired results. Sustainable funding was therefore essential to its effective implementation.

Dr ESTÉVEZ TORRES (Cuba) outlined his country's immunization programme and the results achieved. Immunization coverage was above 95% for 13 diseases, of which five, including measles, had been eliminated. The incidence of a further two diseases was under 0.1 per 100 000 inhabitants. Morbidity and mortality for the remaining diseases had been reduced by 95%. All the vaccines used in the country were of high quality, eight of them were produced nationally. The country was increasing the number of vaccines from eight to 10, including a nationally produced tetravalent vaccine. A surveillance system had been set up in 1998 to monitor the incidence of poliomyelitis, measles, rubella, mumps and pertussis, which were also covered by a network of diagnostic laboratories. The system of international surveillance had been strengthened to ensure rapid detection of the re-emergence of diseases already eradicated in Cuba. Immunization services operated in 485 polyclinics, in all maternity hospitals and in more than 10 000 schools. The entire child and adult population had been covered since 1962. Considering that immunization was a major factor in promoting child health, he fully supported the draft global immunization strategy.

Ms SICARD (France) commended the draft global immunization strategy, which would undoubtedly do much to strengthen the coordination and effectiveness of the international community in immunization and, in particular, improve coverage in the developing countries. The international community had in recent years supported such initiatives as the Global Alliance for Vaccines and Immunization and the Measles Partnership in Africa, in order to help to prevent vaccine-preventable diseases.

She fully supported the draft strategy. The main problem currently was to make vaccines accessible for extensive poor population sectors in developing countries, to ensure the widest possible coverage and eliminate the gaps in infant immunization. The global strategy should give priority to helping countries overcome the chronic structural problems of their basic health services by focusing on the national and district levels, and above all on the most insecure groups. New vaccines and technologies were promising, and it was essential that they should be marketed at prices that low-income countries could afford. She endorsed the draft resolution and fully supported WHO's role in the priority area of immunization.

Dr PARK Ki-dong (Republic of Korea) fully supported the draft global immunization strategy. While the development and introduction of new vaccines were undoubtedly important, the need to deliver basic vaccines in sufficient quantities and to strengthen vaccine-production capacity should not be overlooked. WHO should indeed play a more active role in that area. His country was willing to take part in the global effort.

Dr MENDOZA (Bolivarian Republic of Venezuela) commended the draft global immunization strategy. Given the high cost-effectiveness of immunization, there could be no real progress in any area of public health without progress in immunization. His country had launched a large-scale, accelerated programme aimed at reaching population sectors previously denied the benefit of social policies, particularly in marginal urban areas, border areas and indigenous communities. New vaccines had been introduced in 2000 and, in the past two years, a national immunization plan had been in place to strengthen the expanded immunization programme. Public investment had been tripled. Agreements had been concluded with other developing countries, such as Brazil, Cuba and India, on increasing national vaccine production, on the principle that domestic production was essential to preserving national sovereignty. The Health Assembly should consider encouraging the creation of non-reimbursable funds to finance immunization in countries unable to afford vaccines. His country had proposed the establishment of an international humanitarian fund to lend viability to the plans for global immunization programmes. If the international community were serious about equity, it was not enough for countries to guarantee full immunization coverage within their own borders; they had to ensure that funding was available to enable all other countries to make marked progress as well.

Dr AL-OWEIDI (Oman) supported the draft global immunization strategy. Immunization was undoubtedly one of the most cost-effective interventions available. The Expanded Programme on Immunization had top priority in Oman, and the immunization rate had been 95% for the past 10 years. The adoption of the proposed strategy by the Health Assembly was likely to lead to additional financial and human resources being allocated to immunization. Cost was an important factor and could in itself be a serious obstacle to implementation. He proposed that a mechanism be set up to support the draft strategy.

Dr AGARWAL (India) praised the report for highlighting not only the technical issues relating to immunization but also the need to develop and strengthen a harmonious relationship between immunization programmes and health systems in a context of global interdependence. India's National Health Policy 2002 required the National Programme for Universal Immunization against Preventable Diseases to be assured an uninterrupted supply of vaccines at affordable prices. To minimize the danger from volatility of the global market and thereby ensure long-term health security, it was envisaged in the Policy that not less than half the vaccines and serums should come from public-sector institutions in India. Furthermore, his country was introducing auto-disable (single-use) syringes.

Mr XIMENES (Timor-Leste) endorsed the draft global immunization strategy. Although his was a poor country, it had devoted between 10% and 11% of its total annual budget to the health sector. Nevertheless the Government was still unable to meet the cost of immunization and was currently endeavouring, in collaboration with WHO and UNICEF, to mobilize substantial bilateral funds. His country would continue to need advice and guidance from WHO in the years ahead pending sufficient capacity of its own. With immunization coverage below 80%, the country was at risk of an outbreak of poliomyelitis following the reported new cases in Indonesia. In collaboration with WHO and UNICEF, steps had already been taken to implement a national immunization campaign in 2005.

Dr ELSAYID (Sudan) fully endorsed the draft global immunization strategy. He associated himself with the statement by the delegate of Gabon and supported the suggestion made by the delegate of Mexico to seek options for financing the introduction of new vaccines. He appealed for technical assistance and guidance to further the integration and strengthening of his country's immunization systems in the context of the Millennium Development Goals. He thanked WHO, UNICEF, Japan and the Global Alliance for Vaccines and Immunization for their support to Sudan, and expressed the hope that it would be continued and extended to help to secure the sustainability of immunization programmes.

Dr SINGAY (Bhutan) welcomed the draft global immunization strategy, which would sustain high immunization coverage, promote the introduction of new vaccines and provide a framework for the implementation of the health-related Millennium Development Goals. He supported the draft resolution.

Ms PODESTA (Australia) supported the draft strategy. WHO must maintain appropriate levels of support for immunization, including surveillance and high coverage. The Western Pacific Region had been declared free of poliomyelitis, but the geographical and resource challenges facing the Region, together with the fragility and variability of global vaccine supplies, made ongoing support necessary.

On the strategy itself, she asked for more details of the respective roles of the Global Alliance for Vaccines and Immunization, The Vaccine Fund, the Measles Partnership, WHO and UNICEF, and how they would work together operationally. WHO must bear in mind the constraints that countries faced in expanding their immunization services. She also called on the Organization to pay attention to quality, safety and the role of public health education in increasing the demand for immunization.

Dr TSHABALALA-MSIMANG (South Africa), associating herself with the statement made by the delegate of Gabon, said that immunization was a key strategy for increasing child survival,

particularly when linked with other interventions such as deworming and vitamin A supplementation. In her country, immunization had been made part of routine child health services under the “reach every district” strategy. However, immunization services still faced many operational challenges, including staff shortages, poor infrastructure, geographical barriers and problems of vaccine storage and supply. New vaccines and technologies might solve those problems in the future. Delays in the immunization of children and other vulnerable groups could lead to severe morbidity and mortality from vaccine-preventable diseases and regional outbreaks due to migration.

She welcomed the draft strategy, but noted that it made no reference to cold-chain management. The improved surveillance mechanism called for would need to take account of the shift in the immunization burden from childhood to other age groups.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) welcomed the efforts of the Global Alliance for Vaccines and Immunization, WHO and UNICEF to strengthen immunization services, improve coverage, encourage the use of new and underused vaccines, and promote safe injection procedures in developing countries with a per capita annual income of less than US\$ 1000. He shared the concerns expressed by many previous speakers about the cost of vaccines, one of the major constraints on many countries’ immunization programmes.

He suggested some amendments to the draft resolution. A new paragraph should be inserted after the fifth preambular paragraph, to read: “Acknowledging the contributions by WHO, UNICEF, GAVI and all partners in their efforts in strengthening immunization services, expansion of immunization coverage and introduction of new and underused vaccines in developing countries”. A new subparagraph 3(1) should be inserted to read: “to ensure the cost of future new vaccines is affordable by countries, in order to accelerate rapid introduction of new vaccines”; that provision reflected the debate in the Committee. The original subparagraph 3(3) should be amended to read: “to report, every three years, to the Health Assembly on progress towards achievement of global immunization targets”. That provision would ensure that the Health Assembly received three reports during the period of validity of the strategy.

Dr AYDINLI (Turkey) said that his country aimed to eradicate measles by 2010. It planned to give all children aged nine months to 14 years – a total of 20 million children – an additional dose of measles vaccine. About 9.5 million children aged 6-14 years had been immunized against measles in a school-based programme: that figure represented 97% coverage. A month-long supplementary vaccination campaign was under way, targeting groups missed during the earlier campaign in 2004. Case-based and laboratory-supported measles surveillance would be introduced later. The target was routine vaccination coverage of above 95%. Turkey also aimed to participate in worldwide collaboration projects to assist other countries with their immunization programmes.

Mr GRBEŠA (Croatia) said that, in his country, immunizations were organized by the State and provided free of charge. The population was immunized against 10 major diseases, including all the Expanded Programme on Immunization target diseases. WHO action was coordinated by a national manager of that Programme at the Croatian National Institute of Public Health. The Government was evaluating new vaccines (e.g. against varicella or pneumococcal disease) to be included in the national immunization schedule in the future. He supported the draft strategy.

Mr SHONGWE (Swaziland), associating himself with the comments made by the delegate of Gabon, welcomed the draft strategy and supported the draft resolution. His country’s Expanded Programme on Immunization provided comprehensive coverage for all children up to the age of five years, and he expressed gratitude for the assistance of WHO, UNICEF and other partners. He shared the concern that developing countries might not be able to afford new vaccines and technologies, and supported the suggestion to establish a special fund for Member States not eligible for support from the Global Alliance for Vaccines and Immunization.

Dr CHITUWO (Zambia) welcomed the draft strategy, which would make an important contribution to implementing the Millennium Development Goals. Zambia's limited experience had shown that the policies described in the strategy were feasible. A countrywide immunization programme in 2003 had reduced measles-related morbidity and mortality to less than 1%. Thanks to community participation, provision of a cold chain, and support by local and international partners, four million children under the age of 15 years had been immunized. With support from the Global Alliance for Vaccines and Immunization, Zambia had introduced *Haemophilus influenzae* type b vaccine and planned to introduce pentavalent vaccines later in 2005. The health services had successfully linked immunization with vitamin A supplementation, deworming, retreatment of insecticide-treated bednets and growth monitoring. The Government had allocated a budget to the immunization programme, but it was concerned about its financial sustainability, owing to the high cost of the new vaccines. He therefore called on partners to mobilize additional resources.

Mrs BELLA ASSUMPTA (Cameroon) thanked the many partners that had enabled her country to improve vaccination coverage and introduce new vaccines against hepatitis B, *Haemophilus influenzae* type b infection and yellow fever. However, routine immunization programmes still required improvement. Immunization being an extremely cost-effective intervention, her country fully supported the draft resolution and the statement by the delegate of Gabon, but wanted more emphasis to be placed on the importance of community participation and empowerment, and the strengthening of the surveillance system at district level.

Dr FOURAR (Algeria), associating himself with the statement made by the delegate of Gabon, expressed his support for the draft strategy. In Algeria the State was responsible for all immunization programmes, but it nevertheless recognized the value of a permanent mechanism ensuring universal access to routine immunization and new vaccines. Regional strategies should be drawn up to reach nomadic populations, often missed by primary health-care and immunization services.

Dr AL-SALEH (Kuwait) said that immunization was a key factor in implementing the health-related Millennium Development Goals and strengthening health systems. He welcomed the draft strategy, with its due emphasis of the importance of routine immunization, especially for children, and highlighting of such groups as adults, adolescents, pilgrims, migrant workers and health professionals. WHO should help countries to adopt appropriate policies and improve training.

He expressed concern about the high cost of vaccines, which was partly due to the difficulty of forecasting vaccine requirements and disease trends. He called on WHO to promote the local production of vaccines with the collaboration of national surveillance authorities, which would reduce costs and increase the choice of vaccines while maintaining quality.

Since the strategy did not mention serums, an important but expensive supplement to vaccines which could be produced safely with no adverse effects on health, he requested WHO to produce guidelines on the participation of pharmaceutical companies and international research centres in their production.

Mr HOHMAN (United States of America) said that, in many countries, poor and marginalized children remained unvaccinated and thus bore the highest burden of mortality from vaccine-preventable diseases. He supported the development of a global immunization strategy, but regretted that the entire draft strategy had been issued too late for thorough review.

Any global immunization strategy must set specific goals for immunization coverage and reductions in disease-specific mortality if it was to be credible and attract international donor support. It must also contribute to the creation of a sustainable health-care delivery system. Monitoring of immunization coverage, disease surveillance and laboratory networks were key components. Countries would be unable to take advantage of new vaccines and new delivery technologies without a strong immunization and health-system infrastructure. WHO and UNICEF might usefully expand the existing infrastructure designed to eradicate poliomyelitis and reduce mortality from measles in order to improve the routine immunization system, surveillance and laboratory capacity for all vaccine-

preventable diseases and the communications and advocacy capacity needed for strengthening the routine immunization system. Health services could use the opportunity provided by immunization to deliver other public health interventions, provided that they were both effective and cost-effective and undertaken with appropriate collaboration with global and country-level partners.

He had some amendments to propose to the draft resolution and suggested that a small drafting group should be convened.

Dr FIKRI (United Arab Emirates) observed that the draft strategy stressed the importance of expanding immunization coverage and the need for international emergency preparedness, the reduction of measles mortality and increased immunization coverage against the most common diseases. Adopting new techniques and new vaccines was an important part of all health services. In his country, 95% of newborn babies were immunized against 10 common diseases. New, safe vaccines were being introduced. The incidence of common diseases was monitored, and the Government adhered to WHO global and regional recommendations.

He supported the draft strategy and called on WHO to monitor its implementation systematically in order to ensure universal immunization coverage. He agreed with previous speakers that assistance should be provided to help poorer countries meet the high cost of purchasing the new vaccines being developed.

Dr KAKAR (Afghanistan) expressed his appreciation of the draft strategy and his support for the draft resolution. His country suffered regular epidemics of vaccine-preventable diseases, including measles and pertussis, and was consequently aware of the importance of optimal immunization coverage. It was grateful to the international partners supporting its immunization programme, which was being upgraded to provide cover against six antigens and would soon include hepatitis B vaccination.

Dr AL-MAZROU (Saudi Arabia) expressed his appreciation of the draft strategy, which aimed to protect children the world over and contribute to implementation of the Millennium Development Goals. His country had improved its immunization coverage, with vaccination against 10 diseases, and new vaccines would be introduced as necessary. The global immunization strategy would strengthen national programmes. It would evolve over time and should therefore be reviewed regularly, as requested in the draft resolution – perhaps even annually.

Dr GULLY (Canada) said that Canada was a strong supporter of global immunization programmes, having contributed Can\$160 million to the Global Alliance for Vaccines and Immunization in February 2005. He asked what the next steps would be when the draft strategy had been adopted, particularly in relation to the projected gap in financing of global immunization activities.

Dr OTTO (Palau) expressed his support for the draft strategy and draft resolution. The immunization coverage against vaccine-preventable diseases of about 95% in his country would be difficult to achieve and sustain without external support. Like the delegate of Australia, he would appreciate details of how the partnership between WHO and UNICEF would work in the field, particularly in the Western Pacific Region.

Mrs LE THI THU HA (Viet Nam) welcomed the draft strategy, which would complement Member States' efforts to implement the Millennium Development Goals. She supported the draft strategy, with the amendments proposed by Thailand.

Dr LUM CHONG (Panama) supported the draft resolution, noting that the Expanded Programme on Immunization had had a major impact in his country over the preceding 25 years. The country had been certified poliomyelitis-free and since 1995 there had been no case of measles. A coverage rate of 95% had been attained for routine immunization. He urged WHO and UNICEF to

maintain their collaboration in support of countries, particularly in seeking strategies for increasing vaccine stocks, to facilitate the introduction of new vaccines and, above all, to maintain vaccine supplies for expanded immunization programmes.

Dr SEYA (Côte d'Ivoire) fully supported the draft strategy and seconded the statement made by the delegate of Gabon. Thanking the international community for the support provided to his country, he highlighted the problems hampering its vaccination programme, including lack of funds for the purchase of vaccines, lack of training and logistical difficulties affecting the vaccination teams, and the adverse effects on social mobilization of the current crisis in Côte d'Ivoire.

Dr NAVARRO MARÍN (El Salvador), supporting the draft global immunization strategy, welcomed the collaboration between UNICEF and the Regional Office for the Americas to strengthen his country's Expanded Programme on Immunization, particularly through the revolving fund. He expressed concern about the cost of immunization, which in his country stood at US\$ 1.79 per inhabitant, having increased for the 2004-2005 campaign against influenza. Despite environmental sanitation measures, there had been an outbreak of rotavirus that year involving some 127 000 children of under four years of age. Unfortunately, the strain involved (G9P8) was possibly one to which children had never been exposed in El Salvador, and he had misgivings about the cost and efficacy of the vaccine. With regard to pertussis, despite a coverage rate of between 100% and 83% over the preceding 10 years, in the past three years cases of the disease had been observed, with 20 cases in 2005 resulting in the death of two children. The situation was worrying given the prohibitive cost of acellular vaccine.

Dr ACHARYA (Nepal) said that, in his country's immunization programme, more than 80% coverage of all antigens had been achieved in 2004; hepatitis B vaccine had been introduced in routine immunization in 2002, with an expansion phase to be completed in 2005; vaccine-preventable disease surveillance had been expanded in 2004 to include measles, neonatal tetanus and Japanese encephalitis. Despite those and other successes, challenges for the programme in his country included the rugged terrain, logistical difficulties, the high cost of maintaining the cold chain, the difficulty of retaining health workers in remote areas, and nearby open borders.

He expressed his appreciation of the generous support received from external development partners, including WHO, and looked forward to continued support. He endorsed the draft global immunization strategy with the amendments proposed by the delegate of Thailand.

Mrs ANGHELUTĂ (Romania), observing that her country's nine-vaccine immunization programme needed further improvement, offered full support for the draft strategy, which would enable the immunization programme in Romania to overcome current constraints and reach the targets for the relevant Millennium Development Goals.

Mr COURT (UNICEF) expressed gratitude for the support for the draft strategy, which drew on many years of country-level experience of WHO and UNICEF. It aimed to stimulate collective global action on immunization and ensure commitment by governments and donor partners to providing maximum coverage for children.

He recognized that new vaccines were expensive and that the budgets of the poorest countries needed time to absorb the costs involved. The draft strategy aimed to provide a platform and framework to enable countries to make those adjustments in reasonable time. Applauding the work of the Global Alliance for Vaccines and Immunization in supporting countries wishing to introduce new vaccines, he said that the draft strategy provided an excellent opportunity of addressing the massive inequities in access to health services around the world. UNICEF would continue to work with countries and partners to ensure that underserved and marginalized populations were reached with vaccines many times a year, opening up the opportunity to provide a package of appropriate health services. Outreach from campaigns against poliomyelitis had already proved that such an approach could be successful. If knowledge gained in that activity could be transferred, the multiple contacts

with children and families that the draft strategy envisaged represented an unprecedented opportunity to protect families from the burden of disease they were currently facing.

Dr ST JOHN (Barbados) expressed support for the amendments to the draft resolution proposed by the delegate for Thailand.

Dr GRANGE (International Paediatric Association), speaking at the invitation of the CHAIRMAN, noted that a two-thirds reduction in vaccine-preventable diseases would contribute significantly to the reduction in child mortality called for in Millennium Development Goal 4. The draft strategy placed a burden on paediatric health workers to contribute their advocacy. They needed to collaborate with other stakeholders, strengthening the capacity of district teams to make optimal use of local resources and opportunities to overcome system-wide barriers. In particular, they had an important role as trainers, ensuring optimum standards of practice – essential for strengthening routine immunization and programme sustainability. She therefore requested Member States to include national paediatric associations and other relevant professional groups in committees for the planning and implementation of immunization programmes. Her Association was currently mobilizing its members to intensify advocacy for child immunization.

Ms KEITH (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, expressed concern that in sub-Saharan Africa immunization coverage had fallen by 25% since the 1990s. The report had failed to mention the negative impact of accelerated disease-control initiatives on district health systems and procurement priorities. Lessons had to be learnt before new strategies and vaccines could be implemented.

She supported the draft resolution's urging of Member States to prioritize immunization as part of an essential health package, but requested that they prioritize vaccines on the basis of better data on burden of disease, as strengthening systems to prevent some two million children's deaths would help move towards the targets of the relevant Millennium Development Goals.

The Fund offered its collaboration and support in gaining access to the hard-to-reach and marginalized populations. She asked the Director-General to give priority to the provision of technical support for health information and human resources for health, and urged that civil society was seen as a key partner in the implementation of the draft strategy. Disaggregated data on system indicators, burden of disease and human resources should be used for reporting back so that informed judgements could be made on health outcomes and sustainability of systems. Demand-side factors also had to be examined and services had to be free at the point of access. Investment in people and health systems was urgently needed for the sake of high-quality of service.

Mrs PHUMAPHI (Assistant Director-General) thanked Member States, regional groupings and other partners for their valuable comments and their support for the draft strategy. She appreciated the concerns about access and the need to engage communities and all stakeholders at national and international levels. She recognized the challenges represented by sustainability in terms of financing and the costing of interventions. Technology transfer and system strengthening were needed, and she welcomed the suggestion made by the delegate of the Bahamas for a report on costing of immunization activities, should that be approved by the Health Assembly.

Some speakers had referred to the financing barriers faced by the Expanded Programme on Immunization. Agreeing that such difficulties posed a major challenge, she welcomed the proposed amendments to the draft resolution and looked forward to the drafting group's output. Many innovations could be used as lessons in that area, such as the revolving fund for vaccine procurement set up by the Regional Office for the Americas, a mechanism that could easily be copied elsewhere.

She also acknowledged an extreme shortage of vaccines, which should be tackled by ensuring adequate demand forecasting and supply on the part of WHO, UNICEF and other partners in the Global Alliance for Vaccines and Immunization and other interested parties.

She applauded the observation that technology transfer was a key issue for the draft strategy; it would continue to have a major influence not simply on the price of vaccines but also on the ability of developing countries to participate in global immunization.

Global immunization goals needed strong public-private partnerships both within the Global Alliance and beyond. It was therefore essential to work with manufacturers; they constituted important partners and were crucial for finding sustainable solutions to affordability, improved access and the resolution of inequities. She appreciated the concerns expressed about the cost of new vaccines, but noted that the cost of hepatitis B vaccine had been greatly reduced since its introduction, in great measure thanks to the increased numbers of developing country manufacturers. The draft strategy gave a commitment to promoting the emergence of multiple manufacturers from both industrial and developing countries.

The Secretariat would continue to work with partners to collect public information by means of national communicable disease surveillance networks; efforts in support of strengthening that area would continue in order to improve accuracy of information.

She agreed that strengthening both systems and routine work on the Expanded Programme on Immunization was crucial to the success of the draft strategy. That would form an important component in the plans to be drawn up with Member States, as mentioned by the delegate of South Africa.

After adoption of the draft strategy by the Health Assembly, Member States would have to carry out country planning, with support from the Secretariat, UNICEF and country-level partners. WHO, UNICEF, other members of the Global Alliance for Vaccines and Immunization and global partners would then provide support to countries to develop costed, multiyear plans, including those elements of the draft strategy that were relevant to country implementation. That work would be followed by comprehensive regional multiyear plans, the whole process being based on global, projected financial needs, national and regional budgets and national, regional and global financial plans. Subsequently, a global plan would be developed based on national and regional plans for reliable monitoring of the goals involved.

The CHAIRMAN suggested that the agenda item should remain open for further discussion.

It was so agreed.

(For approval of the draft resolution, see summary record of the ninth meeting, section 2.)

The meeting rose at 12:50.

EIGHTH MEETING

Friday, 20 May 2005, at 15:05

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)

1. ORGANIZATION OF WORK

The CHAIRMAN announced that the General Committee had decided that, owing to the number of items on the agenda of Committee A that remained to be discussed, items 13.2 Achievement of health-related Millennium Development Goals and 13.21 International migration of health personnel: a challenge for health systems in developing countries should be transferred to the agenda of Committee B.

2. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Sustainable financing for tuberculosis prevention and control: Item 13.4 of the Agenda (Resolution EB114.R1; Document A58/7) (continued from the seventh meeting, section 4)

Dr ISLAM (Secretary) said that, following informal consultations between interested delegations, several further amendments to the draft resolution had been submitted. It was proposed that subparagraphs 1(3) and 1(8) should be merged to form a single subparagraph 1(3) to read “to strengthen integration between financial, operational and social partners by setting up national Stop TB partnerships in each country and to ensure that such partnerships at country level provide a vehicle to support the implementation of long-term plans for expansion of DOTS through national interagency coordination committees”. It was further proposed that in subparagraph 2(4), “under” should be replaced by “in cooperation with”; that “and provide regular reports on the progress made to achieve the goal” should be added at the end of subparagraph 2(5); and that subparagraph 2(6) should be amended to read “to recommend that tuberculosis be specifically mentioned in Goal 6, Target 8, instead of being included among other diseases at the high-level plenary meeting on the outcome of the Millennium Summit of the United Nations General Assembly to review progress in fulfilment of commitments contained in the United Nations Millennium Declaration.”

Responding to a comment by Mr LEÓN GONZÁLEZ (Cuba), the CHAIRMAN suggested that consideration of the draft resolution should be postponed until a revised version of the text incorporating the latest amendments had been circulated.

It was so agreed.

(For approval of the draft resolution, see summary record of the Committee’s ninth meeting, section 2.)

Strengthening pandemic influenza preparedness and response: Item 13.9 of the Agenda (Resolution EB115.R16; Document A58/13)

The CHAIRMAN drew attention to the draft resolution contained in resolution EB115.R16 and to a draft resolution on enhancement of laboratory biosafety proposed by the delegations of Australia, Canada, France, Japan, Malaysia, Marshall Islands, Mexico, Monaco, Netherlands, New Zealand, Norway, Oman, Palau, Singapore, Switzerland, Thailand, Turkey, United Kingdom of Great Britain and Northern Ireland and the United States of America, which read:

The Fifty-eighth World Health Assembly,

Considering that release of microbiological agents and toxins may have global ramifications;

Acknowledging that the containment of microbiological agents and toxins in laboratories is critical to preventing outbreaks of emerging and re-emerging diseases such as severe acute respiratory syndrome (SARS);

Recognizing the work of WHO in promoting laboratory biosafety;

Acknowledging that a number of Member States do have in place effective laboratory biosafety controls and guidelines for laboratory practice in order to manage the risks to laboratory workers and the community from microbiological agents and toxins;

Recognizing that some Member States may not have adequate biosafety controls in place;

Noting that an integrated approach to laboratory biosafety and containment of microbiological agents and toxins promotes global health security,

1. URGES Member States:

(1) to review the safety of their laboratories and their existing protocols for the safe handling of microbiological agents and toxins, consistent with WHO's biosafety guidance;

(2) to implement specific programmes to promote biological safety and laboratory practices or the safe handling and containment of microbiological agents and toxins, consistent with WHO's biosafety guidance;

(3) to develop programmes that enhance compliance of laboratories, including those within the government, at universities and research centres, and in the private sector, particularly those handling highly virulent microbiological agents and toxins, with biosafety guidelines for laboratory practices;

(4) to mobilize human and financial resources to improve laboratory biosafety and containment of microbiological agents and toxins in order to minimize the possibility of laboratory acquired infections and resultant spread to the community;

(5) to encourage the development of biological-safety training programmes and competency standards for laboratory workers in order to improve safety awareness and safe laboratory practices;

2. REQUESTS the Director-General:

(1) to ensure that WHO provides clear leadership to the task of improving laboratory biosafety and containment of microbiological agents and toxins;

(2) to provide support to other relevant programmes and partners in strengthening their efforts to promote improved laboratory biosafety and containment of microbiological agents and toxins;

(3) to provide support to the development and sharing of knowledge and experience among Member States for enhancing laboratory biosafety and containment of microbiological agents and toxins, including the regular update of relevant WHO guidelines and manuals;

- (4) to provide, in response to requests from Member States, technical support for strengthening laboratory biosafety and containment of microbiological agents and toxins;
- (5) to report regularly to the Executive Board on the status of, and risks to, laboratory biosafety and containment of microbiological agents and toxins globally.

Mr GUNNARSSON (Iceland, Representative of the Executive Board) said that the Board had recognized the seriousness of the threat to all countries of an influenza pandemic and at its 115th session had underscored the need to intensify preparedness measures in a spirit of global solidarity. Great concern had been expressed over the inadequate availability of vaccines and antiviral medicines and issues of affordability; members had recognized that it was difficult for WHO to intervene on questions of affordability in the case of materials produced by the private sector. WHO had been requested to support Member States in developing national preparedness plans, and to strengthen its intensified global alert and warning system, the WHO Global Influenza Surveillance Network. The Board had adopted resolution EB115.R16, which recommended a draft resolution for adoption by the Health Assembly.

Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the Member States of the European Union, the acceding countries Bulgaria and Romania, the candidate countries Croatia and Turkey, and the countries of the Stabilisation and Association Process and potential European candidates Albania, Bosnia and Herzegovina, Serbia and Montenegro, and The former Yugoslav Republic of Macedonia, said that the threat of an influenza pandemic required urgent and effective action to strengthen preparedness and response mechanisms. WHO had a vital role to play and its cooperation with the European Union was to be commended. The European Union had strengthened community and national plans of action and was accelerating work on vaccine production and identification of other emergency procedures; it hoped to extend its cooperation with WHO to include the work of the European Centre for Disease Prevention and Control on identification, evaluation and communication of the threats to health posed by communicable diseases. The European Union supported the draft resolution recommended in resolution EB115.R16, and the draft resolution on enhancement of laboratory biosafety, which it also wished to sponsor.

Dr NAKASHIMA (Japan) observed that pandemic influenza preparedness and response was a matter of global health security. The Japanese Ministry of Health was collaborating with other relevant ministries in the development of action plans in accordance with the recommendations made by the national advisory committee on pandemic influenza.

In order to promote national plans there had to be a better understanding of the possible global public health impact of an influenza pandemic. Various assessment methods existed, including the software program FluAid, but they had not been validated by WHO; the Secretariat should undertake research in that area. Outbreak surveillance and the sharing of samples and virus isolates should be enhanced through the WHO Global Influenza Surveillance Network and in accordance with the International Health Regulations (2005). The recent isolation of an oseltamivir-resistant influenza virus from patients receiving treatment with the drug in Japan underscored the need to strengthen research on drug-resistant viruses and their impact on public health.

Dr GULLY (Canada) expressed support for the draft resolution in resolution EB115.R16 and highlighted the importance of epidemiological and laboratory surveillance; emergency preparedness; international interventions during the initial stages of a pandemic, including clear communication with the general public; and vaccine research and development. WHO should develop guidance on policies for the use of antiviral agents and vaccines and for non-medical interventions.

In developing its pandemic influenza plan, Canada had strengthened its preparedness by improving surveillance and emergency responses, developing a real-time alert system and increasing the capacity to share information rapidly. Those enhancements had also improved the ability of the public health system to respond to other health threats. Canada remained vigilant and continued to

collaborate with WHO to ensure that any potential case of severe respiratory illness was quickly identified.

Dr AGARWAL (India) supported the draft resolution recommended in resolution EB115.R16 and urged WHO and other international partners actively to facilitate the commercial production of avian influenza vaccine. Recent outbreaks of communicable diseases, such as avian influenza in south-east Asia, were a stark reminder of the threat of a major influenza pandemic. Once a pandemic had started, it would be too late to undertake activities to minimize its impact; advance planning and preparatory action were essential. Although vaccination was one of the most effective measures to reduce influenza morbidity and mortality, the use of antiviral agents during the first wave of infection was an important measure. WHO should support Member States in stockpiling such medicines to ensure that adequate supplies were available at the start of a pandemic.

Dr NYIKAL (Kenya) supported the draft resolution recommended in resolution EB115.R16. Member States had to develop the ability to respond before an influenza pandemic occurred. Kenya recommended the following strategies. Secure and adequate supplies of vaccine and antiviral agents should be established and plans for their distribution should be drawn up. Annual vaccination of health-care workers in contact with patients against influenza should be mandatory. Education should be strengthened to raise awareness in the general public and among health-care workers of the seriousness and potential impact of an influenza pandemic and of how to prevent, recognize and treat influenza. Coordination, communication and planning in respect of pandemic response should be improved at all levels through a detailed plan. Consideration should be given in advance to the budgets that would be needed.

Ms PODESTA (Australia) also supported the draft resolution contained in resolution EB115.R16. The Health Assembly had a unique opportunity to prepare for the potential threat of an influenza pandemic. Epidemiological surveillance systems must be strengthened across the world. She commended WHO's leadership in preparedness activities, the support it had provided to Member States, and its initiative in convening an informal meeting of influenza vaccine manufacturers, national licensing agencies and government representatives (Geneva, 11-12 November 2004) – a significant achievement in mobilizing vaccine-manufacturing capacity. In addition, the recent WHO consultation on priority public health interventions before and during an influenza pandemic had made significant improvements to the phases of pandemic preparation, including greater attention to the animal infection and early human infection phases, in which there were opportunities for slowing or averting a pandemic.

After the recent outbreaks of SARS and avian influenza in the Western Pacific and South-East Asia Regions, Australia had given high priority to preparedness and was well placed to implement the measures set out in the draft resolution recommended in EB115.R16. It was also contributing technical expertise to support international efforts. WHO's technical expertise and leadership was acknowledged and respected by the Member States of the Regions that had already experienced those outbreaks.

The submission of the draft resolution on laboratory biosafety, of which Australia was a sponsor, was the outcome of a valuable regional meeting on International Laboratory Biosafety and Biosecurity (Singapore, 7-8 April 2005), which had considered the challenges of managing the biological risks involved in keeping safe the dangerous pathogens and toxins used in laboratories. The question was of great importance for the Western Pacific Region given that the previous three outbreaks of SARS had resulted from lapses in biosafety procedures. Many countries in the Region had reviewed their biosafety and laboratory safety policies, developed national guidelines and introduced regulations, leading to the incorporation of biosafety procedures into daily activities and the development of a "biosafety culture". Laboratory biosafety was a global concern; it referred to institutional and personal safety measures designed to prevent the loss, theft or misuse of biological materials. There was currently no international agreement on the criteria for the assessment of laboratory containment procedures nor any uniform standard for biosafety training of laboratory staff.

The increased international sharing of dangerous pathogens for identification, diagnosis and research demanded similar sharing of information and training on best practice in biosafety and biocontainment. In preparing for a possible influenza pandemic, countries should concentrate on preventable aspects, such as the risk of laboratory-acquired infections. Good standards for safe handling, containment and transport of pathogens used in laboratories would strengthen national and global capacities to prevent disease outbreaks without putting a stop to international research and collaboration. She urged support for the draft resolution and thanked those delegations that had cooperated in its drafting.

Mr VOIGTLÄNDER (Germany) said that the risk of cross-species transmission of influenza virus strains and consequently the threat of a pandemic had drastically increased since the outbreak of avian influenza in south-east Asia in 2004. Such outbreaks plus the influenza pandemic of 1957-1958 underlined the need to accelerate comprehensive preparations for a pandemic not caused only by the H5N1 strain. The availability of adequate supplies of a safe and effective vaccine was a prerequisite for reducing the morbidity and mortality caused by a pandemic virus. Some of the problems related to vaccine production mentioned in the report had recently been solved, including technical difficulties and those relating to regulatory questions and intellectual property. Problems remained, however, in respect of the safe handling of genetically modified organisms during the manufacturing process, the development of an “antigen-sparing” vaccine and the limited production capacity.

Consideration of stockpiling vaccine against influenza due to the H5N1 strain should take into account the fact that the efficiency of protection against a virus that had been further modified and could be transmitted quickly between people was not predictable. The production of sufficient quantities of a vaccine for use in clinical studies should, however, be supported. The question of whether an efficient vaccine against a circulating strain of influenza virus could be used to protect the population in the affected regions should also be considered.

He endorsed the draft resolution contained in resolution EB115.R16, whose main points had already been taken into account in Germany’s national influenza pandemic preparedness plans, which had been published at the start of 2005.

Dr VIOLAKI-PARASKEVA (Greece) suggested the addition of a new preambular paragraph to the draft resolution contained in resolution EB115.R16, to follow the paragraph beginning “Noting the gaps in knowledge ...” and reading: “Noting the importance of strengthening linkages and cooperation with the mass media”.

Dr HAMADI (Morocco) said that an existing clinical and biological surveillance strategy would be extended countrywide in September 2005, enabling the onset of an influenza pandemic to be identified. The strategy included the strengthening of provisions put in place in response to SARS. Morocco would also be purchasing antiviral medicines for use in the event of an outbreak. He supported the draft resolution contained in resolution EB115.R16.

Ms FURMAN (Israel), highlighting the global threat presented by a potential influenza pandemic, expressed support for the draft resolution contained in EB115.R16. She requested that Israel be added to the list of sponsors of the draft resolution on enhancement of laboratory biosafety.

Mr NGUYEN HUY NGA (Viet Nam) supported the draft resolution contained in resolution EB115.R16. Since the first cases of human influenza caused by the H5N1 strain of *Influenzavirus A*, there had been 76 confirmed cases, including 37 fatalities, across 27 provinces and cities throughout the country. All the cases had occurred in areas with outbreaks in poultry, and 72% had links with sick or dead poultry. As yet there was no clear evidence of human-to-human transmission, but further research was needed, given the increase in the numbers of confirmed cases with no links to sick or dead poultry, asymptomatic cases and family clusters. One health worker was among those infected.

From the outset of the avian influenza outbreak, Viet Nam’s national steering committee for SARS and A/H5N1 influenza had met regularly, developing detailed plans for influenza control and

issuing directives and technical guidance on preventive measures, treatment, sample taking, environmental hygiene and disinfection. Provincial steering committees had been established to provide guidance for outbreak control. In January 2005, the Government had established an interagency working group comprising high-ranking technical experts and senior staff from the ministries of health and of agriculture and rural development, and representatives of WHO and FAO.

Viet Nam had been collaborating closely with WHO in avian influenza control. Technical and material support had been mobilized from various partners for activities from epidemiological investigation to training of laboratory staff. In late April 2005, a team of WHO experts had visited Viet Nam to assess the epidemic situation and propose public health actions, and a WHO meeting on case management and research on influenza due to A/H5N1 virus had recently been held. Since December 2004 Viet Nam had sent more than 100 human clinical samples to WHO influenza laboratories for joint study. Viet Nam greatly appreciated the substantial technical and material support for avian influenza control provided by WHO and other partners.

Over the past two years, Viet Nam had made considerable efforts in avian influenza prevention and control, but major additional efforts and funding would be needed to strengthen laboratory capacity, train laboratory staff, strengthen and expand curative health facilities, and accelerate information, education and communication activities. Support was also needed in formulating a national preparedness plan, improving communications and coordination, both within Viet Nam and between the country and the international community, and in establishing stockpiles of antiviral medicines, whose cost was a challenge for Viet Nam. WHO support would also be necessary for research in areas such as transmission routes, animal reservoirs of the virus, asymptomatic carriers, susceptibility, genetics and family factors. He fully supported the draft resolution contained in resolution EB115.R16.

Dr KYAW NYUNT SEIN (Myanmar), supporting the draft resolution contained in resolution EB115.R16, said that preparedness planning, including simulation exercises and prevention activities, were essential and should start immediately, with support from WHO and OIE, in order to minimize the effects of a possible influenza pandemic. Coordination between countries and between the public and private sectors was all-important. Tolerance and understanding should also be brought to bear in implementing the International Health Regulations (2005), given their importance for containing a pandemic.

Dr TSHABALALA-MSIMANG (South Africa) stressed the need for preparedness against an influenza pandemic. For countries, particularly developing countries, that might not have sufficient supplies of vaccine to cope with a pandemic, local vaccine manufacture should be encouraged. Support from developed countries in setting up vaccine manufacturing facilities would greatly assist in reducing the burden of disease and the impact of outbreaks.

South Africa was updating its plans and surveillance under the auspices of the National Institute for Communicable Diseases, a member of the WHO Global Influenza Surveillance Network. Strengthening collaboration between organizations responsible for human and animal health was continuing: close cooperation between the departments of agriculture and health had led to the successful containment of an outbreak of avian influenza in ostriches in South Africa in 2004.

Technical support for health-promotion strategies before and during a pandemic that averted panic was critical. Health promotion should be continuous and cooperation with the mass media was important in that regard. Although preparations for a pandemic had been started, more effort was required; success would depend on collaboration between countries, experts, and better-resourced partners. South Africa supported both draft resolutions.

Mr SPEZIA (Brazil), supporting the draft resolution contained in resolution EB115.R16, said that Brazil had been developing a preparedness plan for an influenza pandemic since 2003. A special committee established at the end of that year had proposed, among other things: improving the management mechanisms of the planning process; facilitating and improving communication among members via an online discussion forum; expanding the committee to include representatives from

other strategic institutions; strengthening and expanding animal and human influenza surveillance systems; increasing vaccine production capacity; increasing knowledge of viral circulation in Brazil's tropical regions; and studying possible epidemic scenarios.

The Butantã Institute was aiming to become self-sufficient in the near future in the manufacture of seasonal influenza vaccine but, although it was already capable of doubling its production capacity to 40 million doses in the event of an emergency, it did not have the technology to produce a pandemic influenza vaccine, a matter of great concern to the Brazilian Government, as was the worldwide shortage of antiviral medicines.

Dr PARK Ki-dong (Republic of Korea) said that pandemic influenza preparedness was a health priority in his country. It had formulated action plans, begun to stockpile antiviral medicines, initiated a medium-term project to expand its vaccine production capacity, and conducted simulation exercises. A standing committee of representatives of government agencies and academia had been established to strengthen cooperation between researchers in the areas of human and animal health, and the Government was promoting joint research efforts to enhance interdisciplinary collaboration. International collaboration was also being strengthened.

The recent incident involving the spread of A/H2N2 virus, although tackled promptly by WHO, was a matter of great concern, serving as a reminder that new influenza infection could be acquired from genetic recombination in laboratories as well as from outbreaks in poultry. It was essential that Member States recognize the need for greater biosecurity in their preparedness and response activities and, consequently, to implement adequate measures. He urged WHO to analyse the overall situation of biosecurity and reflect the results in the global plan, and strongly supported both draft resolutions.

Dr AL-SALEH (Kuwait) said that, although he supported both draft resolutions, he proposed insertion of the words "to WHO regional offices, FAO, OIE and neighbouring countries" between the words "influenzas" and "particularly" in subparagraph 1(5) of the draft resolution contained in resolution EB115.R16, to ensure that reporting would be correct and of benefit to other countries. He also expressed support for the proposed amendment concerning the mass media.

Dr CHEN Xianyi (China) said that the analysis of the threats of pandemic influenza and the proposals for effective preparedness measures had been extremely useful in establishing China's national pandemic influenza preparedness plan and avian influenza information network. China had improved its technology, material stocks and testing capacities, was conducting research into an H5 vaccine and had taken steps to set up intersectoral prevention and control mechanisms. There had been fruitful cooperation, too, with WHO in disease surveillance and the collection of virus strains.

To ensure adequate levels of preparedness, global efforts were essential. Intercountry cooperation needed to be enhanced, and WHO's coordination and technical guidance increased to provide for a more rapid exchange of information. Adequate supplies of vaccines and antiviral agents must also be available. Vaccine production, however, was confined mainly to the developed countries, while production capacity in developing countries, which were far more prone to outbreaks of avian influenza, was inadequate. Steps must therefore be taken to ensure that countries had adequate stocks of vaccine when required. Antiviral agents were an effective way of treating and controlling disease due to *Influenzavirus A*, but their high cost would prevent some developing countries from acquiring them. As part of a long-term strategy, therefore, WHO might consider establishing a not-for-profit international research network for the benefit of all Member States. At the same time, it should support countries that had the manufacturing capacity to improve their manufacturing techniques and vaccine quality, so that high-quality, affordable vaccines could be produced quickly when needed.

He supported the draft resolution contained in resolution EB115.R16.

Mr LÉON GONZÁLEZ (Cuba) expressed support for the draft resolution recommended in resolution EB115.R16. Annual vaccination of populations at risk was one of the most effective ways of preventing an influenza pandemic. The high cost of the vaccines, however, made it increasingly

difficult for developing countries to prevent epidemics, and Cuba urged the Secretariat to study ways of making vaccines more affordable.

The draft resolution on enhancement of laboratory biosafety needed improvement. In places the language was confusing. There was insufficient emphasis on the need to enhance cooperation between Member States and WHO in order to strengthen technological and technical capacities needed to increase biosafety in laboratories. Furthermore, laboratory biosafety and the containment of microbiological agents and toxins were referred to as if they were two separate concepts, whereas the very term “biosafety” covered any type of containment activity for microbiological agents and toxins. He had several amendments to propose and would submit them in writing.

Mr SHEIKH (Pakistan) supported the draft resolution in resolution EB115.R16. The likely huge loss of life and serious economic consequences of an influenza pandemic meant that immediate action for pandemic preparedness should be taken. He shared the concern of previous speakers about the inadequate availability and affordability of vaccines and antiviral medicines.

He also shared concerns about the draft resolution on enhancement of laboratory biosafety, in particular those noted by the delegate of Cuba. He specifically proposed that in subparagraph 2(1), the words “provides clear leadership to” should be replaced by “plays an important role, in accordance with its mandate, towards ...” and that the words “through an intergovernmental process” should be added at the end of subparagraph 2(3).

Mr ABDOO (United States of America), acknowledging the imminent and growing threat of an influenza pandemic, noted that the H5N1 virus in Asia was evolving; its lethality for a broad range of mammals and birds appeared to have increased significantly. The potential immediacy of pandemic influenza and magnitude of its health, economic and social impacts made it a high priority for the international community, and must be addressed forthwith. National preparedness and response plans must be drawn up and implemented well in advance, and global, collective effort was essential. His country had allocated substantial resources to ensure maximum preparedness against an influenza pandemic. It had cooperated with WHO to post expert staff from the Department of Health and Human Services in WHO offices in Manila and at headquarters, and planned to send staff to Viet Nam in the near future. It was also leading efforts to develop a safe and effective vaccine against H5N1 influenza, and to expand the availability of antiviral agents effective against that particular strain. Such efforts must respect intellectual property rights and strong national regulatory requirements. Vaccine development was being pursued through short-term and long-term strategies, which needed public and private partners’ cooperation.

He commended the efforts of WHO at headquarters and regional level in helping countries to increase surveillance and laboratory capacities, and in emphasizing the need for transparency and accurate case reporting.

Since the Board’s adoption of resolution EB115.R16, Member States had proposed certain amendments. First, the preambular paragraph beginning “Concerned that organizations responsible ...” should be replaced by “Emphasizing the need to strengthen collaboration on human and zoonotic influenzas with organizations responsible for animal and human health at local, national and international levels”. Secondly in the preambular paragraph, beginning “Recognizing the need ...”, the word “interventions” should be replaced by “cooperation”. Lastly, it was proposed that subparagraph 2(7) should be amended to read: “to continue to develop WHO’s plans and capacity to respond to an influenza pandemic, and to be able to provide technical assistance, capacity-building and technology transfer related to H5N1 influenza vaccines and diagnostics to developing countries, as well as to ensure clear communication with Member States”.

He fully supported the draft resolution on enhancement of laboratory biosafety, and asked that his country should be included as a sponsor.

Dr STRAUSS (Austria) said that an influenza pandemic would be a major health threat, with significant consequences for public health-care systems and infrastructures. The Austrian Ministry of Health had developed a national influenza pandemic plan setting out the principles of the response of

the health-care system at all administrative levels. The mandates of different ministries had been clearly defined by working groups dealing with national crisis and catastrophe management.

She fully supported the draft resolution recommended in resolution EB115.R16, which covered all the activities necessary to fight an influenza pandemic. Early detection and containment would be essential to decrease the impact of a pandemic, and the maintenance by WHO of a stockpile of antiviral medicines for immediate responses in emergency situations constituted an important initiative.

Dr DAYRIT (Philippines) welcomed the efforts of those countries affected to control and eradicate H5N1 influenza virus infection, and thanked WHO for its leadership. His Government had intensified its preparedness measures to prevent the virus entering the country and to mitigate the effects were that to happen. The concerted efforts of the departments of agriculture and health and the private sector, specifically the poultry industry, had resulted in a comprehensive national preparedness plan, in which the country had been subdivided into eight areas, where systematic well-designed containment measures could be implemented and public information broadcast rapidly – experience from the SARS outbreak had shown that public panic could wreak havoc on the economy and domestic and international tourism.

He endorsed the comments of the Australian delegate about the need for heightened awareness and measures to prevent laboratory-acquired infection. He supported the draft resolution contained in EB115.R16, but, in order to highlight the role of the media in educating the public about the threat of the H5N1 virus and appropriate responses, suggested insertion of the words “to make effective use of media and other appropriate communication channels” after “influenza pandemic and” in subparagraph 1(6).

Dr FERNÁNDEZ GALEANO (Uruguay), having expressed support for the draft resolution contained in resolution EB115.R16, said that, since the 1980s, Uruguay’s national influenza reference centre had been studying the circulation of influenza virus strains using samples taken from public and private health centres all over the country. Initial results about the viral type and subtype circulating in the population were confirmed by the Centers for Disease Control and Prevention in the United States of America. That surveillance contributed to the work being undertaken by countries in the southern hemisphere to develop vaccines. The extensive experience acquired and continual updating of techniques and human resources had prepared the national influenza reference centre to cope with an influenza pandemic. Future activities would include a study of older hospitalized patients, a group at high risk for influenza; participation in the national committee for preparation for an influenza pandemic; continued year-round surveillance throughout the country; development of protocols for molecular subtyping of neuraminidase in circulating strains; and the promotion of external quality control.

Dr PIRA (Guatemala) said that virulent diseases such as SARS and avian influenza would find a rich terrain in countries like Guatemala, where the crowded living conditions and incomplete coverage by health services could result in uncontrollable transmission in the absence of preventive measures. Guatemala had improved its capacity to detect and respond to epidemic emergencies, but it was impossible to predict pandemics. With the SARS epidemic, Guatemala had discovered the limitations of existing means to prevent international spread, but had taken steps to strengthen its infrastructure and develop its institutional capacity to cope with emergency situations through a system of epidemiological vigilance and by reinforcing the risk management unit at the Ministry of Public Health. International public health emergencies required a global response. The Global Outbreak Alert and Response Network provided an international, multidisciplinary technical response to such outbreaks, and was the only global network that gave countries rapid access to the necessary experts and operational resources, helped them with control measures, provided rapid technical support for the affected population, investigated incidents and contributed to risk assessment. That network must have truly global coverage, beyond political or other differences, so that all would benefit.

Mr VAN DER HEIDEN (Netherlands) stressed the importance of preparations for a possible pandemic influenza outbreak. Strong global coordination was essential, both before and during a pandemic, and WHO should play a leading role. Preparation should cover risk assessment tools such as influenza surveillance, and the development of multisectoral preparedness plans, as recent crises in the Netherlands had shown the importance of cooperation with other national emergency relief structures. It should also include the development and implementation of a risk communication policy, the acquisition of antiviral agents and plans for their deployment, and assured vaccine production capacity. He fully supported the draft resolution contained in EB115.R16.

Dr WANGCHUK (Bhutan) commended the report. The issue underscored the need for rapid implementation of the International Health Regulations (2005). He expressed appreciation for the rapid response by the Regional Office for South-East Asia, and welcomed its work on mechanisms aimed at coordinating the response by stakeholders in the Region and elsewhere. He endorsed the draft resolution on the enhancement of laboratory biosafety and that contained in resolution EB115.R16. He also urged WHO to increase regional and country allocations for combating such events and for building regional technical capacity.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) said that the well-recognized threat of an influenza pandemic was a major challenge to WHO and individual countries. The recent technical briefing on the state of preparedness that was necessary had been most useful. The United Kingdom had recently published a national contingency plan, which was under constant review; ways of speeding up vaccine production were being explored in consultation with manufacturers. The United Kingdom relied on WHO to make appropriate contingency plans, which might involve the shifting of resources at short notice to provide a strong and coherent response. It endorsed the draft resolution contained in resolution EB115.R16 and also that on the enhancement of laboratory biosafety, which addressed an aspect that was an essential complement to any action against an influenza pandemic.

Dr GARCÍA (Bolivarian Republic of Venezuela) supported the draft resolution on strengthening pandemic influenza preparedness and response. The panic triggered in his country at the time of the SARS outbreak had underlined the social as well as the health element of such events. Any solution therefore had to be multidisciplinary. The Government had set up a multidisciplinary, intersectoral committee to draw up a national preparedness and response plan. It had also strengthened its institutional network, with a large increase in the number of doctors, to improve epidemiological surveillance of acute respiratory infections, and was directing financial resources to provide vaccines for high-risk groups in 2005-2006. He called for improved world availability of the vaccines for rapid control of outbreaks.

Venezuela particularly welcomed the draft resolution on the enhancement of laboratory biosafety, as the number of laboratory units in his country had been increased in order to decentralize diagnosis, and enhanced surveillance programmes were needed to ensure biosafety, good laboratory practices and quality control.

Mr GRBEŠA (Croatia) said that Croatia had a laboratory for influenza virus detection and identification, which also acted as its national influenza centre and national correspondent of the WHO global FluNet, actively exchanging data on isolated, unidentified viruses. Some 12% of the population were vaccinated against influenza each year. In preparation for an eventual pandemic, a national plan had been established, covering vaccine purchase, health-care capacities and an early-warning network. The national epidemiology network, in service for more than 80 years, was capable of detecting and reporting all outbreaks at an early stage. Croatia supported the draft resolution on pandemic influenza preparedness.

Dr NAVARRO MARÍN (El Salvador), after expressing support for the draft resolution contained in resolution EB115.R16, concurred with the observations by the delegate of Guatemala.

El Salvador had heeded the recommendation in resolution WHA56.19 to increase influenza vaccination. In 2004 and 2005, immunization campaigns had been organized for persons aged 60-65, infants aged from 6 to 23 months and health workers directly in contact with sick persons. The campaigns had been successful and acceptable to the population, with coverage exceeding 98%, thanks to a large publicity campaign financed by the national institute of social security. The Ministry of Health had maintained laboratory surveillance of circulating viruses in the country over the past three years, with confirmation of strains by the Centers for Disease Control and Prevention in the United States of America. Legislation was in the process of being approved that would ensure funds for the purchase of vaccines on a continuing basis. The Expanded Programme on Immunization and the national epidemiology unit were drawing up a plan of action with details of interventions and the division of responsibilities in the case of a pandemic. Among the problems for poor countries were the cost and supply of vaccines and medicines for influenza and the country's limited response capacity.

Ms DE HOZ (Argentina) supported the draft resolution contained in resolution EB115.R16. With regard to the draft resolution on enhancement of laboratory biosafety, she noted that the introduction of effective biosafety controls and codes of practice for risk management of microbiological agents in laboratories and their alignment at the international level would be covered during the meeting in 2005 of States Parties to the Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on their Destruction. Insufficient time had been allowed for consideration of the draft resolution. Nevertheless, she proposed that a new subparagraph be introduced after subparagraph 1(3) reading: "to develop an information system or register to permit identification of highly virulent microbiological agents or toxins handled by laboratories belonging to the Government, universities and research centres and in the private sector". She also proposed a new subparagraph to follow subparagraph 1(6), to read: "to develop contingency programmes for the accidental release of microbiological agents and toxins in order to minimize their effects and control their propagation".

Dr OMI (Regional Director, Western Pacific Region) said that the latest epidemiological data on H5N1 virus infection revealed some important changes, which had been detected in the northern part of Viet Nam since January: milder clinical symptoms with a lower case-fatality rate; an increased number of clusters; detection of asymptomatic cases in close contacts; and an expanded age range of cases. Intense efforts were being made to obtain more information, but it could not be ruled out that the H5N1 virus had become slightly more infectious than previously. An emergency consultation organized by WHO on 6 and 7 May in Manila on the risk of a pandemic had concluded that the recent evidence indicated that the virus was posing a continuing and potentially growing pandemic threat.

Dr ASAMOA-BAAH (Assistant Director-General) commented that the world was living on borrowed time with regard to a possible pandemic of influenza, although, as mentioned by some speakers, it was difficult to forecast an evolving situation with so many unknown factors. WHO welcomed the draft resolution contained in EB115.R16 because it covered all areas in which action by Member States and the Secretariat was required. He was grateful in particular to the importance attached to the mass media, the need for increased cooperation among Member States, the need for technological cooperation and transfer, and the critical issue of equitable access to affordable vaccines, antiviral agents and other essential supplies.

Dr ISLAM (Secretary) read out the proposed amendments to the draft resolution contained in resolution EB115.R16. Greece had proposed a new eighth preambular paragraph, to read: "Noting the importance of strengthening linkages and cooperation with the mass media;". The United States of America had proposed a new preambular paragraph 9 to read: "Emphasizing the need to strengthen collaboration on human and zoonotic influenzas with organizations responsible for animal and human health at local, national and international levels;"; and in the eleventh preambular paragraph it proposed amending the word "interventions" to "cooperation". In subparagraph 1(5), Kuwait proposed inserting, after the word "influenzas", the words "to the regional offices of WHO as well as the Food

and Agriculture Organization of the United Nations, the Office International des Epizooties and neighbouring countries.”. In subparagraph 1(6), the Philippines proposed the insertion of “to make effective use of media and other appropriate communication channels,” after the words “influenza pandemic”. In subparagraph 2(7), the United States of America had proposed the insertion, after the words “influenza pandemic and”, of the words: “to be able to provide technical assistance, capacity-building and technology transfer related to H5N1 influenza vaccines and diagnostics to developing countries, as well as”.

The draft resolution, as amended, was approved.¹

With regard to the draft resolution entitled “Enhancement of laboratory biosafety” the CHAIRMAN noted that several amendments had been proposed and suggested that the Secretariat prepare and circulate a revised version for consideration by the Committee at a later meeting.

It was so agreed.

(For approval of the draft resolution, see summary record of the Committee’s thirteenth meeting.)

Antimicrobial resistance: a threat to global health security: Item 13.10 of the Agenda (Resolution EB115.R6; Document A58/14)

Mr GUNNARSSON (Iceland, Representative of the Executive Board) reported that at its 115th session the Board had considered the global public health burden imposed by antimicrobial resistance, which was due largely to inappropriate use of antimicrobial agents. That had been considered in the larger context of the irrational use of medicines, which caused serious mortality and morbidity, wasted resources and led to increased antimicrobial resistance. Members of the Board had appreciated the report on the rational use of medicines by prescribers and patients,² which noted that despite publication of a strategy for containment of antimicrobial resistance and two previous Health Assembly resolutions on the matter, only limited action had been taken to contain resistance. The Board, recognizing the urgent need to strengthen efforts to promote more rational use of medicines, and contain antimicrobial resistance, had adopted resolution EB115.R6, which recommended a draft resolution for adoption by the Health Assembly.

Dr DE URIOSTE BLANCO (Bolivia) supported the draft resolution but considered that it should more strongly emphasize the rational use of medicines. She therefore proposed that the title should be amended to read: “Antimicrobial resistance in the context of rational use of medicines”. She also proposed that the second preambular paragraph should begin: “Acknowledging that the containment of resistance to antimicrobial agents and their rational use are prerequisites for” The words “and rational use of antimicrobial agents” should be added after the words “antimicrobial resistance” in the second preambular paragraph. The fourth preambular paragraph should be broadened in scope, to read: “Recalling also the findings of various WHO reports”. At the end of the sixth preambular paragraph, a reference should be made to resolution WHA57.14 on scaling up treatment and care for HIV/AIDS, which was closely related to the issues of drug resistance and rational use of medicines. In the seventh and subsequent paragraphs, each mention of containing antimicrobial resistance should be accompanied by a reference to containment of irrational use of medicines in the context of strategies for both the promotion of rational use and the containment of antimicrobial resistance.

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA58.5.

² Document EB115/40.

Ms IMAI (Japan) said that Japan recognized that the emergence of antimicrobial resistance had to be tackled by the international community because it could spread across national borders. WHO should continue to take the lead in combating the problem, building on its 30 years of experience in promoting the rational use of medicines. Japan had been taking comprehensive measures to stem antimicrobial resistance, including post-marketing surveys on the use of antibiotics, surveillance of infections caused by drug-resistant bacteria and prevention of nosocomial infections. She supported the draft resolution, as it would contribute to the reinforcement of measures to control drug resistance in Member States.

Dr WINT (Jamaica), speaking on behalf of the Member States of the Caribbean Community, applauded the importance given to the wider issue of rational use of medicines. As there were minimal drug-manufacturing capabilities in the Caribbean, most countries of the region had to use scarce foreign exchange to import medicines and could not, therefore, afford wastage through unnecessary or excessive use. Some of the recommended interventions were being implemented, such as creating national formularies, setting up drugs and therapeutics committees at all levels of health systems and programmes to increase access to medicines, and drafting legislation on generic medicines. Technical assistance was needed in capacity-building for formulating detailed policies and strategies and for identifying approaches to influence prescribing habits and to engage civil society in the rational use of medicines at the household level. In the Caribbean, the required microbiological laboratory capacity for monitoring resistance was grossly underdeveloped. Those countries therefore recommended that subparagraph 2(2) of the draft resolution should be amended by addition of the words “including the strengthening of the necessary laboratory capacity” after “Member States”.

Mr ADAMCZEWSKI (Poland) said that all countries ought to appoint intersectoral teams to evaluate drug resistance and use of antibiotics and to take steps to maintain their effectiveness. Drug resistance had various causes, including excessive use of antibacterial preparations in health-care systems and the overuse of antimicrobial agents in animal breeding and treatment. Poland had been monitoring drug resistance and antibiotic use since 1997. In 2000, it had established a national programme and in 2004 had launched a new national programme to take stock of antibiotic use and take remedial action. As no new antimicrobial agents had been developed since the 1980s, resistance was a growing problem for policy-makers, and Poland looked to WHO to provide support in that area.

Dr GULLY (Canada) said that Canada recognized the continuing implications of the use of antimicrobial agents in humans, animals and aquaculture. It was taking steps such as tracking resistance levels and antimicrobial use in order to take appropriate measures to control the spread of resistant bacteria and viruses, including promotion of the rational use of medicines. Canada supported WHO's work and recommendations and encouraged the Secretariat to establish a forum for international exchange and development of common initiatives; direct more of its human and financial resources towards ensuring the containment of antimicrobial resistance and the promotion of rational use of medicines; work with Member States to develop coherent, comprehensive and integrated national approaches to implement the WHO global strategy to contain antimicrobial resistance; and regularly monitor the sales of antimicrobial agents and the level of resistance of bacteria and viruses in all sectors of health care systems.

Mr VAN DER HEIDEN (Netherlands) recalled that WHO had identified antibacterial resistance as the foremost problem in its report on priority medicines for Europe and the world.¹ Although surveillance of resistance, prevention of communicable diseases and international cooperation were important in combating the threat of antimicrobial resistance, he stressed the need for research and

¹ Document WHO/EDM/PAR/2004.7.

product development, as called for in the report, which underscored the need for economic and other stimuli. He supported the draft resolution.

Dr MOETI (Botswana) said that promotion of rational drug use had been a priority for his country's Ministry of Health for almost two decades. Poor prescribing practices had resulted in extensive inappropriate use of medicines, higher costs, and greater complexity of treating common conditions. In order to implement previous resolutions on the rational use of drugs, Botswana had established a national standing committee on drugs to coordinate national therapeutic policy and guide prescribing practices, following the principles of an essential medicines list and common treatment guidelines to harmonize treatment practices in the public and private sectors for diseases of public health importance. Antibiotic policies had also been set for different hospital levels in the referral chain, and annual antibiotic surveys had been conducted at referral medical laboratories to assist clinicians in selecting medicines according to local drug-sensitivity patterns. The effective implementation of those policy initiatives at health facility level had, however, been limited by severe human resource constraints and competing priorities, resulting in rising costs and growing drug resistance. He supported the draft resolution. Botswana hoped for continued assistance from WHO in its renewed efforts to implement the strategy for the containment of antimicrobial resistance.

Dr HAMOUIYI (Morocco) supported the draft resolution. Rationalizing the use of medicines would not only reduce resistance but also improve access and increase availability. It was therefore imperative to implement the actions recommended by WHO for adaptation to local conditions, including training of physicians, pharmacists and health personnel to sensitize them to the need to rationalize the prescription and use of antimicrobials agents. Communication was needed to inform the public of the individual and collective risks of self-medication with antimicrobial agents and of the importance of completing treatment regimens. Health insurance organizations had to be involved in order to prevent physicians from prescribing several drugs in cases for which a single drug would be sufficient. Nationally agreed therapeutic protocols were required.

Dr OPIO (Uganda) said that his Government had taken steps to address antimicrobial resistance, including promotion of rational drug use by involving health professionals and their professional associations and councils, which had an important role to play in peer education; strengthening the national drug regulatory authority; introducing quality assurance measures through the Uganda Bureau of Standards; and taking measures to guarantee adequate supplies of drugs, recognizing that shortages sometimes contributed to irrational use. He welcomed the draft resolution and appealed for intensified collaboration and support at international and regional levels.

Professor CARS (Sweden), speaking on behalf of the five Nordic countries, welcomed the draft resolution, which was timely and essential to support other initiatives in international health, including attainment of the health-related targets of the Millennium Development Goals. As underlined in WHO's *World report on knowledge for better health*,¹ most of the developing world's burden of morbidity and mortality was preventable through existing health interventions, including use of medicines. That burden persisted owing to the inadequacy of health systems: in addition to problems of access, quality of service, including irrational use of medicines, was a major problem. The use of antimicrobial agents must therefore be seen in the overall context of health-systems development, including functions such as stewardship, human resources, financing and delivery of equitable, effective and efficient services. The Nordic countries considered that rational use of antimicrobial agents would greatly benefit the development of sustainable health systems in general, in which rational use of medicines was a crucial component.

¹ *World report on better knowledge for health: strengthening health systems*. Geneva, World Health Organization, 2004.

Experiences around the world showed that successful interventions were possible, but a concerted, powerful public health response to the problem of antimicrobial resistance had not yet been forthcoming. The containment of antimicrobial resistance must be considered a global public good for health, and the issue must receive more attention and resources. The Nordic countries urged that the draft resolution should be adopted, considering it to be necessary for joint endeavours for the prevention and containment of infectious diseases in general.

Ms DEL VALLE MATA LEÓN (Bolivarian Republic of Venezuela) suggested that in paragraph 1 of the draft resolution Member States should be urged: (a) to monitor and control the non-human use of antibiotics, especially the quantity and therapeutic category of antibiotics used to promote growth in animals intended for human consumption; (b) to earmark resources specifically for the containment of antimicrobial resistance; and (c) to channel human and financial resources into the upgrading of regional bacteriological laboratories. Those amendments would supplement that proposed by the delegate of Jamaica and were of great relevance, as it would be impossible to meet the targets set without adequate funds or personnel.

She proposed that in paragraph 2 the Director-General should be requested to promote the appropriate use of antimicrobial agents in various sectors affecting the human environment; she was particularly concerned by the practice, which had been considered hazardous since the 1970s, of using antibiotics to promote the growth of animals intended for human consumption.

Ms VALDEZ (United States of America) said that the alarming increase in resistance of pathogens to antimicrobial medication must be tackled at all levels of the health-care system. There were no standards for measuring the compliance of prescribers and patients with rational use, and disease-specific, evidence-based standards should be set. Unless efforts were made to contain and combat antimicrobial resistance, progress against the diseases targeted in internationally agreed development goals was unlikely.

WHO should focus on measurable, sustainable, practical ways of increasing rational use of medicines, while building stronger and more effective health systems; well-functioning health systems were a precondition for rational use. Helping Member States to establish appropriate training standards for pharmacists would therefore be of great practical value. Effective health systems were crucial for ensuring that high-quality medicines were used to maximum therapeutic benefit while minimizing the potential for drug resistance, especially for diseases such as malaria, tuberculosis and AIDS. Improvements in the functioning of health systems must keep pace with the increased purchasing power devolving from grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria and other investments. The Secretariat and Member States must work together to ensure appropriate use of antiretroviral medicines, in order to prevent HIV becoming resistant. The growing number of antimicrobial-resistance pathogens underscored the need for improved surveillance of resistant microbes. WHO was in the best position to coordinate regional and international efforts to heighten the efficiency of such surveillance.

She supported the draft resolution as it stood.

Dr CICOGLA (Italy) observed that the consequences of the inappropriate use of antimicrobial agents were a matter of great concern for all countries and called for a robust public health response. Although he welcomed the draft resolution, insufficient emphasis had been placed on the role of health authorities and drug regulatory bodies in improving the availability of information about medicines, including antimicrobial agents, as a means of limiting resistance. He asked for confirmation that his views would be taken into account.

Dr REN Minghui (China) said that antimicrobial resistance was an increasingly serious problem. He supported the draft resolution but proposed that the title should be changed to "containment of antimicrobial resistance" and that in subparagraph 2(3), the word "support" be replaced by "collaborate with", with removal of the phrase "in strengthening their efforts". Greater prominence should be given to methods of controlling the use of antimicrobial agents in animal

husbandry and avoiding administration of the same agents to humans and animals. Feasible mechanisms for rotating the use of antimicrobial agents should be established on the basis of the status of drug resistance. Reference should also be made to the establishment of a storage system for varieties of antimicrobial agents.

Dr YOT TEERAWATTANANON (Thailand), recognizing that antimicrobial resistance could generate substantial yet avoidable health-care costs and lead to loss of life, supported the draft resolution, but proposed some amendments. A new subparagraph 1(2) should be inserted, reading “to enhance the proper use of antimicrobial agents, including the development and enforcement of national standard practice guidelines for common infections in public and private health sectors, and consider the selection of effective short-course antimicrobial treatment for patients who might potentially display poor compliance”. A further subparagraph should be added after subparagraph 1(4), worded “to monitor effectively and to control nosocomial infections, which are one of the most common sources of antimicrobial resistance”. His Government supported the prescription of generic drugs in the belief that that policy would lead to the rational use of antimicrobial agents; however, since poor-quality medicines caused drug resistance, he proposed inclusion of a further subparagraph urging Member States “to ensure the quality of the antimicrobial agents used in medical practice”.

Information on antimicrobial resistance was of great importance, and, as the most expensive treatment was not necessarily the most effective, he requested the inclusion in paragraph 2 of two new subparagraphs, 2(6) and 2(7). They would request the Director-General “to provide up-to-date information on antimicrobial resistance at regional and subregional levels” and “to provide evidence of cost-effective strategies for the prevention and control of antimicrobial resistance at national and local levels”.

Mr LEÓN GONZÁLEZ (Cuba) affirmed the need to find solutions, in view of the impact of antimicrobial resistance on the international health system; it undermined the ability of national, regional and international health systems to deal with diseases. Intersectoral collaboration was needed to cope with a problem that had both economic and health implications, and all sectors of society should join with health authorities in contending with antimicrobial resistance. WHO should reinforce international coordination. In his country, a national body operating under the aegis of the Ministry of Public Health was charged with coordinating all matters related to antimicrobial resistance.

He supported the draft resolution, but, like the delegate of China, wanted the title to be changed to widen the scope of the resolution, either to “Resistance to antimicrobial agents: a problem for world health” or “The need to combat antimicrobial resistance”.

Dr PRESERN (United Kingdom of Great Britain and Northern Ireland) expressed her support for the draft resolution as it stood. It was both welcome and timely. At a later date, her Government would like to see a broad resolution on the rational use of medicines, perhaps updating resolution WHA47.13.

Dr PHOYA (Malawi) welcomed the strategies set out in the draft resolution because studies conducted in her country had shown that most of the commonly-used antibiotics had reduced effectiveness. The essential medicines programme used in Malawi over the past two decades was accompanied by an essential medicines policy and training of health workers in the rational use of drugs and appropriate prescription practices. Owing to the migration of health workers, there was, however, a continual need to train new staff, and she would appreciate any assistance in both training and in monitoring the development of resistance to antibiotics in current use.

She suggested that, for the sake of consistency, the term “antimicrobial resistance” should be used throughout the text.

Mr KYAW THU NYEIN (Myanmar) strongly endorsed the report. As the rational use of antimicrobial agents by providers had to be evidence-based, the findings of all studies on the

sensitivity of antimicrobial agents and of epidemiological analyses of the spread of antimicrobial resistance should be widely circulated. Furthermore, laboratories at various levels should be upgraded, not only for testing the sensitivity of antimicrobial agents but also to ensure their proper prescription. For example, gastroenteritis did not usually require treatment with antimicrobial agents, but providers tended to provide them just to be on the safe side. Improvements in laboratory capacity and technology were essential in order to permit rapid detection of antimicrobial resistance, and programmes should be strengthened so as to minimize the spread of resistance to drugs for AIDS and tuberculosis. Such measures were also important to prevent primary and secondary resistance.

Mr VOIGTLÄNDER (Germany) agreed with the report but commented that Member States should be urged to set specific requirements to make antibiotics subject to prescription, in order to channel their use and restrict self-medication.

Dr WANGCHUK (Bhutan) welcomed the timely effort to contain antimicrobial resistance. His country's essential medicines programme and advocacy of the rational use of medicines had been highly successful in that it had permitted free health care at a sustainable cost. The rapid development of resistance of some common microorganisms to antimicrobial agents jeopardized some of the gains in health care. For that reason, he endorsed the draft resolution but proposed that the title be changed to "Antimicrobial resistance: a threat to global public health".

Mr SPEZIA (Brazil) said the identification of microorganisms resistant to antimicrobial agents had become a matter of global importance. The severity of clinical cases caused by such organisms, which were proliferating, and the lack of resources available to tackle the issue justified the interest in the subject. His Government was aware of the importance of determining the sensitivity to antimicrobial agents of microorganisms that caused hospital infections and of anticipating antimicrobial resistance. Similarly, it recognized that it was vital to conduct epidemiological investigations and prevent and control the spread of resistant bacteria. It was concerned about the rational use of medicines by doctors and patients and about the large number of people who had no access to essential medicines. That lack of access was one of the reasons for the irrational use of medicines. He supported the amendment to the draft resolution proposed by the delegate of Bolivia.

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

The meeting rose at 17:55.

NINTH MEETING

Saturday, 21 May 2005, at 09:10

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)

1. THIRD AND FOURTH REPORTS OF COMMITTEE A: (Documents A58/55 and A58/56)

Dr BUSUTTIL (Malta), Rapporteur, read out of the draft third and fourth reports of Committee A.

The reports were adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Antimicrobial resistance: a threat to global health security: Item 13.10 of the Agenda (Resolution EB115.R6; Document A58/14) (continued from the eighth meeting, section 2)

Dr AL-SALEH (Kuwait) said that antimicrobial resistance was increasingly widespread and knew no boundaries. Many countries had yet to adopt the rational use of antimicrobial substances, and few had hitherto implemented the relevant Secretariat strategy. He suggested the establishment of a global database and therefore proposed to amend subparagraph 1(4) in the draft resolution by adding the words “with periodic reports and tables prepared by WHO to be submitted annually, to the World Health Assembly”. In addition, subparagraph 2(4) should be expanded by addition of the words “and to establish databases on the use of antimicrobial agents and on antimicrobial resistance globally and to ensure their availability to Member States and other parties through an annual report.”

Although other databases of medicine use existed, that which he proposed would be specific to the use of and resistance to antimicrobial agents. Such information at the international level would assist in identifying trends fostering rational use and improving therapeutic policies at local, national and international levels and helping the Organization to determine the magnitude of the problem and find the best solutions.

Dr PARIRENYATWA (Zimbabwe) said that his country's multifaceted interventions to promote the rational use of antibiotics included a strong drug and therapeutic policy advisory committee, a list of essential drugs and standard treatment guidelines, including treatment protocols on use of antiretroviral therapy for the private and public sectors. A medicines control authority provided information on the quality of medicines. A national microbiology reference laboratory conducted serotyping and provided susceptibility patterns for enteric pathogens, with the assistance of WHO and the Centers for Disease Control and Prevention in the United States of America. The expanded use of medicines for HIV/AIDS and opportunistic infections posed a further challenge of antimicrobial resistance. The question of whether traditional medicine controlled or exacerbated antimicrobial resistance should be investigated, as should the effects of malnutrition and poverty on treatment compliance. Zimbabwe therefore called for strengthening of national and regional monitoring bodies.

¹ See page 353.

Dr AL MUTAWAA (United Arab Emirates) supported the draft resolution. Rational use of drugs meant timely treatment at lowest cost. Irrational use of therapeutic agents was a serious problem affecting roughly half the world's population. Rational use, especially of antimicrobial agents, helped to prevent waste of resources and resistance. It required a strategy for monitoring drug resistance at all levels of treatment, including users. Health networks must be efficient and seek to rationalize resources. Her country's policies embraced the establishment of lists of essential medicines for all levels of therapy, committees in health institutions, a monitoring system, regulations on the advertising of drugs and assessment of alternative therapies.

Dr FOURAR (Algeria) said that the alarming situation with regard to antimicrobial resistance and the inappropriate use of antimicrobial agents demanded action such as establishing mechanisms to reduce access to self-medication; basic on-the-job training of health personnel; education and communication; formulation of standardized, agreed protocols for treatment of the main conditions for which the use of antibiotics was inappropriate or unjustified; and strengthening capacity of surveillance laboratories. Such actions would help to change antibiotic prescribing practices. In addition, the Secretariat should provide more support for States that had established their own antimicrobial resistance surveillance networks. Algeria supported the draft resolution.

Dr CAMPBELL (New Zealand) strongly supported the rational use of medicines, and recalled the definition given in the WHO policy paper on core components of promoting rational use of medicines: "patients receive medication appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community."¹ New Zealand had legislation on the use of antimicrobial agents, had education programmes for consumers and providers, and monitored use and resistance levels, for human and animal health alike. He asked what further work was in hand to implement resolution WHA37.33, on rational use of drugs, especially in the light of the policy paper issued in 2002. He supported the draft resolution but stressed that the problems of antimicrobial resistance should be tackled through the promotion of rational use of medicines.

Dr OTTO (Palau) said that one contributory factor to antimicrobial resistance in his country was the pressure exerted by patients on health personnel to prescribe antibiotics. That point could be reflected in the draft resolution by addition of the words "including patient and consumer education" in subparagraphs 1(5) and 2(4), in the latter case in front of the wording proposed by the delegate of Kuwait relating to the establishment of a database. The education of patients and the public on the rational use of medicines should make them aware that pressure to prescribe could lead to antimicrobial resistance.

He supported the Chinese delegate's proposal to amend the title of the draft resolution.

Dr ASSI GBONON (Côte d'Ivoire) said that antimicrobial resistance had been on the increase for some years in her country, and the Institut Pasteur (the national and subregional reference laboratory) had been monitoring the situation since 1982. The creation in 1987 of a surveillance unit had marked the start of standardization of in-vitro techniques for monitoring resistance to therapeutic agents at the Institut.

Poor use of antimalarial agents had resulted in therapeutic failure rates of between 15% and 60%, and the use and therapeutic value of other antimalarial agents were being monitored at sentinel sites. A national programme to monitor the emergence of HIV strains resistant to antiretroviral therapy was being implemented, and her country counted on the support of WHO and other partners to assist them in epidemiological surveillance.

¹ Document WHO/EDM/2002.3.

She called attention to the further problem of the sale of medicines at markets and on the street, with the attendant problems of self-medication and irrational use, which increased antimicrobial resistance. The problem was exacerbated in her country by the current crisis.

She supported the proposed draft resolution.

Dr KALESHA (Zambia) also supported the draft resolution. She stressed training and continuing medical education, both before and in service, as well as the rational use of medicines by providers as vital elements in mitigating the major threat to world health posed by antimicrobial resistance. As a few cases of drug-resistant tuberculosis had been recorded in Zambia, it was critical to strengthen surveillance systems, especially as the prevalence of tuberculosis was still high. The life-long treatment of HIV/AIDS posed a challenge to efforts to promote the cost-effective use of antimicrobial agents while encouraging adherence to treatment.

Dr NYIKAL (Kenya) commented that the rational use of medicines was particularly important in developing countries, where regulation, registration, quality control and market surveillance were weak, and poor adherence to treatment guidelines meant there was easy access to prescription-only medicines. That led to resistance, rendering old, affordable medicines unusable and forcing the use of expensive medicines that were not available to the people who needed them most. Recent cases of resistance to medicines for malaria and tuberculosis had caused particular concern. In order to tackle those problems, Kenya had adopted several strategies, including strengthening the regulatory system, establishing and revising treatment guidelines, training health personnel to use medicines appropriately and to adhere strictly to guidelines, and setting up therapeutic committees in all health facilities and a national laboratory to monitor bacterial resistance. Kenya would require support from WHO in those endeavours. Resistance spread across borders, and therefore the issue was an international one. Although he supported the draft resolution, he asked to see in writing the many amendments that had been proposed.

Dr SAÍDE (Mozambique) endorsed the report but considered that the problem of resistance extended beyond antimicrobial agents to the more rational use of all medicines. That issue should be discussed in greater depth on other occasions.

Dr AL-OWEIDI (Oman) said that, in order to control antimicrobial resistance, the participation of the private health sector should be encouraged and patients made aware of the need for rational use of antimicrobial agents. He concurred with the comments by the delegate of Kuwait and expressed his support for the draft resolution.

Dr AHMED (Pakistan) said that the growth of the pharmaceutical industry and lack of effective national and international regulatory mechanisms had led to medicines, including antimicrobial agents, being available from pharmacies without prescription in many countries. Pakistan shared the concern of other Member States about antimicrobial resistance and strongly supported the draft resolution.

Mrs WIENKAMP-WEBER (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that nurses, pharmacists and physicians were responsible for the coordinated functions of prescribing, dispensing and administering medicines and for their rational use. Her Council was alarmed at the extensive misuse of antimicrobial agents and the resulting widespread antimicrobial resistance. It was also concerned about the use of injections in non-sterile conditions, which resulted in the spread of infections, particularly hepatitis B and C, and the increasing presence of counterfeit and substandard medicines in many regions, which contributed further to the spread of antimicrobial resistance, including resistance to antimalarial and antiretroviral medicines.

She urged the Secretariat and governments to institute policies and mechanisms to support rational use of medicines, in particular by establishing multidisciplinary bodies to regulate and monitor medicine use; monitoring the prescribing behaviour of health professionals, with a view to avoiding unnecessary use of antimicrobial agents and injections; raising awareness among health professionals

and the public about counterfeit and substandard medicines; educating patients and communities on the proper use of medicines; developing and disseminating evidence-based clinical guidelines for health professionals; and maintaining appropriate levels of staffing and supply of medicines. Her organization would continue to work with the millions of nurses worldwide to promote rational use of medicines and combat the threat of antimicrobial resistance.

Dr LEPAKHIN (Assistant Director-General) said that he had noted the emphasis on several components of the global strategy to contain antimicrobial resistance, including the need to monitor, control and study the use of antibiotics not only to treat human beings but also in agriculture and animal husbandry, and the importance of strengthening drug regulatory authorities. Many Members had indicated that they would like to receive more technical support from WHO, but expansion of that work within the Secretariat would depend, however, on the level of funding available, and few donors had so far expressed an interest in that regard. Although some countries had recommended that regional reference laboratories should be established, the Secretariat considered that every country should have its own national reference laboratory.

Most delegates had stressed the link between antimicrobial resistance and the rational use of medicines in general and had called for more work in that area. The Secretariat would continue to promote rational use of medicines and provide support to Member States to establish and implement national programmes. Specific areas of interest in the coming biennium included adherence to long-term treatment, which was especially important in the treatment of HIV/AIDS, and the rational use of medicines by consumers and in the community. The concomitant use of conventional and traditional medicines was an important aspect. The Secretariat was willing, and had the technical expertise, to provide support to countries in promoting the rational use of medicines and containing antimicrobial resistance, but he stressed that it could do so only if more funds were made available.

The CHAIRMAN said that a drafting group would work on a further version of the draft resolution to take into account the amendments proposed.

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

Sustainable financing for tuberculosis prevention and control: Item 13.4 of the Agenda (Resolution EB114.R1; Document A58/7) (continued from the eighth meeting, section 2)

The CHAIRMAN invited the Committee to consider the following revised draft resolution, which incorporated amendments proposed by the delegations of India, Uganda and the United States of America:

The Fifty-eighth World Health Assembly,
Having considered the report on sustainable financing and tuberculosis control;
Aware of the need to diminish the global burden of tuberculosis and thereby lower this barrier to socioeconomic development;

Noting with concern the increasing number of cases of multidrug-resistant tuberculosis, and worsening morbidity and mortality among HIV-positive tuberculosis patients, especially in the African Region;

Welcoming the progress made towards achieving the global tuberculosis-control targets for 2005 following the establishment, in response to resolution WHA51.13, of the Stop Tuberculosis Initiative;¹

Noting the need to strengthen health systems development for the successful delivery of tuberculosis-control activities;

¹ Now known as the Stop TB Partnership.

Stressing the importance of engagement of the full range of health providers in delivering the international standard of tuberculosis care in line with the strategy of directly observed treatment, short-course (DOTS);

Concerned that lack of commitment to sustained financing for tuberculosis control will impede the sound long-term planning necessary to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

Encouraging the development of a global plan for the period 2006-2015, which will address the need for sustained financing in order to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

1. ENCOURAGES all Member States:

- (1) to estimate the total resources required for prevention and control of tuberculosis, including HIV-related tuberculosis and multidrug-resistant tuberculosis, in the medium-term, and the resources available from domestic and international sources in order to identify the funding gap;
- (2) to fulfil the commitments made in endorsing resolution WHA53.1 and hence the Amsterdam Declaration to Stop Tuberculosis, including their commitment to ensure the availability of sufficient domestic resources and of sufficient external resources to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;
- (3) to strengthen integration between financial, operational and social partners by setting up national Stop TB partnerships in each country and to ensure that such partnerships at country level provide a vehicle to support the implementation of long-term plans for expansion of DOTS through national interagency coordination committees;
- (4) to ensure that all tuberculosis patients have access to the universal standard of care based on proper diagnosis, treatment and reporting consistent with the DOTS strategy by promoting both supply and demand;
- (5) to strengthen prevention of, and social mobilization against, tuberculosis;
- (6) to set up collaboration between tuberculosis and HIV programmes, in order to address more effectively the dual tuberculosis/HIV epidemic;
- (7) to integrate the prevention and control of tuberculosis in the mainstream of their health development plans;

2. REQUESTS the Director-General:

- (1) to intensify support to Member States in developing capacity and improving the performance of national tuberculosis-control programmes within the broad context of strengthening health systems in order:
 - (a) to accelerate progress towards reaching the global target of detecting 70% of new infectious cases and successfully treating 85% of those detected;
 - (b) to sustain achievement of that target in order to reach the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;
- (2) to strengthen cooperation with Member States with a view to improving collaboration between tuberculosis programmes and HIV programmes, in order:
 - (a) to implement the expanded strategy to control HIV-related tuberculosis;
 - (b) to enhance HIV/AIDS programmes, including delivery of antiretroviral treatment for patients with tuberculosis who are also infected with HIV;
- (3) to implement and strengthen strategies for the effective control of, and management of persons with, drug-resistant tuberculosis;

- (4) to take the lead in cooperation with national health authorities in working with partners to devise, strengthen and support mechanisms to facilitate sustainable financing of tuberculosis control;
- (5) to enhance WHO's support to the Stop TB Partnership in its efforts to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration and provide regular reports on the progress made to achieve the goals;
- (6) to recommend that tuberculosis be specifically mentioned in Goal 6 and Target 8, instead of being included among other diseases at the high level plenary meeting on the outcome of the Millennium Summit of the United Nations General Assembly to review progress in fulfilment of commitments contained in the United Nations Millennium Declaration;
- (7) to promote research and development for new control tools as part of the global plan to stop tuberculosis.

Dr RUIZ (Mexico) suggested that the following phrase should be added at the end of paragraph 2(1)(a): "and to report to the World Health Assembly in 2007 on progress made to the end of 2005".

The draft resolution, as amended, was approved.¹

Draft global immunization strategy: Item 13.8 of the Agenda (Documents A58/12 and A58/12 Add.1) (continued from the seventh meeting, section 4)

The CHAIRMAN invited the Committee to consider the following draft resolution, which had been revised by an informal drafting group.

The Fifty-eighth World Health Assembly,

Having considered the report on the draft immunization strategy;²

Alarmed that globally and in some regions immunization coverage has increased only marginally since the early 1990s, and that in 2003 more than 27 million children worldwide were not immunized during their first year of life;

Recognizing that each year 1.4 million children under five years of age die from diseases preventable by currently available vaccines;

Further recognizing that each year an additional 2.6 million children under five years of age die because of diseases potentially preventable by new vaccines;

Acknowledging the contributions by WHO, UNICEF, GAVI and all partners in their efforts in strengthening immunization services, expansion of immunization coverage and introduction of new and underused vaccines in developing countries;

Welcoming the achievements of the accelerated disease-control initiatives against poliomyelitis, measles, and maternal and neonatal tetanus in immunizing previously unreached populations, and noting that these initiatives have established extensive networks on which surveillance for other disease and health trends can be built or expanded;

Concerned that, owing to financial, structural and/or managerial constraints, national immunization programmes fail to reach all who are eligible for immunization, particularly children and women, underuse many existing vaccines, and are not widely introducing new vaccines;

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA58.14.

² Document A58/12.

Emphasizing the need for all countries to strive towards achieving the internationally agreed development goal in the United Nations Millennium Declaration of reducing by two thirds, between 1990 and 2015, the under-five child mortality rate;

Recalling the target of the United Nations General Assembly's twenty-seventh special session on children (2002) to ensure full immunization of children under one year of age, with at least 90% coverage nationally, and at least 80% coverage in every district or equivalent administrative unit;

Recognizing that resolution WHA53.12 highlights immunization as a major factor in promoting child health;

Having considered the draft global immunization vision and strategy,

1. ENDORSES the Global Immunization Vision and Strategy;
2. URGES Member States:
 - (1) to meet immunization targets expressed in the United Nations General Assembly special session on children;
 - (2) to adopt the Global Immunization Vision and Strategy as the framework for strengthening of national immunization programmes between 2006 and 2015, with the goal of achieving greater coverage and equity in access to immunizations, of improving access to existing and future vaccines, and of extending the benefits of vaccination linked with other health interventions to age groups beyond infancy;
 - (3) to ensure that immunization remains a priority on the national health agenda, and is supported by systematic planning, implementation, monitoring and evaluation processes, and long-term financial commitment;
3. REQUESTS the Director-General:
 - (1) to mobilize resources to promote the availability and affordability in countries of future new vaccines based on evidence of epidemiological profiles;
 - (2) to work closely with the Global Alliance for Vaccines and Immunization (GAVI), UNICEF and other partners to provide support to Member States in implementation of the Global Immunization Vision and Strategy;
 - (3) to strengthen relations at global, regional and subregional levels with UNICEF, GAVI and other partners in order to mobilize the needed resources for countries, in particular developing countries, to implement the Global Immunization Vision and Strategy;
 - (4) to report every three years to the Health Assembly on progress towards achievement of global immunization targets, including those expressed in the United Nations General Assembly special session on children.

Mr ABDOO (United States of America) recalled that the drafting group had agreed to replace the word "endorses" in paragraph 1 with "welcomes". The draft strategy had been issued too late for his Government to study it thoroughly and it could not, therefore, endorse it yet.

Mrs PHUMAPHI (Assistant Director-General) asked for an assurance that the proposed amendment would not delay implementation of the strategy.

Mr ABDOO (United States of America) pointed out that subparagraph 2(2) of the draft resolution urged Member States to adopt the strategy as the framework for strengthening of national immunization programmes, which he understood to mean that it would be implemented immediately.

The draft resolution, as amended, was approved.¹

Infant and young child nutrition: Item 13.11 of the Agenda (Resolution EB115.R12; Document A58/15)

Mr GUNNARSSON (Iceland, Representative of the Executive Board), introducing the item, said that the draft resolution contained in resolution EB115.R12 represented a fragile compromise. The occurrence of *Enterobacter sakazakii* and other microorganisms in powdered infant formula had been the subject of a draft resolution submitted to the Fifty-seventh World Health Assembly by the delegations of Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Nepal and Palau. At the 115th session of the Executive Board in January 2005, a working group of 22 members had agreed on the draft before the Committee.

The problem of contaminated infant formula was widespread: there had already been two outbreaks of salmonellosis in France in 2005, and WHO's international network of food safety authorities (INFOSAN) had been activated in March and April 2005 to alert the authorities in 32 Member States and territories outside the European Union to which the contaminated formula had been exported. The issue was emotive. The draft resolution sought to reflect the views expressed in a balanced way and provided clear guidance to WHO, FAO and the Codex Alimentarius Commission for updating standards, guidelines and recommendations relating to processed foods for infants and young children. It would be difficult to amend it substantially without reopening the debate.

Dr AYDINLI (Turkey) said that his country promoted breastfeeding as the best way of safeguarding the right of infants and young children to adequate nutrition. The percentage of mothers breastfeeding their infants for the first six months had risen from 1.3% in 1998 to 20.8% in 2003, and the number of baby-friendly hospitals had risen from 141 to 323. Turkey had signed the International Code of Marketing of Breast-milk Substitutes and the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding, and had adopted regulations relating to powdered infant formula that were in line with European Union directives.

Dr OTTO (Palau) said that the sponsors of the draft resolution were disappointed with the way in which it had been handled. The Secretariat had required them to revise the original text three times before it was submitted to the Fifty-seventh World Health Assembly, thereby delaying its submission until the last day, with the result that the delegations of several large countries had said that they had not had sufficient time to consider it, although 16 Member States had spoken in its support. The draft resolution had then been submitted to the Executive Board at its 115th session, although in the meantime the Secretariat had revised it without consulting the sponsors. Even though only one of the sponsors had a mission in Geneva, the Secretariat could have contacted all of them through their missions in New York, through the Regional Office for the Western Pacific, at the addresses they had given when registering for the Health Assembly, or at the Regional Committee meeting in Shanghai, China, in September 2004. Although the Secretariat had apologized at the 115th session of the Executive Board for the lack of transparency with which the draft resolution had been handled, his concern was to ensure that the Organization conducted its work in a way that was transparent, accorded respect and dignity to every Member State, irrespective of size, and was consistent with the image, reputation and status of WHO.

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA58.15.

The draft resolution before the Committee contained some valuable provisions, but the sponsors wanted to strengthen it further, particularly in relation to health claims, warnings about inherent health risks, and conflicts of interest arising from sponsorship. He realized that the Board had worked hard to reach a compromise. Nevertheless, since the issue had been raised the year before, infants had died in France and New Zealand from diseases contracted from contaminated infant formula. An unknown number of children in countries to which formula was exported were at risk of those diseases. By adopting the draft resolution, the Health Assembly would convey a clear warning about the risks inherent in some infant foods.

He wondered why such an important issue had been championed by six tiny nations and questioned by big and powerful ones. Was WHO not convinced of its responsibility to protect all the infants of the world? Did the Organization want to use its authority to protect infants – or big business? Every infant had the right to survive, and every mother had the right to be informed of any health risks associated with the foods she might give to her child. He called on Member States to support the draft resolution.

Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the Member States of the European Union, the acceding countries Bulgaria and Romania, candidate countries Croatia and Turkey, and the countries of the Stabilisation and Association Process and potential candidate countries Albania, Bosnia and Herzegovina, Serbia and Montenegro, and The former Yugoslav Republic of Macedonia, said that WHO must take a stance on the issue of infant and young child nutrition, in view of the serious events in one of the Union's Member States. The European Union had sponsored resolution EB115.R12 which had been adopted after intense discussions. The draft resolution it contained was well-balanced and should be acceptable to all parties. She urged Member States to approve it forthwith, bearing in mind the amount of work that had gone into it.

Dr CONOMBO-KAFONDO (Burkina Faso) supported the draft resolution. Despite the monitoring and quality-control systems in place, powdered infant formula contaminated with *Salmonella agona* had recently been exported to 11 countries including Burkina Faso. Although the countries concerned had been alerted to the danger by WHO's international network of food safety authorities, the lack of a quality-control system for imported foodstuffs in those countries meant that the risks remained. A stronger international system of alert and closer cooperation and coordination in quality control was therefore needed, together with the establishment of quality-control laboratories in the importing countries.

Ms LAMBERT (South Africa) expressed support for the draft resolution, the views expressed by the delegate of Palau and the statement that would follow on behalf of the Member States of the African Region. South Africa promoted optimal infant and young child feeding, including exclusive breastfeeding for the first six months of life and continued breastfeeding up to two years of age or beyond. The fact that *E. sakazakii* had so far been detected only in Europe and New Zealand did not mean that there was no contamination in Africa. Africa had a high percentage of preterm, low-birth-weight and immunocompromised infants, and consequently a high risk of microbial infection; additional infection from commercial products could not be tolerated. Any recall of infant feeding products due to contamination must extend to the developing countries. It was therefore important to act urgently and not to wait until the Codex Alimentarius Commission met in November 2006. The Health Assembly must direct the Commission to speed up its work in the area and to demand higher standards at the manufacturing level, so as to ensure that the world's infants were safeguarded against *E. sakazakii*. Meanwhile product labels, which for most mothers were an exclusive source of information, needed to be fully informative, clear, user-friendly and graphic. It was the task of governments to inform mothers about intrinsic contamination and ways of reducing risks through correct preparation and use of infant formula; it could not be left to the manufacturers.

The draft resolution required some amendment. Reference to resolution WHA55.25 needed to be added to the preambular section as it endorsed the Global strategy for infant and young child feeding; the word "inappropriately" in the preambular section weakened the resolution and should be

deleted; at the end of subparagraph 1(2), all the words following “young children” should be deleted; in subparagraph 1(5) the words “funded and” should be inserted before “reviewed”; and in subparagraph 2(2), the words “and the subsequent Health Assembly resolutions” should be added at the end.

Mr NASIB ALI (Yemen) agreed with the previous speaker and her proposed amendments. All nutrition and health claims should be carefully examined by the Codex Alimentarius Commission: packaging of foods for infants and young children should state only the facts. Subparagraph 1(3) should be expanded to reflect the fact that breast-milk substitutes were not sterilized; a reference to programmes in subparagraph 1(4) would make the paragraph more comprehensive; and subparagraph 2(3) needed to be strengthened by references to the danger of transmission of *E. sakazakii*.

Dr PARIRENYATWA (Zimbabwe) expressed support for the comments by the delegate of Palau, the amendments proposed by the delegates of South Africa and Yemen, and for the draft resolution. Zimbabwe greatly appreciated the material, technical and financial support provided by WHO and UNICEF for implementation of elements of the Global strategy on infant and young child feeding. It was disquieted by the risks associated with *E. sakazakii* and other microorganisms in powdered infant formula, and particularly concerned about the health and nutritional claims made by the manufacturers of breast-milk substitutes, most of which seriously undermined breastfeeding and infant health by misleading mothers, many of whom had limited literacy levels. The draft resolution should be strengthened to ensure that WHO did not give implicit endorsement to the proliferation of unfounded health claims; WHO should urgently give appropriate guidance to the Codex Alimentarius Commission on that issue. He proposed that the word “regularly” in subparagraph 3(4) should be replaced by “each even year, along with the report on the status of implementation of the International Code of Marketing of Breast-milk Substitutes and relevant resolutions,”.

Dr RAHANTANIRINA (Madagascar), speaking on behalf of the Member States of the African Region, emphasized their concerns over recent alerts to the risk of serious illness caused by *E. sakazakii* and other microorganisms in powdered infant formula. Such illnesses could compromise efforts to achieve the Millennium Development Goals in Africa.

Despite the fact that breastfeeding was engrained in the Region’s culture, the rate of exclusive breastfeeding during the first six months was low, ranging from 3% to 17%. The situation was even worse in western and central Africa, where there were no measures to reduce mother-to-child transmission of HIV, and where between 5% and 20% of babies born to HIV-positive mothers were infected through breast-feeding. Although many African countries were implementing programmes to reduce that transmission, access to antiretroviral agents and training of health professionals to help mothers make informed choices about feeding were still a problem. The use of local products for supplementary feeding needed to be encouraged, and national resources mobilized to that end. Proper nutrition was the cornerstone of child survival and development. More than 50% of infant deaths in sub-Saharan Africa were caused by inadequate feeding, and 1.5 million children died each year through not being breastfed, yet advertising and marketing of breast-milk substitutes were intensifying despite the problems with contaminants. Breast-feeding was the most effective and cheapest way to reduce infant mortality, even in areas with a high HIV prevalence. The draft resolution, which she supported, could be strengthened to protect the most vulnerable infants.

The International Code of Marketing of Breast-milk Substitutes had been incorporated into the national legislation of 22% of Member States, which had also carried out compliance-monitoring activities, and 26% of Member States had adopted a policy or taken voluntary measures based on the Code. For most mothers using powdered infant formula, however, product labels were the only source of information, and they must be informed of the serious risks associated with *E. sakazakii* contamination. Furthermore, although the number of cases of infection seemed low, the mortality rate was high. The incidence of infection in African countries might be high, since deaths from diseases such as meningitis, septicaemia and necrotizing enterocolitis had never been attributed to feeding

practices, and, although most processed food for infants and young children sold in Africa was imported, warnings and recalls were only recent events. The risk of contamination during manufacture should therefore be treated as a public health matter and an international integrated surveillance and notification system established, with support for the countries of the African Region in strengthening their quality-control capacities at the national and regional levels. Parents and carers should be alerted to the potential dangers of contamination. The Codex Alimentarius Commission must act decisively and should pursue a policy of zero tolerance towards contamination by any pathogenic agent of processed foods for infants and young children.

She supported the various amendments proposed. African Member States would continue to defend, promote and support exclusive breastfeeding for the first six months, and maintain their efforts to draw up and implement relevant policies and strategies.

Professor SHRESTHA (Nepal) said that, despite the strong support in 2004 for the 2005 World Health Day slogan “Make every mother and child count”, the draft resolution had still not been approved. Unknown numbers of children had died during that time. Justice delayed was justice denied to infants who were unable to make their own voices heard. The Health Assembly must act to prevent further loss of life by adopting a strengthened draft resolution. At the Fifty-seventh World Health Assembly, 16 countries had supported the draft resolution but a small number of Members had succeeded in delaying its adoption, thus depriving children of their rights; he shared the concerns expressed by the delegate of Palau in that connection.

He endorsed the proposed inclusion of a reference to resolution WHA55.25 endorsing the Global strategy for infant and young child feeding in the preambular section; deletion of the words following “young children” from subparagraph 1(2); and inclusion of a reference to programmes in subparagraph 1(4). He urged all delegates to support the draft resolution.

Dr MOETI (Botswana) shared the concern that the intrinsic contamination of powdered infant formula with *E. sakazakii*, *Salmonella* and other microorganisms had caused severe illness, particularly among preterm, low-birth-weight and immunocompromised infants. That was especially worrying for countries with high HIV/AIDS prevalence, where many HIV-positive mothers used infant formula instead of breastfeeding.

Botswana was committed to implementing the global strategy on infant and young child feeding to promote, protect and support optimal infant and young child feeding practices, and appreciated WHO’s support in that regard. Botswana’s programme on the prevention of mother-to-child transmission of HIV provided free infant formula for one year to HIV-positive mothers enrolled in the programme, counselling them to avoid breastfeeding, while HIV-negative mothers were counselled to breastfeed exclusively for six months, with continued breastfeeding up to two years and beyond. Those whose HIV status was unknown were encouraged to undergo tests so that they could make informed decisions about child feeding. To improve infant and young child nutrition and the safety and quality of infant formula, he encouraged WHO, FAO and other agencies, including the Codex Alimentarius Commission, to continue to undertake research, monitoring and evaluation, and to develop guidelines and standards in line with emerging issues related to child nutrition and hygienic practices for the manufacture and regulation of foods for infants and children, particularly the control of contamination by pathogenic organisms.

He proposed further amending the sixth preambular paragraph to read “Concerned that nutrition and health claims may be used to promote the sale of breast-milk substitutes instead of breastfeeding”; inserting the words “by independent health providers” after the words “information and training” in subparagraph 1(3); inserting the words “and other incentives” after the words “financial support” in subparagraph 1(4); and deleting the word “explore” from subparagraph 2(3), since adding appropriate warning messages was desirable.

Dr ADOI-AGYARKO (Ghana) proposed two amendments to the draft resolution: the addition of a new fifth preambular paragraph to read “Recognizing the need for parents and caregivers to be fully informed on the known public health risks of intrinsic contamination of powdered infant

formula”, and the deletion of the words “where applicable” from subparagraph 1(3), as they weakened the resolution and placed responsibility for product safety on consumers rather than manufacturers. The industry must be held responsible for the consequences of intrinsic contamination at all times.

In Ghana, two brands of powdered infant formula had recently been found to be contaminated with *S. agona* and had been recalled. It was not yet known exactly how many children could have been affected. Ghana continued to promote breastfeeding but, for those reliant on powdered formula, it was essential to know that the labelling on such products, as the only source of information for users, was correct. She urged the Committee to support the draft resolution with the amendments proposed.

Dr AL-MAZROU (Saudi Arabia) said that his country had adopted the International Code of Marketing of Breast-milk Substitutes, and had also issued its own national code early in 2005. He supported the draft resolution as amended by the delegates of Palau, South Africa and Yemen. He further proposed in subparagraph 1(3) the addition of the word “unsterilized” between the words “are informed that” and “powdered infant formula” and supported the deletion of the words “where applicable”. He appealed to the Committee to support the draft resolution as amended, in order to protect children throughout the world from the risks inherent in irrational use of breast-milk substitutes.

Dr IWASAKI (Japan), observing that his country had participated actively in the work of the Codex Alimentarius Commission, called on Member States to cooperate closely in the revision of the Recommended International Code of Hygienic Practice for Foods for Infants and Children, in which the Commission was considering incorporating a provision relating to guidance for health professionals with respect to the handling of infant formula. There should be no duplication or overlap in the work of WHO and the Codex Alimentarius Commission, and he therefore suggested that the draft resolution should be amended by adding “and constructively” after “actively” in subparagraph 1(9), and by inserting “and taking into account the work undertaken by the Codex Alimentarius Commission,” after “in collaboration with FAO,” in subparagraph 3(1).

Mr SHONGWE (Swaziland) said that his was one of many African countries where optimal infant and young child nutrition contributed significantly to the reduction of infant and young child morbidity and mortality. Swaziland had endorsed and implemented all the previous Health Assembly resolutions on infant and young child nutrition. It had made major gains in breastfeeding, with the rates of exclusive breastfeeding increasing from 7% in 1986 to 28% in 2002. In some rural communities, those rates had risen to about 51%. All children under six years of age received vitamin A supplementation; all salt for human consumption was iodized; and all Swaziland’s hospitals had been certified as baby-friendly. The International Code of Marketing of Breast-milk Substitutes was in the final stages of being incorporated into national legislation, and the revised public health act already contained important clauses on infant and young child nutrition. Swaziland appreciated the technical and financial support of WHO, UNICEF and other partners, and looked forward to continued support in connection with infant and young child nutrition.

In the draft resolution, he suggested deletion of the word “inappropriately” in the sixth preambular paragraph and the addition of “and subsequent relevant resolutions of the Health Assembly” at the end of subparagraph 2(2). In subparagraph 3(4), the word “regularly” should be replaced by “each even year ...” as suggested by the delegate of Zimbabwe. He supported the draft resolution thus amended.

Dr WANGCHUK (Bhutan) said that his country followed WHO and UNICEF recommendations on infant feeding practices, and promoted exclusive breastfeeding. It shared the concerns regarding the inappropriate use of nutrition and health claims to promote the sale of breast-milk substitutes, and supported the draft resolution with the proposed amendments, including those by the delegate of Nepal.

Dr HAMADI (Morocco) supported the draft resolution. In addition to the benefits of breastfeeding, additional nutritional benefits might be derived from vitamin A and D supplementation, which were added to flour and dressing oil in Morocco as a result of the decision of an interministerial committee for feeding and nutrition that had been set up in the 1980s.

Dr CAMPBELL (New Zealand) strongly endorsed breastfeeding as the best option for young children. Where children were not breastfed, appropriate, understandable and accessible advice on the potential health risks associated with powdered infant formula should be given to everyone involved in infant nutrition. New Zealand's position had been reinforced by a recent infant death in a neonatal unit attributable to *E. sakazakii* infection. Other Member States might learn from his country's experience to ensure that parents and carers of infants, and institutions caring for preterm and immunocompromised infants, were made aware of the non-sterile nature of powdered infant formula, and took appropriate steps. New Zealand had given detailed advice to the public and the health sector on the safe preparation of powdered infant formula.

New Zealand was participating actively in the review by the Codex Alimentarius Commission of the Recommended International Code of Hygienic Practice for Foods for Infants and Children, and looked forward to a revised text focusing on issues relating to powdered infant formula. He strongly endorsed the draft resolution, and emphasized the need for the Codex Alimentarius Commission to complete its work on powdered infant formula.

Mr SAMO (Federated States of Micronesia) said that the draft resolution contained in resolution EB115.R12, which his country had sponsored, might be further improved by deleting the words "where applicable" from subparagraph 1(3), and "explore the necessity of" from subparagraph 2(3).

Dr PHOOKO (Lesotho) said that, in circumstances where six months' breastfeeding was not possible or where infant formula was unavailable, a holistic approach to issues of infant and young child feeding needed to be taken. The training of health personnel and others involved in infant feeding should focus on not only infant formula, but the use, preparation and handling of locally available feeds as well. Carers should also be taught that all infant and young child feeds might contain pathogens, and must be prepared and used appropriately; they should also be made aware of other causes of infant and young child morbidity and mortality, such as malnutrition and diarrhoea, which were directly linked to poor sanitation and unsafe drinking-water.

In most developing countries, poverty, exacerbated by HIV/AIDS, contributed directly to infant and young child morbidity and mortality. Although the breast milk of HIV-positive mothers contained HIV, most such mothers practiced prolonged breastfeeding since they could not afford replacement feeding. Even where infant formula was supplied freely, criteria such as accessibility, feasibility, and affordability, might not apply. All issues having an adverse impact on infant and young child nutrition should therefore be highlighted, and interventions should focus on all aspects.

Mr JANG Il Hun (Democratic People's Republic of Korea) expressed support for the draft resolution. Mortality rates for children under five had begun to deteriorate in his country in the mid-1990s as a result of successive natural disasters. There had, in particular, been an increase in the number of malnourished children and the number of children dying from major childhood diseases including diarrhoea and acute respiratory infections. His Government had made extensive efforts to redress the situation with the support of WFP, UNICEF and other international organizations, paying special attention to the increased production and supply of nutritious foods for children. Child nutrition had improved significantly as a result, and mortality and morbidity rates were declining. Building national capacity, therefore, and encouraging development assistance had a sustained, positive impact on child health. His country greatly appreciated the support of WHO, UNICEF and other international organizations and trusted that it would continue in order to strengthen the national capacities of Member States.

Professor IVANOV (Bulgaria) commented that the request to the Codex Alimentarius Commission to establish appropriate microbiological criteria and standards for powdered infant formula was timely. International unified microbiological indicators and standards should be introduced for all foods intended for infant and young child nutrition, with a view to minimizing the health risks and facilitating the free movement of such foods in all Member States. The Bulgarian Ministry of Health, WHO and UNICEF were supporting the promotion of exclusive breastfeeding and the improvement of infant and child feeding. Action had been taken to improve the skills of health professionals in order to support, protect and promote breastfeeding and complementary feeding; and training in baby-friendly hospitals was being provided. Work was also being done to improve the knowledge of pregnant and breastfeeding women, and to raise public awareness generally. His Government highly appreciated WHO activities relating to the improvement of infant and young child nutrition, and supported the draft resolution.

Ms RIMESTAD (Norway), speaking on behalf of the Nordic countries Denmark, Finland, Iceland, Sweden and Norway, recalled that the Health Assembly had adopted several resolutions relating to the promotion of healthy infant and young child nutrition. She appreciated WHO's work in following up the Global strategy for infant and young child feeding. Breastfeeding was crucial to reducing child mortality, and the efforts to improve infant and young child nutrition contributed directly to achievement of the Millennium Development Goals.

The food safety aspects relating to foods intended for infants and young children were a focus of the draft resolution. WHO and the Codex Alimentarius Commission must give due attention to standards for hygienic practices and the labelling of such foods. The recent outbreak in France of *S. agona* infection in infants, that had been linked to powdered infant formula, and the information in December 2004 about *E. sakazakii* in infant formula, indicated that microbial contamination of powdered breast-milk substitutes could jeopardize infants' health. There was clearly a need for appropriate guidance and information to be given to all concerned. The International Code of Marketing of Breast-milk Substitutes was an important tool in connection with health claims, independent research and potential conflicts of interest. Its 25th anniversary in 2006 would provide an opportunity to revitalize the Code as an important tool for health promotion. In addition, the WHO child growth standards to be launched later in the year would be of importance for surveillance and for improving infant and child health.

She trusted that the draft resolution would be adopted by the Health Assembly.

Dr PYAKALYIA (Papua New Guinea), thanking WHO for bringing such an important subject before the Health Assembly, said that the main task was to make the draft resolution stronger. The issue concerned the health of infants and children throughout the world. The risks were serious and immediate action was needed to strengthen existing regulations. He supported the position of Palau and the amendments proposed by South Africa and other countries.

Dr REN Minghui (China) said that WHO's Global strategy for infant and young child feeding had played an important role in improving the health of infants and children. Although the recommendation for six months of exclusive breastfeeding had had a positive impact, WHO targets had not yet been attained. More effective measures were needed. However, where breastfeeding was impossible, the quality and safety of substitutes were becoming increasingly essential. China took note of the outcome of the FAO/WHO joint expert workshop on *E. sakazakii* and other microorganisms in powdered infant formula. In fact, that product was not sterile and presented particular risks for infants. Manufacturers should be obliged to inform consumers of the correct use of such products. For example, the labelling should indicate clearly that the product should be fed to infants immediately after mixing with water. Such measures could do much to improve infant health. The member for China on the Executive Board had taken part in drafting the resolution. The comprehensive text heeded various national concerns and required manufacturers and distributors to include in their labelling warnings about rational use of the product. He requested the Director-General to work with the Codex Alimentarius Commission in risk assessment regarding possible forms of contamination of

powdered infant formula by microorganisms. Implementation of the resolution, which China supported, would enhance the safety of powdered infant formula.

Ms VALDEZ (United States of America) said that early infancy and the time after cessation of breastfeeding were the most dangerous period for the nutritional well-being of children. Growth faltered earlier than previously thought and the transition to mixed diets had not received enough attention. National governments and the private sector needed to address the potential for contamination of *E. sakazakii* and other pathogens in infant formula. National policies and standards should be based on the best science and the Codex Alimentarius Commission was developing such data-driven product standards and reviewing standards for infant formula, including the manufacture of powdered infant formula. The United States had been the first to bring the issue of *E. sakazakii* contamination of infant formula to the attention of the Codex committees in order to update the Recommended International Code of Hygienic Practice for Foods for Infants and Children and address concerns about pathogens in infant formula. The Codex Committee on Food Hygiene had noted the existence of many data gaps needing to be filled to enable countries and scientists to gauge the risks posed by *E. sakazakii*. The Codex Alimentarius Commission had progressed significantly but its processes should be allowed to work out before Member States developed the necessary national policies to ensure the highest quality and choice for infant and young child nutrition appropriate for local circumstances. Deliberations must be science-based. Should a breast-milk substitute be chosen, issues connected with *E. sakazakii* infectivity would need to be considered and special attention given to safe preparation and handling procedures. In some regions and situations, effective alternatives to powdered infant formula products would be needed for infants at high risk. Viable solutions would probably involve segments of the public health and commercial distribution networks, from the education of carers to product standards, in line with national and cultural needs. Against that background the Executive Board had negotiated the text of the draft resolution, which represented a balanced compromise drawing attention to *E. sakazakii* while respecting ongoing Codex processes. Member States had wished to avoid action that would impede progress in the right places. The United States remained committed to working through the Codex Alimentarius Commission and with WHO and FAO to develop strong science-based standards for the quality and choice of infant and young child nutrition. As the delegate of Palau had said, the draft resolution was a fragile compromise and the United States aligned itself with comments made by the Nordic countries, the European Union and China in strongly supporting it as it stood. She was unable to support some comments from the floor, especially those not firmly grounded in available data or those attempting to circumvent the Codex Alimentarius Commission processes and mandate.

Mr EDWARDS (Marshall Islands) said that his country's Primary Health Care Bureau had for many years encouraged infant breastfeeding. Where that was not possible an infant formula was used but some breast-milk substitutes had been found to contain dangerous microorganisms. The Marshall Islands supported the draft resolution.

Ms PORNPIT SILKAVUTE (Thailand) welcomed the draft resolution. Thailand was seriously concerned about the contamination of powdered infant formula with *E. sakazakii*. The infants at greatest risk were neonates, especially in the event of pre-term delivery, low birth weight and immunocompromised mothers. After an outbreak in April of 2005, investigation had revealed three *E. sakazakii*-contaminated powdered infant formula products out of 62 samples tested. The contaminated products, imported from three different countries, had been immediately recalled and destroyed. The companies concerned had been fined under the National Food Act. The Thai Food and Drug Administration had cooperated with the media to raise public awareness of the issue, and such contamination was closely monitored. Several approaches to the problem were well reflected in the draft resolution, which Thailand strongly supported.

Dr ZAHER (Egypt) expressed her support for the suggestions by South Africa, Yemen and Zimbabwe. In Egypt, the Ministry of Health had developed a comprehensive strategy to safeguard the health of infants and young children, including a law on food products and marketing, especially advertising. That law required cooperation and compliance with health ministry regulations and covered powdered infant formula preparations for infants and young children. It required good manufacturing practices for powdered milk and the exclusion of any pathogens for both locally manufactured and imported powdered milk. Chapter 5 of the law concerning nutrition of young children prohibited marketing before confirmation by an official laboratory of compliance with Egyptian specifications. It also forbade the use of additives or colouring agents in foods for infants and young children unless in conformity with health ministry requirements.

Mr ABID (Iraq) said that he hoped that the draft resolution would be adopted by the Health Assembly. The main risk was not so much the contamination of breastfeeding substitutes by *E. sakazakii* as powdered preparations contaminated by being made up with unsafe water. Breastfeeding for the first six months of life would avoid such risks of contamination and diarrhoea. The use of breast-milk substitutes in countries without a satisfactory food hygiene system harmed the health of infants and young children and lowered current rates of breastfeeding. He supported the resolution as amended by South Africa, Yemen and Saudi Arabia.

Dr LARIVIÈRE (Canada) strongly supported the draft resolution and said that it should be adopted as it stood. The text had involved long negotiations in the Executive Board and consensus had been laborious. It was important for the draft resolution to be adopted by the current Health Assembly by consensus, although that looked unlikely. The implementation of the resolution would require a clear understanding of the distinct roles and responsibilities of the various partners: WHO, the Codex Alimentarius Commission and national health authorities. Canada welcomed the comprehensive approach adopted by WHO and the inclusion of important elements such as the nutrition of mothers and micronutrient deficiencies. Focusing on contentious issues tended to avert attention from the comprehensive nature of safeguarding the health of infants and young children. Since November 2004 Health Canada had been recommending exclusive breastfeeding for the first six months of life, thus aligning itself with resolution WHA55.25.

Dr ELSAYID (Sudan) fully supported the draft resolution, with due consideration of all amendments proposed by South Africa, Yemen and Madagascar. Millions of infants and young children in his country and in other developing countries continued to die of infectious diseases before their fifth birthday, and he consequently urged approval of the draft resolution, as amended. He called on the Secretariat to follow up on the implementation of the resolution and to spare no effort in obtaining and sharing information in order to ensure infant safety while the Codex Alimentarius Commission continued its work.

Mr RYAZANTSEV (Russian Federation) said that, for the sake of consensus, he was prepared to support the draft resolution. However, he raised some concerns about the provisions relating to warnings on packages of breast-milk substitutes. Subparagraphs 1(3) and 2(3) were contradictory. The former urged Member States to convey explicit warnings on product packaging regarding the potential for contamination of powdered infant formula with pathogenic microorganisms, while the latter requested the Codex Alimentarius Commission to explore the necessity of adding warning messages on product packaging. The Codex Alimentarius Commission should first study the matter and then make recommendations to Member States on the advisability of including warning messages on packaging; countries could then decide for themselves whether to add warnings. It was not advisable for infant formula packaging to carry warnings of the possibility of contamination by *E. sakazakii* or salmonellas because such warnings might cause undue anxiety, among both specialists making decisions on infant feeding and infant-formula users. As a result, consumers might reject infant formula products and instead feed infants on cow's milk, kefir and cereals, which could impair their

growth and development in the first year of life. It would be preferable to strengthen microbiological controls at all stages of the powdered infant formula production process, including the import stage.

Ms HALTON (Australia) acknowledged the work of her South Pacific colleagues, especially Palau, in bringing forward a draft resolution on the crucial issue of providing protection to young children. Clearly, breastfeeding drew universal support, as evidenced by various Health Assembly resolutions and the domestic policies that many countries were pursuing. In practice, however, for some women and children breastfeeding was not possible. Consequently, Australia, like many other countries, was keen to ensure that women, carers and health professionals were supported in providing advice so that good choices could be made to protect the health of young children.

Acknowledging the efforts of countries in the arduous negotiation of a consensus document within the Executive Board, she observed that many members had come with strong views on particular elements of the early draft of the resolution, but enormous goodwill had been shown by everyone involved, precisely because of the desire to do something positive for the health of young children. The significant, albeit fragile, consensus reached at the 115th session was one to which all countries had been prepared to commit. Australia commended them for their willingness to compromise and supported approval of the draft resolution.

Mrs AHO (Togo) said that her country had a serious problem with specious advertising encouraging mothers to feed their children with inappropriate products. Some companies did not respect the regulations on the matter and put up giant advertisements with messages that were often unclear, too small to read or not readable at all by illiterate mothers, for whom it was the image that counted. The draft resolution invited Member States to take certain measures in that regard, but she called on WHO also to take responsibility vis-à-vis such firms and their use of various advertising gimmicks. She thanked the Organization for the support it had provided to enable Togo to conduct a nutritional survey, which had highlighted the relationship between malnutrition and poverty. She also sought support for the country's nutritional recovery programme for malnourished children. She supported the draft resolution with the amendments proposed by South Africa.

Dr AHMED (Pakistan) said that Pakistan shared the concerns of other countries regarding contamination of powdered infant formula with pathogenic microorganisms. There could be no doubt about the hazards of bottle-feeding and the benefits of breastfeeding. However high the standards were for infant formula, there would always be some risk of contamination. Pakistan had enacted legislation in 2002 on protection of breastfeeding, prohibiting the promotion of infant formula and other baby foods and encouraging breastfeeding. The problem lay in enforcing such regulations. Violations by commercial organizations must be monitored and dealt with appropriately. Mindful of the importance of safeguarding the health of infants and young children, Pakistan supported the draft resolution. It also urged the Codex Alimentarius Commission to expedite the revision of its recommendations on hygienic practices for the manufacture of foods for infants and young children.

Ms JALLOW (Gambia) associated herself with the remarks made by the delegate of Palau and strongly supported the amendments proposed by South Africa, Yemen, Zimbabwe, Ghana, Nepal and others, specifically on health claims and non-sterility of infant formula products. The issue under discussion was an emotional one; it was to be hoped that those emotions would guide the Health Assembly towards the protection of infants globally.

Dr KIENENE (Kiribati) said that consideration of the important topic of infant and young child nutrition in the agenda of the Health Assembly should not be seen as an endorsement of formula-feeding. Breastfeeding was still the best source of nutrition for infants, especially exclusive breastfeeding during the first six months of life. That was the practice being promoted in most countries, including his. He thanked the members of the Executive Board for having maintained the momentum of the draft resolution and, especially in retaining its essence in the face of significant opposition. In a commercialized world, health decision-makers would always be faced with weighing

health against wealth. He urged the Health Assembly to come to a wise decision, for the sake of the world's children and in the name of public health, not to commercialize health. Kiribati associated itself with the sentiments expressed by the delegate of Palau and, with due regard to the amendments proposed by various Members, supported the draft resolution.

Mr SILBERSCHMIDT (Switzerland) said that Switzerland, like many other countries, gave clear priority to breastfeeding. Reaffirming that the text before the Committee represented a compromise, he urged all Members to give careful consideration to the advisability or otherwise of reopening the debate; it might not be possible again to find a compromise acceptable to all. Switzerland favoured approval of the draft resolution as proposed by the Board.

Mr PERDOMO (Bolivarian Republic of Venezuela) proposed that under paragraph 1 of the draft resolution Member States should also be urged to establish legal mechanisms enabling them to enforce the letter and spirit of the International Code of Marketing of Breast-milk Substitutes, including sanctions and preventive measures, so that action could be taken in response to the suspected presence of any pathogenic organism potentially jeopardizing the health of infants and young children. In paragraph 2, he suggested that there should be reference to more active participation by parents in the work of the Codex Alimentarius Commission and that precautionary strategies should be established and strengthened to guard against possible harm to the health of infants and young children, emphasizing the primacy of health over trade.

Dr MAMADOU-YAYA (Central African Republic) said that infant survival in his country continued to be threatened by a series of ills, including diarrhoeal diseases and malnutrition. Infant mortality was rising and 13% of neonates were underweight at birth. Encouraging progress had been made in promoting exclusive breastfeeding for the first six months of life and continued breastfeeding up to the age of two or beyond, thanks to the Baby-Friendly Hospital Initiative, and a draft law relating to the International Code of Marketing of Breast-milk Substitutes was currently under review, but further work was needed. Given the problems raised by breastfeeding in the context of HIV/AIDS, standards and guidelines were more necessary than ever in order to guarantee the quality and, above all, the safety of breast-milk substitutes on the market. He urged approval of the draft resolution.

Dr PHOYA (Malawi) aligned herself with other speakers who had proposed amendments to the draft resolution. While more data might be desirable in support of some of the amendments proposed, there could be no delaying while infants and children risked exposure to contaminated formula. Malawian supported and promoted exclusive breastfeeding, and most Malawian women did breastfeed. However, owing to the high prevalence of HIV/AIDS, mothers were being advised on infant feeding options to prevent mother-to-child transmission of HIV. Since some women therefore used infant formulas with the accompanying risk of contamination, Malawi supported the draft resolution as amended.

Dr BRUNET (France) said that, on two occasions in 2005, his country had been faced with outbreaks of serious illness caused by the contamination of breast-milk substitutes. The first had been due to *E. sakazakii* and the second to *S. agona*. His Government was therefore well aware of the importance of the issue and very anxious to arrive at the best possible solution.

After a lengthy debate at the 115th session of the Board, members had adopted resolution EB115.R12. The clear reference in the preamble of the draft resolution contained in that resolution to serious or even lethal risks associated with the possible intrinsic contamination of breast-milk substitutes was satisfactory, as was the strengthening of the text through a reference to the need to inform practitioners, parents and families about the fact that those products were not sterile. The resolution was important and every word of it was meaningful, but it would not change reality. What counted most was the political will to bring about the requisite changes in Member States, in agreement with industry and with the support of international organizations. It was vital to ensure that Codex Alimentarius Commission completed its work as soon as possible. At the same time, it was

necessary to step up efforts to improve preventive action and enhance the capacity for surveillance and rapid response. In that connection, the European Commission's surveillance network and WHO's international network of food safety authorities were to be commended on circulating warnings from the French authorities about the episode of *S. agona* infection. Although substantial progress had been made within WHO, much work still needed to be done in other settings. That was why the draft resolution should be adopted without delay.

Dr AGARWAL (India), recalling the debate on the draft resolution on infant and young child nutrition at the previous Health Assembly, explained that his country had introduced a statutory ban on health and nutrition claims regarding food for infants and young children. India had only one accepted formulation of low osmolarity oral rehydration salts, which was in line with that advocated by WHO and UNICEF. Detailed guidelines had been issued on infant and young child nutrition by the Government and a partnership had been formed with a view to reviving and improving exclusive breastfeeding rates. Moreover, legislation, which had entered into force at the beginning of 2004, prohibited all advertising of foods for babies under two years of age and banned any sponsorship of health-care systems by manufacturers of baby foods.

His Government appreciated the thrust of the draft resolution. The combined efforts of FAO, WHO and the Codex Alimentarius Commission to elaborate safety standards and guidelines on foods for infants and young children were crucial, but they should be participative and take into account evidence from developing countries. The basic aim of such standards should be to ensure that products were safe and properly labelled and that they met nutritional needs. At the same time, all the requisite steps must be taken to guard against the risk of microbiological contamination of powdered infant formula. The preamble should have drawn attention to the role of industry along the lines of paragraph 44 of the Global strategy for infant and young child feeding, which made it incumbent upon the industry to ensure that processed food products for infants and children complied with the applicable Codex Alimentarius standards and the Codex Code of Hygienic Practice for Foods for Infants and Children, as well as with national measures to give effect to them.¹

Dr SAÍDE (Mozambique) said that the issue of infant and young child nutrition was of great concern to his Government, particularly in view of the HIV/AIDS pandemic and the reported contamination of powdered infant formula. He therefore endorsed the comments of, and the amendments proposed by, the delegates of Palau, South Africa and Zimbabwe.

He recommended that the packaging of infant formula should be fully and correctly labelled and should not create the impression that those products were completely safe.

Dr DELAVAR (Islamic Republic of Iran) supported the draft resolution subject to some amendments. In subparagraph 1(2), the sentence should end with the words "young children". Subparagraph 1(3) should place more emphasis on breastfeeding, and be reworded: "to ensure that clinicians and other health-care providers, community health workers, families, parents and other caregivers, particularly of infants at high risk, are provided with enough information on breastfeeding and, in situations where infants are not breastfed, are trained in a timely manner on the preparation ...". The words "where applicable" in the last phrase of the subparagraph should be deleted.

Dr NYIKAL (Kenya) endorsed the views of the delegates of Palau, South Africa and Yemen. He supported the draft resolution but proposed that in subparagraph 3(2) the word "encourage" should be replaced with "initiate" and the word "promote" should be changed to "support", in order to strengthen the text by ensuring that a specific person took action on the matter.

¹ Document WHA55/2002/REC/1, Annex 2.

Dr CHANDRA (Fiji) said that the authorities in his country were committed to securing exclusive breastfeeding for the first six months of an infant's life through the Baby-Friendly Hospital Initiative. Some hospitals had already achieved that status. The Food Safety Act of Fiji provided for compliance with Codex Alimentarius standards. His country had adopted a code for the marketing of breast-milk substitutes, which was enhanced with provisions drawn from the United Nations Convention on the Rights of the Child, thereby ensuring that the Government honoured its legal obligation to implement the code. He therefore supported the amended draft resolution.

Dr HERMIYANTI (Indonesia) said that the practice in her country was exclusive breastfeeding for the first six months of a baby's life and continued breastfeeding up to the age of two years or beyond. In order to protect children, the Government had taken steps to ban the marketing of infant formula. The recent findings regarding *E. sakazakii* and other microorganisms in powdered infant formula would certainly give rise to worry everywhere, but particularly in developing countries. She strongly endorsed the draft resolution, as amended by Nepal.

Dr VIOLAKI-PARASKEVA (Greece) commented on the importance of the issue. Recalling the lengthy debates that had taken place at the Thirty-fourth World Health Assembly before the adoption of the International Code of Marketing of Breast-milk Substitutes, she called on all Member States to endorse the main ideas contained in the draft resolution without watering them down with amendments. Parents all over the world had the right to be informed about the intrinsic contamination of powdered infant formula, and WHO was to be commended for quickly passing on the recent alert. She supported the draft resolution.

Ms DE HOZ (Argentina) reported that a meeting had just been held in Buenos Aires on the implementation of the Global strategy for infant and young child feeding.

Warnings about *E. sakazakii* should be placed forthwith on the labels of powdered infant formula. Since leaving the matter up to the Codex Alimentarius Commission could result in protracted negotiations and a delay of up to seven years, it would be preferable for the current Health Assembly to issue instructions to the Commission on that subject.

In Argentina, the National Institute of Industrial Technology had developed the capacity to cultivate *E. sakazakii* and the Government was in a position rapidly to make application of such a procedure mandatory for manufacturers of infant food. Whereas it would be undesirable for the labels of products to encourage mothers to use a particular feed on the basis of claims that were not substantiated by scientific evidence, it would be advisable to avoid the conflicts of interests that might arise if manufacturers were to sponsor research related to infant feeding.

Dr CHITUWO (Zambia) explained that his country had embraced the slogan "Make every mother and child count". For that reason, it endorsed the statements made by the delegates of Ghana, South Africa, Yemen and Zimbabwe. The lives of infants who for various reasons did not have the chance to be breastfed must be protected. It was the responsibility of the Committee to meet that challenge. Surely with modern technology it was possible to label breast-milk substitutes with information about product sterility, among other things.

He supported the draft resolution, subject to the amendments proposed.

Dr MUKELABAI (UNICEF) said that UNICEF was fully committed to providing support to countries to put the recommendations contained in the draft resolution into practice in order to ensure the adequate growth and development of all children. UNICEF had helped many countries to implement the Global strategy on infant and young child feeding, because breastfeeding and appropriate complementary feeding could not be overemphasized as a means of maintaining proper nutrition of infants and young children. Malnutrition was one of the main underlying causes of half the deaths of children under the age of five. UNICEF hoped that the resolution would represent an adequate response to the genuine concerns of developing countries, where child malnutrition and under-five mortality were highest. It therefore supported the approval of the draft resolution.

Ms ARENDT LEHNERS (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, said that her Association had officially endorsed the Global strategy for infant and young child feeding and distributed nearly 5000 copies to members and other relevant organizations, which it had urged also to endorse the strategy. Governments should be encouraged to define national goals and objectives regarding breastfeeding within a realistic timeframe, and to measure outcomes. Improvement of breastfeeding and complementary feeding practices, as defined in the global strategy, could prevent a substantial proportion of mortality in infants under five years of age, thus contributing to the attainment of the Millennium Development Goals.

Experts, including lactation consultants, from all the Member States of the European Union, had drawn up a Blueprint for Action to protect, promote and support breastfeeding, which had been made available on the European Commission's web site. That was a step in the right direction, as was the development of specific national action plans by some countries.

The Health Assembly was urged to adopt a strong resolution covering all the items contained in the original proposal submitted to the previous Health Assembly and taking account of the amendments just proposed. Nutrition and health claims should not be allowed. An additional resolution was needed to deal with the question of *Enterobacter* contamination of powdered infant formula. The labels affixed to such products should provide full information for parents, including the fact that powdered infant formula was not sterile.

Organizations should follow the example of her Association and refuse sponsorship by manufacturers and distributors of infant formula. More research on infant health and nutrition was needed, but as such research provided the basis for public health policies that too should be free from commercial influence in order to avoid any conflict of interest.

Ms MALONE (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, said that the industries' priority was to provide products that represented a safe feeding alternative for infants and young children, including those with special dietary problems. She shared the concerns of the international health community about the potential impact of microorganisms in food products. The matter could be effectively managed by taking into account the scientific evidence to date, principles of food safety management and WHO's policy. She welcomed the work of the Codex Committee on Food Hygiene on revision of the code of practice for foods for infants and children, and agreed on the need, expressed by the Codex Committee, for the joint FAO/WHO expert consultations to do further risk assessment work on the microbiological risk of *E. sakazakii* and other microorganisms in powdered infant formula.

She encouraged Member States to consider the following facts: powdered infant formula met the composition, hygiene and labelling criteria established by national legislation or Codex standards; formula was inherently safe when handled, prepared and used in accordance with the manufacturer's instructions; instances of *E. sakazakii* contamination were rare and, in most cases, occurred in neonatal intensive care units; and a risk of infection arose when reconstituted formula was kept outside the refrigerator for prolonged periods of time. The provision of information and education about proper handling of foods was consistent with underlying food safety management principles and health policies advocated by WHO. Clinicians, other health-care providers and community workers, in particular those responsible for the care of infants at high risk, should always be provided with appropriate and clearly understood information on packages and should receive training on the proper handling, preparation and use of powdered infant formula. To avoid potential risk from inappropriate preparation, manufacturers provided "a clear, conspicuous and easily readable and understandable message" to consumers that included "instructions for appropriate preparation, and a warning against the health hazards of inappropriate preparation" as called for by Article 9 of the International Code of Marketing of Breast-milk Substitutes. The provisions of Article 1 of that Code clearly stated the Code's aim, to be achieved inter alia "by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information...". Governments should have the flexibility to formulate and implement national measures in line with the Global strategy on infant and young child feeding, in order to create an environment that would enable mothers, families and other

caregivers to make and implement informed choices about optimal feeding practices for infants and young children.

Mr NIKIEMA (Consumers International), speaking at the invitation of the CHAIRMAN and also on behalf of the International Baby Food Action Network, highlighted the potential of the draft resolution to contribute to furthering the right of children to attain the highest possible standard of health. A strong resolution should be adopted, on the basis of evidence rather than politics, to help achieve the Millennium Development Goal of reducing under-five mortality.

A decision by the Health Assembly that sponsorship of health professionals and institutions by the infant food industry was unacceptable would contribute to increasing public trust, as would a call to ensure that only independently funded and reviewed research should form the basis for public health policies. The Health Assembly should further insist that infant food manufacturers adhered to their stipulated roles under the Global strategy for infant and young child feeding, but its endorsement of the placement of health and nutritional claims on foods for infants and young children would jeopardize the spirit of political coherence that it had been striving to uphold. On the other hand, endorsing the recommendation to place information on product labels regarding the non-sterile nature of powdered infant formula and about the potential risks of formula feeding would contribute greatly to fulfilling the rights of parents to receive full and accurate information. Delaying a decision by waiting for the Codex Alimentarius Commission to finish its work would mean denying babies and parents their right to protection. The draft resolution did not seek to ban infant formula, but rather to protect the rights and health of consumers.

Ms ARENDT LEHNERS (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, presented a statement on behalf of La Leche League International. Breastfeeding was the cornerstone of lifelong good health and provided an equal start for male and female infants. In an age of technological advance, such a low-cost, simple and effective source of nourishment, which was independent of social status, should not be overlooked. The health benefits of breastfeeding also extended to mothers, reducing the risk of postpartum haemorrhage, breast, endometrial and ovarian cancers, and osteoporosis. Breastfeeding empowered women by giving them the ability to act and the right to do so. An environment that supported breastfeeding was one that ensured the right of women to be enabled to make informed choices, to have legal protection and social support for breastfeeding in public and at work, and to have access to skilled counselling and sympathetic support. It was a global responsibility to create such an environment.

Despite the advantages, less than 35% of all infants were exclusively breastfed, even for the first four months of life. Inappropriate marketing of breast-milk substitutes and a general lack of appreciation of the economic value of breastfeeding contributed to keeping the proportion low. Breast-milk substitutes could significantly compromise the health and well-being of mothers and children, especially given that current powdered infant formula was not sterile and could occasionally contain pathogens. Such challenges reinforced the call for action as set out in the Global strategy for infant and young child feeding.

The League had long been committed to the promotion of breastfeeding and possessed one of the world's largest collections of materials on the subject. The strength of its approach lay in mother-to-mother support – breastfeeding, although natural, was a behaviour best learnt by watching other mothers.

Mr ABDEL WAHAB (Yemen) pointed out that there was evidence that children had become infected with *E. sakazakii* after being fed with formula prepared from previously unopened packages of powdered infant formula and that the pathogen had been shown to be present within powdered formula manufacturing facilities. Infection with *E. sakazakii* might well be rare, but it was still causing unnecessary deaths and it was possible that not all such deaths were recorded. It was difficult to confirm or deny much of the reported information. There was a need to strengthen surveillance and control mechanisms to gain a clearer understanding of the situation. While the Codex Alimentarius

Commission was playing an important role in such work, it was slow in reaching decisions and immediate action was needed to protect babies and infants.

Dr LEITNER (Assistant Director-General) said that the subject of the draft resolution was complex and straddled two different areas of work, nutrition and food safety. It was therefore sometimes difficult to delineate responsibilities for the protection of infants and young children. The task was clearly a burden to be shared.

Breastfeeding was the best way to nourish infants and young children but where use of breast-milk substitutes was unavoidable, it was vital to ensure that they were safe and that procedures for handling, preparation and use were also without risks to health. While specific country situations must be taken into consideration, there was also a common interest in being rapidly alerted in cases of known contamination of products. WHO and FAO had therefore initiated the international food safety authorities network (INFOSAN) and a food safety emergency network (INFOSAN Emergency), to permit the rapid sharing of information and best practices. It was important to continue to seek expert advice and to take account of the recommendations of national and international standard-setting bodies, including Codex Alimentarius. There should also be a stronger link between the various parties concerned, including public health systems, health-care personnel and infant formula manufacturers, to ensure that information reached those who needed it. Product labelling was only one source of such information; there were many others that also required strengthening, and work in that area would clarify which were the best vehicles for providing timely and accurate information.

The threat to infants and young children was real. Approval of the draft resolution would permit immediate and effective action while work continued to assess the situation.

The CHAIRMAN suggested that further discussion of the item should be postponed until a revised text of the draft resolution, incorporating the various amendments proposed, had been circulated. He further suggested that an informal working group of interested delegations should meet to consider the revised text.

It was so agreed.

(For approval of the draft resolution, see summary record of the fourteenth meeting, section 2.)

The meeting rose at 13:15.

TENTH MEETING

Monday, 23 May 2005, at 10:15

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)

1. FIFTH REPORT OF COMMITTEE A (Document A58/57)

Dr BUSUTTIL (Malta), Rapporteur, read out the draft fifth report of Committee A.

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Social health insurance: Item 13.16 of the Agenda (Resolution EB115.R13; Document A58/20)

Mr GUNNARSSON (Iceland, Representative of the Executive Board), introducing the item, said that a report on social health insurance had been considered at the 114th session of the Executive Board. After long discussions, the Board had requested the preparation of a broader background paper on health financing and a draft resolution for consideration at its 115th session. At that session, the Board had recognized the objective of universal coverage, and emphasized the importance of health financing policies to its achievement. Numerous modifications had been proposed to the draft resolution, including the changing of its title to “Sustainable health financing, universal coverage and social health insurance” to reflect the wider mandate. In adopting resolution EB115.R13, the Board had recommended a draft resolution to the Health Assembly.

Dr SUPACHAI KUNARATANAPRUK (Thailand) speaking on behalf of Member States of the South-East Asia Region, said that, as Target 1 of the Millennium Development Goals was to reduce by half the proportion of people living on less than US\$ 1 a day by 2015, the most important related health policy goal was to provide financial protection from impoverishment resulting from medical expenditures. The health sector could play a major role by ensuring financial protection for the poor and the poorest from user fees through free and adequate access to public health services. A national strategic plan, in the short term to protect the poor and in the long term to achieve universal coverage, would be needed. Sustainable financing was a major concern to all countries. The national health account was a useful tool for monitoring the magnitude and profile of health expenditure from relevant sources and its development should be supported by WHO. The long-term financial projection of total needs and the resource availability was important for the identification of shortfalls and the resources that needed to be mobilized to fill the gaps and ensure financial sustainability. The Region’s Member States fully supported the draft resolution but proposed that the second preambular paragraph should be expanded to read: “Noting with concern that health-financing systems in most developing countries mostly rely on household out-of-pocket payments that can be catastrophic and impoverish households especially poor ones, and need to be further developed ...”. A new subparagraph 1(1) should be added to read “to formulate and reach consensus, in consultations with all partners, on a national strategic

¹ See page 354.

plan taking into account long-term financial stability, to achieve universal coverage and to focus policy priority on financial protection for the poor against catastrophic payments and impoverishment, in order to accelerate achievement of Millennium Development Goal 1". In subparagraph 1(2), the words "the insurees" should be replaced by "all citizens"; in subparagraph 2(1), the words "in coordination with United Nations agencies and other relevant partners" should be inserted after "Member States"; the last part of subparagraph 2(3) should be amended to read "... and lessons learnt on universal coverage including social health insurance and other prepayment methods;" and a new subparagraph 2(6) should be added that would read: "to report every three years, until 2015, to the Health Assembly on progress towards achievement of universal coverage."

Dr WINT (Jamaica), speaking on behalf of the Member States of the Caribbean Community, endorsed the goal of achieving universal coverage for basic health services through sustainable financing, with special emphasis on social health insurance, and in particular the reference in the report (paragraph 8) to serious gaps in the financing of health services. As the report made clear, there was a need to generate sufficient resources, ensure greater efficiency in spending, and contain costs. Although it was the government's responsibility to ensure social health protection, each country had to customize its own solution. To that end, member countries were reviewing the current use of financing mechanisms, which were tending towards universal coverage and social health insurance. The most common mechanism was tax revenue with or without co-payment, but co-payment schemes raised the question of means testing to identify those who should be payment-exempt. Certain countries needed assistance to obtain information on the real cost of providing services. Another mechanism was modest growth of private health insurance (as in Jamaica, for example). A third was targeted social insurance to support vulnerable groups. Jamaica had recently implemented a national health fund financed by a combination of tax on tobacco products, a modest payroll tax and a government contribution in order to provide direct assistance through a medicines-benefit scheme to all individuals suffering from 15 chronic noncommunicable conditions, institutional support to the health-delivery system and priority programmes such as health promotion. A fourth mechanism was purchase of private services by the government on behalf of poor members of the population. Another mechanism was external inflows including voluntary donations. He supported the draft resolution with the amendments proposed by the delegate of Thailand.

Dr IWASAKI (Japan) supported the draft resolution. Japan provided health insurance for all its citizens, with free access to any health-care facility. For more than 40 years, efforts had focused on maintaining universal coverage and improving quality of care. In the past, advances in medical technology and an ageing population had forced changes in the health insurance system and, for sustainability, Japan was seeking to create an economically-balanced universal system. A major concern was the rapid increase of health expenditure. According to OECD data, total health expenditure in comparison with the gross domestic product was not much higher in Japan than in other countries but health expenditure was increasing faster than national income. The current challenge was to harmonize the health insurance system with the overall economy while maintaining the quality of the health service. Japan supported WHO's policy of sharing experience in that field.

Dr NYIKAL (Kenya), speaking on behalf of the Member States of the African Region, said that more than 25 years previously all the Region's countries had committed themselves to the Declaration of Alma-Ata which had set primary health care as the strategy for the realization of affordable good-quality health care. Although many countries had been unable to meet that target of health for all by the year 2000, all remained committed to universal protection and the promotion of health. The primary health-care pathway remained relevant, subject to political commitment and adequate financing, but contained many obstacles, largely due to poverty: large informal sectors, limited administrative, managerial and institutional capacities; low quality of care, especially in public health facilities; the need to build consensus among stakeholders; weak solidarity, weak government stewardship; and a dearth of relevant data. However, with the backing of the people, the political and

financial commitment of governments, and sustained support by health development partners, such obstacles could be overcome. Accumulated evidence clearly indicated that disparities in the quality of health care available to the different income groups had widened, partly due to impoverishing out-of-pocket payments. In many African countries health care was still financed largely, sometimes up to 65%, by out-of-pocket payments. The only way to ensure universal protection from catastrophic health-care expenditures, therefore, was some form of prepaid financing mechanism, without which sustained access, especially for the vulnerable and poor, could not be guaranteed and the chances of achieving the Millennium Development Goals, health for all and the Abuja targets would be dismal.

Reliance on general tax to fund national health services was an unsustainable option for most countries of the Region. Social health insurance appealed because it pooled health risks and contributions of households, business and government to provide a uniform benefit package of care for all the insured. Even within that option, however, governments would need to contribute to social health insurance funds on behalf of citizens unable to pay as well as its own employees. Since it had taken developed countries some 70 years to attain universal coverage, African countries should not be discouraged but should set out towards that goal at once, starting from a mix of financing mechanisms – user fees, community-based mechanisms, insurance coverage for specific groups, limited tax-based contributions and external financing – to social health insurance and other government-supported schemes. The specific form of universal coverage in each individual country would depend on its history, culture, level of solidarity, administrative, managerial, legal and institutional capacities, and prevailing economic and political situation, and would need to be tailored to particular needs and circumstances. Some countries might opt for a single scheme; others might choose several schemes under a common regulation. Each country would also have to decide on the pace of transition. All, however, were agreed that the transition process would need to incorporate stronger safety nets – exemption and waiver mechanisms within the existing health-financing system – to ensure that vulnerable groups, especially the poor, had adequate access to health care.

The draft resolution required some amendment. A new preambular paragraph was needed, possibly at the beginning, that would read: “Noting that for the last 25 years the world has been committed to universal access to affordable-quality health care as stated in the Alma-Ata Declaration of 1978”. In addition, three new subparagraphs should be added to paragraph 1 that would read:

- to strengthen safety nets, such as exemption and waiver mechanisms, within the existing health-financing system so as to ensure adequate access to health care for the poor while making preparations for transition to universal coverage for all citizens;

- to ensure that social health insurance is developed within an explicit and comprehensive health-financing policy and strategic plan; and

- to ensure that all the relevant government ministries and other main stakeholders are adequately involved in the whole process of feasibility analysis and planning, designing, implementing and evaluating social health insurance.

In subparagraph 2(2) the words “and the International Monetary Fund” should be added immediately after “the World Bank”, and a new subparagraph should be added to paragraph 2 that would read: “to study the impact of macroeconomic policies of international financial institutions on efforts to increase access to health services and to report its findings to the Fifty-ninth World Health Assembly.”

Professor TLOU (Botswana) endorsed the draft resolution with the amendments proposed by the delegate of Kenya. In Botswana, the government was the main provider of health-care services through general taxation. A system of user fees, introduced in 1973-74, currently made an insignificant contribution to expenditure within the health service. Government health expenditure had risen sharply, on the other hand, even allowing for significant donor contributions towards HIV/AIDS services. The report provided valuable information on alternative health-care financing systems that could give protection against financial risk while guaranteeing affordable access to necessary services. Recognizing the need to sustain its health-care system within a cost-recovery policy framework, the Ministry of Health had consulted various stakeholders on health-financing reform initiatives. Issues

raised included viable alternatives to the present system, equity, access, efficiency and sustainability in the context of existing levels of poverty and unemployment, and revenue-generating potential. To obtain the required data, Botswana had launched, with the support of WHO, a national health accounts project in 2004, which was currently at the data analysis stage. Botswana looked forward to further support from partners as it studied options open to it, and in identifying and developing the necessary capacity in the insurance, financial and health administration sectors to assist in the management and implementation of such systems and the development of the necessary regulatory framework.

Mr BAILÓN (Mexico) commended the report, which identified the main points that must be addressed by a financing reform aimed at reducing out-of-pocket expenditures and thus the number of families facing catastrophic health-care costs. In 2002, Mexico had initiated a popular health insurance scheme based on the principle of solidarity in health financing. The scheme included shared responsibility according to the capacity to pay of unwaged families, who accounted for half Mexico's population (some 50 million people). By the end of 2006, a little over 23% of the total population, or half the number of families who, in 2000, had had no health coverage, would have health insurance under the scheme. Universal coverage would be achieved by 2010 when the scheme was fully in place.

In keeping with the recommendations in the report, health-financing reform in Mexico had been so designed as to include incentives for disease prevention and high-quality medical care, as well as a guarantee of financial sustainability when establishing the new scheme in law and modifying the operation of the public health services, by promoting innovative mechanisms for the financing of services and competition between providers. He supported the draft resolution and urged Member States to continue to share their experiences of working with that type of scheme.

Dr LARUELLE (Belgium) remarked that social health insurance in Belgium was based on solidarity and sought to provide universal coverage. Although the financial costs and challenges were significant, in particular given the ageing population and the high standard of care, the overall benefits were obvious, and it remained one of the pillars of Belgian society and of Government action. The development of sound mechanisms of social health insurance and increase in coverage were long-term objectives and required a long-term commitment by Member States and the Secretariat.

He proposed several amendments to the draft resolution. In subparagraph 1(1), "include a method of prepayment of financial contributions for health care" should be replaced by "include one or more methods of prepayment of financial contributions for health care, according to the ability to pay". In subparagraph 1(2), "insurees will receive" should be replaced by "individuals will have access to". The words "and that are coherent with the functioning of the national health system" should be added at the end of subparagraph 1(3), and a new sentence that would read "This may imply the articulation of different systems of social protection in health" should be added at the end of subparagraph 1(5). In subparagraph 1(6), "and civil society actors" should be added after "health-financing organizations".

Mr VOIGTLÄNDER (Germany) commended the report and supported the draft resolution. Social health insurance and tax-funded health systems must be seen in the wider context of universal coverage and health financing. Through technical cooperation Germany supported its partner countries in developing solidarity-based systems with prepayment of financial contributions for the health sector, in order to spread the risks of ill health across the population and reduce the large number of people forced into poverty every year by out-of-pocket payments. The choice of financing mechanisms must take into account a country's cultural, historical and political situation.

The momentum to accelerate the progress towards the health targets of the Millennium Development Goals and the fact that many countries were unlikely to attain those goals were focusing renewed attention on health systems. Although effective and affordable interventions existed to reduce much of the disease burden and increased funding was available for some types of intervention, weak health systems were a constraint to delivery. The challenge was to determine how best to make health systems work in low-income countries. Germany therefore welcomed the Global Health Initiative on

health systems, which, it hoped, would indeed become a global collaboration between relevant national, international and nongovernmental organizations, Member States and donors.

Member States that decided to develop a social health insurance system should receive the best technical support possible. German Technical Cooperation was collaborating with ILO and WHO in that regard, making every effort to redefine responsibilities in line with the different roles of each organization at all levels. Germany urged the Secretariat to meet the increasing demands for technical support in the development of social health insurance systems.

Mr ABDOO (United States of America) endorsed the goal of comprehensive health insurance. All Member States would benefit from a robust discussion of how to strengthen health-care coverage. It would be useful for the Secretariat to provide a report on the various possibilities for achieving universal coverage, including market-based approaches. Member States and the Secretariat should give due consideration to the benefits of a private system that could focus direct government resources where they were most needed. Those benefits included individual choice, reduction in tax burdens, flexibility, innovation and efficiency. Subsidies to purchase private insurance could achieve equity in a private system. Further, government systems had several disadvantages: greater bureaucracy, higher taxation, long waiting times, rationing of care and less efficiency, thereby decreasing access to and quality of health care; they were also difficult to sustain in the face of growing demand, ageing populations and increasing costs. Countries required competitive financing and delivery systems that were responsive to health-care needs and made the most of advances in medical science and technology. Member States would therefore be best served by the provision of data on the broadest possible range of options, private and public systems and mixes of the two, that would expand coverage and minimize out-of-pocket payments while achieving efficiency, transparency and sustainability and be adaptable to meet their specific political, socioeconomic and health situation. The public and private sectors both had critical roles to play.

The United States could accept the draft resolution.

Mr SAMO (Federated States of Micronesia) expressed appreciation for the Secretariat's work with Member States in the Western Pacific Region to develop sustainable health-financing systems, universal coverage of health-care services and social health insurance. Those efforts should be accelerated. He supported the draft resolution and urged other Member States to do likewise.

Mrs REID (United Kingdom of Great Britain and Northern Ireland) welcomed the emphasis in the draft resolution on universal coverage of basic health services through a system of financing that avoided fees for services and the exposure of sick people to risk of financial catastrophe, and focused on prepayment and risk-pooling. The resolution should not show any bias towards one particular health-financing system; solutions must be found to correspond with each country's particular needs, and should be country-led. She therefore proposed that the words, "social health insurance" should be deleted from the title; in subparagraph 1(2) "insurees" should be replaced by "users"; in subparagraph 1(7), "general taxation" should be inserted before "social health insurance schemes"; in subparagraph 2(1), "particularly prepayment schemes, including social health insurance" should be replaced by "which minimize fee-for-service and exposure of users to catastrophic financial risk"; and in subparagraph 2(3) "social health insurance" should be replaced by "health-financing systems".

Dr REN Minghui (China) said that in 1998 China had established a basic social health insurance system that was gradually being expanded with the aim of achieving universal coverage for all those living in rural areas by 2010. The implementation of such systems in developing countries faced serious challenges, including the provision of medicines and other supplies. Universal coverage was a long-term goal and must take into account specific country differences, for example, in income levels and culture. Health financing should be strengthened to improve the balance between income and expenditure. Coverage, technology and the standard of care should be improved gradually, in line with economic development. Management capacity should be enhanced to ensure sound social health

insurance surveillance and appropriate early warning systems. The Secretariat should intensify its support to Member States in those areas, in particular in respect of exchange of information and transfer of technology. China supported the draft resolution.

Dr OPIO (Uganda) said that Uganda's strategic health plan called for a per capita annual expenditure of US\$ 28, whereas actual expenditure, jointly funded by the Government, donors and out-of-pocket payments by users, was only US\$ 18. The funding gap had had a negative impact on health indicators, such as infant mortality, maternal mortality and mortality in children under five years of age, and on the quality of health-care services. The Government had been exploring different financing options. A study commissioned in 2001 to determine the feasibility of introducing social health insurance had shown it to be a viable option that would provide a stable source of revenue for the health sector, allow for a more equitable distribution of financial burdens in accordance with the ability to pay, and provide an instrument for increasing efficiency in the provision of health-care services and in improving their quality. It could also free general revenue currently used in providing care for households in the middle- and upper-middle income levels, permitting reallocation of funds for public health and for subsidizing those with lower incomes. A Cabinet memorandum on social health insurance had been disseminated with a view to reaching consensus among all stakeholders. Uganda supported the draft resolution with the amendments proposed by the delegates of Kenya and the United Kingdom.

Dr CHETTY (South Africa) said that South Africa was currently examining social health insurance options and endorsed the objectives of equity in access and financing. People should be able to access health-care services when they needed them, irrespective of their ability to pay, and households should be able to contribute according to their ability to pay and be protected from financial risk when accessing health services. She supported the draft resolution with the amendments proposed by the delegate of Kenya, in particular the calls in subparagraph 1(5) for pragmatism in the face of dynamic socioeconomic change and in subparagraph 1(6) for governments to exercise stewardship of health-financing reforms.

Mr ASPLUND (Sweden) supported the draft resolution. Given the vital role of medicines in ensuring health services of good quality, he suggested that subparagraph 1(2) should be amended by inserting "including medicines" after "good-quality health services".

Dr CAREY (Bahamas) said that, like other countries, Bahamas had recognized that the current system of health financing was inadequate to ensure the provision of equitable health services of acceptable quality. The rising cost of health care and the move towards universal coverage had necessitated a review of the current system, under which public hospitals and community clinics provided services free of charge on delivery that were financed from a general fund. On assuming office in 2002, the Government had initiated a study on the feasibility of introducing social health insurance as the basis of future health financing. Devising an appropriate plan for the introduction of such a scheme had proved complicated, however. The requirements were that all those employed in the formal and informal sectors should make a financial contribution and that the scheme should achieve universal coverage. The relatively high average income meant that the private health insurance sector was strong, covering around 50% of the population. In addition, comprehensive medical services were available in the country so that expectations regarding the services to be offered under social health insurance were high. Bahamas welcomed the guidance provided in the report, appreciated the technical support provided by PAHO in the area under discussion, and supported the draft resolution.

Dr VIOLAKI-PARASKEVA (Greece) said that the range of options for health financing should include public and private systems and mixes of the two, so that countries could make a choice in accordance with their political and socioeconomic circumstances. The key to achieving the goal of

health for all lay in finding financing mechanisms that would permit the population in every country to have equitable access to an acceptable standard of health-care services. Greece therefore supported the draft resolution but proposed that it should be amended by addition of a new preambular paragraph to read "Having considered that the whole population in every country has the right to equitable access to an acceptable standard of care in order to achieve the goal of health for all".

Dr AL DARMAKI (United Arab Emirates) said that his country had taken several steps to implement social health insurance, taking into account the lessons learnt by other countries. Draft legislation to make social health insurance compulsory was currently under review. The public and private sectors would be involved and the aim was to permit sufficient flexibility to facilitate implementation on an equitable basis by the competent authorities. A department had been established within the health ministry of Abu Dhabi to ensure that implementation was of the highest possible standard. The pilot project there would subsequently be expanded to the other Emirates. He supported the draft resolution and endorsed the comments made by the delegates of Belgium and the United States.

Dr MENDOZA (Bolivarian Republic of Venezuela) said that in the 1960s the Constitution required the country's health system to provide health care for those unable to pay for it. The result had been an unbalanced system that gave priority to medical treatment, ignored disease prevention and health promotion, and excluded part of the population from health services. It had also resulted in privatization of the health sector. The 1999 Constitution had established the principle of free, universal health care, resulting in the creation of a single public health system which removed all inequalities. He therefore supported the amendments proposed by the delegate of the United Kingdom to the title of the resolution and to subparagraph 1(2), so that all citizens, not only those covered by an insurance scheme, would receive health services. Public health problems were the responsibility of the State, and it was not appropriate to leave them to be resolved through private solutions.

Dr ZAHER (Egypt), welcoming the report, said that, for the past four years, her country's health ministry had been seeking the best way of providing financially sustainable comprehensive coverage with high-quality health care. The present social health insurance system covered only half the population. She supported the draft resolution but suggested that the Director-General should be further requested to support research on actuarial and costing methods and financing systems, support the sharing of experience in health insurance and support institutional capacity building by funding twinning programmes.

Dr PARIRENYATWA (Zimbabwe) welcomed the discussion of sustainable financing of universal health-care coverage. He endorsed the amendments proposed by the delegates of Kenya and the United Kingdom. In African and developing countries, the financing of health systems posed considerable challenges. In Zimbabwe, 12% of the total budget was allocated to health, and there was a clear policy on user fees, providing exemptions for children under five, mothers attending district hospitals during pregnancy, at delivery and during six weeks after delivery, and all persons over 65 undergoing treatment in public hospitals who were not privately insured. Emergency treatment was available for all in both public and private hospitals, the question of payment being raised only when the patient's condition had stabilized. Universal coverage would be desirable, because only 10% of the population had private health insurance; everyone else had to be paid for, either from their own pockets or by the Government. A universal health insurance scheme could be funded through either voluntary or compulsory contributions. In working towards such a scheme, Zimbabwe would welcome actuarial assistance from WHO.

Dr RUBIANA (Indonesia) said that her country was experiencing a rise in health-service costs. For the past three decades, it had been endeavouring to establish a social insurance system, which had started with Government employees and had subsequently been expanded to take in large private

companies. Finally, in 2004, a national health insurance law had been introduced to cover the entire population. Unfortunately, the numbers covered by the health insurance scheme were still low, comprising only 30% of the population. In the informal sector, which employed about 70% of the population, people tended to be unaware of the scheme, which made it difficult to implement. She therefore recommended that subparagraph 1(7) of the draft resolution should include mention of organizing the informal sector within a social health insurance system. As health insurance schemes tended to emphasize treatment rather than health promotion and disease prevention, she recommended the specific inclusion of those aspects in the health services in subparagraph 1(2).

Ms SICARD (France) said that health-financing systems had still to be developed in many countries, to enable their populations to enjoy access to health care and protection from financial risk. There were no ready-made solutions that could be transposed from one country to another, and every financing system must take account of local situations, including the respective roles of the public and private sectors. The quality of wholly public systems often left something to be desired, whereas entirely private systems tended to restrict access to health care, as recent studies by the OECD had shown. The French system was mixed, some costs being covered by the public scheme and the portion charged to patients often being covered by private insurance. The health reform of 2000 had introduced universal coverage while leaving the existing systems intact; nobody who had been resident on French territory for more than three months was without health insurance. She supported the draft resolution, emphasizing that expenditure on health should be regarded as a source of wealth.

Dr ASSI GBONON (Côte d'Ivoire) said that, in her country, the present social insurance system covered only 15% of the population. Of the rest, 33% lived below the poverty threshold and 12% in extreme poverty. Reform was under way, and a law passed in 2001 had established a national social security system, the chief element of which was universal health insurance; its aims were to reduce disparities, to improve access by easing the financial burden on individuals, and to enhance national solidarity. Priority had been given to the agricultural sector, in which a pilot experiment had been carried out. The health financing systems in many developing countries were in need of reform to guarantee better access. Technical support for capacity building was especially important, and she therefore welcomed the draft resolution, with the amendments proposed by the delegate of Kenya.

Dr RAHANTANIRINA (Madagascar) said that her Government aimed to improve access to high-quality health services, on the basis of equity and according to the principle of community involvement. The State health budget was complemented by a scheme for financial participation by users, which ensured the availability of essential medicines in health centres and improved the quality of services. Part of the cost recovery went towards an "equity fund", which was used to finance services for the poor in basic health centres. Complementary health insurance schemes had been set up at the community level in some health districts, with the support of partners, to enable the rural population to receive health services at all times. Health insurance based on social security was not yet a part of the health system, even though the private sector favoured that mechanism. Universal coverage had not yet been achieved, although most of the population did enjoy access to health care. The chief remaining problem was coverage of the high cost of specialist hospital treatment. She supported the draft resolution as amended by the delegates of Kenya and the United Kingdom.

Dr AHMED (Pakistan) recalled that the highest attainable standard of health was the right of every citizen. That implied universal access to high-quality health care, but the amount of resources required posed a tough challenge to developing countries. No single system could provide the solution for all countries, as their economies differed so widely; it was therefore important to have alternative options for health financing. He supported the draft resolution, emphasizing that many developing countries needed more financial and technical assistance to enable them to create sustainable health financing systems to ensure universal access.

Dr MATHESON (New Zealand) said that the central issue was equity of access to health services, regardless of the method used. In *The world health report 2000*, the top ranking for equity in financing had been given to countries with proportional systems of funding.¹ Under New Zealand's progressive tax system, persons with high incomes made a proportionately greater contribution than those with low incomes. It would be inequitable for low-income earners to be denied access to health care because the user charges were too high. He asked whether the Secretariat's current understanding of the concept of equity differed from that in *The world health report 2000*. He supported the draft resolution, as amended by the delegate of the United Kingdom.

Dr DAYRIT (Philippines) welcomed the report, the draft resolution and the amendments proposed. In the past three years, his Government had given priority to efforts to achieve universal health coverage, by setting up the Philippines Health Insurance Corporation. That initiative had more than doubled the proportion of the population covered by social insurance, from 30% to 75%, largely owing to the large-scale enrolment of indigents. Nevertheless, it was a continuing challenge to maintain the level of annual social insurance necessary to cover those unable to pay. By law, local and national government authorities had to pay for the health care of indigents, but local governments were increasingly reluctant to do so in the face of other pressing priorities such as road and bridge construction. The Corporation was looking at other innovative ways of maintaining insurance premiums, including sponsorship by private companies and vote-seeking Congressmen and extrabudgetary contributions from central government. He would welcome the continued sharing of information about sustainable health financing among Member States and with the Secretariat.

Dr UPUNDA (United Republic of Tanzania) supported the draft resolution, which sought to ensure that the ownership of health services rested with the people. He welcomed the efforts of WHO and its partners to ensure that health systems provided equitable access.

Dr EVANS (Assistant Director-General), replying to comments, recalled that resolution EB115.R13 had originated almost two years previously as a request for a working paper on social health insurance. From the outset, the priority had been to ensure universal access to health care by whatever means possible, following principles relating to pooling and prepayment. Responding to the question from New Zealand regarding the definition of equity, he said that the focus was on all people in need of health-care services and not just those that already had access to them. It was clear that the burden of direct and indirect costs of health services could endanger people's financial well-being or indeed propel them into poverty.

The CHAIRMAN suggested that a revised version of the draft resolution, incorporating the amendments proposed, should be prepared for consideration by the Committee at a later stage.

It was so agreed.

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

¹ *The world health report 2000. Health systems: improving performance*. Geneva, World Health Organization, 2000.

Antimicrobial resistance: a threat to global health security: Item 13.10 of the Agenda (Resolution EB115.R6; Document A58/14) (continued from the ninth meeting, section 2)

The CHAIRMAN drew attention to the following revision of the draft resolution contained in resolution EB115.R6, which incorporated amendments proposed by the delegations of China, Cuba, Kuwait, Palau, Thailand and the Bolivarian Republic of Venezuela, and which would be considered by a working group:

Containment of antimicrobial resistance [China]/Antimicrobial resistance: the need to address such resistance ~~a threat to global security~~ [Cuba]

The Fifty-eighth World Health Assembly,

Having considered the report on rational use of medicines by prescribers and patients;

Acknowledging that the containment of antimicrobial resistance is a prerequisite for attaining several of the internationally agreed health-related goals contained in the United Nations Millennium Declaration;

Recalling the recommendations of the Second International Conference on Improving Use of Medicines (Chiang Mai, Thailand, 2004);

Recalling also the findings of WHO's report on "Priority medicines for Europe and the world",¹ and the Copenhagen Recommendation from the European Union conference on "The Microbial Threat" (Copenhagen, 1998);

Aware that the spread of antimicrobial resistance recognizes no national boundaries and has reached proportions that require urgent action at national, regional and global levels, especially in view of the decreasing development of new antimicrobial agents;

Recalling previous resolutions WHA39.27 and WHA47.13 on the rational use of drugs, WHA51.17 on antimicrobial resistance, and WHA54.14 on global health security;

Recognizing the efforts of WHO in collaboration with governments, universities, the private sector and nongovernmental organizations to contain antimicrobial resistance, thereby contributing to prevention of the spread of infectious diseases;

Noting that, despite some progress, the strategy for containment of antimicrobial resistance has not been widely implemented;²

Wishing to intensify efforts to contain antimicrobial resistance and to promote rational use of antimicrobial agents by providers and consumers in order to improve global health security;

Re-emphasizing the need for a coherent, comprehensive and integrated national approach to promoting the containment of antimicrobial resistance;

Convinced that it is time for governments, the health professions, civil society, the private sector and the international community to reaffirm their commitment to ensuring that sufficient investment is made to contain antimicrobial resistance,

1. URGES Member States:

(1) to ensure the development of a coherent, comprehensive and integrated national approach to implementing the strategy for containment of antimicrobial resistance taking account, where appropriate, of financial and other incentives that might have a harmful impact on policies for prescribing and dispensing;

(2) to enhance proper use of antimicrobial agents, including through development and enforcement of national standard-practice guidelines for common infections, in

¹ Document WHO/EDM/PAR/2004.7.

² Document WHO/CDS/CSR/DRS/2001.2.

public and private health sectors, and to consider the selection of effective and short-course antimicrobial treatment for potentially poor-compliance patients;

~~(2)~~**(3)** to consider strengthening their legislation on availability of medicines in general and of antimicrobial agents in particular;

~~(3)~~**(4)** to mobilize human and financial resources in order to minimize the development and spread of antimicrobial resistance, in particular by the promotion of the rational use of antimicrobial agents by providers and consumers;

(5) to monitor effectively and to control nosocomial infections, one of the most common sources of antimicrobial resistance;

~~(4)~~**(6)** to monitor regularly the use of antimicrobial agents and the level of antimicrobial resistance in all relevant sectors, **and to report back annually to WHO;**

~~(5)~~**(7)** actively to share knowledge and experience on best practices in promoting the rational use of antimicrobial agents, **including patient and consumer education;**

(8) to assure quality of antimicrobial agents used in medical practice;

(9) to monitor and control the non-human use of antibiotics, specifically the quantity and therapeutic group of those antibiotics used to promote growth in animals intended for human consumption;

(10) to allocate financial resources exclusively for containing resistance to antimicrobials;

(11) to allocate human and financial resources to the strengthening of regional bacteriological laboratories;

2. REQUESTS the Director-General:

(1) to strengthen the leadership role of WHO in containing antimicrobial resistance;

(2) to accelerate the implementation of resolutions WHA51.17 and WHA54.14 concerning the containment of antimicrobial resistance by expanding and strengthening the provision of technical support to Member States, at their request;

(3) to **collaborate with** ~~support~~ other relevant programmes and partners **in order to** ~~strengthening their efforts~~ to promote the appropriate use of antimicrobial agents by scaling up interventions proven to be effective;

(4) to **provide** support **for** the sharing of knowledge and experience among stakeholders on the best ways to promote the rational use of antimicrobial agents, **including patient and consumer education, and to establish databases on the use of antimicrobials and on antimicrobial resistance globally and to ensure their availability to Member States and other parties through a periodic annual report;**

(5) to promote the appropriate use of antimicrobial agents in spheres other than human, specifically in the practice, considered hazardous since the 1970s, of using antibiotics as growth-promotion agents in animals intended for human consumption;

(6) to provide support for the generation of up-to-date information on antimicrobial resistance at regional and subregional levels;

(7) to provide support for gathering of evidence on cost-effective strategies for prevention and control of antimicrobial resistance at national and local levels;

~~(5)~~**(8)** to report to the Sixtieth World Health Assembly, and subsequently on a regular basis, on progress achieved, problems encountered and further actions proposed in implementing this resolution.

(For approval of the draft resolution, see summary record of the twelfth meeting, section 3.)

Infant and young child nutrition: Item 13.11 of the Agenda (Resolution EB115.R12; Document A58/15) (continued from the ninth meeting, section 2)

The CHAIRMAN drew attention to the following revision of the draft resolution contained in resolution EB115.R12, which incorporated amendments proposed by the delegations of Botswana, Ghana, Islamic Republic of Iran, Japan, Kenya, Micronesia (Federated States of), Nepal, Saudi Arabia, South Africa, Swaziland, Yemen and Zimbabwe, and which would be considered by a working group:

The Fifty-eighth World Health Assembly,

Recalling the adoption by the Health Assembly of the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22), resolutions WHA39.28, WHA41.11, WHA46.7, WHA47.5, WHA49.15, ~~and particularly resolution WHA54.2~~ on infant and young child nutrition, appropriate feeding practices and related questions, **and particularly WHA55.25, which endorses the global strategy for infant and young child feeding;**

Having considered the report on infant and young child nutrition;

Aware that the joint FAO/WHO expert meeting on *Enterobacter sakazakii* and other microorganisms in powdered infant formula held in 2004 concluded that intrinsic contamination of powdered infant formula with *E. sakazakii* and *Salmonella* had been a cause of infection and illness, including severe disease in infants, particularly preterm, low birth-weight or immunocompromised infants, and could lead to serious developmental sequelae and death;¹

Noting that such severe outcomes are especially serious in preterm, low birth-weight and immunocompromised infants, and therefore are of concern to all Member States;

Bearing in mind that the Codex Alimentarius Commission is revising its recommendations on hygienic practices for the manufacture of foods for infants and young children;

Recognizing the need for parents and caregivers to be fully informed of known public-health risks of intrinsic contamination of powdered infant formula;

Concerned that ~~there are reports of~~ nutrition and health claims ~~being~~ **may be** used ~~inappropriately~~ to promote the sale of breast-milk substitutes instead of breastfeeding;

Acknowledging that the Codex Alimentarius Commission plays a pivotal role in providing guidance to Member States on the proper regulation of foods, including foods for infants and young children;

Bearing in mind that on several occasions the Health Assembly has called upon the Commission to give full consideration, within the framework of its operational mandate, to evidence-based action that it might take to improve the health standards of foods, consistent with the aims and objectives of relevant public health strategies, particularly WHO's global strategy for infant and young child feeding (resolution WHA55.25) and Global Strategy on Diet, Physical Activity and Health (resolution WHA57.17);

Recognizing that such action requires a clear understanding of the respective roles of the Health Assembly and the Codex Alimentarius Commission, and that of food regulation in the broader context of public health policies;

Taking into account resolution WHA56.23 on the joint FAO/WHO evaluation of the work of the Codex Alimentarius Commission, which endorsed WHO's increased direct involvement in the Commission and requested the Director-General to strengthen WHO's role in complementing the work of the Commission with other relevant WHO activities in the areas of food safety and nutrition, with special attention to issues mandated in Health Assembly resolutions,

¹ FAO/WHO Expert Meeting on *E. sakazakii* and other Microorganisms in Powdered Infant Formula: Meeting Report. Microbiological Risk Assessment Series No. 6, 2004, p. 37.

1. URGES Member States:

- (1) to continue to protect, promote and support exclusive breastfeeding for six months as a global public health recommendation, taking into account the findings of the WHO Expert Consultation on optimal duration of exclusive breastfeeding,¹ and to provide for continued breastfeeding up to two years of age or beyond, by implementing fully the WHO global strategy on infant and young child feeding that encourages the formulation of a comprehensive national policy, including where appropriate a legal framework to promote maternity leave and a supportive environment for six months' exclusive breastfeeding, a detailed plan of action to implement, monitor and evaluate the policy, and allocation of adequate resources for this process;
- (2) to ensure that nutrition and health claims are not permitted ~~on~~ **for** foods for infants and young children; ~~except where specifically provided for in relevant Codex Alimentarius standards or national legislation;~~
- (3) to ensure, ~~in situations where infants are not breastfed,~~ that clinicians and other health-care providers, community **health** workers and families, parents and other caregivers, particularly of infants at high risk, are provided with **enough** information and training **by independent health providers**, in a timely manner on the preparation, use and handling of powdered infant formula in order to minimize health hazards; are informed that powdered infant formula **are not sterilized and** may contain pathogenic microorganisms and must be prepared and used appropriately; and, ~~where applicable,~~ that this information is conveyed through an explicit warning on packaging;
- (4) to ensure that financial support **and other incentives for programmes and health** professionals working in infant and young child health does not create conflicts of interest;
- (5) to ensure that research on infant and young child feeding, which forms the basis for public policies, is always independently **funded and** reviewed in order to ensure that such policies are not unduly influenced by commercial interests;
- (6) to work closely with relevant entities, including manufacturers, to continue to reduce the concentration and prevalence of pathogens, including *Enterobacter sakazakii*, in powdered infant formula;
- (7) to continue to ensure that manufacturers adhere to Codex Alimentarius or national food standards and regulations;
- (8) to ensure policy coherence at national level by stimulating collaboration between health authorities, food regulators and food standard-setting bodies;
- (9) to participate actively **and constructively** in the work of the Codex Alimentarius Commission;
- (10) to ensure that all national agencies involved in defining national positions on public health issues for use in all relevant international forums, including the Codex Alimentarius Commission, have a common and consistent understanding of health policies adopted by the Health Assembly, and to promote these policies;

2. REQUESTS the Codex Alimentarius Commission:

- (1) to continue to give full consideration, when elaborating standards, guidelines and recommendations, to those resolutions of the Health Assembly that are relevant in the framework of its operational mandate;
- (2) to establish standards, guidelines and recommendations on foods for infants and young children formulated in a manner that ensures the development of safe and appropriately labelled products that meet their known nutritional and safety needs, thus

¹ As formulated in the conclusions and recommendations of the Expert Consultation (Geneva, 28-30 March 2001) that completed the systematic review of the optimal duration of exclusive breastfeeding (see document A54/INF.DOC./4).

reflecting WHO policy, in particular the WHO global strategy for infant and young child feeding and the International Code of Marketing of Breast-milk Substitutes **and subsequent relevant resolutions of the Health Assembly**;

(3) urgently to complete work currently under way on addressing the risk of microbiological contamination of powdered infant formula and establish appropriate microbiological criteria or standards related to *E. sakazakii* and other relevant microorganisms in powdered infant formula; and to provide guidance on safe handling and ~~explore the necessity~~ on adding warning messages on product packaging;

3. REQUESTS the Director-General:

(1) in collaboration with FAO, **and taking into account the work undertaken by the Codex Alimentarius Commission**, to develop guidelines for clinicians and other health-care providers, community workers and family, parents and other caregivers on the preparation, use and handling of infant formula so as to minimize risk, and to address the particular needs of Member States in establishing effective measures to minimize risk in situations where infants cannot be, or are not, fed breast milk;

(2) ~~to encourage and promote~~ **initiate and support** independently reviewed research, including by collecting evidence from different parts of the world, in order to get a better understanding of the ecology, taxonomy, virulence and other characteristics of *E. sakazakii*, in line with the recommendations of the FAO/WHO expert meeting on *E. sakazakii*, and to explore means of reducing its level in reconstituted powdered infant formula;

(3) to provide information in order to promote and facilitate the contribution of the Codex Alimentarius Commission, within the framework of its operational mandate, to full implementation of international public health policies;

(4) to report to the Health Assembly ~~regularly~~ **each even year, along with the report on the status of implementation of the International Code of Marketing of Breast-milk Substitutes and relevant resolutions**, on progress in the consideration of matters referred to the Codex Alimentarius Commission for its action.

(For approval of the draft resolution, see summary record of the fourteenth meeting, section 2.)

eHealth: Item 13.17 of the Agenda (Resolution EB115.R20; Document A58/21)

Dr CHEN Xianyi (China) welcomed the proposals on the use of information technology to improve the efficiency and quality of health-care delivery. China supported the expansion of eHealth applications and the formulation of development strategies, research, and relevant legal and ethical standards. His Government attached importance to building a national health information system and had launched a web-based surveillance reporting system in 2004, in which more than 40 000 health institutions nationwide reported on the disease situation. Efforts to strengthen the information system for communicable diseases and public health emergencies would be intensified.

Activities in the eHealth area should be commensurate with a country's level of use of information technology and the nature of the work involved. Decisions about speed of work, priorities and operational methods should be made cautiously. In promoting the application of eHealth, the Secretariat should provide appropriate guidance in line with a country's circumstances. Telemedicine could overcome problems of distance but not those related to poverty; in regions where the affordability of care was a problem, remote health care would be difficult to maintain and operate. If the network was used appropriately to provide health-care workers in remote and poor areas with information and advice, service and training, however, better results would be achieved. As countries' management and operating systems, culture and levels of information technology use differed, one uniform set of eHealth standards and norms was not appropriate. The Secretariat should assist countries that had started late in the development of health information standards and norms,

promoting more exchange and cooperation among countries and regions. It should recommend proven strategies suitable for particular country circumstances. The application of eHealth required a large financial investment; however, care should be taken to ensure that it was not technology-driven and motivated by commercial concerns.

With those comments, China supported the draft resolution.

Dr DAHL-REGIS (Bahamas), speaking on behalf of the Member States of the Caribbean Community, emphasized the importance and timeliness of the agenda item, as developments in information and communications technology presented a great opportunity for advancement in health care worldwide. The impact of that technology was vast and growing, but ensuring that the benefits reached the neediest communities remained a challenge. An optimal balance must be ensured among human and physical resources, technology, and pharmaceuticals, and equitable access to health services must be provided, particularly in remote and underserved areas. The world was facing a crisis in human resources for health. She urged the Secretariat to explore better the use of eLearning in education, training and continuing professional development and support of health workers, and she welcomed the request made to that effect in subparagraph 2(4) of the draft resolution.

The countries of the Caribbean Community faced unique challenges: increased international travel meant that tourists and other visitors far outnumbered the resident populations. Electronic health record systems that shared data with common standards helped because they could be updated with the latest information whenever and wherever care was given. The Secretariat must respond to the need for better synergy between information and communications technology and health. To realize the potential of teleconsultations, electronic health records, computerized prescriber order entry systems and other applications, numerous challenges had to be overcome, including organizational barriers; traditional issues of security, privacy and confidentiality; legal and ethical issues of accountability and liability; and norms, standards and system interoperability. She supported the draft resolution.

Dr LARUELLE (Belgium) said that a major advantage of information and communications technology in the area of health was guaranteeing patients' access to medical and paramedical resources, particularly in places with limited infrastructure. A principal risk associated with the development of that technology in the area of health was the creation of large databases of sensitive personal information, which required a high level of protection. He therefore proposed two amendments to the draft resolution: in subparagraph 2(1), the words "and ethical rules" should be inserted between the words "technical solutions" and "in the area of eHealth"; and in subparagraph 2(4), the words "in the deployment of eHealth infrastructure in countries with limited access to medical care" should be inserted between the words "including" and "in the training of health-care professionals".

Dr MANDIL (Sudan) supported the draft resolution and endorsed the comments made by previous speakers. There should be a common understanding of what was meant by the term "eHealth"; the definition given in the report should be modified to state that eHealth involved the use of information and communications technology to support health and health-related fields, including the management of health-care services, health statistics and epidemiology, health literature, health education for both medical staff and patients, and knowledge.

Until recently, the Secretariat had given eHealth low priority. The draft resolution signalled a welcome reconsideration. The subject cut across all activities of health care and health-care support, and should be tackled in a coordinated, unfragmented fashion, by both Member States and the Secretariat.

The draft resolution was more relevant to the Secretariat than Member States, which had made significant progress in eHealth over the past few years, moving ahead of the Secretariat. Support had mostly been provided by ITU, the World Bank, UNDP and Member States themselves. The vast majority of industrially developing Member States already had in place the necessary policy and strategies and were making notable achievements. Sudan had established a national telemedicine

network, which was also used for teleeducation, and it would soon launch a major pilot effort to computerize core information functions in 12 hospitals and 12 health centres, to form a national health network. Other countries had made even greater progress.

Yet significant needs remained to be met. Member States relied on the Secretariat to make specific technical contributions, such as the recently launched Health Metrics Network, to national eHealth systems, which could use the Network as a source of information and in return contribute relevant data. Energy and resources could be focused on developing similar tools and instruments that only a body such as WHO could develop. It should focus on specific technical solutions for strengthening eHealth infrastructure and developing relevant applications in countries. WHO could recommend: a minimum data set for medical records and a patient identification scheme; generic telemedicine protocols, as telemedicine and teleeducation were of great importance in underserved areas; and general models for countries to adapt. Trust was an important issue in digital security and confidentiality, and WHO could advise countries on how trust services could complement digital signatures and other security systems. WHO should also provide guidance in the area of legislation on eHealth.

He suggested the addition of a new subparagraph to the draft resolution, possibly after subparagraph 2(2), requesting the Director-General to propose that the Executive Board at its 117th session should focus attention on a few specific issues, targeted at specific results that would contribute to national solutions; that would represent a more focused approach to eHealth support that was directly relevant to the realities of eHealth in Member States. The Board could then review the issues and set priorities for action.

Professor TLOU (Botswana) welcomed the draft eHealth strategy, which dealt with an important health-care issue for all countries. Her Government accorded high priority to the integration of information and communications technology in all sectors and was formulating a four-fold policy. First, a strong foundation for eHealth needed to be built, by identifying the necessary technical infrastructure and supporting standards, reviewing legislation and policy for data-protection concerns relating to personal health information and establishing an eHealth council to provide national leadership and guidance in the development of eHealth initiatives. Secondly, health-care professionals throughout the health system would be provided with technology-based tools, training and systems to enable them to deliver high-quality patient care. Thirdly, access to health services and information would be improved by expanded use of radio and television, providing patients with access to health-care providers by telephone and introducing telemedicine to enable remote patient-physician consultation and diagnosis. Fourthly, the impact of eHealth interventions in strengthening health system performance and improving disease surveillance and emergency rapid response capacity would be monitored and evaluated.

Use of such technology in health information systems in Botswana was already expanding, and it was hoped that WHO would provide guidance and technical support in that area. She expressed satisfaction that the draft strategy addressed the issue of ensuring equitable access for vulnerable and disadvantaged groups. She supported the draft resolution.

Mr GHEORGHE (Romania), supporting the draft resolution, said that Romania was strongly committed to eHealth and was working closely with the Secretariat to draw up a plan of action to implement the Health Academy project. The experience gained should be of interest for other countries, with which it would be willingly shared.

Dr NYIKAL (Kenya) said that Kenya was planning to implement eHealth. The Ministry of Health had established an eHealth working group, bringing together the public and private sectors and chaired by the Permanent Secretary or the Director of Medical Services. The Ministry had written a proposal for a pilot project, focusing on public health. If it were successful, it would be extended to cover other areas.

Expressing support for the draft resolution, he suggested the inclusion of a new subparagraph to follow subparagraph 2(2), to read: “to facilitate the development of a model prototype eHealth system which, with appropriate modification, can be established in national centres and networks of excellence for eHealth.” It was important for the Secretariat to provide uniform support to countries on the issue by giving them a model that could be easily replicated.

Mr AL ROMAITHI (United Arab Emirates) said that eHealth was an essential component of primary health care. A project had been established linking all the primary health-care centres and hospitals in his country by telecommunications, so that patient information could be accessed and processed, irrespective of the patient’s location. Efforts were under way to enhance the quality of primary health care delivered and to increase efficiency. Telemedicine was used to provide additional and better medical care and to obtain specific information for making correct decisions. Useful lessons had been learnt from international projects and adapted to his country’s needs. Programmes had been initiated in Abu Dhabi and would subsequently be extended to the whole country. Expressing support for the draft resolution, he said that his country would use ethical principles in applying its provisions.

Dr AL-SALEH (Kuwait) said that eHealth was the future for health information, as it would expedite improvements in health services. He supported the draft resolution, but suggested several amendments. He proposed to add at the end of subparagraph 1(5) the words “and respect for the principle of confidentiality of information, private life, justice and equality”. In subparagraph 1(1), the phrase “in the various areas of health administration” should be added after the word “eHealth”. In subparagraph 1(7), the word “electronic” should be inserted immediately before the phrase “public-health information systems”. Subparagraph 1(3) should be prolonged by addition of: “and make use of the electronic programmes of WHO and other health organizations and seek their support in the area of eHealth.” Subparagraph 2(2) should begin: “to expand the use of documentary information electronically through the Organization and submission of regular reports and”. He endorsed the points made by previous speakers on the draft resolution.

Dr SHEVYRYOVA (Russian Federation), expressing support for WHO’s work in the area of eHealth, observed that the official WHO web site was a vital source of information for consolidating countries’ efforts to solve health-care problems, draw up national health-care strategies and improve the quality of medical care provided to patients. Her country was developing an eHealth programme for knowledge sharing for disease prevention, publicizing the national vaccination programme and communicable and noncommunicable disease surveillance, providing distance learning for health-care professionals, and other areas of health care. Further work was needed for the universal implementation of eHealth systems, and international standards and legislation should be drawn up. She supported the draft resolution.

Ms RØINE (Norway) fully supported the draft resolution, with amendments proposed by several countries concerning the application of ethical principles. eHealth could contribute to strengthening health systems in all countries and support health personnel in developing countries in building institutions and broadening access to education. Further research was required into the ability of eHealth to alleviate the lack of health personnel in developing countries, and she welcomed the focus on documentation and analysis in that regard. The Norwegian centre for telemedicine, a WHO collaborating centre, was working with developing countries on access to distance learning. The third European eHealth conference (Tromsø, Norway, 23-24 May 2005), hosted in conjunction with the European Commission, was due to tackle several issues raised in the draft resolution.

Dr VIOLAKI-PARASKEVA (Greece) commented that information and communications technology could be of great benefit to public health strategies, although more investment in human resources and information was required. It was important to remember the ethical, human rights and

legal issues involved in its application. She therefore proposed that in the fourth preambular paragraph of the draft resolution, the words “, human rights and ethical issues,” be added after “equity”.

Dr MOSA (Madagascar) said that the strengthening of information and communications technology was a priority in his country and Government departments were instructed to use its whenever possible. In the health ministry, training was provided for departmental personnel at the highest level, and the administrative services had been networked. Access to information in remote areas was a particular problem during the rainy season, but the technology was being extended to those areas, allowing timely information exchange and access to new medical developments for health professionals. He supported the draft resolution.

Mr POMOELL (Finland) said that eHealth applications and services could contribute to informing, educating and empowering the public; stimulating innovations in health policy; health promotion and the prevention of ill-health; and improving the quality and management of health data as well as care delivery and health system management. eHealth could promote more equitable access to health information and services by connecting the public, health professionals, health information providers and policy-makers. Data protection and security were of great importance in the processing of personal data. Exchange of information among health professionals, health-care planners, researchers, funding bodies, administrators and the public was a further priority, in addition to ensuring reliable and compatible documentation methods. Continuous training and education were required for health professionals in the adoption and use of eHealth. Its use should include a comprehensive evaluation of local surroundings and needs in order to provide cost-effective, high-quality, efficient solutions.

Dr MIZUSHIMA (Japan) said that, in establishing an eHealth system, attention should be paid to both the hardware required and the information to be processed, and care should be taken to respect the confidentiality of personal information. Japan had significant experience in setting up information and communication systems, in both Japan and developing countries, and was willing to share that experience with other Member States. In its experience, eHealth was an effective, efficient means for providing medical care in sparsely populated areas and for patients suffering from chronic diseases. He cited the Health InterNetwork Access to Research Initiative as an effective application of eHealth, providing doctors in sparsely populated areas with free access to the latest medical literature. The Secretariat had also set up medical information systems in urban and rural areas that contributed to solving the unequal distribution of doctors. Lifestyle-related diseases which caused stroke or heart disease could be prevented by an eHealth system to which busy people would have access via Internet and telephones.

The meeting rose at 12:45.

ELEVENTH MEETING

Monday, 23 May 2005, at 15:00

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

eHealth: Item 13.17 of the Agenda (Resolution EB115.R20; Document A58/21) (continued)

Ms WILSON (Canada) observed that eHealth could help improve the delivery of both health information and services, so having the potential to improve the health of people wherever they lived. Canada supported and commended WHO in its endeavours to facilitate the deployment of eHealth in developing countries, but would need to examine further the potential for Canadian involvement. Canada supported the draft resolution.

Dr SINGER (United States of America) said that his country strongly supported the use of health information technology in order to improve the quality and efficiency of health care and to provide care based on consumers' interests and sound information. The eHealth strategy had to have a clear focus in order to maximize use of the Secretariat's capacities and lead to measurable results at country level. Clear methods for setting priorities must be established globally, regionally and nationally. Full engagement of all interested stakeholders would help to ensure the expertise and capacity needed. To help Member States to adopt the basic requirements for services, the Secretariat must carefully set priorities within existing competencies and current resources. Health technology was changing rapidly, and national information infrastructures varied widely across Member States, which needed appropriate infrastructures and systems if they were to make full use of the data gathered for framing their policies. Further, the fact that many current technological advances in a rapidly changing field were made in the private sector required a flexible yet cautious approach.

He agreed with the delegate of Sudan that the given definition of eHealth was too broad and lacked reference to health, but nevertheless supported the draft resolution as drafted; it was a balanced effort to promote international, multisectoral collaboration to integrate eHealth into public health systems and ultimately to improve health outcomes for everyone.

Mr ASPLUND (Sweden) said that, to meet the ever-growing demand from citizens for accessible, efficient and high-quality health-care systems, the use of modern information technology in the health-care sector was a difficult but necessary measure. Sweden had recently established a national high-level group for eHealth, incorporating key stakeholders in the health-care sector, chiefly to draw up a national plan for eHealth. The challenges included legal obstacles, confidentiality, security and public trust. The forthcoming eHealth strategy could be an important and strategic tool for further progress.

Dr YOT TEERAWATTANON (Thailand) called for all users of the Internet for health-related purposes to collaborate in order to enhance the value of eHealth and create a safe environment for meeting health-care needs. Ethical concerns in eHealth should include not only confidentiality of information, dignity and privacy, as stated in the report, but also accuracy of information and accountability of those involved. He supported the draft resolution with the amendments proposed by Belgium and the United Arab Emirates to emphasize the need for ethical rules in eHealth for the sake of accuracy, reliability, accountability and liability.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) commented that his country had been working since 1992 on a telematic health network that incorporated the principal strategic components of eHealth, namely scientific and technical information, education, health services, research, health monitoring and health management. The network's overall objective was to provide health workers with prompt and efficient access to high-quality scientific and technical information for purposes of health care, administration, education and research, and to enable the health workers themselves to become active producers of information and knowledge.

The report set no timetable for finalization of the draft strategy on eHealth after further consultations. As the fifth preambular paragraph of the draft resolution indicated that a WHO eHealth strategy would serve as a basis for WHO's activities on eHealth, it was premature to consider a draft resolution before completion of further consultation. Additionally, the report did not state how long such consultation would take, nor was that issue mentioned in the draft resolution. He suggested adding a subparagraph to paragraph 2 on setting a time limit for completion of the strategy, after which it could be submitted to the appropriate Health Assembly. Further, the main lines of the proposed strategy should include wording along the lines of: "to ensure that eHealth intended for citizens, patients and health professionals is in line with universally accepted quality, safety and ethics standards."

Dr AHMED (Pakistan) said that Pakistan, as a strong supporter of the use of information and communication technologies in the health field, welcomed the drafting of a eHealth strategy to serve as the basis for coordinating both eHealth policies internationally and WHO's activities on eHealth. Acknowledging the potential impact of advances in such technologies on health-care delivery, public health, health education, research and other health-related activities, Pakistan was using them to upgrade its health information and management systems and establishing a national resource centre for the purpose. He supported the draft resolution.

Dr PARIRENYATWA (Zimbabwe) emphasized the need for developing countries to embrace electronic technology, adding that an eHealth committee was being set up in Zimbabwe. Electricity was vital to eHealth; all district hospitals in Zimbabwe had been electrified, and an electrification programme for rural clinics was progressing. Furthermore, computerization of rural schools and clinics was being spearheaded by the Government at the highest level with a view to ensuring future accessibility to eHealth. Zimbabwe would welcome technical assistance and the provision of equipment from WHO, partners and developed countries in that regard, particularly with respect to computer hardware and software. Zimbabwe was seriously affected by a shortage of health specialists, such as radiologists, and telemedicine was one area of eHealth able to be used to alleviate the constraints that rural and provincial health specialists faced in diagnostics. Zimbabwe supported the draft resolution.

Dr PHOYA (Malawi) said that the time had come for health-care systems to benefit from advances in information technology. Malawi had launched a few pilot eHealth initiatives, covering integrated disease surveillance, electronic medical records in two teaching hospitals, an electronic fingerprint register for HIV-infected patients, and the general health management information system. However, those databases were neither integrated nor interconnected. Malawi therefore looked forward to the leadership and technical assistance of WHO in implementing the proposed eHealth strategy, which would not only assist in improving the health information management system but also improve other areas of health services delivery, such as tracking progress in implementation of the work programme and providing targeted continuing education for health workers stationed in inaccessible areas. She endorsed the draft resolution, as amended by Kenya for the development of a prototype eHealth system.

Mrs REID (United Kingdom of Great Britain and Northern Ireland) stated that she recognized that information technologies formed an important component of effective use of finite resources in delivering health and social-care services responsive to the needs and wishes of patients and carers.

She requested a clear estimate of the resources needed to develop and implement the draft eHealth strategy and information on which departments would be involved before the draft resolution was adopted.

Dr ASSI GBONON (Côte d'Ivoire) said that, although information and communications technologies were emerging in her country, no formal policy was as yet in place for eHealth, and experience was limited. With assistance from partners, some isolated experiments with remote diagnosis had been undertaken. Medical personnel had been enthusiastic about the experiments, but had also raised concerns about ethical aspects. Côte d'Ivoire commended WHO's initiative, called for assistance for the development of eHealth in developing countries, and supported the draft resolution.

Dr BEHBEHANI (Assistant Director-General) thanked delegates for their comments, which would be useful in developing the eHealth strategy. The topic was complex, owing in part to the newness of the concept. A committee had been formed, incorporating all relevant clusters and representatives of all the regions, together with some other United Nations agencies; part of its mandate was to examine that complexity, including legal, ethical and confidentiality issues, and standardization of medical data for exchange purposes, one important aspect being coordination with other agencies. WHO already had agreements with ITU and UNESCO, would continue to consult with the United Nations Economic and Social Council and had visited the World Bank to examine the potential for cooperation. Equally important was the need for cooperation between Member States, some of whom had already made considerable progress in the area, while many still needed to catch up. It was to be hoped that countries could work together in regional groups. The medium- to long-term goal was that eHealth would be used as an instrument for health-care delivery and knowledge management in the Member States. A start had also been made on education, with tests in several countries, and progress was being made in informing the public and teaching schoolchildren. Since eHealth represented a long-term commitment by the Organization, it was not yet possible to supply a cost figure as the United Kingdom had requested. In the programme budget for 2006-2007, provision had been made by some of the different clusters working in the area. Further information would be submitted to the Executive Board at its next session, including information on the areas in which work would be undertaken and the estimated budget for the priority areas.

The CHAIRMAN announced that a new version of the draft resolution, incorporating the amendments proposed, would be distributed the following day.

(For approval of the draft resolution, see the summary record of the twelfth meeting, section 3.)

Implementation of resolutions (progress reports): Item 13.19 of the Agenda (Documents A58/23 and A58/23 Add.1)

Prevention and control of iodine deficiency disorders (Resolution WHA52.24)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Australia, Bhutan, Bolivia, Brazil, Cameroon, Canada, Chile, China, Cuba, Nepal, New Zealand, Norway, Oman, Philippines, Sweden, Switzerland, Thailand, United Kingdom of Great Britain and Northern Ireland, United States of America and Zimbabwe, which read as follows:

The Fifty-eighth World Health Assembly,

Having taken note of WHO's report on iodine status worldwide;¹

Affirming the priority of preventing and controlling iodine deficiency disorders contained in resolutions WHA49.13 and WHA52.24, and the elimination target set by the United Nations General Assembly twenty-seventh special session;²

Concerned that iodine deficiency disorders remain a serious public-health threat in that they cause invisible brain damage to hundreds of millions of children as well as visible goitre, cretinism, stillbirth, miscarriage and physical impairment;

Noting that the global battle against iodine deficiency disorders through universal salt iodization constitutes one of the most cost-effective interventions, contributing to economic and social development;

Recognizing that in the past decade 2000 million more people have adopted the use of iodized salt, but that despite that substantial progress fully one third of the world's population still remain at risk, mostly in the poorest and economically least developed areas;

Realizing that a sustainable solution such as universal salt iodization is needed in order to maintain the regular intake of trace amounts of iodine, because deficiency disorders cannot be eradicated, and interruption of such regular intake paves the way for their return;

Convinced that sustainability of control activities requires communication and public education in order to maintain the continuing use of iodized salt and to avoid the reappearance of deficiency disorders in the absence of long-term control strategies;

Applauding the establishment in 2002 of the global Network for Sustainable Elimination of Iodine Deficiency as a model of public/private collaboration among stakeholders for a worldwide effort, in which a number of salt associations are founding members along with international development agencies and community-oriented organizations,

1. URGES Member States:

- (1) to strengthen their commitment to sustained elimination of iodine deficiency disorders as part of their regular health programmes and anti-poverty efforts through universal salt iodization;
- (2) to take urgent measures to reach the remaining third of the world population, mostly the poorest and economically disadvantaged groups;
- (3) to include health promotion in their control strategies so that the use of iodized salt becomes a standard practice based on awareness of the need for iodine in the diet in order to ensure physical well-being, especially for expectant and breastfeeding mothers and infants;
- (4) to establish multidisciplinary national coalitions that include salt producers and the education and media sectors, in order to monitor the state of iodine nutrition every three years and to report to the Health Assembly on progress;

2. REQUESTS the Director-General:

- (1) to strengthen cooperation with Member States, at their request, with international organizations, including UNICEF, bilateral aid agencies and international bodies such as the International Council for Control of Iodine Deficiency Disorders, the Micronutrient Initiative, and the Global Alliance for Improved Nutrition, in providing technical assistance to regulators and salt producers in producing and marketing iodized salt, strengthening quality control systems and facilitating a network of reference laboratories for estimation of iodine intake;

¹ *Iodine status worldwide: WHO Global Database on Iodine Deficiency*. Geneva, World Health Organization, 2004.

² United Nations General Assembly resolution S-27/2.

- (2) to strengthen advocacy efforts involving public media and civil society for renewed commitment to combating iodine deficiency disorders, including appropriate research with relevant partners;
- (3) to report on implementation of this resolution to the Sixtieth World Health Assembly, and periodically thereafter.

Dr LARIVIÈRE (Canada) said that the purpose of submitting the draft resolution was to draw the Health Assembly's attention to the health gains achieved through universal salt iodization since its introduction in 1993, to the need for further measures to control iodine deficiency disorders among populations still at risk, and to the need to monitor the impact of collective efforts. Sustainable universal salt iodization required intensified collaboration and mutual support between and among national health authorities, WHO, committed international organizations and iodized-salt producers, especially the many small, local manufacturers. He commended all parties that had contributed to the elimination of iodine deficiency disorders. He pointed out that, in the original text of the draft resolution submitted, the last preambular paragraph had contained a reference to Kiwanis International, which had contributed financial support, and requested that the original text of the draft resolution should be maintained.

The delegations of Guatemala, Peru and the Bolivarian Republic of Venezuela had asked to be added to the list of sponsors.

Dr WANGCHUK (Bhutan) said that his country had eliminated iodine deficiency disorders in 2003, and had been declared the first country in south-east Asia to eliminate them as a public health problem. Bhutan had had one of the highest goitre rates, at about 65%, and an average urinary iodine concentration of less than 50 µg/l. After intensive consultation with many stakeholders, a salt-iodization plant had been established, with UNICEF's assistance. Iodized salt consumption was monitored at household level, and the elimination of the disorders had been a combined effort. Since the current concern was to sustain that state and prevent their re-emergence, he urged all relevant bodies to maintain their assistance. Bhutan fully supported the draft resolution.

Dr YOT TEERAWATTANANON (Thailand) said that iodine intake was still insufficient in his country, where iodine deficiency disorders had long been recognized as a major public health problem. Despite efforts since 1965 Thailand was unlikely to achieve the international target of eradication by the end of 2005. Thailand intended to continue giving the programme high priority, and therefore supported the draft resolution.

Mr RYAZANTSEV (Russian Federation) said that his country accorded a high priority to iodine deficiency; more than half the population was affected and more than 60% lived in regions where the micro-element was naturally lacking. Since 1999 regulations for prophylactic measures had been introduced by legislative bodies. Natural iodine deficiency was exacerbated by low consumption of products containing iodine, such as fish, especially among low-income groups. Significant assistance had been provided in recent years by UNICEF and other international organizations, including a prevention project, involving studies of the prevalence of iodine in the environment, with a view to providing medicinal and rehabilitation measures, particularly for those of school age. He thanked WHO and UNICEF for their assistance in those efforts.

Dr PRETTEL (Peru), confirming his country's sponsorship of the draft resolution, said that lack of iodine in pregnancy and infancy remained a major cause of mental disability, underlining the need for permanent prophylaxis, especially for pregnant and breastfeeding women, and children under two years of age. Iodized salt was a most effective and efficient treatment, but other methods, such as iodine-enriched products, might be used in developed countries. The essential requirement was regular monitoring systems. Lack of continuous surveillance led to reduced awareness of the problems and their recurrence. He proposed that, in subparagraph 2(3), the words "and periodically thereafter" should be replaced by "and every three years from 2007 onwards".

Mr ADAMCZEWSKI (Poland) supported the draft resolution. Poland had long experience in efforts to reduce iodine deficiency disorders. Preventive non-obligatory iodization had been introduced in 1935 and interrupted only twice: during the Second World War and during the period of martial law in the early 1980s. Since 1997 household salt had been obligatorily iodized, with a resultant significant drop in the goitre rate. Thanks to the national programme, Poland had moved from the group of countries endemic for those disorders to that of countries with adequate iodine provision.

Mrs AHO (Togo), speaking on behalf of the Member States of the African Region, said that, despite progress, iodine deficiency was still a regional public health problem. Priority must be given, as a matter of urgency, to the salt-provision programme for the most vulnerable population groups, and resources provided in order to combat the deficiencies.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) paid tribute to the delegate of Peru, an international authority on the subject who had done much in the international campaign to prevent and control deficiency disorders. As noted in the report, there were still 54 countries that did not iodize salt. Those that did must ensure that the programmes were sustained; otherwise the problem would remain. Cuba had in 1994 established a national group for grading salt, involving the ministries of public health, industry, education and internal trade because the problem called for a multisectoral approach. His country was willing to make its experience available, and he fully supported the draft resolution.

Ms MOENG (South Africa) said that the elimination of iodine deficiency disorders was a priority for her country. It had been implementing salt iodization regulations since 1995, had established a national network, including government departments, United Nations partners, industry and consumer groups, and formulated a comprehensive implementation strategy involving health promotion and close monitoring. Despite regulations, however, compliance could not be guaranteed without regular monitoring. Visible signs of iodine deficiency, such as goitre, had been reduced, although pockets remained in some rural areas. The use of non-iodized and insufficiently iodized salt remained a major concern, and eliminating the disorders by the end of 2005 might not be possible. Discussions with industry were in progress to address the concerns. She endorsed the draft resolution.

Dr MOHAMED (Oman) expressed concern about the reported insufficiency of iodine intake in 54 countries and unavailability of data for 9% of the world's population. Iodine was an important micronutrient and an essential agent in combating mental disability. The Secretariat should work with other relevant bodies to combat iodine deficiency, and establish a timetable for its elimination. Such action was also important to the achievement of the United Nations Millennium Declaration's health-related goals.

Dr TADA (Japan) said that WHO's commendable action had done much to assist progress during the past decade in combating iodine-deficiency disorders. Since taking up the matter in its Global Issue Initiative in 1994, Japan had given technical support to some countries for the production or import of iodized salt, in addition to distribution, quality control and legislation, and had helped to organize training courses. Japan supported the programme and expected WHO and other agencies and countries concerned to continue efforts to strengthen iodized salt programmes in the remaining 54 countries, and to ensure programme continuity in other countries. He supported the draft resolution.

Dr PARIRENYATWA (Zimbabwe) supported the draft resolution. The prevalence of iodine deficiency in Zimbabwe remained a public health concern, although universal salt iodization had been a recognized success, with more than 89% of households having access to iodized salt. In 1995 existing legislation had been amended to make salt iodization mandatory with iodine levels of 30-90 ppm. Sentinel site surveillance every two years had been instituted in 10 districts.

Zimbabwe appreciated the support received from WHO, UNICEF and other partners, but required additional technical support to create an electronic database, to integrate the monitoring and

surveillance of those disorders into the health information system, to provide adequate laboratory capacity for iodine analysis, and to have a supply of salt test kits always readily available.

Ms SICARD (France) fully supported WHO's activity, and highlighted the need for countries to develop national strategies to eliminate iodine deficiency disorders. In France, reduction in those disorders, mainly in the east of the country, had been stipulated in the Public Health Law of August 2004. In contrast, significant numbers of the population, mainly children under five years of age, were on the threshold of excessive iodine intake. Because deficiency correction had to be balanced against a potential risk of overconsumption, universal iodization of salt could not be adopted by France, whose strategy simply targeted certain food vehicles, particularly bread.

France also worked with the salt industry in order to reduce the salt content of manufactured foods, in line with WHO's Global Strategy on Diet, Physical Activity and Health. It was important to establish consistency between overall salt consumption and the strategy of iodization of food. She therefore proposed the insertion of new fifth and sixth preambular paragraphs, to read:

Recognizing that the final choice on a measure should always be defined taking into account the degree of iodine deficiency in order to manage the risk of excessive iodine intake in the most sensitive populations, namely infants;

Noting the Global Strategy on Diet, Physical Activity and Health (resolution WHA57.17) and the necessity that action in respect of iodine deficiency is compatible with the strategy recommendation to limit salt (sodium) consumption from all sources;

In subparagraph 1(1), the word "including" should be added between "efforts" and "through". Should those amendments be accepted, France wished to cosponsor the draft resolution.

Dr RAHANTANIRINA (Madagascar) thanked WHO for its efforts towards eliminating iodine deficiency disorders. Madagascar had adopted a wide range of measures under a national strategy to eliminate those disorders, and a health survey in 2003 had shown a reduction in the incidence of goitre to 3.5%. The difficulty of ensuring that small producers iodized salt, poor enforcement of legislation on salt iodization, and wide fluctuations in the iodine content of the salt marketed were some of the remaining problems. Action was needed to sustain the encouraging progress made, particularly in quality assurance and in information, education and communication. She proposed that in subparagraph 1(3) of the draft resolution the words "and mental" should be inserted between the words "physical" and "well-being", and the end of the subparagraph amended to read "... mothers, infants and young children".

Dr MATHESON (New Zealand) strongly supported the draft resolution with the amendment proposed by France so that the text was in line with the recommendation of WHO's Global Strategy on Diet, Physical Activity and Health to limit salt (sodium) consumption from all sources and ensure that salt was iodized.

Dr DELAVAR (Islamic Republic of Iran) said that, although salt iodization coverage was more than 95% in his country, it was unlikely that iodine deficiency disorders could ever be fully eliminated because regular interruption of iodine intake would lead to a recurrence. He fully supported the draft resolution and wished to be added to the list of cosponsors.

Ms NGHATANGA (Namibia) said that Namibia had eliminated iodine deficiency disorders six years earlier as a result of legislation on the production, import and marketing of iodized salt. That step, following a collaborative effort between the public and private sectors and development agencies, had ensured sustainability and prevented the interruption of regular iodized salt intake. Prevention and control of iodine deficiency disorders had been made part of the national nutrition programme for the sake of sustainability. Although 90.3% of households in Namibia were using iodized salt, appropriate communication strategies were needed to reach the rest. She supported the draft resolution.

Ms HALBERT (Australia), affirming that the inclusion of iodized salt in diets was a relatively simple and cost-effective measure to prevent iodine deficiency disorders, noted that the need for iodized salt was greatest in the Asia-Pacific region. Australia had provided grants to the International Council for Control of Iodine Deficiency Disorders and other partners under a global programme to pioneer projects aimed at eliminating those disorders in, for example, regions of China. By 2000, as a result of those partnerships, 66% of at-risk populations had iodized salt in their diets; most of the rest lived in the poorest and economically least developed countries. The sustainability of existing programmes and their extension to populations not adequately covered required public education, particularly for women of reproductive age and children, to encourage the consumption of iodized salt. It was also necessary to monitor the iodine content of iodized salt and actual dietary intake. She supported the draft resolution.

Dr SINGER (United States of America) strongly supported the elimination of iodine deficiency disorders and welcomed the draft resolution. Progress in his country over the past 70 years had highlighted the importance of continued dialogue among all parties concerned, including the private sector. The United Nations General Assembly special session on children in 2002 had encouraged the engagement of all public and private partners, including WHO and UNICEF, governments, salt producers and their trading partners, and civil society. He supported the draft resolution with the amendments proposed by France and Madagascar.

Dr M'BENGUE (Côte d'Ivoire) encouraged WHO to continue its efforts towards eliminating iodine deficiency. She endorsed the amendments proposed by the delegate of Madagascar. Following a 1994 feasibility study on salt iodization, Côte d'Ivoire had introduced regulatory measures for the production and marketing of domestic salt, conducted awareness-raising campaigns, and encouraged producers to prepare for iodization of salt; iodized salt had been mandatory since 1997. An evaluation in 2004 had shown 84.4% of households to be using iodized salt and significant progress towards eliminating iodine deficiency disorders. The presence on the market of imported non-iodized salt and of hyper-iodized salt, lack of public awareness of those disorders and the virtual absence of quality assurance, however, were still causes for concern. Consideration was therefore being given to revising and adapting the pertinent legislation, organizing a system of control and surveillance, and setting up an integrated communication plan. She asked for Côte d'Ivoire to be included as a cosponsor of the draft resolution.

Dr QUIROGA MORALES (Bolivia) stressed the need for sustainability in the areas of promotion, intersectoral action and, above all, follow-up. She supported the draft resolution.

Dr DAYRIT (Philippines) said that, over the past three years, the use of iodized salt in his country had more than trebled to about 80% of households. For that success, advocacy alone had not sufficed, as iodized salt cost about 25% more than non-iodized salt. Furthermore, local governments had to be constantly reminded of their responsibility under 1995 legislation to ensure that marketed salt was iodized. Experience in the Philippines had shown that the entire salt industry had to play a part in ensuring that iodized salt was bought and used. He therefore proposed that subparagraph 1(4) of the draft resolution should be amended to read: "to establish multidisciplinary national coalitions that include the salt industry (salt producers, distributors and retailers) and the education and media sectors, ...".

Mr RECINOS TREJO (El Salvador) said that the 35 countries of the group of the Americas, on whose behalf he was speaking, had made significant progress towards eliminating iodine deficiency disorders. However, persistent problems remained concerning sustainability. He favoured any strategy based on the promotion of universal salt iodization, cooperation among Member States, and education and communication, and strongly supported the draft resolution.

Dr KANDUN (Indonesia) said that the prevalence of iodine deficiency disorders among schoolchildren in Indonesia had been put at around 11.4%, and some nine million people lived in areas severely endemic for those disorders. The Government had implemented several programmes to reduce the incidence and prevalence of disorders, including promotion of salt iodization, food diversification and the distribution of iodine capsules to schoolchildren and young girls in affected areas. He supported the draft resolution.

Dr XIAO Donglong (China) expressed his appreciation of WHO's work in helping to establish national intersectoral committees on the elimination of iodine deficiency disorders, universal salt iodization and monitoring, and for the cooperation with UNICEF and other international organizations to improve developing countries' prevention and control capacity. With more than 700 million people living in iodine-deficient areas, China was one of the most seriously affected countries. Nevertheless, after years of effort, iodine deficiency disorders had been eliminated in 2000. Serious challenges remained, however, including incomplete supply networks of iodized salt in some areas, illegal salt production, and a recurrence of the disorders in some areas. China would continue its cooperation with WHO and other relevant international organizations in order to achieve sustainability. He supported the draft resolution.

Dr MORICONI (Italy) expressed his strong support for the draft resolution, with the amendments proposed by France, and asked for Italy to be included in the list of sponsors.

Mr ASPLUND (Sweden) supported the amendments put forward by the delegate of France.

Dr ACHARYA (Nepal) said that, with only 63% of households using enough iodized salt, iodine deficiency was a major public health problem in Nepal. Some control activities had been introduced and the long-term aim was universal salt iodization. Nepal welcomed the draft resolution and wished to be added to the list of sponsors.

Dr HAMOUIYI (Morocco) asked WHO to provide technical support to all countries in, first, the evaluation of national programmes, by setting up laboratories for quality assurance of iodized salt and epidemiological surveillance of ioduria and the incidence of neonatal hypothyroidism; secondly, preparing a protocol for sentinel surveillance of the impact of salt iodization on public health; and, thirdly, contributing to the sustainability of programmes through awareness days in schools. He supported the draft resolution.

Ms SAIZ MARTÍNEZ ACITORES (Spain) welcomed the draft resolution. Although improved access to iodized salt and public education campaigns were undoubtedly a priority, it should not be forgotten that cardiovascular diseases were the leading cause of mortality in many countries and hypertension a determining factor. For vulnerable groups such as pregnant women and schoolchildren, excessive salt consumption was actually a risk factor. Therefore, and in order not to contradict WHO's recommendations in the Global strategy on diet, physical activity and health, she supported the amendment proposed by France and fully endorsed the draft resolution, as amended.

Dr KAKAR (Afghanistan) said that iodine deficiency disorders had been common in several localities in Afghanistan, the whole of the country indeed being considered iodine-insufficient. With the support of UNICEF and WHO, salt from four mines was being iodized and distributed throughout the country. Local production was nevertheless too low to meet the needs of the population, and any support to improve further the provision of iodine nutrition would be welcome. He supported the draft resolution.

Dr LARUELLE (Belgium) supported the draft resolution with the amendments proposed by France and asked that Belgium be added to the list of sponsors.

Professor LING (International Council for the Control of Iodine Deficiency Disorders), speaking at the invitation of the CHAIRMAN and on behalf of the Network for Sustained Elimination of Iodine Deficiency, urged all Member States to persevere in the global fight against iodine deficiency. Elimination programmes directly contributed to attainment of six Millennium Development Goals, but, although many countries had eliminated iodine deficiency disorders by 2005, many others had not. Notwithstanding progress, there was an alarming downward trend in usage of iodized salt in some areas. Because iodine deficiency disorders could not be eradicated, if iodine intake decreased, rates of deficiency disorders would increase. If the international community relaxed its efforts at present, even the progress achieved might be reversed. The draft resolution would provide the necessary framework for Member States to carry on the fight.

Eliminating iodine deficiency disorders represented one of the few truly sustainable development efforts. It required making the production and use of iodized salt a habit, without necessitating further interventions. The International Council did not advocate the use of more salt, simply iodized salt. Elimination was an extraordinary bargain: World Bank economists had calculated that each dollar spent on prevention yielded a productivity gain of US\$ 28. Saving a child from brain damage cost a mere US\$ 0.02-0.09 per year. His Council and other development agencies could provide assistance, but Member States bore the burden and responsibility for ensuring that their children grew up without brain damage to fulfil their potential and lead socially and economically productive lives. Failure to follow the efforts through would be harshly judged by history.

Dr LE GALÈS-CAMUS (Assistant Director-General) said that combating iodine deficiency remained a public health priority, for which an inexpensive, safe and effective strategy existed. Despite the considerable progress made, iodine deficiency persisted in all too many countries, and, even in those where efficacious programmes had been put in place, it was essential to ensure their long-term viability. Even though iodization of salt remained the most cost-effective approach, it had to be adjusted in keeping with local epidemiological situations and people's needs, with close collaboration between professionals, public health experts, and producers and distributors of salt. It was essential to ensure that the quality could be controlled, and that iodized salt could be afforded by the poorest sectors of the population.

Promotional campaigns to heighten the effectiveness of existing local programmes should be aimed at encouraging the adoption of solutions that would prevent the effects of iodine deficiency without boosting salt consumption, as that would conflict with WHO's Global Strategy on Diet, Physical Activity and Health. To date, there were no data to suggest that average salt consumption had risen in the wake of iodization or as a result of the promotion of iodized salt.

Other means could be used to supply iodine, but in all cases surveillance and impact assessment were essential, for both controlling the quality of the medium used and ensuring correct iodine content. They were therefore vital components of any national or local programme to combat iodine deficiency.

Dr ZUPAN (Assistant Secretary) read out the proposed amendments. New fifth and sixth preambular paragraphs should be inserted, to read:

Recognizing that the final choice on a measure should always be defined taking into account the degree of iodine deficiency in order to manage the risk of excessive iodine intake in the most sensitive populations, namely infants;

Noting the Global Strategy on Diet, Physical Activity and Health (resolution WHA57.17) and the necessity that action in respect of iodine deficiency is compatible with the strategy recommendation to limit salt (sodium) consumption from all sources;

In the last preambular paragraph the phrase "community-oriented organizations" should be replaced by "Kiwaniis International". Subparagraph 1(1) should conclude: "including through universal salt iodization". In subparagraph 1(3) the words "and mental" should be added after "physical", and "and young children" after "infants". In subparagraph 1(4) the words "salt producers" should be replaced by "the salt industry (salt producers, distributors and retailers)". In subparagraph 2(3) "periodically" should be replaced by "every three years".

Dr PARIRENYATWA (Zimbabwe) suggested that it was inappropriate to single out Kiwanis International for special mention in the last preambular paragraph.

Dr SINGER (United States of America) said that he would prefer to retain the mention of Kiwanis International, since it was an international organization that had raised more than US\$ 75 million for UNICEF's activities related to iodine deficiency control in 80 countries.

Dr PARIRENYATWA (Zimbabwe) said that he had no major objection to including the name.

Mr AITKEN (Office of the Director-General) confirmed that the last preambular paragraph of the draft resolution accordingly retained the mention of Kiwanis International.

The draft resolution, as amended, was approved.¹

Traditional medicine (Resolution WHA56.31)

Dr RUBIANA (Indonesia) said that her Government had formulated a basic policy and regulations on traditional medicine. Therapies that had proved safe and effective would be integrated into the health-care system. The registration of traditional medicinal products and the certification of manufacturers making them on a large-scale had existed for many years. Furthermore, her country's medical society had recognized and accepted acupuncture as a bona fide method of treatment; the certification of acupuncturists went back many years, but licensing was still in its early stages. In order to accelerate the development of traditional medicine, a centre had been set up in each province in order to promote its use, offer safe and effective services, conduct research and clinical trials, and organize training programmes. Several herbal medicines had been developed and were being used by medical practitioners. Her Government intended to work closely with traditional medical practitioners' organizations in order to supervise and monitor traditional medical practices and, to that end, it had facilitated the establishment of several traditional medicine practitioners' associations.

Herbal medicine was the most popular traditional medicine in her country owing to the great diversity of the Indonesian flora. Most people used herbal medicine in their daily lives to promote health and prevent disease. Since herbal medicine had a bright future, her Government was trying to safeguard the intellectual property rights of traditional methods and medicine formulas.

With regard to resolution WHA56.31, the Director-General should be requested to develop an action plan, with clear targets and a definite timeframe, for the development of traditional medicine.

Dr TCHAMDJA (Togo), speaking on behalf of the Member States of the African Region, said that resolution WHA56.31 on traditional medicine had been welcome, because it dealt with a key element of African countries' health policies. The Region had adopted a strategy on traditional medicine and an African Day of Traditional Medicine was celebrated. Although efforts were being made in each State to explore the potential of traditional medicine in a rational manner, the sector was still poorly organized. The African countries thus commended the establishment of a department for traditional medicine within WHO and hoped that substantial resources would be placed at its disposal so that it could function efficiently.

Mr PAK Jong Min (Democratic People's Republic of Korea) drew attention to the fact that traditional medicine was assuming increasing significance as the health sector started to make more effective use of the abundant resources offered by medicinal plants.

In his country, traditional medicine had long been highly valued and efforts were being made to pass on that legacy and modernize its technology and methods. A faculty of traditional medicine

¹ Transmitted to the Health Assembly in the Committee's sixth report and adopted as WHA58.24.

existed in all medical universities, and specialists of Koryo (traditional) medicine were being trained on a systematic basis. Treatments tended to combine traditional and modern techniques and, for that reason, the research and development of traditional medicine were being vigorously pursued. As a result, traditional medicine accounted for 50% of the health care dispensed in his country.

The Academy of Koryo Medicine in Pyongyang, the centre for treatment, research and training, was a WHO collaborating centre. Participants in the Regional Consultation on Development of Traditional Medicine in the South-East Asia Region (Pyongyang, 22-24 June 2005) would exchange experiences and discuss ways of strengthening cooperation among countries in the Region. His country would do all it could to foster the development of traditional medicine.

Dr NYIKAL (Kenya) explained that in Kenya traditional medicine was practised openly and formed part of communities' belief systems. Most patients seeking help from conventional hospitals did so only after undergoing treatment from traditional health practitioners and sometimes they used both forms of therapy simultaneously. The Ministry of Health had therefore established a department with a mandate to implement its policy on traditional medicine. A bill drafted as a follow-up to a national congress on improving the quality of traditional health care was being currently debated in Parliament and an inventory of traditional practitioners was being drawn up. The main challenge Kenya had to face was protecting the knowledge of traditional practitioners through intellectual property rights. For that reason, his Government maintained its support for the resolution.

Dr ANZI (Côte d'Ivoire) said that in his country the political will to promote traditional medicine had been reflected in the launch of a national programme in 2001. Policy on traditional medicine and a traditional pharmacopoeia had been drawn up and a five-year plan for their implementation was in the process of being approved. Three bills on traditional health practitioners' organizations and a code of good practice had been tabled in the National Assembly. Three associations had been recognized and 6346 traditional medicine practitioners had been listed, of whom 93 had been trained in conventional anatomy and hygiene. In an effort to improve the safety and efficacy of traditional therapies and practices, the University of Abidjan had laid out a botanical garden, while a general survey of the country's flora had made it possible to identify some plants of great medicinal value. Researchers and teachers had been trained and research laboratories had been built in order to turn the African pharmacopoeia to good account.

He thanked WHO for enabling the African Intellectual Property Organization to hold meetings on making greater use of traditional medicine and the traditional pharmacopoeia and asked WHO to contribute to equipping the Research Centre into Medicinal Plants and the programme for promoting traditional medicine.

Dr PARIRENYATWA (Zimbabwe) said that most Zimbabweans consulted a traditional medicine practitioner at some point in their lives. The Traditional Medical Practitioners Act of 1996 provided the regulatory framework. The health ministry had created a directory of traditional medicine to promote and coordinate work and established research laboratories for herbal medicines within the national institute of health research. The greatest challenge facing countries was the issue of intellectual property rights over herbal medicines: countries sometimes needed to prove that a particular species of plant really belonged to them. He urged WHO to do more work in that area.

The countries of the Southern African Development Community had adopted a common approach to traditional medicine. He supported the WHO strategy for traditional medicine and called upon the Organization to do more to follow up resolutions that had been adopted.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that, as he understood it, Member States were intended merely to take note of the progress report, not make substantive comments about the situation in their own countries.

Dr LEPAKHIN (Assistant Director-General) noted that many countries had achieved much in the field of policy and safety and efficacy of traditional medicines, and he welcomed the comments by the delegate of Togo.

WHO's most important achievement over the previous two years had been the creation of a global database on national policies and regulation of herbal medicines, based on the survey responses of 141 Member States. A summary report of the findings would be published later that year. In their responses, numerous Member States had asked WHO to continue its technical support under the strategy for traditional medicine.

Guidelines on safety monitoring of herbal medicines in pharmacovigilance systems and the results of clinical trials of treatment using a combination of traditional Chinese and Western medicine to treat severe acute respiratory syndrome had been published in 2004. The fourth volume of WHO monographs on selected medicinal plants would be published later in 2005. Guidelines on good agricultural and collection practices for medicinal plants had also been published. The rational use of medicinal plants was very important, and guidelines had been issued on the provision of reliable information on traditional and similar medicines to consumers. Basic training and safety guidelines for qualified practitioners were in preparation. Training workshops on regulation of herbal medicines for national drug regulatory authorities had been held in all six WHO regions. The Secretariat did a great deal of work in the field of intellectual property rights for traditional medicines.

Implementing the recommendations of the *World report on violence and health*
(Resolution WHA56.24)

Dr WINT (Jamaica) said that his country suffered a high and growing level of violence, which took its toll on national security and the emergency health services. The Government had launched the *World report on violence and health* nationally, appointed a focal point within the Ministry of Health, and created a national violence-prevention alliance, which brought together a broadly representative group of stakeholders with the aim of preventing violence against children and women. A violence-surveillance system had been established in the health sector and the police service. A geographical mapping initiative in the capital city helped to focus interventions on high-risk communities. He thanked WHO and PAHO for their support.

Dr TCHAMDJA (Togo) said that implementation of the resolution was of great importance to Member States of the African Region. Violence-prevention workshops had been organized in the Region, involving various agencies and research institutes. People were becoming more aware of the need to prevent violence, and WHO should continue its advocacy efforts. More international resources were needed in order to combat violence in its various forms.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that his country had appointed a violence-prevention coordinator under a deputy minister within the Ministry of Public Health. The report of a working group on violence had been published, including a plan of action for the prevention of violence in the family. Workshops and presentations had taken place in all regions, with the participation of nongovernmental organizations such as the highly influential Federation of Cuban Women, community members and family doctors and nurses, who were in a position to collect valuable data on violence. Progress therefore had been made, but WHO must continue its efforts.

Dr XIAO Donglong (China) said that WHO had done a great deal to raise public awareness about violence prevention, in the form of guidelines, standards, surveillance mechanisms and training. Nevertheless, many health authorities were still not fully aware of the public health impact of violence, so WHO, UNICEF and other international bodies should intensify their efforts to publicize the issue. Health ministries should be encouraged to work more closely with nongovernmental organizations and carry out advocacy at community level.

Dr LE GALES-CAMUS (Assistant Director-General) said that the *World report on violence and health* had generated regional, national and local initiatives: for example, almost 100 countries had designated a violence-prevention focal point. She recalled that the Eighth World Conference on Injury Prevention and Safety Promotion would take place in South Africa in 2006.

Strategic approach to international chemicals management (Resolution WHA56.22)

Dr HASEGAWA (Japan) said that his country had contributed to the preparatory meetings for the development of a strategic approach to international chemicals management and agreed with WHO's approach. The health sector must be involved in international chemicals management, and chemicals management authorities needed to be integrated into the mainstream of health policy. Japan would continue to support the activities of the International Programme on Chemical Safety. He called on the Secretariat to support Member States in formulating their chemicals management policies so as to take individual country situations into account.

Ms PORNPIT SILKAVUTE (Thailand) said that her country was formulating a national master plan on chemical safety and a national chemical management profile. Chemicals management was important at both national and international levels. Multisectoral partnerships were needed in order to promote the safe use of chemicals. She called on the Secretariat to ensure that health aspects were given due consideration in the strategic approach to international chemicals management.

Dr TCHAMDJA (Togo), speaking on behalf of the Member States of the African Region, said that chemicals accounted for a large proportion of world trade, but the lack of awareness about their harmful effects posed a threat to developing countries. He supported the proposal to hold a high-level international conference on chemicals management in February 2006.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the manufacture of chemicals was of major economic importance, but their contribution to morbidity and mortality in the world was still to be determined. Some chemicals manufacturing had been moved to developing countries, which was a cause for concern. He asked whether "chemicals" should be understood to include medicines. He also asked whether a programme had been set up to develop the strategic approach, and when it was likely to be completed.

Dr ASSI GBONON (Cote d'Ivoire) said that WHO should continue to play a leading role in the health-related aspects of international chemicals management. Her country had sometimes wondered whether solvents or active principles used for the manufacture of medicines, or even precursors, counted as chemicals. States should be encouraged to integrate chemicals management into mainstream health policy. More effective methods were needed to control adverse health effects on the general population, and also to monitor chemicals manufacturers, particularly in developing countries without many resources. Countries should adopt their own national chemical safety programme, in line with the International Programme on Chemical Safety. She called for support to developing countries in that task and encouraged the Secretariat to coordinate the sector and continue its efforts to elaborate the strategic approach to international chemical management.

Dr LEITNER (Assistant Director-General) said that chemical safety and the impact of chemicals on human health was a growing area of concern. Despite the gaps in knowledge about exposure and risks, the available scientific evidence indicated that urgent action was needed. The increase in trade in chemicals, the transfer of manufacturing facilities to developing countries and the large-scale application of chemicals in agriculture and manufacturing made it essential to apply appropriate safety measures, particularly when the toxicity of the chemicals in question was not known.

UNEP was the lead partner in the strategic approach to international chemicals management, but many of the other partners looked to WHO and other health authorities for guidance regarding the

impact of chemicals on human health. The Stockholm Convention on Persistent Organic Pollutants had entered into force in 2004, and the first Meeting of the Conference of the Parties had taken place a few weeks earlier. WHO had been asked to assist in finding safer alternatives to some of the chemicals concerned.

The term “chemicals”, in the sense used in the strategic approach, did not include medicines or their precursors. The strategic approach concentrated on chemicals that had adverse effects on ecosystems and/or human health.

Health authorities should participate in the third session of the Preparatory Committee for the Development of a Strategic Approach to International Chemicals Management (Vienna, 19 to 24 September 2005). The Secretariat could provide funding for at least two health departments from each Region to attend. There was already considerable discussion about the institutional arrangements that would be set up once the strategic approach had been adopted, and the health sector should be there to state its case.

It was important to promote partnerships between the public and private sectors and between the international community and national authorities. Much work remained to be done in order to have good safety systems in place that protected human health.

Promotion of healthy lifestyles (Resolution WHA57.16)

Dr FOURAR (Algeria) affirmed that promotion of healthy lifestyles should be an integral part of national programmes for prevention, screening and comprehensive management of noncommunicable diseases, which were a significant public health problem in Algeria. After carrying out a survey of risk factors using the WHO STEPwise approach to surveillance, the country was in the process of developing a national programme for integrated management of noncommunicable disease, the main components of which were consensus guidelines for treatment, promotion of healthy lifestyles, training, and information, education and communication.

Mrs KRISTENSEN (Denmark), speaking also on behalf of the other Nordic countries, Finland, Iceland, Norway and Sweden, urged WHO to take a leading role in combating the alarming upward trend of noncommunicable diseases and therefore give priority to following up on resolution WHA57.16. Comprehensive strategies were needed that tackled the whole range of determinants, including societal structures, environmental factors and lifestyles. That, in turn, implied committed action by all sectors, as the problem of noncommunicable diseases could not be solved by individuals or by the health sector working alone. Follow-up should be closely linked to other ongoing processes within WHO, including those associated with the WHO Framework Convention on Tobacco Control, the work of the Global Commission on Social Determinants of Health and the Global Strategy on Diet, Physical Activity and Health. The upcoming Sixth Global Conference on Health Promotion in Bangkok would be a timely opportunity to bring those major initiatives together.

More knowledge was still needed on how to change lifestyles effectively. Priority had to be given to compiling such knowledge and to developing and implementing new evidence-based methods. At the same time, better use should be made of existing methods that had proved to be effective. The comprehensive strategy on noncommunicable diseases being developed by the Regional Office for Europe could provide Member States with the best available knowledge for effective disease prevention and health promotion and serve as a useful tool.

Mrs AREEKUL PUANGSUWAN (Thailand) expressed appreciation for WHO's attempts to strengthen capacity for effective health promotion, particularly through PROLEAD, a programme initiated by the Regional Office for the Western Pacific that trained health promotion leaders from countries in the Region. Thailand had provided financial and human resources for the programme, which had yielded fruitful outcomes thus far. Such collaborative initiatives could well be developed and expanded in other regions.

She looked forward to the emergence of a substantive charter on health promotion from the Sixth Global Conference on Health Promotion (Bangkok, 7 to 11 August 2005), which Thailand was

hosting. To further work on health promotion, such conferences should be held on a regular basis, for example, every three years, and be open to participation by people from outside the health sector who worked on health promotion. Thailand urged the Director-General to establish mechanisms for the organization of regular global health promotion conferences.

Dr MIZUSHIMA (Japan) encouraged Member States to develop effective programmes for the promotion of healthy lifestyles in order to compare their situation with that of other countries and exchange information through an objective index. Japan had accumulated significant experience in the prevention and control of noncommunicable diseases and the promotion of healthy lifestyles, and was willing to share its experience and technical support. In April 2005, Japan had co-organized, with the Regional Office for the Western Pacific, a joint Japan-WHO international visitors' programme on noncommunicable diseases prevention and control, inviting health officers from Member States in the Region to the National Institute of Public Health in Japan. The programme had produced many fruitful results.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) highlighted the key roles of primary health care, intersectoral action and community participation in the promotion of healthy lifestyles. The Cuban model of primary health care, which sought to provide comprehensive care for families, individuals and communities, promoted healthy lifestyles through systematic disease prevention and health education activities by health personnel and activists in community organizations. Promotion of healthy lifestyles enjoyed broad popular and intersectoral participation: one programme, on health and quality of life, focused on environmental and behavioural risk factors. Cuba welcomed the progress reported with regard to healthy ageing, school health, physical activity, and oral health promotion, and applauded WHO's plans to continue providing support for capacity building for health promotion at the national and local levels. The Sixth Global Conference on Health Promotion in Bangkok would undoubtedly help to identify best practices and enhance work on promotion of healthy lifestyles.

Dr AL-SALEH (Kuwait) pointed out that health ministers were not ministers of the sick or of disease; promoting health and healthy lifestyles was a key part of their work. Kuwait was working to promote healthy lifestyles and prevent noncommunicable diseases by tackling known risk factors. The Government was seeking to ensure that people received the right information to enable them to prevent disease and remain healthy. Physicians should be urged to provide such information as part of all regular check-ups, so that people were aware of the risk factors for diseases such as cancer.

Mr HOHMAN (United States of America) said that his delegation looked forward to the upcoming Sixth Global Conference on Health Promotion. At the 115th session of the Executive Board, clarification had been sought about the status of the projected outcome of the conference, but no reply had been given. He therefore asked again whether a Bangkok charter for health promotion would have the force of a consensus document negotiated by the international community or simply provide informal guidance to Member States?

Dr TANGI (Tonga) noted that some Member States were still not doing enough or allocating enough resources to implement healthy lifestyle programmes. They appeared, however, to be merely following WHO's example: it had been reiterated repeatedly that lifestyle-related diseases accounted for more than 45% of the global disease burden, yet in the last Programme budget only a relatively small amount had been allocated to promotion of healthy lifestyles and prevention of noncommunicable diseases. Those and lifestyle-related diseases were the most common health problems in the Pacific Islands, which, although their resources were limited, were trying their best to address those problems. WHO could do the same in allocating funding in future for the important area of health promotion and noncommunicable disease prevention.

Dr BELBEISI (Jordan) said that Jordan, like most developing countries, was grappling with a double burden of both communicable and noncommunicable diseases. Some communicable diseases had been brought under control in recent years, but morbidity and mortality from noncommunicable diseases were rising. A risk factor survey in 2004 indicated the magnitude of the problem: 22% of the population over 18 years of age suffered from hypertension and 18% from diabetes; 25% used tobacco; and 35% did not engage in regular physical exercise. Jordan strongly supported the promotion of healthy lifestyles in order to combat those diseases.

Ms THOMPSON (European Commission) said that the Commission, aware of the leading causes of obesity and the major noncommunicable diseases, had made the promotion of good nutrition and physical activity a key priority in its health policy and intended to launch a comprehensive strategy for that purpose in 2006. In preparation it had created a forum called Diet, Physical Activity and Health – a European Platform for Action, involving representatives of all stakeholders, including the food industry, advertisers, retailers, fast-food restaurants, and nongovernmental organizations. The forum would establish a baseline, mapping what each of its members was currently doing to promote healthy eating and regular exercise. Members would then draw up action plans for planned new initiatives and new investments in 2006. In addition, a network of experts on nutrition and physical activity from European Union Member States, WHO and consumer and health nongovernmental organizations had been established to advise the Commission on the creation of a European Community strategy to improve nutrition, reduce and prevent diet-related diseases, promote physical activity and fight obesity. The Commission hoped that that approach and the results that it yielded would be internationally applicable.

Dr LE GALÈS-CAMUS (Assistant Director-General) commented that health promotion encompassed more than the prevention of disease; that broader conception had to be considered both in talking about health promotion and in formulating programmes, including those of WHO. Strengthening capacity at regional and national levels remained a priority for WHO. Programmes such as PROLEAD in the Western Pacific Region were still too limited, and it was hoped to extend such programmes soon to other regions.

The Sixth Global Conference on Health Promotion in Bangkok would allow re-examination of the topic of health promotion in the light of the new challenges associated with the current health situation, particularly those posed by globalization. A Bangkok charter would update the 1986 Ottawa Charter for Health Promotion, which was not an official document adopted by health ministries or WHO. A draft version of the Bangkok charter would be posted on the WHO web site; Member States would have the opportunity to submit comments, which would be incorporated into the draft before the conference. The document would undergo further revision during the conference. It was expected that the conference would not be an end in itself, but would give rise to a series of subsequent health promotion events and to the establishment of programmes in all regions, which would build upon the results of the conference.

WHO Framework Convention on Tobacco Control

Dr AL-LAWATI (Oman) expressed pleasure that there were currently 63 Contracting Parties to the WHO Framework Convention on Tobacco Control and that the first session of the Conference of the Parties would be held in February 2006. What provision would be made to ensure financial support for participation in the conference by countries that had ratified the Convention? Noting that World No Tobacco Day was held each year on 31 May, he pointed out that the theme was decided only in March, leaving the Regional Office for the Eastern Mediterranean little time to translate all the documents. He encouraged the Secretariat to set the theme for future World No Tobacco Day much further in advance.

Dr TCHAMDJA (Togo) said that 12 countries in the African Region had organized meetings of health authorities with a view to developing strategies to strengthen capacity for tobacco control and intersectoral work. Efforts were being made to encourage more countries to ratify the Convention. He asked for increased support from WHO in order to implement the provisions of the Convention in the African countries.

(For continuation of the discussion, see summary record of the twelfth meeting, section 3.)

The meeting rose at 18:10.

TWELFTH MEETING

Tuesday, 24 May 2005, at 09:15

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)
later: Pehin Dato ABU BAKAR APONG (Brunei Darussalam)
later: Dr B. SADRIZADEH (Islamic Republic of Iran)

1. SIXTH REPORT OF COMMITTEE A

Dr BUSUTTIL (Malta), Rapporteur, read out the draft sixth report of the Committee.

The report was adopted.¹

2. ORGANIZATION OF WORK

Ms RØINE (Norway) asked whether the working group considering the draft resolution on infant and young child nutrition could meet again in order to try to reach consensus on a revised text, which it had so far failed to do. Otherwise there was a serious risk that the agenda item might have to be deferred for further consideration by the Executive Board, which would mean yet another year of discussions.

Dr ISLAM (Secretary) said that it was hoped that a meeting of the working group could be held later in the day. In reply to a question from Mr BENTO ALCÁZAR (Brazil), he said that that draft resolution was the only such text before the Committee that was being considered by a working group.

3. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Implementation of resolutions (progress reports): Item 13.19 of the Agenda (Documents A58/23 and A58/23 Add. 1) (continued from the eleventh meeting)

- **WHO Framework Convention on Tobacco Control** (Document A58/23 Add.1) (continued from the eleventh meeting)

Dr HERMIYANTI (Indonesia) recalled that her country had been actively involved in regional and international negotiations on the Framework Convention. Unfortunately, opposition from farmers and the tobacco industry had so far made it difficult to sign or ratify the treaty.

Professor TLOU (Botswana) said that her country had ratified the Framework Convention in January 2005. It was reviewing its legislation to facilitate implementation of the Convention's provisions but had already legislated to control smoking in public places. Sustained action would be

¹ See page 354.

required to achieve the public health objectives of the treaty. The Secretariat should continue to support Member States in formulating educational programmes on the harmful effects of tobacco and in implementing the provisions of the treaty.

Dr HASEGAWA (Japan) said that the Framework Convention was the first step in promoting global tobacco control. Japan had ratified the treaty in June 2004 and was coordinating tobacco-control activities among relevant ministries. It was expanding educational programmes on the health effects of tobacco. Legislation to prevent passive smoking had already resulted in a significant decline in the smoking rate among adult men in the past few years. The Secretariat should continue its efforts to promote ratification of the treaty by Member States, taking into account the specific situation in each country.

Ms WILSON (Canada) welcomed the progress made since the entry into force of the Framework Convention and urged all Member States that had not yet done so to ratify the Framework Convention. She expressed appreciation of the tireless work to ensure a comprehensive worldwide approach to tobacco control, and looked forward to the first session of the Conference of the Parties.

Ms LAMBERT (South Africa) applauded the countries that had ratified the Framework Convention. South Africa had done so in April 2005 and looked forward to the first session of the Conference of the Parties. Ratification had been delayed by intensive lobbying of parliamentarians by the tobacco industry, despite strong national tobacco-control legislation. The industry's tactics necessitated vigilance, and, in pursuance of resolution WHA54.18, the Secretariat should intensify its monitoring and surveillance of the industry's activities and report as soon as possible on the industry's attempts to influence the development and implementation of public health policy globally.

The report of the second session of the Open-ended Intergovernmental Working Group on the WHO Framework Convention on Tobacco Control would be useful for preparing for the first Conference of the Parties.

Ms MULVEY (Corporate Accountability International), speaking at the invitation of the CHAIRMAN and on behalf of the Network for Accountability of Tobacco Transnationals as well as her own organization (formerly Infact), said that the two organizations she was representing were collaborating with many governments to ensure wide acceptance of the treaty. The useful recommendations of the Intergovernmental Working Group to the Conference of the Parties would be the base for implementation of the substance of the treaty, including the ban on tobacco advertising, promotion and sponsorship. She had noted the efforts to establish a Convention secretariat that was institutionally linked to WHO but accountable to the Conference of the Parties and fully funded, and the consensus that the rules governing the participation of observers at that Conference should facilitate that of public-interest nongovernmental organizations while preventing the infiltration of the tobacco corporations, their subsidiaries and affiliates.

Multinational tobacco companies had a fundamental conflict of interest with the objectives of the treaty and were becoming increasingly aggressive and sophisticated in their attempts to undermine it. She cited examples of tactics negotiators had had in mind in drafting parts of the Framework Convention. Pursuant to resolution WHA54.18, Member States and the Director-General should remain alert to efforts by the tobacco industry to interfere in health policy development and other tobacco-control measures. The Director-General should be requested to report to the Health Assembly on such activities. Nongovernmental organizations were watchdogs, supporting the treaty's swift implementation. The Conference of the Parties and the Secretariat must have the ability and the political will to withstand pressure from outside forces, including non-Parties and the tobacco industry.

Ms MYNDIUKOVA (Framework Convention Alliance on Tobacco Control), speaking at the invitation of the CHAIRMAN, welcomed the ratifications of the Framework Convention and congratulated countries that had begun implementing tobacco-control measures.

The growing, manufacture and trade of tobacco, tobacco use and the resulting diseases were related to many world problems and to all eight Millennium Development Goals. Since the start of the formal negotiations on the Framework Convention, more than 12 million people had died of tobacco-related diseases, and the tobacco industry had significantly expanded its markets in the developing world, targeting women in particular, who endangered not only their own health but that of their families and unborn children. She urged all countries to ratify the Framework Convention and implement strong tobacco-control measures without delay. Most measures called for in the treaty cost little, and some even raised revenue: all would save government resources and, more importantly, lives.

Mrs WIENKAMP-WEBER (International Council of Nurses), speaking at the invitation of the CHAIRMAN and also on behalf of the International Pharmaceutical Federation and the World Medical Association, said that the three organizations had established the World Health Professions Alliance in order to mobilize nurses, pharmacists and physicians worldwide and to enhance a multidisciplinary approach to health and social issues. A key activity was providing support for the Framework Convention, with mobilization of the organizations to petition their governments to support the treaty.

She commended WHO's leadership on tobacco control and its choice of theme for World No Tobacco Day 2005, "Health professionals against tobacco". Health professionals worldwide were frustrated by the increasing use of tobacco products, and particularly concerned that the tobacco industry continued to target young people, women and developing countries to expand its markets. It was therefore disturbing that tobacco-control measures were weak or non-existent in many countries and that only 66 countries had so far ratified the Framework Convention. The organizations she represented had collaborated with WHO and international nongovernmental organizations in developing a tobacco code of practice for health profession organizations, were continuing to collect data to inform their anti-tobacco activities and had developed resources and guidelines for training on tobacco control and cessation of smoking.

Dr BETTCHER (Framework Convention on Tobacco Control) said that he had taken note of the comments and recommendations. The Framework Convention had become one of the most widely embraced treaties in United Nations history. Since preparation of the report, three more Member States had become Contracting Parties: the Democratic People's Republic of Korea, the Republic of Korea and Saudi Arabia. The exact date in February 2006 and venue of the first session of the Conference of the Parties would be confirmed soon. The Secretariat was continuing to provide technical support to Member States to become Contracting Parties and in implementing the Framework Convention and, pursuant to resolution WHA54.18, was issuing monthly reports on the results of its monitoring of the tobacco industry. Member States that had not become Contracting Parties would need to do so by November 2005 in order to participate as full voting members in the first session of the Conference of the Parties.

In response to the delegate of Oman, he said that, at its second session, the Open-ended Intergovernmental Working Group had proposed establishing a travel fund to defray the travel costs of attendance at the Conference of the Parties of delegates from low-income and lower-middle-income countries. That approach would be followed for the first session.

Resolution WHA42.19 had designated 31 May of each year as World No Tobacco Day. The themes for each year were selected as far in advance as possible, and the Secretariat would take note of the comments made by Member States in considering future subjects.

The Committee noted the progress reports.

Pehin Dato Abu Bakar Apong took the Chair.

Ministerial Summit on Health Research: Item 13.18 of the Agenda (Document A58/22)

Dr YOUSSEF (Maldives, Representative of the Executive Board) reported that, during its 115th session, the Executive Board had discussed a draft resolution on the Mexico Statement from the Ministerial Summit on Health Research (Mexico City, 16 to 20 November 2004). Members of the Board had agreed to continue the debate by electronic means. As a result, a revised draft resolution had been formulated, and was contained in paragraph 8 of document A58/22.

Mr BAILÓN (Mexico) thanked WHO for having designated Mexico as the host country for the Summit, which had been the largest gathering of health ministers ever held on the topic of health research. The interaction among producers, funders and users of health research had been extremely fruitful. The Mexico Statement on Health Research was a call to strengthen health research as an essential move for achievement of the Millennium Development Goals. He urged Member States to heed that call and to approve the draft resolution.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) endorsed the Mexico Statement on Health Research and supported the draft resolution. Such a resolution was needed to provide a framework for action by the Secretariat, Member States, the scientific community and development partners to ensure that health policy was underpinned by evidence-based research, taking into account the target date for the attainment of the Millennium Development Goals, which was only 10 years away. The text of the draft resolution had been circulated electronically among Board members and contained square brackets to signify wording on which agreement had not been reached owing to time constraints. He proposed that further consideration by the Committee should be postponed, pending informal consultations to try to achieve consensus on the text.

Ms KONGSVIK (Norway), speaking on behalf of the Nordic countries, said that greater focus on health research had been a major achievement of the Mexico meeting. Research was needed on health systems and ways of achieving the Millennium Development Goals and health for all. Health systems must be able to provide comprehensive, universal and equitable health services of high quality, while influencing the social determinants of health. That was a challenge for all, and especially for the developing world. More research was needed to strengthen the knowledge base for decision-making in health policy, especially with regard to the organization and financing of health systems on the basis of pooled risks and shared resources, and to increase the capacity of developing countries to gather data and conduct relevant research. Emphasis should be placed on structures at the national level that were appropriate for the kind of research needed. Member States should commit themselves to providing the necessary funding to implement the draft resolution once adopted.

Attention should also be focused on increasing access to research findings. The Canadian Institutes of Health Research had introduced early registration of clinical trials, and it might be worth making public registration compulsory. The draft resolution called for a voluntary system of linking registers of clinical trials. More evidence was needed of the health benefits, side-effects and economic costs of new techniques and pharmaceutical products.

The Nordic countries supported the proposal for a new WHO research programme on health-systems research and strongly favoured adopting a consensus resolution to reflect the spirit of the Mexico Statement on Health Research. She agreed with the delegate of Thailand for further consultations.

Dr TRAORE (Mali) said that the draft resolution faithfully reflected the Mexico Statement. He suggested, however, that subparagraph 2(4) be amended to specify that research findings should be used in decision-making.

Dr WINT (Jamaica) welcomed the Mexico Statement and looked forward to the adoption of a strong resolution on health research. The countries in the Caribbean Community had a strong tradition of biomedical health research, and the Caribbean Health Research Council was working with health ministries in the region to define the health research agenda for the future. There were many challenges, including closer alignment of the research agenda with health service needs, strengthening of research capacity (especially in ethical and systematic reviews), translating and communicating findings to stakeholders at policy, programme and community levels, and mobilizing the necessary resources. Those efforts would require technical assistance.

Dr MBONEKO (Burundi) welcomed the draft resolution and the aim of making the results of high-quality research available to all who needed them. As the Director-General had said in his opening statement, action without knowledge was wasted effort just as knowledge without action was a wasted resource. The chief obstacle to research was invariably a lack of funds. The public and private sectors in the rich countries must ensure that the poor countries received sufficient financial and technical assistance to develop their health research activities, which were vital for attaining the Millennium Development Goals.

Dr NYIKAL (Kenya) said that in his country the national research institute was funded from the health ministry's budget and by development partners. There was a national ethical review board and three institutional review boards, but the link with policy-making needed strengthening. At the Mexico Summit, emphasis had been placed on coordinating research in and between countries. Kenya, Uganda and the United Republic of Tanzania were establishing an East African health research council, which would coordinate research and link the findings to policy decision-making. He supported the draft resolution, and proposed the addition in subparagraph 4(1) of the words "and to report on progress to the Fifty-ninth World Health Assembly".

Mr SHONGWE (Swaziland) emphasized the need for high-quality research to form the evidence base for policy. His country had recently revived its national health research department and its national health research and ethics committee, which would advise the Minister of Health on issues such as clinical trials. It would need significant technical support from WHO in its endeavours to institutionalize health research. He endorsed the draft resolution.

Mr ABDOO (United States of America) said that the Ministerial Summit had provided a platform for the interchange of ideas and expertise and had emphasized the critical need for investment in health research and innovation. Governments should review the Mexico Statement carefully and explore ways to support investment in order to strengthen their health systems. High-quality health research required transparency, sustainable investment and a strategic vision for translating research findings into policy. He had several amendments to propose to the draft resolution, and welcomed the idea of a drafting group to finalize the text.

Ms IMAI (Japan) endorsed the view that health research should be promoted as a basis for health policy. The term "takes note of" was more appropriate than "endorses" in paragraph 1 of the draft resolution, as many countries, including her own, had not been represented at the Ministerial Summit, and much of the content of the Mexico Statement was included in the draft resolution.

Dr ZAINAL ARIFFIN HAJI YAHYA (Brunei Darussalam) agreed that research on health systems should be treated as a priority in informing policy-makers and supported the draft resolution.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the conclusions of the successful Ministerial Summit needed to be implemented. In Cuba, health research was regarded as a necessary investment to identify needs that could be met through science and technology. It was conducted on the basis of regularly updated five-year plans by research institutions, universities and science centres, and the

findings were applied within the national health system. There were still major social and economic disparities in the Americas which held back the transfer of knowledge. Health research should be conducted according to the shared Millennium Development Goals, in which human development was spurred by the concept of equity. The Summit had also emphasized that research should focus on priority health problems, as part of a policy to ensure the efficient and equitable distribution of quality health services. Once research had been completed, the findings should be made available both locally and internationally. Through eHealth, scientific knowledge could be transmitted to the most remote areas, and an experiment along those lines was under way in Cuba. He supported the draft resolution.

Dr BRUNET (France) welcomed the outcome of the Ministerial Summit. The draft resolution should be an opportunity to put more emphasis on WHO's current and future research activities and to underline the ethical dimension of health research. He intended to propose an amendment to that effect and agreed with previous speakers that a drafting group should be set up to finalize the text.

Ms PODESTA (Australia) welcomed the recommendations of the Ministerial Summit, which were in line with the agenda of the WHO Advisory Committee on Health Research: health research was crucial for strengthening health systems, improving equity in health systems and advancing development; strong national health research systems were needed, underpinned by principles of ethics and equity; evidence should be used in formulating policy and deciding on prevention and treatment; and research must be published, assessed and disseminated by means appropriate to the users. She supported the draft resolution.

Dr XIAO Donglong (China) said that strong national health systems were needed to achieve the Millennium Development Goals. Health policies and systems should be based on high-quality health research, and effective steps should be taken to ensure the quality of research, while supporting the research capabilities of developing countries. The public should be kept informed of health research findings. WHO had an important role to play in promoting health research to facilitate achievement of those Goals.

Mr BASSE (Senegal) supported the proposal for a drafting group.

Dr AHMED (Pakistan) said the Mexico Statement on Health Research was a landmark. Health research was vital for ensuring the equitable distribution of high-quality health care. Most current research was on clinical questions, and the Secretariat could play a useful coordinating role in ensuring that the results were shared among Member States; however, the focus should shift to health systems research, to evaluate the available interventions and to identify better ones. He supported the draft resolution, and the proposal to convene a drafting group.

Mrs SACKSTEIN (International Alliance of Women), speaking at the invitation of the CHAIRMAN, expressed concern that only about 4% of global funding for health research was being spent in middle- and low-income countries. The Alliance supported the Mexico Statement and especially the recommendations to close the gap between knowledge and practice in order to strengthen malfunctioning health systems. Many inequities in health stemmed from biases related to gender, ability to pay, race or social class. To achieve Millennium Development Goal 5, "Improve maternal health", governments and civil society must investigate the socioeconomic determinants of maternal mortality and morbidity. That Goal should be understood to include an integrated approach to all core aspects of reproductive health, including access to contraception and safe abortion. Family planning services and care and interventions during pregnancy should be available locally, and research would help to determine which local settings were suitable. For Goal 3, "Promote gender equality and empower women", attention should focus on the inequalities experienced by women and girls. In the light of Goal 6, research should be encouraged into linking work to combat HIV/AIDS with reproductive health services. There was a severe lack of funding for certain areas of health

research of vital importance for women and girls, such as appropriate antiretroviral medicines and dosage for HIV-infected children, childhood obesity, physical activity for the young and the old, noncommunicable diseases caused by modern diets and lifestyle, and mental illness.

Ms BOFFI (International Federation of Pharmaceutical Manufacturers Associations), speaking at the invitation of the CHAIRMAN, supported WHO's initiative in setting up the International Clinical Trials Registry Platform and welcomed dialogue with all stakeholders. The pharmaceutical industry favoured transparency and access to information on clinical trials and had adopted a joint position on registering ongoing trials and reporting the results of completed ones through a range of private- and public-sector portals. The Federation would shortly be launching a "one-stop" internet search portal with links to various sites containing data provided by pharmaceutical companies. Any approach to disclosure must further the objective of greater transparency and access while supporting innovation. Stakeholders must work together to consider the public health implications of broader disclosure and its relevance to decision-making in health care; privacy concerns; national legislative and regulatory issues; and the impact on innovation and stakeholder involvement. The pharmaceutical industry strongly supported the standards for disclosure agreed at the stakeholder meeting hosted by WHO in Geneva in April 2005, and the Federation's members would continue working with the Secretariat on standard-setting in that area.

Dr EVANS (Assistant Director-General), replying to the debate, welcomed the broad support expressed for the process set in train by the Ministerial Summit.

The CHAIRMAN suggested that the agenda item should remain open, pending the outcome of the discussions of the drafting group.

It was so agreed.

(For approval of the draft resolution, see summary record of the fourteenth meeting, section 2.)

Scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS
(resolution WHA57.14): Item 13.20 of the Agenda (Document A58/23)

Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the Member States of the European Union, the acceding countries Bulgaria and Romania, the candidate countries Croatia and Turkey, and the countries of the Stabilisation and Association Process and potential European Union candidates, Albania, Bosnia and Herzegovina, Serbia and Montenegro, and The former Yugoslav Republic of Macedonia, said that, at the end of 2004, 39.4 million people were living with HIV/AIDS, 95% of them in developing countries, with 5 million new infections every year and more than 8000 people dying every day. The number of cases of infection both within the European Union and in neighbouring countries had increased. The European Union supported WHO's initiatives towards achieving the health-related Millennium Development Goals. Balance had to be maintained between treatment and care, and prevention, and the UNAIDS prevention strategy should be based on reliable evidence, in which regard WHO had a critical role as a cosponsor of that programme. The latest statistics confirmed the increase in the number of women affected by HIV/AIDS, particularly in sub-Saharan Africa and the Caribbean, the risk of infection for women between the ages of 15 and 24 being 2.5 times greater than that for young men owing to both biological and social factors. All HIV/AIDS policies should focus particularly on women, with support for reproductive and sexual health and associated rights. Success would be possible only with universal access to high-quality reproductive health-care services and their better integration into HIV/AIDS care. A high level of political and financial commitment must be maintained for information, services and research in reproductive and sexual health. It was also important to provide treatment and care and to ensure reproductive choice for people infected with HIV, in line with the objectives of the International

Conference on Population and Development (Cairo, 1994). The European Union and its Member States were increasing their efforts in HIV/AIDS prevention, treatment and care, and a ministerial conference (Vilnius, 16 and 17 September 2004) had resulted in strengthened coordination.

While expressing full support for the “3 by 5” initiative, she was concerned about the lack of progress in the prequalification of medicines. The delays encountered were causing difficulties in buying medicines through the Global Fund to Fight AIDS, Tuberculosis and Malaria. Regular, significant contributions were made to the project by several European Union Member States and the European Commission. The necessary efforts to ensure the success of the project should be made forthwith. The European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007-2011), adopted by the European Commission in April 2005, would provide participating developing countries with technical and financial support to fight the three diseases effectively and guarantee access to treatment.

Almost all countries had adopted national policies on HIV/AIDS, but funding, even though more plentiful than before, deplorably remained insufficient. She called for implementation of concrete, effective, focused and coherent measures against HIV/AIDS, including global prevention, universal access to treatment, and effective responses from health systems.

Dr HAMOUIYI (Morocco) said that, in Morocco, a national programme to combat AIDS had been established in 1986. The fact that the highest authorities of a Muslim, Arab, African country were committed to fighting HIV/AIDS had facilitated the introduction of a national strategy, which had been instrumental in keeping the incidence of the disease very low. That commitment had also made it possible, despite the sociocultural and religious context, to talk openly about condoms and other means of preventing the transmission of HIV and had prompted the Government to devise a national programme covering prevention, free treatment with triple combination therapy, monitoring of all persons living with HIV and mass media campaigns. The information, education and communication activities had been conducted with the active, committed participation of all sectors of society and thanks to the provision of the requisite funding from the national budget, United Nations agencies and bilateral cooperation.

Under the national strategy for combating AIDS over the period 2002-2004, sentinel surveillance was extended to 24 sites, second-generation HIV sentinel surveillance had been introduced, and epidemiological studies had been conducted on sexually transmissible diseases and drug resistance. Plans for the future included preparation of the national strategic plan for 2006-2010, in collaboration with all programme partners. He thanked WHO and other United Nations agencies for their support and supported all the initiatives that had been proposed.

Dr SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, said that only 700 000 of the estimated 6 million people needing antiretroviral treatment currently received it, 310 000 of whom were in Africa. As the effectiveness of antiretroviral therapy in resource-constrained settings had been proven, Member States should continue to strengthen prevention and treatment interventions and develop capacity to deal with the emergence of drug resistance. Access to treatment, prevention, care and support for those living with HIV/AIDS were integral parts of a comprehensive health-sector response at national level, but required adequate financial support; social stigmatization, discrimination, gender inequality, economic constraints, limitations in health-care capacity, and inadequate human resources were among the major impediments. He emphasized the need to reduce the costs of antiretroviral treatment further, recognized the need to strengthen health systems and human resources, and underlined the importance of WHO's work in helping developing countries to obtain safe, effective, affordable antiretroviral medicines and diagnostic tests. He asked for an update on the “3 by 5” initiative.

Traditional medicine could play a major role, either in combination with evidence-based medicine or alone. More research should be undertaken into its use in the treatment of opportunistic infections.

African Member States were committed to applying the “Three Ones” principle, to improve coordination and harmonization of HIV/AIDS control activities in countries. Short- and long-term human resources strategies would be developed and implemented to train, recruit and retain health workers and create mechanisms to provide better salaries, incentives and working conditions. Resource allocation would be increased to strengthen health and social systems, in order to guarantee their capacity effectively to deliver HIV/AIDS prevention, treatment, care and support services. Research into traditional medicine would be strengthened. Bilateral trade agreements would take into consideration the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights, and he called for intensified support to countries in that regard.

He encouraged the Secretariat to continue: to strengthen its stewardship role and technical capacity to respond to the HIV/AIDS pandemic in a coordinated manner; to link the scaled-up response to HIV/AIDS to a broad effort to strengthen national health systems; to provide guidance to Member States on the development of national policies and research into traditional medicine; to support African countries in making applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria; and to intensify work on nutrition in the context of HIV/AIDS.

Dr TADA (Japan) said that the encouraging results of the “3 by 5” initiative should be analysed and reflected in future HIV/AIDS programmes. She also commended WHO’s efforts to strengthen prevention alongside treatment, in order to balance the two. In view of the importance of coordination, her Government agreed with the “Three Ones” principle, but was concerned that some coordination appeared to be donor-driven. In order for programmes to be sustainable, all development partners should work together with the recipient countries. As HIV/AIDS was closely related to social and cultural factors, Japan had begun to train and deploy volunteers to work at grass-roots level and to support nongovernmental organizations in the field. She asked WHO to place more emphasis on human resources development and technical support in the field, to ensure sufficient numbers of experts for HIV/AIDS programmes.

Mrs AHO (Togo) thanked WHO, UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria for their support. Her Government shared the concern expressed by the European Union about the rising number of women who were living with AIDS and AIDS orphans. An integrated approach to combating AIDS, malaria and tuberculosis should be emphasized and more funds found to care for AIDS orphans, especially in Africa. The Secretariat should contact all the funding bodies concerned, to speed up the unduly-long disbursement of funds.

Although nongovernmental organizations played an important role, they did not frame national policies. More resources should therefore be placed at the disposal of governments, and the Regional Office for Africa should encourage consensus between governments and nongovernmental organizations. All Member States should join forces and pool their resources to combat AIDS, as it was a fight that concerned them all.

Mrs REID (United Kingdom of Great Britain and Northern Ireland) requested clarification of plans for the successor to the “3 by 5” target. Her Government hoped that consensus could be reached on an ambitious but realistic target for scaling up AIDS treatment and care. It favoured working towards an international agreement on universal access to AIDS treatment by 2010. Any new target and associated strategies should be integrated with prevention measures as part of a comprehensive response to HIV/AIDS; reflect the processes and priorities of Member States; be integrated into health and social systems to avoid creating parallel and unsustainable mechanisms; and meet the needs of women and children as a priority, with disaggregated monitoring systems to allow tracking of specific groups. She expressed support for efforts to improve coordination between WHO and other United Nations agencies in increasing prevention, treatment and care, including clarification of roles and responsibilities.

Dr OPIO (Uganda), commending the progress made in implementing resolution WHA57.14, said that, following the announcement of the “3 by 5” initiative, Uganda had strengthened its health-care system to expand treatment and care in a coordinated and comprehensive response to HIV/AIDS. Some 55 000 AIDS patients in Uganda (about 40% of those with the disease) had access to antiretroviral treatment, with drugs obtained from WHO prequalified companies. Maps had been drawn showing the exact locations of various services, including antiretroviral treatment, counselling and testing (for which there was at least one facility in every district), and prevention of mother-to-child transmission of HIV. HIV/AIDS services were being provided in accordance with the “Three Ones” principle. He called on WHO to continue giving the necessary technical support so that progress could be made, and encouraged development partners to assist in health systems development, which was crucial to further success in implementing the resolution.

Dr MOSA (Madagascar) reported alarming seroprevalence rates for specific groups in his country: 11% of sex workers and 11% of the rural population were infected with HIV. Although overall prevalence remained low, at about 1.14%, drastic measures were being taken to prevent a disastrous and uncontrollable epidemic. Besides financial assistance from the Global Fund to Fight AIDS, Tuberculosis and Malaria, the fight against HIV/AIDS was backed by political commitment at the highest level, and a national committee had been set up in the Presidency to coordinate strategies.

Mrs TSENILOVA (Ukraine) said that expanded access to antiretroviral treatment formed an essential part of the response to the HIV/AIDS epidemic in Ukraine, and was accorded the same importance as care and support, social security and assistance for patients. Treatment for AIDS had become widely available, with the number of people receiving antiretroviral treatment increasing eight-fold to more than 1600 in the nine months to May 2005 with a target of around 3000 by the end of 2005. In the past year, three laboratory centres had been established to improve diagnostic facilities and viral load determination.

Within the framework of the “3 by 5” initiative, and with technical support from WHO, national treatment protocols and minimum standards of antiretroviral treatment had been drawn up, and the training of medical and social welfare staff had begun. Pilot projects involving alternative therapies were being organized to avoid breaks in treatment and the risk of drug resistance. Ukraine was the only country in Europe and Central Asia participating in the project to improve coordination and assure consistency with the “Three Ones” principle, and the project was being implemented successfully.

Ukraine greatly appreciated the support of WHO and UNAIDS and counted on continued support in consolidating national initiatives.

Mr POMOELL (Finland), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, welcomed WHO’s efforts within the UNAIDS framework to implement the “Three Ones” principle in 10 countries. Collaboration on HIV/AIDS issues across WHO’s programmes was particularly important. The reference in the report to the prequalification of antiretroviral medicines was disappointingly brief; more information about WHO’s work would have been useful, given its crucial importance for funding instruments such as the Global Fund to Fight AIDS, Tuberculosis and Malaria. He therefore urged the Director-General to devote the requisite resources and attention to that issue and to keep Member States informed of any funding problems.

Several actions were crucial to the implementation of the “3 by 5” initiative. Vulnerable and marginalized groups should be given comprehensive and non-discriminatory coverage. The existing health infrastructure must be strengthened in a long-term, sustainable manner. Tools ensuring that individuals complied with treatment regimens must be developed, and strategies and solutions for life-long treatment devised. Emphasis should be on improving regular health-care services and separate, parallel treatment entities should be avoided. Special attention should be given to ensuring that treatment was equally accessible to girls, women and HIV-positive health workers. Voluntary

counselling and testing services should be integrated with sexual and reproductive health care. All treatment must include a preventive component.

He asked how prevention was incorporated into the “3 by 5” activities, and for more information about the Secretariat’s experience with the HIV/AIDS and health systems platform.

Dr XIAO Donglong (China) noted that the improvement of health infrastructures had greatly contributed to the treatment and control of HIV/AIDS. China greatly appreciated the efforts of WHO and other international and nongovernmental organizations to improve the access of developing countries to pharmaceutical and diagnostic products. Despite progress, providing antiretroviral treatment for three million people would be extremely difficult owing to the high cost of medicines, which created a heavy burden for countries and jeopardized the attainment of the “3 by 5” target. China hoped that WHO would take further action to resolve such issues in the near future. All parties should cooperate actively to enable more patients to receive standardized treatment and fulfil the “3 by 5” target.

Dr SHEVYRYOVA (Russian Federation) underlined the importance of ensuring access to antiretroviral treatment for all those infected with HIV. National health systems should be strengthened as a basis for implementing the “3 by 5” initiative, which was essential in guaranteeing such access. She fully supported the Secretariat’s guidelines on equity and accessibility of medical treatment, including for vulnerable groups, such as injecting drug users, sex workers, and prisoners, and the initiative of WHO and UNAIDS to establish HIV/AIDS rapid response units. She welcomed the various guidelines issued, including on treatment for women living with HIV and preventing mother-to-child transmission of HIV, and endorsed the need for further improvements in national epidemiological surveillance systems and for behavioural research in individual population groups. The “Three Ones” principle was fundamental to enhancing coordination and programmes in the fight against HIV/AIDS.

Dr ADJA (Côte d’Ivoire) encouraged the Secretariat in its efforts to improve care for people living with HIV/AIDS. His Government had created a special ministry for HIV/AIDS responsible for policy, advocacy, mobilization at all levels and coordination of initiatives. State assistance to patients had gradually been increased and a strategic plan, a multiparty committee and a plan for monitoring and evaluation had been established. The health ministry played a central role through the national programme in providing care for persons living with HIV/AIDS and reducing mortality and morbidity. Despite many problems, nearly 10 000 patients were receiving antiretroviral treatment, and there existed 80 centres for care, diagnosis and prevention of mother-to-child transmission of HIV. The Government requested the support of WHO and other partners to increase the number of care centres so as to improve and extend care to the entire country, train doctors and health workers in integrated care and give all patients access to treatment by reducing the cost of antiretroviral agents. Côte d’Ivoire would like Abidjan to be made a focal point for the “3 by 5” initiative in order to speed up activities. He supported the statement by the delegate of Togo.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) expressed concern that the funds committed by donors represented only 83% of the amount needed for the implementation of the HIV/AIDS programme. It appeared that the “3 by 5” milestone for December 2004 had been achieved in developing countries but there was no information on the results in developed countries, the progress of prevention programmes, the present state of the epidemic, or the prospects of discovering an effective vaccine. In Cuba, nationally-produced generic antiretroviral agents had gradually been introduced from 2001, resulting in 100% coverage by the end of 2002. Cuba was able to provide five different combinations free of charge to all persons needing such treatment. The preventive work carried out by medical staff, family members, other professionals and even HIV-positive people was particularly important. As a modest contribution to the HIV/AIDS effort, Cuba had sent 1900 health workers to 31 African

countries and had offered assistance to countries in the Caribbean, one of the most affected areas. WHO must continue to work with other specialized agencies to combat the epidemic effectively.

Ms GILDERS (Canada) commended the progress made by WHO and its partners on the “3 by 5” initiative, the linking of the initiative with existing tuberculosis control programmes and primary health care and WHO’s cooperation with countries to develop strategies for the sustainable financing of life-long HIV treatment and care, which were important to the integration of a scaled-up HIV/AIDS response within existing health systems. In the context of long-term treatment, Canada also encouraged efforts to address human resource needs, including training for formal and informal caregivers in the provision of care to individuals with HIV/AIDS. As women accounted for nearly half the people living with HIV/AIDS and often faced barriers in access to prevention and treatment, the Secretariat should provide guidance on integrating HIV/AIDS with sexual and reproductive health programmes and services. It should also strengthen its work on accessibility of treatment to ensure that the most vulnerable benefited from the “3 by 5” initiative.

Dr MUGURUNGI (Zimbabwe) drew attention to the need to increase access to counselling and testing services, for nutrition to be more closely considered, especially for persons with HIV and AIDS, and for increased access of women and children to comprehensive care and treatment. He urged WHO and other partners to increase resources so as to permit achievement of the “3 by 5” targets.

Dr RUIZ (Mexico) said that his country’s policies against HIV/AIDS were based on prevention, integrated care, respect for human rights and the active participation of society, and, as announced at the Thirty-eighth session of the United Nations Commission on Population and Development (New York, 4-8 April 2005), its prevention strategies from the beginning of the pandemic had ensured one of the lowest incidence rates of HIV/AIDS in the Americas, cases being confined to specific population groups. Transmission by blood transfusion had been eliminated and prenatal transmission kept under control. Prevention strategies aimed at men who had sex with men, injecting drug users, and sex workers had been strengthened and implicated civil society organizations. Mexico had also made other important advances. The 2006 target for free access to antiretroviral agents for all persons living with HIV/AIDS had been reached by the end of 2003. Action was also being taken to overcome the stigmatization and discrimination associated with HIV/AIDS. It was vital for WHO to continue to promote negotiations and consultations to obtain lower prices for antiretroviral agents and diagnostic reagents.

Dr DAHL-REGIS (Bahamas), speaking on behalf of the member countries of the Caribbean Community, said that her region had a high prevalence of HIV/AIDS but in some instances the epidemic had been successfully slowed. In Bahamas the incidence of HIV/AIDS had decreased and transmission of HIV from mother to child had been interrupted. A coordination mechanism, the Pan Caribbean partnership against HIV/AIDS, involved various partners in efforts to harmonize policies, tackle destigmatization and mobilize resources. Many countries had increased the use of antiretroviral agents and within two years maternal mortality and admissions to hospital had been reduced. Such efforts, however, had required a shift in resources from chronic noncommunicable diseases even though the latter contributed more to mortality in the region than HIV/AIDS. Commitment to care and treatment continued to have the support of the peoples and governments but it might not be possible to continue antiretroviral therapy if prices increased. In that regard, she endorsed the statements made on behalf of the European Union and the Nordic countries and the proposal by the United Kingdom. The Caribbean States therefore requested WHO to accelerate the prequalification of drugs and to increase the number of manufacturers of antiretroviral agents so that they did not become hostage to the prices of a single manufacturer.

Ms SICARD (France) reiterated her country’s full support for WHO’s renewed leadership in the fight against AIDS through its “3 by 5” initiative. Although the intermediate December 2004 target

had been attained, information on WHO's timetable for evaluating the results of the initiative would be useful. If the targets were not reached, it would be necessary to analyse the reasons and draw the conclusions, particularly in respect of the roles of each stakeholder. France welcomed the establishment of the Global Task Team led by UNAIDS which was responsible for drawing up recommendations to rationalize, simplify and harmonize the practices of the multilateral agencies in the fight against AIDS. Greater support at country level seemed to be the top priority, in particular by strengthening health systems and training human resources. The question of human resources had become critical owing to a lack of staff in all sectors involved in the fight against AIDS and more generally in the health sector. A link between HIV/AIDS and reproductive health services was essential. France reaffirmed its support for the prequalification programme, and its commitment to the Global Fund to Fight AIDS, Tuberculosis and Malaria. France was also involved through the ESTHER network for therapeutic solidarity in hospitals, which had signed a memorandum of understanding with WHO in October 2004 in relation to practical cooperation. Substantial progress would not be made without a change of scale in the financing of the fight against AIDS. France proposed a pilot operation based on an international tax on air tickets or kerosene. She requested further information on the main potential difficulties that could arise from application of the WTO agreements on medicines and on the measures taken to strengthen the prequalification programme.

Mrs LE THI THU HA (Viet Nam) commended WHO's leadership in scaling up treatment and care for HIV/AIDS. Recent estimates indicated that 215 000 people were living with HIV/AIDS in Viet Nam, of whom 30 000 (about 15%) required antiretroviral therapy. The Government imported antiretroviral agents at a cost of nearly US\$ 5000 per person per year and, under the new national HIV/AIDS strategy, aimed to provide antiretroviral drugs for 70% of people living with AIDS, with a short-term target of treating 15 000 HIV-positive people by the end of 2005. It therefore needed to find ways of making antiretroviral therapy easily and cheaply available. The Global Fund to Fight AIDS, Tuberculosis and Malaria had approved a US\$ 12 million project to strengthen care and treatment in the 20 worst affected provinces, including the supply of antiretroviral agents for 2000-3000 people for the next two years. Unfortunately, however, because of the declassification of some of the prequalified antiretroviral agents, WHO had been unable to procure the necessary supplies, and the Government had recently asked UNICEF to supply them instead. The associated paperwork alone had caused many months of delay.

The Government was willing to strengthen its own capacity to produce antiretroviral agents and encourage domestic manufacturers to seek WHO prequalification status for their products, although that was a slow and costly process for small companies. Access to second-line treatment needed to be harmonized at international level, since it was a considerable burden on individual countries.

The Government was trying to coordinate various projects on HIV/AIDS prevention and control with funding from external partners, in order to make better use of resources. The "Three Ones" principle was being applied in the national programme, and a separate administration for HIV/AIDS control had recently been established. Viet Nam looked forward to future collaboration with WHO and all other partners.

Mr BASSE (Senegal) said that HIV prevalence in Senegal was relatively low, and great emphasis was therefore placed on prevention policies. WHO should continue to stress the prevention element in the "3 by 5" programme which, in Senegal, owed its success to its balanced and integrated approach, combining prevention and treatment.

A draft resolution on WHO's role in harmonizing operational development activities at country level had been approved by Committee B. Coordination in HIV/AIDS was vital: he therefore called on WHO to use its position as a cosponsor of UNAIDS to promote better coordination of activities, particularly at country level. The project referred to in paragraph 14 of the report was encouraging in that regard. He requested updated information on the implementation of the "3 by 5" initiative at country level and on any plans to ensure its long-term future. He also asked what WHO and other

relevant organizations had done to enable countries to gain maximum benefit from the flexibilities of the Agreement on Trade-Related Aspects of Intellectual Property Rights.

Dr NYIKAL (Kenya) called for progress reports on the scaling up of treatment and care of HIV/AIDS every year. Prevention was crucial to the control of HIV/AIDS and should not take second place to antiretroviral therapy, even though antiretroviral agents were becoming more available and affordable. His country had launched a national strategic plan for the period 2005-2009, which focused on prevention, care and support for those infected and affected by HIV/AIDS, and mitigation of the epidemic's impact on economic and social development.

In 1999, HIV/AIDS had been declared a national disaster. A national coordinating council, with representatives from the Government and civil society, oversaw all activities connected with HIV/AIDS. Constituency-level AIDS committees worked at the grass-roots level, and AIDS control units had been set up in all ministries. The unit established in the Ministry of Health was responsible for treatment and care.

There was an increasing trend for funding from international development partners, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, to be placed with nongovernmental organizations, but his Government was making great efforts to coordinate all activities. Some international initiatives had created cumbersome procedures and parallel administration systems, which slowed up essential work.

Kenya had adopted the "Three Ones" principle and set up programmes and guidelines for voluntary counselling and testing, antiretroviral therapy, prevention of mother-to-child transmission of HIV and blood screening. As a result HIV prevalence had fallen from 13% to 7%, and 38 000 people were undergoing treatment at 194 treatment centres. The greatest challenges facing the country were providing support and care for about 1.5 million AIDS orphans and maintaining the sustainability of the HIV/AIDS programmes. He endorsed the views expressed by the delegates of Finland and Zimbabwe about the main principles that WHO should adopt in its long-term approach to HIV/AIDS.

Dr KOKOLOMAMI (Democratic Republic of the Congo) said that early preventive measures and political commitment at the highest level had enabled his country to maintain one of the lowest rates of HIV prevalence in the Great Lakes region of Africa. However, HIV/AIDS was still a threat: epidemiological surveillance had shown that around two million people were living with AIDS, 40% of whom were under 25 years of age; among the 59 000 pregnant women who had undergone voluntary testing for HIV in 2004, the rate in the under-25 age group had been twice that of the over-25s; and 5200 people were receiving antiretroviral treatment, representing only 2% of the infected population. His country therefore appreciated the "3 by 5" initiative, even though its goals and deadlines would be difficult to achieve. He urged WHO and UNAIDS to support countries in harmonizing their procedures, as population movements could pose problems if protocols for management of antiretroviral agents were not standardized: countries in the Great Lakes region were making efforts in that regard. He also urged that consideration be given to the prevention and management of HIV infection in conflict situations. The use of HIV as a biological weapon delivered by means of rape in armed conflict must be discouraged.

Ms SAIZ MARTÍNEZ ACITORES (Spain) reiterated her country's backing for the "3 by 5" initiative. WHO's efforts in respect of the "Three Ones" principle, in collaboration with UNAIDS and other international partners, were commendable. Nevertheless, all activities in that area needed to be strengthened. Coordination at country level and a balance between prevention, treatment and care required commitment, particularly in the design of strategies, by donor countries and organizations of the United Nations system and between that system and other international organizations.

Mr GARDINER (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that, without adequate investment in community mobilization, expanding activities would lower quality. Funds must be directed to the places where

community involvement could make a difference. Although funding was channelled to country-led responses, much of that investment remained in ministries. Three areas needed urgent attention. First, the current approach to prevention was inadequate. Underlying causes of vulnerability, such as gender inequity, needed to be taken into consideration. The “3 by 5” initiative should revitalize prevention urgently. Young people must be given additional skills if abstinence programming and the “be faithful” strategy were to be effective. Condom promotion and access to high-quality condoms were important. Secondly, people living with AIDS needed to be empowered in order to comply with treatment. Testing for HIV also needed to be part of an empowering process and that could only occur when health providers entered into a partnership with the people they served. Living with HIV and life-long, complex treatment regimens required high motivation. Voluntary counselling and testing should also be an empowering process to ensure that individuals actively managed their care, rather than being passive recipients. The third area was partnership. His organization’s volunteers were underused and underresourced but the situation was even worse for organizations of people living with HIV/AIDS. He therefore urged health ministries to prioritize partnerships with community-based groups by ensuring adequate resources. There was a need for the same generosity and commitment as that which had prevailed following the south Asian tsunami in December 2004 if progress was to be made in the struggle against HIV/AIDS.

Dr CHOW (Assistant Director-General) expressed appreciation for the guidance and insights for advancing treatment and prevention together in an accelerated response. Member States had been instrumental in achieving significant progress in accelerating access to treatment since the “3 by 5” initiative had been launched in 2003. The number of people receiving treatment had more than doubled owing to multiple efforts at the community, district and national levels and significant new resources and support from various sources. Many national governments had taken the lead in building on the “3 by 5” campaign, setting ambitious national targets to expand treatment and improve service delivery, demonstrating that large-scale access to HIV treatment was achievable, effective and increasingly affordable, even in the most resource-poor settings. Data were also available showing that treatment success rates in developing countries were equal to those of many medium- or high-income countries. However, the preceding 18 months had shown that much work was required to ensure progress and to overcome wide discrepancies in access to and quality of treatment programmes, including the need for WHO to promote universal access through a public health approach, measuring progress by means of service availability mapping. Greater harmonization of efforts of national and international partners was needed in accordance with the “Three Ones” principle, as was rapidly expanded testing and counselling, better integration of treatment and prevention, strengthened procurement ensuring an uninterrupted supply of commodities, guaranteed sustainability and ensuring that current expansion of HIV treatment and care reached vulnerable populations equitably. Treatment and prevention were both fundamental to the “3 by 5” initiative. Expanding treatment provided an excellent opportunity to revitalize prevention efforts, engaging health systems and communities in novel ways and identifying new models for service delivery. In order to deliver treatment and prevention services, WHO was committed to making essential packages of treatment and prevention interventions widely available through standardized, simplified and unified approaches that were fully integrated within the broader public sector, as well as using monitoring and evaluation systems for HIV drug resistance.

He shared the concerns expressed by the delegate of Luxembourg over the slow pace of prequalification of HIV medicines. The Secretariat was working with the Global Fund to Fight AIDS, Tuberculosis and Malaria to identify bottlenecks and reduce delays. On the subject of women and HIV/AIDS, WHO was a convening partner in the Global Coalition on Women and AIDS and was preparing to measure access to treatment for women and children in every country. With regard to nutrition, the Secretariat was working with WFP to ensure that adequate nutrition was a critical part of the package received by all people living with HIV/AIDS. On the question of new treatment targets, the UNAIDS-led Global Task Team was working to identify the next set, possibly for 2008. On HIV/AIDS and health systems, technical assistance, notably in the areas of tuberculosis and malaria,

was being coordinated in order to build health systems, so as to ensure that investment in HIV led to stronger health systems as a top priority. With regard to the comments by the delegate of Finland on prevention, the Secretariat had a responsibility to improve prevention in the health sector and its contributions included a policy directive on testing and counselling, encouraging all health workers to be trained in prevention, stressing targeted interventions using tool kits, norms and direct technical assistance for vulnerable populations, and preventive tools for people with HIV/AIDS. It was also strengthening approaches for prevention of mother-to-child transmission of HIV, integrated with comprehensive care and treatment for women infected with HIV.

Dr LEPAKHIN (Assistant Director-General) fully agreed that antiretroviral agents must be of good quality: there were too many substandard drugs on the market that could cause complications and even drug resistance. WHO, not being a drug regulatory authority, had taken responsibility for controlling antiretroviral quality through its prequalification project. Despite early criticism, prequalification work was acknowledged and appreciated by the most stringent drug regulatory authorities. Thanks to the support of the Director-General and various governments and major donors, the project continued to develop, and WHO was committed to continuing and strengthening that activity. In reply to the delegate of Mozambique, he said that WHO had organized a network to help countries to monitor the impact of the Agreement on Trade-Related Aspects of Intellectual Property Rights on access to medicines, and, with the help of the French Government, was supporting countries in making full use of the flexibilities allowed under that Agreement. Work on the use of traditional medicines for the treatment of opportunistic infections had also continued.

The Committee took note of the report.

Antimicrobial resistance: a threat to global health security: Item 13.10 of the Agenda (Resolution EB115.R6; Document A58/14) (continued from the tenth meeting, section 2)

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland), speaking in his capacity as chairman of the informal working group, drew attention to a revised version of the draft resolution recommended in resolution EB115.R6, which reflected the consensus reached in the group and read as follows:

Improving the containment of antimicrobial resistance

The Fifty-eighth World Health Assembly,

Having considered the report on rational use of medicines by prescribers and patients;

Acknowledging that the containment of antimicrobial resistance is a prerequisite for attaining several of the internationally agreed health-related goals contained in the United Nations Millennium Declaration;

Recalling the recommendations of the Second International Conference on Improving Use of Medicines (Chiang Mai, Thailand, 2004);

Recalling also the findings of relevant WHO's reports, including on "Priority medicines for Europe and the world",¹ and the Copenhagen Recommendation from the European Union conference on "The Microbial Threat" (Copenhagen, 1998);

Aware that the spread of antimicrobial resistance recognizes no national boundaries and has reached proportions that require urgent action at national, regional and global levels, especially in view of the decreasing development of new antimicrobial agents;

Recalling previous resolutions WHA39.27 and WHA47.13 on the rational use of drugs, WHA51.17 on antimicrobial resistance, and WHA54.14 on global health security;

¹ Document WHO/EDM/PAR/2004.7.

Recognizing the efforts of WHO in collaboration with governments, universities, the private sector and nongovernmental organizations to contain antimicrobial resistance, thereby contributing to prevention of the spread of infectious diseases;

Noting that, despite some progress, the strategy for containment of antimicrobial resistance has not been widely implemented;¹

Wishing to intensify efforts to contain antimicrobial resistance and to promote rational use of antimicrobial agents by providers and consumers in order to improve global health security;

Re-emphasizing the need for a coherent, comprehensive and integrated national approach to promoting the containment of antimicrobial resistance;

Convinced that it is time for governments, the health professions, civil society, the private sector and the international community to reaffirm their commitment to ensuring that sufficient investment is made to contain antimicrobial resistance,

1. URGES Member States:

- (1) to ensure the development of a coherent, comprehensive and integrated national approach to implementing the strategy for containment of antimicrobial resistance taking account, where appropriate, of financial and other incentives that might have a harmful impact on policies for prescribing and dispensing;
- (2) to enhance ~~proper~~ rational use of antimicrobial agents, including through development and enforcement of national standard-practice guidelines for common infections, in public and private health sectors, ~~and to consider the selection of effective and short-course antimicrobial treatment for potentially poor-compliance patients;~~
- ~~(2)~~(3) to ~~consider strengthening~~ strengthen, as appropriate, their legislation on availability of medicines in general and of antimicrobial agents in particular;
- ~~(3)~~(4) to mobilize human and financial resources in order to minimize the development and spread of antimicrobial resistance, in particular by the promotion of the rational use of antimicrobial agents by providers and consumers;
- (5) to monitor effectively and to control nosocomial infections, ~~one of the most common sources of antimicrobial resistance;~~
- ~~(4)~~(6) to monitor regularly the use of antimicrobial agents and the level of antimicrobial resistance in all relevant sectors, ~~and to report back annually to WHO;~~
- ~~(5)~~(7) ~~actively to share~~ actively knowledge and experience on best practices in promoting the rational use of antimicrobial agents, ~~including patient and consumer education;~~
- ~~(8) to assure quality of antimicrobial agents used in medical practice;~~
- ~~(9) to monitor and control the non-human use of antibiotics, specifically the quantity and therapeutic group of those antibiotics used to promote growth in animals intended for human consumption;~~
- ~~(10) to allocate financial resources exclusively for containing resistance to antimicrobials;~~
- ~~(11) to allocate human and financial resources to the strengthening of regional bacteriological laboratories;~~

2. REQUESTS the Director-General:

- (1) to strengthen the leadership role of WHO in containing antimicrobial resistance;
- (2) to accelerate the implementation of resolutions WHA51.17 and WHA54.14 concerning the containment of antimicrobial resistance by expanding and strengthening the provision of technical support to Member States, at their request;

¹ Document WHO/CDS/CSR/DRS/2001.2.

- (3) to collaborate with ~~support~~ other relevant programmes and partners in order ~~in strengthening their efforts~~ to promote the appropriate use of antimicrobial agents in the context of the rational use of medicines, by scaling up interventions proven to be effective; and (4) to provide support for the sharing of knowledge and experience among stakeholders on best practice ~~the best ways to promote the rational use of antimicrobial agents, including patient and consumer education, and to establish databases on the use of antimicrobials and on antimicrobial resistance globally and to ensure their availability to Member States and other parties through a periodic annual report;~~
- (5) ~~to promote the appropriate use of antimicrobial agents in spheres other than human, specifically in the practice, considered hazardous since the 1970s, of using antibiotics as growth promotion agents in animals intended for human consumption;~~
- (6)(4) to provide support for the generation of up-to-date information on antimicrobial resistance at regional and subregional levels and to make this available to Member States and other parties;
- (7)(5) to provide support for gathering and sharing of evidence on cost-effective ~~strategies~~ interventions for prevention and control of antimicrobial resistance at national and local levels;
- (5)(8)(6) to report to the Sixtieth World Health Assembly, and subsequently on a regular basis, on progress achieved, problems encountered and further actions proposed in implementing this resolution.

An issue that had been raised frequently in the discussions had been the importance of securing improvements in the containment of antimicrobial resistance in the context of the rational use of medicines, which needed to be seen in a broader framework. The issue might be given further consideration in due course.

The draft resolution, as amended, was approved.¹

Dr Sadrizadeh resumed the Chair.

eHealth: Item 13.17 of the Agenda (Resolution EB115.R20; Document A58/21) (continued from the eleventh meeting)

The CHAIRMAN invited the Committee to consider a revised text of the draft resolution contained in EB115.R20 incorporating amendments proposed at previous meetings, which read as follows:

The Fifty-eighth World Health Assembly,

Having considered the report on eHealth;

Noting the potential impact that advances in information and communication technologies could have on health-care delivery, public health, research and health-related activities for the benefit of both low- and high-income countries;

Aware that advances in information and communication technologies have raised expectations for health;

Respecting the principles of equity, **human rights, and ethical issues** and considering differences in culture, education, language, geographical location, physical and mental ability, age, and sex;

Recognizing that a WHO eHealth strategy would serve as a basis for WHO's activities on eHealth;

¹ Transmitted to the Health Assembly in the Committee's seventh report and adopted as resolution WHA58.27.

Recalling resolution WHA51.9 on cross-border advertising, promotion, and sale of medical products through the Internet;

Stressing that eHealth is the cost-effective and secure use of information and communications technologies in support of health and health-related fields, including health-care services, health surveillance, health literature, and health education, knowledge and research,

1. URGES Member States:

- (1) to consider drawing up a long-term strategic plan for developing and implementing eHealth services **in the various areas of health administration, which** includes an appropriate legal framework and infrastructure and encourages public and private partnerships;¹
- (2) to develop the infrastructure for information and communication technologies for health as deemed appropriate to promote equitable, affordable, and universal access to their benefits, and to continue to work with information and telecommunication agencies and other partners in order to reduce costs and make eHealth successful;
- (3) to build on closer collaboration with the private and non-profit sectors in information and communication technologies, so as to further public services for health **and make use of the electronic programmes of WHO and other health organizations, and to seek their support in the area of eHealth;**
- (4) to endeavour to reach communities, including vulnerable groups, with eHealth services appropriate to their needs;
- (5) to mobilize multisectoral collaboration for determining evidence-based eHealth standards and norms, to evaluate eHealth activities, and to share the knowledge of cost-effective models, thus ensuring quality, safety and ethical standards **and respect for the principles of confidentiality of information, private life, justice and equality;**
- (6) to establish national centres and networks of excellence for eHealth best practice, policy coordination, and technical support for health-care delivery, service improvement, information to citizens, capacity building, and surveillance;
- (7) to consider establishing and implementing national **electronic** public-health information systems and to improve, by means of information, the capacity for surveillance of, and rapid response to, disease and public-health emergencies;

2. REQUESTS the Director-General:

- (1) to promote international, multisectoral collaboration with a view to improving compatibility of administrative and technical solutions **and ethical rules** in the area of eHealth;
- (2) **to expand the use of documentary information electronically through the organization and submission of regular reports,** to document and analyse developments and trends, to inform policy and practice in countries, and to report regularly on use of eHealth worldwide;
- (3) **to facilitate the development of a model prototype eHealth system which with appropriate modification could be established in national centres and networks of excellence for eHealth;**
- ~~(3)~~(4) to provide technical support to Member States in relation to eHealth products and services by disseminating widely experiences and best practices, in particular on telemedicine technology; devising assessment methodologies; promoting research and development; and furthering standards through diffusion of guidelines;

¹ eHealth is understood in this context to mean use of any information and communication technologies locally and at a distance.

- (4)(5) to facilitate the integration of eHealth in health systems and services, including **in the deployment of telemedicine infrastructure in countries where medical coverage is inadequate and** in the training of health-care professionals and in capacity building, in order to improve access to, and quality and safety of, care;
- (5)(6) to continue the expansion to Member States of mechanisms such as the Health Academy, which promote health awareness and healthy lifestyles through eLearning;¹
- (6)(7) to provide support to Member States to promote the development, application and management of national standards of health information; and to collect and collate available information on standards with a view to establishing national standardized health information systems in order to facilitate easy and effective exchange of information among Member States;
- (7)(8) to support in the area of eHealth regional and interregional initiatives or those among groups of countries that speak a common language;
- (9) to submit to the Executive Board, at its 117th session, a list of proposed specific activities upon which the Secretariat will focus, which should be entirely aimed at tools and services that Member States can incorporate into their own national solutions or adapt as necessary, and an outline of the budgetary implications of proposed activities.**

Dr AL-SALEH (Kuwait) proposed an amendment to subparagraph 1(1), to include the words “sectors including health” before the word “administration”.

Dr MANDIL (Sudan) supported that proposal. In subparagraph 1(5), he proposed that the words “private life, justice” be replaced by “privacy, equity”, and suggested that footnote 1 be deleted. The substance of subparagraph 2(3) was contained in subparagraph 2(9); but if the former were to be maintained, the reference to a prototype should be deleted, and the word “system” should be replaced by “solutions”. His preference, however, was to remove subparagraph 2(3).

Dr SINGER (United States of America) proposed that the fourth preambular paragraph should begin “Respecting human rights, ethical issues and the principles of equity”. He accepted the inclusion of the last preambular paragraph and agreed to deletion of footnote 1. In subparagraph 1(1), he concurred with the amendment proposed by the delegate of Kuwait. He was unclear about the intention of the proposed amendment to subparagraph 1(3) and asked for further clarification. Subparagraph 1(5) was redundant and consequently he proposed to delete it; if it were retained, he would favour the wording proposed by the delegate of Sudan. In subparagraph 2(1), he preferred the word “guidelines” to “rules”. Subparagraph 2(2) should begin “to expand the use of electronic information through the submission of regular reports”. He agreed with the delegate of Sudan that subparagraph 2(3) should be deleted and subparagraph 2(9) retained instead. The amended wording of subparagraph 2(5) was acceptable.

Dr NYIKAL (Kenya) agreed with the delegate of Sudan that the word “prototype” in subparagraph 2(3) should be deleted, but said that the subparagraph should be retained, as developing countries needed specific guidance on how to set up eHealth systems. Subparagraph 2(9) was too general.

Dr AL-SALEH (Kuwait) explained that there was a discrepancy in the English translation from the Arabic of subparagraph 1(3) and that “electronic programmes” should be replaced by “eHealth services”.

¹ eLearning is understood in this context to mean use of any electronic technology and media in support of learning.

Dr VIOLAKI-PARASKEVA (Greece) suggested that it would be helpful to see the proposed amendments incorporated in a new draft.

Dr SINGER (United States of America) thanked the delegate of Kuwait for the clarification. Commenting on the intervention by the delegate of Kenya on subparagraph 2(3), he said that there was a huge range of eHealth programmes in different countries, which would have to be addressed in such a prototype. He therefore suggested that the first line of subparagraph 2(3) be reworded to read: “to facilitate the development of possible model eHealth systems”.

Dr NYIKAL (Kenya) considered that the word “possible” was superfluous; he accepted deletion of the word “prototype”.

Mr AITKEN (Office of the Director-General) read out the proposed amendments. The fourth preambular paragraph should begin: “Respecting human rights, ethical issues and the principles of equity ...”. In subparagraph 1(1) “sectors including” should be inserted after “in the various areas of” and the footnote should be deleted. In subparagraph 1(3) “eHealth services” should replace “electronic programmes”. Subparagraph 1(5) should conclude “confidentiality of information, privacy, equity and equality”. In subparagraph 2(1) “ethical rules” should be replaced by “ethical guidelines”. Subparagraph 2(2) should begin: “to expand the use of electronic information through the submission of regular reports ...”. Subparagraph 2(3) should begin “to facilitate the development of model health solutions”, to which proposal Dr NYIKAL (Kenya) gave his support.

The draft resolution, as amended, was approved.¹

The meeting rose at 12:45.

¹ Transmitted to the Health Assembly in the Committee’s seventh report and adopted as resolution WHA58.28.

THIRTEENTH MEETING

Tuesday, 24 May 2005, at 15:15

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Social health insurance: Item 13.16 of the Agenda (Resolution EB115.R13; Document A58/20) (continued from the tenth meeting, section 2)

Mr AITKEN (Office of the Director-General) drew attention to the revised draft resolution on sustainable health financing and universal coverage, incorporating amendments proposed by the delegations of Belgium, Egypt, Greece, Indonesia, Kenya, Sweden, Thailand and the United Kingdom of Great Britain and Northern Ireland, which read:

The Fifty-eighth World Health Assembly,
Having considered the report on social health insurance;¹

Recalling the Declaration of Alma-Ata adopted at the International Conference on Primary Health Care, 1978 and resolution WHA51.7 on Health-for-all policy for the twenty-first century;

Noting **with concern** that health-financing systems in ~~many~~ **most developing** countries **rely mainly on household out-of-pocket payments that may be catastrophic and impoverish households especially poor ones, and** need to be further developed in order to guarantee access to necessary services, while providing protection against financial risk;

Accepting that, irrespective of the source of financing for the health system selected, prepayment and pooling of resources and risks are basic principles in financial-risk protection;

Considering that the choice of a health-financing system should be made within the particular context of each country;

Acknowledging that a number of Member States are pursuing health-financing reforms that may involve a mix of public and private approaches, including the introduction of social health insurance;

Noting that some countries have recently been recipients of large inflows of external funding for health;

Recognizing the important role of State legislative and executive bodies in further reform of health-financing systems with a view to achieving universal coverage;

Having considered that the whole population in every country has the right to equitable access to an acceptable standard of care in order to achieve the goal of health for all,

1. URGES Member States:

(1) to formulate and reach consensus, in consultations with all partners, on a national strategic plan, taking into account long-term financial sustainability, to achieve universal coverage, and to focus policy as a priority on financial protection

¹ Document A58/20.

for the poor against catastrophic payments and impoverishment, in order to accelerate achievement of Millennium Development Goal 1;

~~(1)~~**(2)** to ensure that health-financing systems include **a one or more** methods ~~for~~ of prepayment of financial contributions for health care, **according to the ability to pay**, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care;

~~(2)~~**(3)** to ensure adequate and equitable distribution of good-quality health care infrastructures and human resources for health so that ~~the insurees~~ **[all citizens (Thailand)] [the individuals (Belgium)] [users (United Kingdom)]** receive **[have access to (Belgium)]** equitable and good-quality health services, **including medicines, according to the benefits package, and health promotion and disease prevention services;**

~~(3)~~**(4)** to ensure that external funds for specific health programmes or activities are managed and organized in a way that contributes to the development of sustainable financing mechanisms for the health system as a whole **and that are coherent with the functioning of the national health system;**

~~(4)~~**(5)** to plan the transition to universal coverage of their citizens so as to contribute to meeting the needs of the population for health care and improving its quality, to reducing poverty, to attaining internationally agreed development goals, including those contained in the United Nations Millennium Declaration, and to achieving health for all;

~~(5)~~**(6)** to recognize that, when managing the transition to universal coverage, each option will need to be developed within the particular macroeconomic, sociocultural and political context of each country, **which may imply the articulation of different systems of social protection in health;**

~~(6)~~**(7)** to take advantage, where appropriate, of opportunities that exist for collaboration between public and private providers, ~~and~~ health-financing organizations, **and civil society actors** under strong overall government stewardship;

~~(7)~~**(8)** to share experiences on different methods of health financing, including **general taxation**, the development of social health insurance schemes, **and informal sector** and private, public, and mixed schemes, with particular reference to the institutional mechanisms that are established to address the principal functions of the health-financing system;

(9) to strengthen safety nets, such as exemption and waiver mechanisms, within the existing health-financing system so as to ensure adequate access to health care for the poor while making preparations for transition to universal coverage of all citizens;

(10) to ensure that social health insurance is developed within an explicit and comprehensive health-financing policy and strategic plan;

(11) to ensure that all relevant government ministries and other main stakeholders are adequately involved in the whole process of feasibility analysis, and planning, designing, implementing and evaluating social-health insurance;

2. REQUESTS the Director-General:

(1) to provide, in response to requests from Member States, in coordination with organizations of the United Nations system and other relevant partners, technical support for strengthening capacities and expertise in the development of health-financing systems which minimize use of fee-for-service mechanisms and exposure of users to catastrophic financial risk, particularly prepayment schemes, including social health insurance, with a view to achieving the goal of universal coverage and taking account of the special needs of small island countries and other countries with small populations; and to collaborate with Member States in the process of social dialogue on health-financing options;

- (2) to provide Member States, in coordination with the World Bank, **the International Monetary Fund** and other relevant partners, with technical information on the potential impact of inflows of external funds for health on macroeconomic stability;
- (3) to create sustainable and continuing mechanisms, including regular international conferences, subject to availability of resources, in order to facilitate the continuous sharing of experiences and lessons learnt on **universal coverage, including social health insurance health-financing systems and other prepayment methods**;
- (4) to provide technical support in identifying data and methodologies better to measure and analyse the benefits and cost of different practices in health financing, covering collection of revenues, pooling, and provision or purchasing of services, taking account of economic and sociocultural differences;
- (5) to provide support to Member States, as appropriate, for developing and applying tools and methods to evaluate the impact on health services of changes in health-financing systems as they move towards universal coverage;
- (6) to study the impact of macroeconomic policies of international financial institutions on efforts to increase access to health services and to report its findings to the Fifty-ninth World Health Assembly;**
- (7) to report, every three years, until 2015, to the Health Assembly on progress towards achievement of universal coverage;**
- (8) to provide support for actuarial studies and costing research;**
- (9) to provide support for institutional capacity building through twinning programmes and by financing such programmes.**

Dr LARUELLE (Belgium), referring to subparagraph 1(3), said that it had been agreed to retain the word “individuals” in the text.

Dr KRECH (Germany) proposed that in subparagraph 2(1) the phrase “use of fee-for-service mechanisms” should be replaced by “user fee systems”. In addition, the words “particularly prepayment schemes, including social health insurance,” should be reinstated and followed by “tax-funded systems or mixes of both;”.

Ms YUAN (United States of America), proposing several amendments to the draft resolution, said that the title should be amended to read “Sustainable health financing and universal insurance coverage”. In the penultimate preambular paragraph, the words “universal coverage” should be amended to read “the goal of universal insurance coverage”. The final preambular paragraph should be deleted since no general acceptance yet existed of what constituted equitable access to an acceptable standard of care in an international context. In subparagraph 1(1), the words “universal coverage” should be expanded to “the goal of universal insurance coverage”, and “Millennium Development Goal 1” should be replaced by “eradicating extreme poverty and hunger”. In subparagraph 1(2), “according to” should be replaced by “recognizing”. In subparagraph 1(3), the word “individuals” should be retained but “receive” deleted. In subparagraph 1(4), the final words “national health system” should be amended to “national public and private health systems”. In subparagraph 1(5), the words “universal coverage” should be expanded to “meeting the goal of universal insurance coverage”. In subparagraph 1(6), the words “universal coverage” should be expanded to “meet the goal of universal insurance coverage”. In subparagraph 1(9), the word “mechanisms,” should be followed by “market-based incentives, and risk pooling,” and “universal coverage” should be expanded to read “the goal of universal insurance coverage”. In subparagraph 1(10), the word “social” should be replaced by “universal”. In subparagraph 1(11), “main stakeholders” should be followed by a comma and “including, where appropriate, private-sector and faith-based stakeholders,” and the final words “social-health insurance” should become “universal health insurance”.

In subparagraph 2(1), the words “minimize use of fee-for-service mechanisms and exposure” should be replaced by “enable market efficiencies to reduce costs, increase individual choice, and

minimize exposure". In subparagraph 2(3), the term "universal coverage" should read "universal insurance coverage" (and similarly in subparagraphs 2(5) and 2(7)) and the words "social and market" should be inserted before "health-financing systems". Subparagraph 2(6) should be deleted since studies of the sort referred to did not fall within WHO's mandate. In subparagraphs 2(8) and 2(9), the word "support" should be preceded by "appropriate", and she asked for an estimate of the cost of implementing those requests.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) said that he would have considerable difficulty with some of the comments just made by the delegate of the United States. In particular, he had concerns about the phrase "social health insurance", since it did not define a particular model of financing. Repeated use of that term in the text might lead to the resolution's being interpreted as promoting one particular health-financing model. Such financing in his country was taxation-based and the three forms of financing should be adequately reflected. He would prefer the title of the resolution to be "Sustainable health financing and universal coverage". He supported the option of the word "individuals" in subparagraph 1(3). Subparagraphs 1(10) and 1(11) should be replaced by a single subparagraph, reading "to ensure that, if social health insurance is developed as an option, it is part of a comprehensive financing plan,".

He supported the German delegate's proposed wording of subparagraph 2(1). Subparagraphs 2(6), 2(8) and 2(9) could be deleted.

Mr MCKERNAN (New Zealand) agreed with the previous speaker, commenting that the amendments proposed by the United States of America would alter the nature of the draft resolution. Health financing in his country, too, was taxation-based and "universal insurance coverage" had a much more restrictive connotation.

Mr BENTO ALCÁZAR (Brazil) said that he, too, would have serious difficulties in accepting the amendments proposed by the United States of America, especially regarding "universal insurance coverage". Brazil's health system covered everyone, even the significant segment of the population working in the informal market and not covered by any other system.

Dr REN Minghui (China) shared the concerns of the previous speakers. He wanted to see the proposed amendments in writing and suggested that a formal or informal working group would be necessary to enable the Committee to consider the proposals further.

Dr CICOONA (Italy) said that Italy, which also had a taxation-based health system, shared and supported the comments made by the United Kingdom.

Dr MOETI (Botswana) said that Botswana's health system was also largely financed from general taxation. "Universal insurance coverage" seemed too narrow a term for what he understood to be the purpose of the draft resolution and significantly changed its meaning. The United States of America had suggested that the final preambular paragraph be deleted on the grounds that it was new text needing to be negotiated. Yet "access to an acceptable standard of health care" was entirely consistent with the principle of Health for All, to which WHO subscribed. The new paragraph enhanced the document and should cause no difficulty.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) could not accept the amendment proposed by the delegate of the United States of America: "universal insurance coverage" was not a generic term. In his understanding, "universal coverage" meant the provision of universal access to health cover from whatever source of financing and the term should be retained, unless a scientific committee had introduced fresh nomenclature. He favoured adopting the revised draft resolution as it stood or with minor amendments. He supported the suggestion by China to convene a working group.

Mr HILMERSON (Sweden) endorsed the views expressed by the delegates of the United Kingdom and New Zealand since he, too, would have difficulty accepting the amendments proposed by the United States of America.

Mr BAILÓN (Mexico) said that he wanted to comment on the amendments proposed by the United States of America, but would await the Chairman's proposal on further procedure. Referring to the Spanish version of the text, he suggested that the term "*pago anticipado*" should be used throughout as the equivalent of "prepayment".

The CHAIRMAN suggested that the Committee should suspend consideration of the draft resolution and convene a working group.

It was so agreed.

(For approval of the draft resolution, see summary record of the fourteenth meeting, section 2.)

Strengthening pandemic influenza preparedness and response: Item 13.9 of the Agenda (Resolution EB115.R16; Document A58/13) (continued from the eighth meeting, section 2)

The CHAIRMAN drew attention to the revision of the draft resolution on enhancement of laboratory biosafety, incorporating amendments proposed by a working group, which read:

The Fifty-eighth World Health Assembly,

Considering that release of microbiological agents and toxins may have global ramifications;

Acknowledging that the containment of microbiological agents and toxins in laboratories is critical to preventing outbreaks of emerging and re-emerging diseases such as severe acute respiratory syndrome (SARS);

Recognizing the work of WHO in promoting laboratory biosafety;

Acknowledging that a number of Member States do have in place effective laboratory biosafety controls and guidelines for laboratory practice in order to manage the risks to laboratory workers and the community from microbiological agents and toxins;

Recognizing that some Member States may not have adequate biosafety controls in place;

Noting that an integrated approach to laboratory biosafety ~~[and containment of microbiological agents and toxins]~~ [including containment of microbiological agents and toxins] ~~promotes global health security~~ **helps improve protects global public health,**

1. URGES Member States:

(1) to review the safety of their laboratories and their existing protocols for the safe handling of microbiological agents and toxins, consistent with WHO's biosafety guidance;

(2) to implement specific programmes to promote ~~biological safety and biosafety~~ laboratory practices for the safe handling ~~[and containment of microbiological agents and toxins]~~ [including containment of microbiological agents and toxins], consistent with WHO's biosafety guidance;

~~(3) to develop programmes that enhance compliance of laboratories, including those within the government, at universities and research centres, and in the private sector, particularly those handling highly virulent microbiological agents and toxins, with biosafety guidelines for laboratory practices;~~

(3) to develop national programmes that enhance compliance of laboratories, including those within the government, at universities and research centres, and in the private

sector, particularly those handling highly virulent microbiological agents and toxins, with biosafety guidelines for laboratory practices;

~~(3) to develop an information system or register to permit the identification of highly virulent microbiological agents or toxins handled by laboratories belonging to the Government, universities and research centres and in the private sector;~~

(4) to ~~[develop preparedness plans and]~~ mobilize **national and international** human and financial resources to improve laboratory biosafety ~~[including developing preparedness plans] [and, as appropriate, develop preparedness plans], [and containment of microbiological agents and toxins]~~ [including containment of microbiological agents and toxins] in order to minimize the possibility of laboratory acquired infections and resultant spread to the community;

~~(5) to cooperate with other Member States and WHO in facilitating access, particularly by developing countries, to technologies and technical measures that help increase laboratory biosafety;~~

(5) to cooperate with other Member States to facilitate access to laboratory biosafety equipment, including personal protective equipment and containment devices, for the prevention and control of laboratory acquired infection;

~~(6)(5)~~ to encourage the development of biological-safety training programmes and competency standards for laboratory workers in order to improve safety awareness and safe laboratory practices;

~~(7) to develop contingency programmes for the accidental release of microbiological agents and toxins to minimize their effects and control their propagation;~~

2. REQUESTS the Director-General:

(1) to ensure that WHO **plays an important active role, in accordance with its mandate, towards** ~~provides clear leadership to~~ the task of improving laboratory biosafety and containment of microbiological agents and toxins;

(2) to provide support to other relevant programmes and partners in strengthening their efforts to promote improved laboratory biosafety and containment of microbiological agents and toxins;

(3) to provide support to the development and sharing of knowledge and experience among Member States for enhancing laboratory biosafety ~~[and containment of microbiological agents and toxins]~~ [including containment of microbiological agents and toxins], including the regular update of relevant WHO guidelines and manuals **[through an intergovernmental process]** ~~[with active participation of Member States]~~ [in consultation with Member States];

(4) to provide, in response to requests from Member States, technical support for strengthening laboratory biosafety ~~[and containment of microbiological agents and toxins]~~ [including containment of microbiological agents and toxins];

(5) to report regularly to the Executive Board on the status of, and risks to, laboratory biosafety and containment of microbiological agents and toxins globally.

Ms GILDERS (Canada), speaking in her capacity as chairman of the informal working group, said that the group had recognized the significance of the draft resolution, the first to come before the Health Assembly on that important issue, and had resolved all but three issues. However, a further informal group consisting of Australia, Canada, China, Cuba, Mexico, New Zealand, Pakistan, Switzerland and the United States of America, meeting earlier that day, had agreed proposals for the outstanding issues too.

Throughout the text, it had been agreed to remove the square brackets around “including containment of microbiological agents and toxins”. In the final preambular paragraph, the word “protects” should be replaced by “promotes”.

In subparagraph 1(2), the words “and transport” should be added after “safe handling” at the suggestion of Mexico. In subparagraph 1(3), the words “national preparedness plans and” should be inserted before “national programmes”. In subparagraph 1(4), the final square brackets should be deleted, so that the text would read:

to mobilize national and international human and financial resources to improve laboratory biosafety, including containment of microbiological agents and toxins, in order to minimize the possibility of laboratory-acquired infections and resultant spread to the community;

Regarding subparagraph 2(3), the question of how the WHO guidelines and manuals would be updated, whether in consultation with Member States or through an intergovernmental process, had provoked much discussion, but the wording “in consultation with all Member States with a view to accommodating their concerns;” had been agreed. Subparagraph 2(5) should be amended to read: “to report regularly to the Executive Board on the implementation of this resolution”, as the Director-General could not be requested to report to the Executive Board on the status of risks when no appropriate mechanisms existed for that purpose.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) accepted those amendments, but considered that the language would gain from review and clarification by the Secretariat.

The CHAIRMAN took it that the Committee was prepared to approve the resolution.

The resolution, as amended, was approved.¹

The meeting rose at 16:00.

¹ Transmitted to the Health Assembly in the Committee’s seventh report and adopted as resolution WHA58.29.

FOURTEENTH MEETING

Wednesday, 25 May 2005, at 09:20

Chairman: Dr B. SADRIZADEH (Islamic Republic of Iran)

1. SEVENTH REPORT OF COMMITTEE A (Document A58/62)

Dr BUSUTTIL (Malta), Rapporteur, read out the draft seventh report of Committee A.

Mr AITKEN (Office of the Director-General), referring to the draft resolution on eHealth (agenda item 13.17), said that, when adopted, the resolution would contain as a footnote the definition of eHealth which had been omitted from document A58/62.

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Infant and young child nutrition: Item 13.11 of the Agenda (Resolution EB115.R12; Document A58/15) (continued from the tenth meeting, section 2)

The CHAIRMAN drew attention to the revised version of the draft resolution contained in resolution EB115.R12, which incorporated amendments proposed by a working group and read:

The Fifty-eighth World Health Assembly,

Recalling the adoption by the Health Assembly of the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22), resolutions WHA39.28, WHA41.11, WHA46.7, WHA47.5, WHA49.15, WHA54.2 on infant and young child nutrition, appropriate feeding practices and related questions, and particularly WHA55.25, which endorses the global strategy for infant and young child feeding;

Having considered the report on infant and young child nutrition;

Aware that the joint FAO/WHO expert meeting on *Enterobacter sakazakii* and other microorganisms in powdered infant formula held in 2004 concluded that intrinsic contamination of powdered infant formula with *E. sakazakii* and *Salmonella* had been a cause of infection and illness, including severe disease in infants, particularly preterm, low birth-weight or immunocompromised infants, and could lead to serious developmental sequelae and death;²

Noting that such severe outcomes are especially serious in preterm, low birth-weight and immunocompromised infants, and therefore are of concern to all Member States;

Bearing in mind that the Codex Alimentarius Commission is revising its recommendations on hygienic practices for the manufacture of foods for infants and young children;

¹ See page 354.

² FAO/WHO Expert Meeting on *E. sakazakii* and other Microorganisms in Powdered Infant Formula: Meeting Report. Microbiological Risk Assessment Series No. 6, 2004, p. 37.

Recognizing the need for parents and caregivers to be fully informed of ~~known~~ **evidence-based** public-health risks of intrinsic contamination of powdered infant formula **and the potential for introduced contamination, and the need for safe preparation, handling and storage of prepared infant formula;**

Concerned that nutrition and health claims may be used to promote ~~the sale of~~ breast-milk substitutes ~~instead of~~ **as superior to** breastfeeding;

Acknowledging that the Codex Alimentarius Commission plays a pivotal role in providing guidance to Member States on the proper regulation of foods, including foods for infants and young children;

Bearing in mind that on several occasions the Health Assembly has called upon the Commission to give full consideration, within the framework of its operational mandate, to evidence-based action that it might take to improve the health standards of foods, consistent with the aims and objectives of relevant public health strategies, particularly WHO's global strategy for infant and young child feeding (resolution WHA55.25) and Global Strategy on Diet, Physical Activity and Health (resolution WHA57.17);

Recognizing that such action requires a clear understanding of the respective roles of the Health Assembly and the Codex Alimentarius Commission, and that of food regulation in the broader context of public health policies;

Taking into account resolution WHA56.23 on the joint FAO/WHO evaluation of the work of the Codex Alimentarius Commission, which endorsed WHO's increased direct involvement in the Commission and requested the Director-General to strengthen WHO's role in complementing the work of the Commission with other relevant WHO activities in the areas of food safety and nutrition, with special attention to issues mandated in Health Assembly resolutions,

1. URGES Member States:

(1) to continue to protect, promote and support exclusive breastfeeding for six months as a global public health recommendation, taking into account the findings of the WHO Expert Consultation on optimal duration of exclusive breastfeeding,¹ and to provide for continued breastfeeding up to two years of age or beyond, by implementing fully the WHO global strategy on infant and young child feeding that encourages the formulation of a comprehensive national policy, including where appropriate a legal framework to promote maternity leave and a supportive environment for six months' exclusive breastfeeding, a detailed plan of action to implement, monitor and evaluate the policy, and allocation of adequate resources for this process;

(2) to ensure that nutrition and health claims are not permitted for ~~foods for infants and young children~~ **breast-milk substitutes, except where specifically provided for in national legislation;**²

(3) to ensure that clinicians and other health-care personnel, community health workers and families, parents and other caregivers, particularly of infants at high risk, are provided with enough information and training by ~~independent~~ health-care providers, in a timely manner on the preparation, use and handling of powdered infant formula in order to minimize health hazards; are informed that powdered infant formula ~~are not sterilized and~~ may contain pathogenic microorganisms and must be prepared and used appropriately; and, **where applicable**, that this information is conveyed through an explicit warning on packaging;

¹ As formulated in the conclusions and recommendations of the Expert Consultation (Geneva, 28-30 March 2001) that completed the systematic review of the optimal duration of exclusive breastfeeding (see document A54/INF.DOC./4).

² The reference to national legislation also applies to regional economic integration organizations.

- (4) to ensure that financial support and other incentives for programmes and health professionals working in infant and young-child health does not create conflicts of interest;
 - (5) to ensure that research on infant and young-child feeding, which **may** forms the basis for public policies, ~~is always independently funded and reviewed in order to ensure that such policies are not unduly influenced by commercial interests~~ **always contains a declaration relating to conflicts of interest and is subject to independent peer review**;
 - (6) to work closely with relevant entities, including manufacturers, to continue to reduce the concentration and prevalence of pathogens, including *Enterobacter sakazakii*, in powdered infant formula;
 - (7) to continue to ensure that manufacturers adhere to Codex Alimentarius or national food standards and regulations;
 - (8) to ensure policy coherence at national level by stimulating collaboration between health authorities, food regulators and food standard-setting bodies;
 - (9) to participate actively and constructively in the work of the Codex Alimentarius Commission;
 - (10) to ensure that all national agencies involved in defining national positions on public health issues for use in all relevant international forums, including the Codex Alimentarius Commission, have a common and consistent understanding of health policies adopted by the Health Assembly, and to promote these policies;
2. REQUESTS the Codex Alimentarius Commission:
- (1) to continue to give full consideration, when elaborating standards, guidelines and recommendations, to those resolutions of the Health Assembly that are relevant in the framework of its operational mandate;
 - (2) to establish standards, guidelines and recommendations on foods for infants and young children formulated in a manner that ensures the development of safe and appropriately labelled products that meet their known nutritional and safety needs, thus reflecting WHO policy, in particular the WHO global strategy for infant and young child feeding and the International Code of Marketing of Breast-milk Substitutes and ~~subsequent other~~ relevant resolutions of the Health Assembly;
 - (3) urgently to complete work currently under way on addressing the risk of microbiological contamination of powdered infant formula and establish appropriate microbiological criteria or standards related to *E. sakazakii* and other relevant microorganisms in powdered infant formula; and to provide guidance on safe handling and on ~~adding~~ warning messages on product packaging;
3. REQUESTS the Director-General:
- (1) in collaboration with FAO, and taking into account the work undertaken by the Codex Alimentarius Commission, to develop guidelines for clinicians and other health-care providers, community **health** workers and family, parents and other caregivers on the preparation, use, ~~and~~ handling **and storage** of infant formula so as to minimize risk, and to address the particular needs of Member States in establishing effective measures to minimize risk in situations where infants cannot be, or are not, fed breast milk;
 - (2) to ~~initiate and support~~ **take the lead in supporting** independently reviewed research, including by collecting evidence from different parts of the world, in order to get a better understanding of the ecology, taxonomy, virulence and other characteristics of *E. sakazakii*, in line with the recommendations of the FAO/WHO Expert Meeting on *E. sakazakii* **and other Microorganisms in Powdered Infant Formula**, and to explore means of reducing its level in reconstituted powdered infant formula;

- (3) to provide information in order to promote and facilitate the contribution of the Codex Alimentarius Commission, within the framework of its operational mandate, to full implementation of international public health policies;
- (4) to report to the Health Assembly each even year, along with the report on the status of implementation of the International Code of Marketing of Breast-milk Substitutes and **the relevant resolutions of the Health Assembly**, on progress in the consideration of matters referred to the Codex Alimentarius Commission for its action.

The draft resolution was approved.¹

Social health insurance: Item 13.16 of the Agenda (Resolution EB115.R13; Document A58/20) (continued from the thirteenth meeting)

Dr LARIVIÈRE (Canada), speaking in his capacity as chairman of the informal working group, said that the group had quickly realized that there was insufficient time to give full attention to all the critical issues raised. Convinced, however, that a strong consensus was essential, it had agreed to propose to the Health Assembly a process of further consideration that would enable WHO to deal more systematically with all the many complex aspects of health-care financing. It was therefore resubmitting the draft resolution recommended by the Executive Board in resolution EB115.R13, with the addition of a new subparagraph 2(6) that would read:

- (6) to report to the Fifty-ninth World Health Assembly, through the Executive Board, on the implementation of this resolution, including on outstanding issues raised by Member States during the Fifty-eighth World Health Assembly.

That approach would ensure that health-care financing would be included on the provisional agenda of the 117th session of the Board; the outstanding issues would be conveyed to Member States through the summary records of the Health Assembly. It would also strengthen the linkages between the commitment shown by Member States and the Secretariat's future work on the question.

Dr MENDOZA (Bolivarian Republic of Venezuela) said that it had been agreed in the informal working group that delegations holding views that they felt needed to be discussed more fully by the governing bodies should make them clear in the Committee. He stated that health was a social and thus collective right imposing a binding duty on governments; it was not an individual matter and, consequently, could not be handled by people acting in isolation. It would be wrong to promote inequitable health systems in which there was privileged funding for one segment of the population that was insured and a precarious supply of services for another segment excluded from coverage, the latter frequently being the larger. Consequently, it was a social imperative that funding of health care, notwithstanding the existence of a private health-care system, should be the responsibility of government, supported by a fiscal contribution or a system of collective and equitable prepayment, such as taxes proportionate to each individual's ability to pay. Application of market laws to funding and health care would generate a serious problem of individual and social inequity. He called for a broader debate and for the Secretariat to establish guidelines to assist all countries in devising health-care funding systems that would be more equitable and in line with their specific situations.

Dr REN Minghui (China), recognizing that differences of view still existed, said that the adoption of the revised resolution would be an important step forward for all countries in improving health financing and health care. He supported the proposed approach. The term "universal coverage" had been translated into Chinese as "universal insurance", and should be corrected.

¹ Transmitted to the Health Assembly in the Committee's eighth report and adopted as resolution WHA58.32.

Dr VIOLAKI-PARASKEVA (Greece) asked why the additional preambular paragraph that she had proposed, stating that everyone had the right to an acceptable standard of health care, had been omitted.

Dr LARIVIÈRE (Canada), speaking in his capacity as chairman of the informal working group, explained that the reason was largely procedural. Many proposed amendments had been relatively minor, but some had been highly sensitive and required a great deal of discussion. The group had considered that the best course, as the first step in achieving consensus, would simply be to withdraw all the amendments and revert to the text proposed by the Executive Board.

Dr NYIKAL (Kenya) added that the lengthy and detailed discussion in the working group had made it impossible to deal with all the amendments in the time available. It had been considered better to have an unamended resolution that would be discussed further the following year than none at all. He supported the revised text, but suggested adding in subparagraph 2(6) a reference to the revision of the draft resolution that had been discussed at the Committee's previous meeting, since it reflected the issues raised and would serve as an important reference document for the Director-General when reporting on those issues.

Mr HOHMAN (United States of America) said that he had no objection to the amendment proposed by the delegate of Kenya; however, not all the amendments put forward by Member States were contained in the text discussed at the previous meeting. The Director-General, when considering the issues raised, should not be confined to that text.

Mr AITKEN (Office of the Director-General) suggested that the additional phrase should also refer to the issues covered in the summary records of the Committee. Replying to a question by Mr HOHMAN (United States of America), he confirmed that no summary record was produced of discussions in informal drafting groups.

Mr HOHMAN (United States of America) said that the Director-General should take account of all the issues raised by Member States, including amendments proposed in the informal working group.

Dr NYIKAL (Kenya) said that, if the summary records did not cover the discussions in the informal working group, two issues raised must be highlighted: strengthening safety nets and exemptions in existing health-financing systems to ensure access to health care for the poor; and studying the impact of the macroeconomic policies of international financial institutions on efforts to improve access to health services.

Mr AITKEN (Office of the Director-General) suggested that, as the discussion in the current meeting would be reported in the summary record, no amendment of subparagraph 2(6) was needed.

The CHAIRMAN said that, in view of that explanation, he took it that the Committee wished to approve the draft resolution contained in resolution EB115.R13 as amended by Canada in the current meeting.

The draft resolution, as amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee's eighth report and adopted as resolution WHA58.33.

Ministerial Summit on Health Research: Item 13.18 of the Agenda (Document A58/22) (continued from the twelfth meeting, section 3)

The CHAIRMAN drew attention to a revision of the draft resolution contained in document A58/22, which incorporated amendments from the informal working group, and which read as follows:

The Fifty-eighth World Health Assembly,

Having considered the Mexico Statement on Health Research resulting from the Ministerial Summit on Health Research **convened by the Director-General of WHO and the Government of Mexico** (Mexico City, 16-20 November 2004);

Acknowledging that high-quality research, and the generation and application of knowledge are critical for achieving the internationally agreed health-related development goals, including ~~those the development goals~~ contained in the United Nations Millennium Declaration, improving the performance of health systems, advancing human development, and attaining equity in health;

Recognizing the need to strengthen evidence-based evaluation of the consequences of health and other policies and practices **impacting on health** at national, regional, and local levels;

Reaffirming the need to create demand for research and to foster participation in the research process;

Sensitive to the need to strengthen national health-research systems by building relevant capacity, developing capable leadership, providing essential monitoring and evaluation tools, improving capacity for ethical review of research, and determining necessary ethical standards and regulations for population health, health care, and clinical research;

Committed to promoting access to reliable, relevant, and up-to-date evidence on the effects of interventions, based on systematic review of the totality of available research findings, and taking into account existing models;

Conscious of the need to identify relatively underfunded areas of research, such as ~~on~~ health systems and public health, where increased resources and leadership would accelerate the achievement of ~~critical health~~ **internationally agreed health-related development** goals;

Emphasizing that research is a global endeavour based on the sharing of knowledge and information ~~within an appropriate ethical framework,~~ **and conducted according to appropriate national ethical guidelines and standards,**

1. ~~[TAKES NOTE of]~~~~[ENDORSES]~~ **ACKNOWLEDGES** the Mexico Statement on Health Research resulting from the Ministerial Summit on Health Research (Mexico City, 16-20 November 2004);
2. **URGES** Member States:
 - ~~{(1) to implement}~~ **consider implementing** the recommendation made by the Commission on Health Research for Development in 1990 that “developing countries should invest at least 2% of national health expenditures in research and research capacity strengthening, and at least 5% of project and programme aid for the health sector from development aid agencies should be earmarked for research and research capacity strengthening”;¹
 - (2) to establish and implement or strengthen a national health-research policy with appropriate political support and to allocate** ~~and, in the context of such a policy, to~~

¹ Commission on Health Research for Development. *Health research: essential link to equity in development*. New York, Oxford University Press, 1990.

~~reallocate a higher priority~~ **adequate funding and human resources for to an adequately funded programme of health-systems research;**

(3) to encourage collaboration with other partners in health research so as to facilitate the conduct of such research within their health systems;

(4) to promote activities to strengthen national health-research systems, including ~~creating informed~~ **the improvement of the knowledge base for decision-making** makers, setting priorities, managing research, monitoring performance, adopting standards and regulations for high-quality research and its ethical oversight, and ensuring participation in such activities of the community, nongovernmental organizations, and patients;

(5) to establish or strengthen mechanisms to transfer knowledge in support of evidence-based public health and health-care delivery systems, and evidence-based health-related policies;

(6) to support, together with WHO's Secretariat and the global scientific community, networking of national research agencies **and other stakeholders** with a view to conducting collaborative research in order to address global health priorities;

(7) to encourage public debate on the ethical dimension and societal implications of health research among researchers, practitioners, patients and representatives of civil society and the private sector and to encourage transparency on research results and on possible conflicts of interest;

3. CALLS UPON the global scientific community, international partners, the private sector, civil society, and other relevant stakeholders, **as appropriate:**

(1) to provide support for a substantive and sustainable programme of health-systems research aligned with priority country needs and aimed at achieving the internationally agreed health-related development goals, including ~~those the development goals~~ contained in the United Nations Millennium Declaration;

(2) to establish a voluntary platform to link clinical trials registers in order to ensure a single point of access and the unambiguous identification of trials with a view to enhancing access to information by patients, families, patient groups and others;

(3) to strengthen or establish the transfer of knowledge in order to communicate, improve access to, and promote use of, reliable, relevant, unbiased, and timely health information;

(4) to provide support for national, regional, and global research partnerships, including public-private partnerships, to accelerate the development of essential drugs, vaccines, and diagnostics, and mechanisms for their equitable delivery;

(5) to recognize the need to involve the relevant authorities in the Member States concerned in the initial planning of health research projects;

(6) to support, together with the WHO Secretariat and Member States, networking of national research agencies **and other stakeholders** to the greatest extent possible as a means of identifying and conducting collaborative research that would address global health priorities;

4. REQUESTS the Director-General:

(1) to undertake an assessment of WHO's internal resources, expertise and activities in the area of health research, with a view to developing a position paper on WHO's role and responsibilities in the area of health research and to report through the Executive Board to the next World Health Assembly;

~~(1)~~**(2) to engage in consultation with interested stakeholders on creation of a programme on health-systems research geared to assisting Member States to accelerate** ~~accelerating~~ achievement of internationally agreed health-related development goals, including ~~those the development goals~~ contained in the United Nations Millennium Declaration;

~~(2)~~(3) to pursue with interested partners the development of a voluntary platform to link clinical trials registers;

(3)(4) to assist in the development of more effective mechanisms to bridge the divide between ways in which knowledge is generated and ways in which it is used, including the transformation of health-research findings into policy and practice;

~~[(4)(5) to convene, consider the possibility, with other interested stakeholders, of convening an a ministerial level international conference on research into human resources for health;]~~

~~(5) — to report progress on the Mexico Statement at the high level plenary meeting of the United Nations General Assembly to review implementation of the Millennium Declaration (September 2005), at a conference on health systems in 2006, and at the next Ministerial summit on health research in 2008.~~

[(6) to ensure that meetings open to all Member States organized by WHO that are characterized as summits or as ministerial summits are first approved by the World Health Assembly.]

Mr BAILÓN (Mexico), speaking in his capacity as chairman of the informal working group, said that, even though some members of the group had expressed legitimate doubts concerning the legal basis for the Ministerial Summit on Health Research held in Mexico in November 2004, those had been addressed by the Secretariat. There had been agreement at all times on the importance of that meeting and the need to approve the draft resolution. After detailed discussion, consensus had been achieved on the whole text apart from subparagraph 4(6), which had been suggested by one Member State. The Secretariat was asked to give its views on that subparagraph.

Mr BURCI (Legal Counsel) said that the Director-General had no objection to the proposed subparagraph, as it would not undermine his authority to convene meetings of ministers to discuss technical matters. In response to queries from Dr REN Minghui (China) and Dr NYIKAL (Kenya), he said that the term “ministerial summits” had been taken at face value, rather than being understood as referring to any meeting of ministers organized by the Director-General.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) expressed support for subparagraph 4(6). In order to keep health research high on the international agenda, he suggested addition of the following phrase to the end of subparagraph 4(5): “and to consider convening the next ministerial-level meeting on health research in 2008”. Health research contributed to achieving the Millennium Development Goals, and an evidence base to guide policy actions was needed.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) asked if Health Assembly approval would be sought for all aspects of ministerial summits, such as venue and financial input, besides subject matter.

Mr BURCI (Legal Counsel) confirmed that that was the Secretariat’s interpretation of subparagraph 4(6).

Ms GILDERS (Canada), expressing support for the draft resolution, agreed with the inclusion of subparagraph 4(6) and the amendment suggested by the delegate of Thailand. In that way, momentum could be maintained but with the checks and balances sought by Member States in place.

Dr AZENE (Ethiopia) highlighted an apparent contradiction: on the one hand, the Director-General could convene any meeting on technical matters, but, on the other, subparagraph 4(6) sought approval from the Health Assembly for all ministerial summits. If the first were true, subparagraph 4(6) was not necessary.

Mr AITKEN (Office of the Director-General) explained that the subparagraph was intended to apply to ministerial summits in the strict sense, and not to meetings at which ministers were present or to meetings of a technical nature that did not aim to take policy decisions.

Dr BELLO DE KEMPER (Dominican Republic), in response to the Legal Counsel's explanation that the subparagraph was intended to apply to all ministerial summits, said that she doubted that such a general statement should be included in a resolution on a specific subject. The idea could be made the subject of a resolution on the work of WHO, to avoid its significance being overlooked.

Mr BURCI (Legal Counsel) replied that the subparagraph had been discussed in the context of the draft resolution under consideration, as would be reflected in the summary records, and that the Secretariat would be bound by it if it was approved. Member States would be free to raise the matter in a future Health Assembly in a more general context, but no such request had been made.

Mr BASSE (Senegal) pointed out that the meetings referred to in subparagraph 4(6) would result in general policy documents, as had been the case at the Ministerial Summit on Health Research in Mexico. It was not clear, however, whether the text applied to all meetings organized by WHO, even those that dealt with matters other than health research. Legal Counsel had just explained that the subparagraph in question appeared in the context of a resolution on health research. If it did not refer solely to meetings on health research, it should be clarified to indicate that it covered all meetings.

Mr BURCI (Legal Counsel) reiterated his understanding that, although it was included in a draft resolution on a specific item, the text was general and was intended to refer to all ministerial summits.

Ms DE HOZ (Argentina), referring to the special organizational relationship between WHO and PAHO, requested clarification on the implication for ministerial meetings at regional level.

Mr BURCI (Legal Counsel) replied that such meetings would not be affected, as the text referred to "meetings open to all Member States", which did not include regional meetings.

Dr NYIKAL (Kenya), supported by Ms MAFUBELU (South Africa), Mr BASSE (Senegal) and Dr AZENE (Ethiopia), said that, if the paragraph was meant to refer to all summit meetings on health, it was not in the right place. If it was meant to be specific, the words "on health research" should be inserted after "WHO".

Mr HOHMAN (United States of America) said that he understood the concern of certain delegates that the subparagraph, which had been proposed by his delegation, might not be in the appropriate place. Its purpose had been to address the concern that when WHO convened a meeting characterized as a ministerial summit, which had political connotations and usually an outcome to be adopted by all Member States, it was preferable for the organization of such meetings to be approved beforehand by the Health Assembly with respect to subject matter, agenda, venue and proposed outcomes. In view of the concerns expressed, he proposed that the Health Assembly should take a decision that meetings open to all Member States convened by WHO and characterized as summits or ministerial summits should be first approved by the Health Assembly.

Mr BURCI (Legal Counsel) said that the Health Assembly could adopt such a decision, but that there was no agenda item that would cover that eventuality. He suggested that it might not be procedurally wise to rush such a decision at the present Health Assembly and suggested that the United States should propose the matter for consideration at the Fifty-ninth World Health Assembly.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) agreed that the proposed subparagraph should specify that it concerned health research. Regarding the proposal by the United States, and seconded by

Ms MAFUBELU (South Africa), he said that the matter should be submitted to the Executive Board for consideration. The Board could then draw up a decision for consideration by the Health Assembly to the effect that all ministerial summits on health should first be approved by the Health Assembly.

Dr BRUNET (France) supported the comments made by the delegates of Senegal and Cuba. The question, which went far beyond health research, should first be discussed in the Executive Board before being taken up by the Health Assembly. Doubts remained, which had only been exacerbated by the Legal Counsel's explanations. Why, for example, should the Director-General's powers be limited for global ministerial summits but not those at regional level? The whole subject required in-depth consideration.

Dr ISLAM (Secretary) said that the amended subparagraph 4(6) would read: "to ensure that meetings open to all Member States on health research organized by WHO that are characterized as summits or as ministerial summits are first approved by the World Health Assembly".

The draft resolution, as amended, was approved.¹

3. EIGHTH REPORT OF COMMITTEE A (Document A58/64)

Dr BUSUTTIL (Malta), Rapporteur, read out the draft eighth report of Committee A.

The report was adopted.²

4. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of the Committee completed.

The meeting rose at 10:25.

¹ Transmitted to the Health Assembly in the Committee's eighth report and adopted as resolution WHA58.34.

² See page 355.

COMMITTEE B

FIRST MEETING

Thursday, 19 May 2005, at 09:15

Chairman: Dr J. WALCOTT (Barbados)

1. OPENING OF THE COMMITTEE: Item 14 of the Agenda (Document A58/48)

The CHAIRMAN, welcoming participants, reminded the Committee that representatives of the Executive Board voiced the Board's views and explained the rationale behind recommendations for the Health Assembly's consideration. He drew the Committee's attention to the third report of the Committee on Nominations,¹ which contained proposals for the offices of Vice-Chairmen and Rapporteur.

Decision: Committee B elected Professor J. Pereira Miguel (Portugal) and Dr M.A. Rahman Khan (Bangladesh) as Vice-Chairmen and Mr Yee Ping Yi (Singapore) as Rapporteur.²

2. ORGANIZATION OF WORK

The CHAIRMAN drew attention to document EB115/2005/REC/1, which contained the resolutions and decisions adopted by the Board in January 2005 and to which frequent reference would be made. He suggested that the Committee should meet from 09:00 until 12:30 and from 15:00 until 18:00, and urged speakers to restrict the length of their contributions to no more than three minutes.

It was so agreed.

He recalled that at its meeting on 16 May 2005 the General Committee had decided that the following subitems under agenda item 13 would be transferred from Committee A: 13.12 (Cancer prevention and control); 13.13 (Disability, including prevention, management and rehabilitation); 13.14 (Public health problems caused by harmful use of alcohol); and 13.15 (International Plan of Action on Ageing: report on implementation). He suggested that agenda item 17.3 (Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution) should be considered after agenda item 16 to enable the Health Assembly to reach an early decision on the restoration of voting privileges for those Member States that had submitted requests for special arrangements to settle arrears in the payment of their contributions.

It was so agreed.

¹ See page 351.

² Decision WHA58(4).

The CHAIRMAN said that, pending approval of the Proposed programme budget 2006-2007, which was currently being discussed by Committee A, it might be premature for the Committee to consider the draft resolution on the Real Estate Fund contained in document A58/44 Corr.1. He suggested postponing consideration of agenda item 18 until after completion of agenda item 17 (Financial matters).

It was so agreed.

3. HEALTH CONDITIONS OF, AND ASSISTANCE TO, THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE: Item 15 of the Agenda (Documents A58/24, A58/INF.DOC./2, A58/INF.DOC./4 and A58/INF.DOC./5)

The CHAIRMAN drew the Committee's attention to a draft resolution entitled Health conditions in the occupied Palestinian territory including East Jerusalem and in the occupied Syrian Golan, proposed by the delegations of Bahrain, Egypt, Jordan, Kuwait, Oman, Qatar, Tunisia and United Arab Emirates, which read:

The Fifty-eighth World Health Assembly,

Mindful of the basic principle established in the Constitution of WHO, which affirms that the health of all peoples is fundamental to the attainment of peace and security;

Recalling all its previous resolutions on health conditions in the occupied Arab territories;

Expressing appreciation for the report of the Director-General on the health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine;¹

Expressing its concern at the deterioration of the economic and health conditions as well as the humanitarian crises resulting from the continued occupation and the severe restrictions imposed by Israel, the occupying power;

Affirming the right of Palestinian patients and medical staff to the health facilities available at the Palestinian health institutions in occupied East Jerusalem;

Deploring the impact on the Palestinian environment and in particular on Palestinian water resources of the disposal of Israeli waste in the West Bank;

Concerned about the possible health effects on the Palestinian people of the "enhanced X-ray machine" used by Israel at Palestinian border-crossing points,

1. CALLS UPON Israel, the occupying power, to halt immediately all its practices, policies and plans which seriously affect the health conditions of civilians under occupation;
2. DEMANDS THAT Israel reverse and stop its practice of dumping waste in the occupied Palestinian territory;
3. EXTENDS its gratitude to Member States, and to intergovernmental and nongovernmental organizations for their continued support in meeting the health needs of the Palestinian people;
4. EXPRESSES its deep appreciation to the Director-General for his efforts to provide necessary assistance to the Palestinian people, the rest of the Arab population in the occupied Arab territories, and other peoples of the region;

¹ Document A58/24.

5. REQUESTS the Director-General:
- (1) to dispatch a fact-finding mission on the deterioration of the health and economic situation in the occupied Palestinian territory;
 - (2) to undertake without delay an independent health-impact assessment of the “enhanced X-ray machine” used by Israel at Palestinian border-crossing points;
 - (3) to take urgent steps, in cooperation with Member States, to support the Palestinian Ministry of Health in its efforts to overcome the current difficulties and to help it during and after the announced Israeli withdrawal from the Gaza Strip and parts of the West Bank, in particular so as to guarantee the free movement of all health personnel and patients within and out of the occupied Palestinian territory including East Jerusalem, and the normal provision of medical supplies to the Palestinian medical premises;
 - (4) to provide health-related technical assistance to the Arab population in the occupied Syrian Golan;
 - (5) to continue providing necessary technical assistance to meet the health needs of the Palestinian people, including the handicapped and injured;
 - (6) to support the development of the health system in Palestine including development of human resources;
 - (7) to report on implementation of this resolution to the Fifty-ninth World Health Assembly.

Mr MELEKA (Egypt), introducing the draft resolution, said that it reflected the deteriorating health conditions of the people in the occupied Palestinian territory including East Jerusalem and the occupied Syrian Golan as a result of the continued Israeli occupation. The current situation made it incumbent on WHO, with the support of the international community, to reaffirm that the health of all peoples was fundamental to the attainment of peace and security. Demolishing homes and constructing blockades that prevented humanitarian assistance reaching those who needed it not only amounted to a violation of the basic human rights of the Palestinian people, but also showed a flagrant disregard for the many relevant international conventions and resolutions, including several adopted by the Health Assembly. He called on the Organization to remind Israel of its obligations in that connection, and requested the Director-General to dispatch a fact-finding mission to investigate the deterioration of the health and economic situations in the occupied Palestinian territory. In addition, Israel had to stop and reverse its practice of dumping waste in the occupied territory, and take steps to prevent the Palestinian people being subjected to the harmful effects of the “enhanced X-ray machine” used at Palestinian border-crossing points. The Arab countries called on WHO to continue to provide support to the Palestinian people despite the many obstacles and problems, and urged the Government of Israel to reconsider its practices and take the necessary steps to improve conditions. He hoped that the draft resolution would be approved by consensus.

Mr MOKHTARI (Islamic Republic of Iran) said that the reports of the Director-General and of the Director of Health, UNRWA¹ painted a grim picture of the situation in the occupied Palestinian territory: many thousands of killed and injured; severe economic recession, with a sharp increase in unemployment and poverty; and many children suffering severe psychological problems. People with medical emergencies were often subjected to delays as they attempted to obtain much-needed treatment, delays which sometimes resulted in death. Despite the efforts of the international community, the enjoyment of good health would remain beyond the reach of the Palestinian people until the occupation came to an end.

Dr AL-WUHAIDI (Palestine) said that Palestine was looking to WHO as a non-political organization to provide continued support to the Palestinian Ministry of Health. The wall/fence

¹ Documents A58/24 and A58/INF.DOC./2, respectively.

constituted an additional obstacle in the daily lives of the people, separating thousands of Palestinians from their families and work, depriving them of their right to education, health and political participation. As a result of the deteriorating economic situation and growing unemployment, there had been a sharp rise in the number of people suffering from anaemia, especially pregnant women and children. He was also concerned about the possible harmful effect on people's health and morale of the "enhanced X-ray machine" used by Israel at border-crossing points. Israel showed its further disregard for the health of local populations by continuing to dump toxic waste on Palestinian land and to build settlements that had an adverse impact on both water supplies and the environment.

He drew attention to the large number of people killed or seriously injured during the recent intifada, and called on Israel to withdraw from all the Palestinian territory it had occupied since 1967, including East Jerusalem and all border checkpoints. Despite Israel's claims that it was offering training and other facilities to the Palestinian people, the price they had to pay for such facilities far exceeded what they would have had to pay elsewhere.

He thanked Member States and intergovernmental and nongovernmental organizations for their continued support in meeting the health needs of the Palestinian people.

Dr TSHABALALA-MSIMANG (South Africa) expressed her condolences to the Government and people of Palestine on the loss of their leader, President Yasser Arafat. It was to be hoped that the peace process would soon reach a successful conclusion, but, in the meantime, the health status of the Palestinian people was being severely compromised. She had noted with particular concern reports relating to interrupted water supplies, flagrant inequities in water distribution and use, and what appeared to be deliberate acts of pollution in the occupied Arab territories, including Palestine. The current situation impeded the free movement of the Palestinian people, and thus restricted their access to health services. A unified, fully functional health infrastructure was essential for the delivery of health services.

The wall/fence, still being constructed even though it constituted a violation of international law, seriously disrupted the provision of health services by isolating clinics and hampering the distribution of medical supplies. Any breakdown in the health infrastructure disproportionately affected the health of women, mothers and children by undermining maternal health care, disrupting vaccination programmes and reducing the likelihood of delivery in optimum conditions. Any interference with health-care workers and ambulance services was a serious cause for concern; reports of health-care workers being injured or killed while performing their duties were shocking. She supported the draft resolution.

Mr BERNIS (Luxembourg), speaking on behalf of the Member States of the European Union, commended the focus by the resolution's sponsors on the health aspects of the situation, and said that he would be proposing several amendments at the appropriate time.

Mr MARTABIT (Chile) expressed concern over the current situation in the occupied Palestinian territories, and urged Israel to lift the restrictions that were preventing the people from receiving proper medical attention. Improving the health of the people in the occupied Arab territories was closely linked to effective implementation of the peace process. The Palestinian people had a right to live in an independent State and to co-exist peacefully with Israel in accordance with relevant United Nations Security Council resolutions. Therefore, it was to be hoped that both Palestine and Israel would do their utmost to reach a just and lasting peace based on mutual respect in the best interests of their citizens and of future generations. Chile supported the draft resolution.

Dr SENAN (Malaysia) urged all Member States to support the draft resolution. The situation in the occupied Palestinian territory continued to be a cause of grave concern to his country, in particular the deterioration in the health conditions of the Palestinian people as a result of the construction of the wall/fence by Israel. He called on WHO to take urgent measures to address the various problems highlighted in the reports of the Director-General and the Director of Health of UNRWA, in particular

the health and nutritional needs of pregnant women and children, the continued decline in immunization coverage and the restrictions on the movement of medical personnel. He strongly supported the call for the Director-General to dispatch a fact-finding mission to the occupied Palestinian territory. As the occupying power, Israel must immediately cease all policies and practices that were having a damaging effect on health, and must allow the Palestinian health system to function properly again.

Mr M.N. KHAN (Pakistan) also expressed grave concern at the health situation in the occupied Palestinian territory, including East Jerusalem and the Syrian Golan. The highest attainable standard of physical and mental health was a vital human right that was being violated by Israeli policies and practices. The Organization, as the world's leading health body, should provide a proper diagnosis and a prescription in the form of an independent and comprehensive health-impact assessment. He was alarmed at Israel's dangerous practice of dumping waste in the West Bank, damaging the environment and the water resources of the Palestinian people and adversely affecting health. The Health Assembly should call for that practice to be halted immediately. The deterioration in conditions was largely due to the economic siege imposed by Israel, and WHO could help to ease the situation by coordinating its activities with other specialized agencies in the occupied territories and by providing financial and technical support. The provision of medical supplies and the free movement of health workers and patients were paramount, particularly during and after the declared Israeli withdrawal from the Gaza Strip and other parts of the West Bank.

He fully supported the draft resolution and called on Member States to endorse it. The international community should express its solidarity with the Palestinian people and should work towards a just, comprehensive and lasting solution of the Middle East problem.

Mr WANG Chuan (China) said that the international community must take into account the humanitarian needs of Arab populations in the occupied territories and take measures to promote and protect their health; he expressed appreciation for the efforts of WHO and other organizations in that regard. The peace process in the Middle East had entered a new phase in which Palestine and Israel had an opportunity to achieve success; for that, it was crucial that both sides persist with political negotiations based on relevant United Nations resolutions. China, like all peace-loving countries, wished to promote peace and stability. Resolution of the conflict in the Middle East would require not just determination and effort on both sides, but also the assistance and support of the international community. For those reasons, he supported the draft resolution.

Dr ESTÉVEZ TORRES (Cuba) said that health conditions in the occupied Palestinian territory were an important issue for the Health Assembly, given the negative effects of the Israeli occupation on its population and on the environment. The violation of the human rights of the Palestinian people was the most flagrant, massive and systematic of its kind, and the numbers of dead and injured, mostly civilians and including many children, continued to increase. He condemned the building by the Israeli Government of the wall around the West Bank and Jerusalem and the expansion of Israeli settlements. Health conditions had continued to deteriorate as a result of that and the restrictions on freedom of movement imposed by Israel, which particularly affected ambulances, health workers and the sick and injured. Patients and medical staff were being denied access to health centres and hospitals, leading to a reduction in the number of immunized children. The Palestinian Ministry of Health had suffered unprecedented damage, which put its very survival in jeopardy. As a result of the continued existence of blockades, curfews and road closures, the multiplication of checkpoints and denial of access to their places of work, tens of thousands of Palestinian families had been cut off from their sources of income and were on the verge of collapse. The great majority of Palestinians suffered or were at risk of suffering from food insecurity, while the supply of international financial resources was declining.

At the same time the environment in the occupied Palestinian territory continued to deteriorate as a result of Israel's dumping of solid nuclear and chemical waste, which contaminated underground water supplies, adversely affecting health. International humanitarian efforts, including those

undertaken by the United Nations, had failed owing to lack of cooperation by the Israeli authorities and their total contempt for the increasing number of resolutions adopted by the United Nations on the subject. He fully endorsed the request to the Director-General in the draft resolution to take urgent steps, in cooperation with Member States, to support the Palestinian Ministry of Health in its efforts to overcome the current difficulties, and to provide health-related technical assistance to the Arab population in the occupied Syrian Golan.

Member States of WHO needed to join forces, notably by calling for full implementation of the successive demands made by the overwhelming majority of members of the international community, through relevant United Nations bodies and the Health Assembly, for the immediate cessation of aggression by Israel against the Arab and Palestinian populations in the occupied territories. He expressed support for the draft resolution.

Dr ELSAYID (Sudan) acknowledged health workers in the occupied Palestinian territories, who had been providing services to Palestinian citizens despite the obstacles imposed by the occupying authorities. Israel's policy of collective punishment, which resulted in women, children and elderly people being killed and housing and environmental structures damaged, was universally condemned. The Director-General should send a fact-finding mission and present a report to the Health Assembly. The refusal of the occupying authorities to permit such a mission violated United Nations resolutions.

Dr JA'AFARI (Syrian Arab Republic), endorsing the draft resolution, said that the Israeli occupation of the Palestinian and Syrian territories had been of significant concern to the international community for decades. It was frequently included on the agenda of international forums and was given non-stop coverage by the media. Israel's response, however, was to escalate its activities.

The poor health status of the Palestinian people in the occupied territory could not be denied. For example, a pregnant woman had been forced to give birth at a checkpoint, after being prevented by Israeli soldiers from reaching hospital; 286 Palestinian children had been killed in the last four years, most of them shot in the head; and Palestinian ambulances bearing the emblem of the International Red Crescent had been bombarded by Israeli tanks, killing health workers. Israel had prevented the building of hospitals and schools in the occupied Golan, forcing Syrian populations there to seek medical care at Israeli hospitals. The Israeli authorities used Palestinian wells to supply their settlements, dumped nuclear waste in the occupied territory, and made use of enhanced X-ray machines, which caused cancer and sterility, at border-crossing points. In view of that situation, the least WHO could do was to adopt the draft resolution. Israel was not only occupying Arab territories in Palestine and Golan but was destroying the environment of those territories in the long term. The path to peace was clear, and was based on justice and international legitimacy. Israel should accept that the international community was right, and heed the 1000 or more international resolutions adopted since 1948 calling for it to end its occupation.

Mr FERGUSON (Canada) expressed his continued concern at the declining living standards and impaired access to basic health facilities and services in the West Bank and Gaza, which had been exacerbated by barrier construction. Canada was a longstanding provider of humanitarian assistance to the Palestinian people, including through contributions designed to meet urgent health needs.

However, with regard to the draft resolution, he regretted the focus on a specific geographical area, the singling out of Palestinians for special attention and, in particular, the request for an independent assessment of X-ray equipment, which in his view served no technical or health purpose and would be a misuse of resources. WHO should focus primarily on achieving the highest possible level of health for all peoples by advancing global health strategies. For those reasons, while commending the sponsors of the resolution for their constructive efforts, he would abstain from the vote.

Mr LEVANON (Israel) said that, although he had been encouraged by statements made in plenary to the effect that WHO was free from politicization, that did not appear to be the case. He had

the impression that the Health Assembly, in singling out one country for attention, was operating a system of double standards, which detracted from the Organization's image and prestige.

The draft resolution, which was basically political, fell outside the scope of the Health Assembly's remit; it did not improve the health of those living in the territories; nor did it call for Israeli-Palestinian cooperation or mention the positive developments that had occurred since the Sharm el-Sheikh summit. He pointed out that medical care for Palestinians was the responsibility of the Palestinian Health Authority, which had been independently managing its health services for over 10 years, whereas the 40 emergency health situations currently existing around the globe were the responsibility of WHO, which should be dealing with those crises, not a political issue.

Two specific allegations in the draft resolution were clearly designed to mislead the Health Assembly. The first was the pollution of water supplies through the disposal of waste in the West Bank. Israel would not pollute water that was used by Israelis as well as Palestinians. The second concerned supposedly harmful X-ray equipment. In fact the equipment in question was a commercial product that did not use ionizing radiation, only radio waves, the intensity of which was in accordance with international standards and did not endanger human health. It was used in several European Union countries and as far as he knew had not been considered to pose any health risks.

He mentioned some of the positive aspects of the situation, including Israel's humanitarian policies, unchanged despite several acts of terrorism by Palestinians. Israel continued to admit Palestinian patients to hospital, provide ambulatory medical care, public health and laboratory services, and training programmes and postgraduate studies for health professionals, and facilitate the transfer of medical donations and medical equipment to centres in Palestinian territories. In the past year more than 35 000 patients from the West Bank and Gaza had been treated in Israeli hospitals. Despite the fact that the Palestinian Authority had halted payments for those services, Israel continued to admit Palestinian patients without delays or restrictions. Under Israeli cooperation with the Palestinian health sector, in the past year, 53 Palestinians had participated in training programmes in Israel, consultative meetings on crucial public health and infectious disease issues had been held, public-health laboratories continued to provide assistance, and a joint initiative to improve the nutritional status of children from both sides had been launched.

Past experience had shown that resolutions did not help to improve the health of Palestinians. He called on his Palestinian partners, instead of tabling political resolutions, to declare publicly their willingness to resume the work of the six joint committees established by mutual accord in the field of health for the benefit of both peoples. He called on Member States to reject the draft resolution, and to steer the Health Assembly away from further politicization to enable it to focus on crucial health issues, which would be of much greater benefit to the welfare of the Palestinian people.

Dr SHANGULA (Namibia) joined in expressing grave concern at the deteriorating health situation in the occupied Palestinian territory. He had particular misgivings about the use of the "enhanced X-ray machine" at border-crossing points, since it was universally accepted that it was morally and ethically wrong to subject individuals to radiation except for diagnostic purposes; it was not allowed for pregnant women, for example, even in low doses. By implication, an enhanced X-ray machine would subject individuals to higher doses of radiation than normal: that was unacceptable and WHO, in view of the clear health implications, should demand that the practice be stopped. The draft resolution addressed health issues – the prime mandate of the Health Assembly – and he therefore supported it.

Dr AMMAR (Lebanon) expressed his concern at the health conditions in the occupied territories, including Palestine, especially given the lack of any restraints at international level on Israeli aggression. He endorsed the observations relating to the negative economic and health effects of restrictions on the movement of goods and people, and of other obstacles that hindered access to health services, particularly for women and children. The construction of a partition wall would exacerbate those effects. Israeli practices breached international law and violated human rights. With regard to the question of the dumping of waste and the pollution of water resources, which would

affect present and future generations, he called on the international community to ascertain the nature of the waste dumped and to condemn the practice. WHO should assess the “enhanced X-ray machine” and its effects and submit a report.

All the issues that had been raised were related to health, and the Organization had a duty to take them into account. He therefore supported the draft resolution, and in particular the request to the Director-General to send a fact-finding mission to the occupied territories.

Mr MOLEY (United States of America) said that his country deeply regretted that the draft resolution was introducing largely political considerations into the debate of the global health body. The United States shared the concern about the situation in the region and the terrible toll that the violence was taking on both the Palestinians and Israelis. It had worked intensively with both sides to find a way forward. However, the question of the final status of the occupied Arab territories was clearly outside the mandate of the Health Assembly. The resolution would neither help to further the search for peace in the Middle East nor improve the health of those living in the occupied territories.

The draft resolution should confine itself to the health of the Palestinian people. The United States was committed to providing assistance to the Palestinian people for primary health care, child survival, maternal health, nutrition and other humanitarian programmes, and was the largest donor to UNRWA. As much of the language in the draft resolution was biased and political in focus, he opposed its adoption and requested that it should be put to a roll-call vote.

Ms SOLTANI (Algeria) expressed concern at the health situation in the occupied Arab territories. She supported the draft resolution, and wished her country to be a sponsor.

Mr SUMIRAT (Indonesia) said that his Government remained deeply concerned about the economic deterioration of the occupied Arab territories and the continued security restrictions imposed by the Israeli forces, which had caused Palestinians much suffering, not only by restricting freedom of movement within the territories but also by restricting their access to medical treatment and health facilities. The construction of the separation wall in the West Bank had added to that suffering, particularly for sick and wounded Palestinians needing immediate health relief. Moreover, the deep psychological trauma experienced by 50% of Palestinian children owing to conflict-related violence was giving rise to aggressive behaviour and the need for mental-health treatment.

Although he appreciated WHO’s efforts, in cooperation with UNRWA and other organizations, to support the Palestinian Ministry of Health in improving the health capacities in the occupied Palestinian territories, he recognized that Palestinian health services could not be improved effectively while the strict security measures remained in place. He therefore reiterated his support for the Palestinian people in their struggle to achieve their basic right to health and freedom and urged delegates to approve the draft resolution.

Dr OTTO (Palau) expressed sadness at the suffering that the peoples of Palestine and Israel continued to experience and expressed the hope that a peaceful resolution to the conflict in the region would be found. Although he commended the more positive direction of the draft resolution, compared to similar past resolutions, he was concerned about two of its provisions. First, hard facts were needed to prove that the deterioration in the economic and health conditions as well as the humanitarian crisis resulted solely from the actions of Israel, as was stated in the fourth preambular paragraph. Secondly, with reference to paragraph 1, it was not clear what were the “practices, policies and plans” that Israel was being called upon to halt; that wording might refer to the political situation. He was therefore unable to support the resolution as drafted.

Dr EL ISMAILI ALAOU (Morocco) recalled that the deteriorating health situation of people in occupied Palestine and Syrian Golan had been discussed for decades, but that the situation had worsened since the wall had been erected. All reports of visits to the region corroborated the evidence

of its impact on health conditions. He supported the draft resolution and urged WHO to intervene to end the health crisis.

Dr AL-RABI (Yemen) noted with concern the deteriorating conditions of the Palestinians. He supported the draft resolution and wished to be added to the list of its sponsors.

Dr JA'AFARI (Syrian Arab Republic) observed that foreign occupation was rejected by the international community at large; indeed that the United Nations had been established to protect humanity from aggression and occupation. The veracity of his previous statement was confirmed by the fact that the delegate of Israel had ignored the occupation by Israel of the Syrian Golan. The Palestinians, Lebanese and Syrians who had been living under Israeli occupation for decades did not need Israeli clinics and doctors; they wanted to end the occupation and be able to live in dignity.

The claim made by the delegate of Israel that the "enhanced X-ray machine" was in normal use in other parts of the world was false, since similar equipment used in a European airport had been dismantled immediately after public protest.

The disposal of waste in the occupied Arab territories should be investigated by a WHO fact-finding committee, which would put to the test the statement by the delegate of Israel that it would not pollute water supplies.

Dr ALI MOHAMMED (Iraq) expressed deep concern about the deteriorating health conditions in the occupied territories, and the hope that WHO would fulfil its humanitarian mission in the occupied Palestinian territories without politicizing it. He strongly supported the draft resolution.

Dr OULD MOHAMED VALL (Mauritania) asked for his country to be added to the list of sponsors.

The CHAIRMAN announced that Mali had also requested that its name be added to the list of sponsors.

Ms BASSO (UNRWA), speaking on behalf of the Director of Health, UNRWA, reported that five years of severe humanitarian crisis in the occupied Palestinian territories had taken a heavy toll in terms of casualties, large-scale destruction of the infrastructure and generalized poverty. The obstacles to humanitarian access had constrained Palestinian development, affected the delivery and quality of services and jeopardized relief assistance. Income per capita had dropped by over half, and the proportion of the population living in poverty had risen from 20% to 60% since 2000; food insecurity was common.

The year 2005 had brought hopes of a breakthrough in the cycle of violence. However, the international community should not lose sight of the continuing and future challenges. All projections suggested that, if the Gaza Strip were to be sealed and isolated from the outside world, the economy would suffocate and the humanitarian conditions would deteriorate further. The residual problems of decades of occupation and conflict would require years of well planned and adequately coordinated efforts to facilitate transition from conflict to recovery and development during the post-disengagement era. In the West Bank, where the roots of the crisis lay in the lack of mobility and access, the separation barrier would worsen rather than improve humanitarian access. According to the Israeli Government, about 14.5% of the West Bank land (excluding East Jerusalem) would lie between the separation barrier and the internationally-recognized Green Line. That land, some of the most fertile in the West Bank, was home to 274 000 people. More than 400 000 Palestinians living to the east of the barrier would need to cross it to get to their farms, jobs and services. About 30% of the Palestinian population in the West Bank would be directly affected by the barrier. In addition, there were currently 220 000 settlers (not including those in East Jerusalem) who controlled 42% of the West Bank territory.

The transition from conflict to recovery and development was greatly hindered by the conditions of land confiscation, a depressed economy and stunted civil institutions, systems and services. Any improvements in the political and security situation owing to implementation of the disengagement plan would not immediately ease the humanitarian crisis or reduce the need for sustaining international assistance. Meeting the basic development needs of the population would be more complex than the current emergency interventions.

Since 2000, UNRWA had requested some US\$ 1000 million to support its programme of emergency humanitarian assistance, in addition to the support it received for maintaining its regular programme activities and to that provided by the international community to the Palestinian Authority. As a major provider of services to about half the population of the occupied Palestinian territories, UNRWA required additional support not only to sustain its much-needed regular activities, but also in order to contribute to the process of rehabilitation and development. UNRWA was keen to maintain close cooperation with local and international partners within the framework of internationally coordinated and supported efforts. WHO's support for the medium-term development plans of UNRWA and the Palestinian Authority would be crucial to the success of that difficult mission, and its technical support for the rehabilitation and development of the Palestinian health-care system would be needed more than ever before.

Dr AL-HUSSEIN (Saudi Arabia) said that the reported health conditions in the occupied Palestinian territories were shameful and were the result of the occupation of that area. He supported the draft resolution.

Mr ALFARARGI (League of Arab States) maintained that the draft resolution was moderate and balanced in both content and form, aiming to present to the Health Assembly the true situation in the occupied Arab territories in Palestine, East Jerusalem and the Syrian Golan. If Israel's version of the facts were true, the Israeli Government should support the resolution so that WHO could produce a report absolving Israel. As it was not known whether the claims made by the delegate of Israel were true, the Committee should not accept them.

Mr BERNS (Luxembourg), speaking on behalf of the Member States of the European Union, welcomed the focus of the draft resolution on the health conditions in the occupied Palestinian territories. Resolutions submitted to the Health Assembly and to other technical agencies of the United Nations, however, should not be political in nature. He therefore proposed that in paragraph 2 of the draft resolution the words "and stop" should be deleted and in subparagraph 5(1) "dispatch" should be replaced by "submit", "mission" should be replaced by "report" and "the deterioration of" should be deleted. Subject to those changes, the European Union and the countries that aligned themselves with it would be able to vote in favour of the draft resolution.

Dr MOSTOFA NUAJE (Libyan Arab Jamahiriya) expressed alarm at the situation facing the people in the occupied Arab territories and strongly supported the draft resolution. He hoped that the United Nations organizations, including UNRWA, would continue their support, as the occupation of Arab territories must be brought to an end, especially in view of the daily suffering of residents in those areas.

Dr JA'AFARI (Syrian Arab Republic) said that the two amendments proposed by the European Union were not in keeping with the requests made by his country and many other Member States, but he agreed to them in order to reach a consensus.

Mr MELEKA (Egypt), speaking on behalf of the sponsors of the resolution, said that he agreed with the amendments proposed by the delegate of Luxembourg.

Dr YOUNES (Secretary) read out the proposed amendments to the draft resolution.

The CHAIRMAN recalled that there had been a proposal to proceed to a roll-call vote.

Mr BURCI (Legal Counsel) set out the protocol for such a process. The Member States whose right to vote had been suspended by a Health Assembly resolution, or which had not submitted credentials, and would therefore be unable to participate in the vote were: Afghanistan, Antigua and Barbuda, Argentina, Armenia, Central African Republic, Comoros, Dominica, Dominican Republic, Georgia, Grenada, Guinea-Bissau, Iraq, Kyrgyzstan, Liberia, Nauru, Niger, Niue, Republic of Moldova, Saint Lucia, Somalia, Suriname, Tajikistan, Trinidad and Tobago, Turkmenistan.

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

The result of the vote was as follows:

In favour: Algeria, Andorra, Austria, Bahrain, Bangladesh, Barbados, Belgium, Bhutan, Bolivarian Republic of Venezuela, Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Cameroon, Chad, Chile, China, Congo, Croatia, Cuba, Cyprus, Czech Republic, Denmark, Ecuador, Egypt, Estonia, Finland, France, Germany, Greece, Hungary, India, Indonesia, Islamic Republic of Iran, Ireland, Italy, Jamaica, Japan, Jordan, Kuwait, Latvia, Lebanon, Lesotho, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Malaysia, Maldives, Mali, Malta, Mauritania, Mauritius, Mexico, Monaco, Morocco, Mozambique, Namibia, Netherlands, New Zealand, Nigeria, Norway, Oman, Pakistan, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Romania, Russian Federation, San Marino, Saudi Arabia, Senegal, Serbia and Montenegro, Slovakia, Slovenia, South Africa, Spain, Sri Lanka, Sudan, Sweden, Switzerland, Syrian Arab Republic, Tunisia, Turkey, Ukraine, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Uruguay, Viet Nam, Yemen, Zimbabwe.

Against: Australia, Fiji, Israel, Marshall Islands, Federated States of Micronesia, Palau, Solomon Islands, United States of America.

Abstaining: Canada, Costa Rica, El Salvador, Guatemala, Honduras, Iceland, Nicaragua, Paraguay, Singapore, Thailand, Togo.

Absent: Albania, Angola, Azerbaijan, Bahamas, Belarus, Belize, Benin, Bolivia, Burundi, Cambodia, Cape Verde, Colombia, Cook Islands, Côte d'Ivoire, Democratic People's Republic of Korea, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guyana, Haiti, Kazakhstan, Kenya, Kiribati, Lao People's Democratic Republic, Madagascar, Malawi, Mongolia, Myanmar, Nepal, Panama, Papua New Guinea, Rwanda, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Samoa, Sao Tome and Principe, Seychelles, Sierra Leone, Swaziland, The former Yugoslav Republic of Macedonia, Timor-Leste, Tonga, Tuvalu, Uganda, United Republic of Tanzania, Uzbekistan, Vanuatu, Zambia.

The draft resolution was therefore approved by 95 votes to 8, with 11 abstentions.¹

Ms HALTON (Australia), speaking in explanation of vote, opposed the continuing consideration of the resolution by the Health Assembly, and expressed concern that the maintenance of the item on its agenda not only introduced inappropriate political issues into that forum but also distracted the Health Assembly from issues that should take a higher priority. Furthermore, the consideration of such political issues by WHO was out of step with the need to streamline and

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA58.6.

rationalize the work of the United Nations and did not contribute effectively to the Middle East peace process.

Dr SADASIVAN (Singapore), speaking in explanation of vote, said that while his country had always supported the peace process in the Middle East, it did not believe that the Health Assembly was an appropriate forum in which to raise political issues.

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

4. REPORT OF THE INTERNAL AUDITOR: Item 16 of the Agenda (Documents A58/25 and A58/45)

Dr YOOSUF (Maldives, Representative of the Executive Board), speaking as Chairman of the Programme, Budget and Administration Committee, said that the report of the Internal Auditor provided a review of audit results from 2004. The Committee had welcomed the information on the status of audit reports, but requested timely and effective follow-up by the Secretariat, in particular to tackle delays in implementing audit recommendations in the Regional Office for Africa. It had reviewed the schedule¹ and acknowledged that all audit recommendations had been monitored until closure of the audit. The Committee had acknowledged the efforts to identify means to improve efficiency and cost-effectiveness in some areas, and those aimed at strengthening the Office of Internal Oversight Services.

Mr JAYATHILAKE (Sri Lanka), referring to paragraph 22 of document A58/25, said that, according to the constitution of his country, the Ministry of Health was responsible for monitoring provincial health activities and the national health policy. WHO's direct involvement with provinces and districts would cause problems of financial accountability and administration by creating two parallel administrative structures. All technical agencies in the health sector were under the ministry's authority and WHO's direct involvement with those agencies at a district level would create confusion. His Government therefore urged WHO to cooperate with the Ministry of Health, according to its mandate and current practice. Under existing arrangements, more than 90% of funds were allocated at provincial and district levels. WHO would be welcome to monitor closely the use of those resources jointly with the ministry.

Ms BLACKWOOD (United States of America) commended the work undertaken by the Office of Internal Oversight Services, which provided value-added, and effective monitoring, evaluation and accountability services. She was concerned, however, that the Internal Auditor had noted weaknesses in some internal controls for accountability and safeguarding resources, and she called for those controls to be strengthened. The effectiveness of the Organization was diminished when audit recommendations remained open, and the reported "growing backlog of audit recommendations" for which there was no reported implementation was a cause for concern. She recommended that Member States should request their regional committees to follow up recommendations so that corrective actions were taken to improve WHO's operations at all levels, as her country planned to do in relation to the audits undertaken in the Region of the Americas. As WHO moved towards decentralization, its operations at country level became increasingly important, and the need for effective, efficient and accountable structures was imperative.

She welcomed the evaluation of the WHO fellowship programme, and urged that the programme should be changed to ensure objectivity in the selection of candidates and a clear purpose

¹ Document A58/25, Annex.

in their assignments, so that when they returned to their home nations the fellows could contribute to sustainable national capacities in the area of health and human resources. She supported the recommendation that WHO should undertake a systematic review at each level, and better integrate fellowships into overall health and human resources policies.

Mr MACPHEE (Canada) welcomed the Internal Auditor's report, particularly its annex, and the strengthening of the Office of Internal Oversight Services, which he considered an essential part of results-based management. He also welcomed the identification of areas where improvements made would lead to greater efficiency and hence to cost savings, which would make additional funds available for particular programme areas of the budget.

Referring to paragraph 3 of document A58/45, he shared the concern expressed regarding delayed implementation of audit recommendations in the Regional Office for Africa, and noted the commitment of the Internal Auditor to make more provision for tracking the issues identified. A checklist of areas where backlogs had occurred should help to solve the problem.

Dr ACHARYA (Nepal) expressed satisfaction with a timely and informative report. The irregularities identified should be addressed promptly, so that they could be corrected in good time and would not recur. There was a need to evaluate the outcome of expenditure under various programmes at country level, and he asked the Internal Auditor to look into the matter and report back, so that Member States could know whether the Organization's resources were being properly used.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland) endorsed the statements made by the delegates of the United States of America and Canada, particularly on the need for tracking the follow-up to audit recommendations. She would like to see a more structured response to those recommendations in future reports.

Referring to paragraph 45 of the Internal Auditor's report, she noted that the implementation of recommendations for improvement in the Regional Office for Africa was currently stalled, and asked for an explanation and a timetable for the resolution of that long-standing problem.

Dr QI Qingdong (China), commending the work done by the Office of Internal Oversight Services, said that he was concerned as to how follow-up was to be done. He stressed the need to strengthen internal oversight services in order to ensure that the same problems did not recur. To facilitate follow-up, a performance indicator should be created, and regular reports should be submitted to the Executive Board.

Mr MCKERNAN (New Zealand) said that he too was concerned to note that some audit recommendations remained open and that no action had been taken on others. In view of the fact that under the Proposed programme budget 2006-2007 a significant increase in total revenue and project expenditure was planned, strong financial discipline was crucial. The Director-General should be requested to provide a report on proposed action on all outstanding audit items.

Mr VAN DER HOEVEN (Netherlands) welcomed the generally positive picture given by the Internal Auditor, but was concerned at the stalled implementation of recommendations in the Regional Office for Africa, which might entail financial risks for WHO.

Mr LANGFORD (Office of Internal Oversight Services), in reply to the delegate of Sri Lanka, said that the report in question was an internal audit addressed to the WHO Representative in Sri Lanka, which dealt with increasing the effectiveness of WHO's work at all levels in countries. He was confident that proper consultation with stakeholders would take place.

Concerning follow-up and implementation, more specific information would be provided in the next report. Since publication of the current report progress had been made, and he expected that by the following year there would be considerable improvement.

As to the evaluation of outcomes at country level, a technical evaluation and performance audit programme was in place to cover both programmatic and administrative issues. Concerning the situation in the Regional Office for Africa, it should be noted that in the past year both the Regional Director and the Director, Administration and Finance had changed, which had affected implementation of the recommendations. An audit was in progress that would give a better picture of the current situation.

The Committee noted the reports.

5. FINANCIAL MATTERS: Item 17 of the Agenda

Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution:

Item 17.3 of the Agenda (Documents A58/31, A58/31 Corr.1 and A58/43 Rev.1)

Dr YOOSUF (Maldives, Representative of the Executive Board), speaking as Chairman of the Programme, Budget and Administration Committee, said that the Committee had noted the reduction in the total amount due for prior years to US\$ 85 million, excluding amounts due under special arrangements which had increased to US\$ 46 million from US\$ 14 million in 2004. The Committee had requested greater clarity in the reporting of payments made under special arrangements, and that future reports should provide up-to-date information on the amount owed by the former Yugoslavia. It had also noted that the voting privileges of 20 Member States remained suspended, but, since Chad had subsequently made payment of all arrears and current contributions, its voting privileges were restored. The Committee had considered the four Member States with arrears at 31 March 2005 to an extent that would justify adoption of a resolution under Article 7. Since sufficient payments had been received from Guinea, Paraguay and Peru, they would no longer be covered by such a resolution. For the remaining Member, Uruguay, the Committee had decided to draft a resolution whereby its voting rights would be suspended from the opening of the Fifty-ninth World Health Assembly unless sufficient payments were received before then. Finally, the Committee had agreed to recommend the proposals made by Georgia, Iraq, Republic of Moldova and Tajikistan. It recommended the five resolutions contained in document A58/43 Rev.1 for consideration by the Health Assembly.

Ms WILD (Comptroller) said that, since the Committee's report, payment had been made in full by Gabon of all its arrears and assessments due for 2005. Payment of arrears had also been made by Antigua and Barbuda, but unfortunately the amount had not been sufficient to remove it from the provisions of Article 7. Discussions had been held with representatives of the Dominican Republic and Liberia concerning their situation, and they intended to present proposals for special arrangements to the Fifty-ninth World Health Assembly. There had also been discussions with Armenia, which intended to present a revised proposal in 2006.

Mr MACPHEE (Canada) urged all Member States to pay their assessed contributions in full and on time. He noted with concern from the report that an even larger number of Member States appeared to have made no payment for the current year, and that a substantial number of assessed contributions remained outstanding. He commended the Secretariat's continuing efforts to resolve that situation, particularly the introduction of special arrangements for the settlement of arrears.

The CHAIRMAN invited the Committee to consider the draft resolution recommended in paragraph 8 of document A58/43 Rev.1.

The draft resolution was approved.¹

The CHAIRMAN invited the Committee to consider the draft resolutions in respect of requests for special arrangements by Georgia, Iraq, Republic of Moldova and Tajikistan set out in paragraph 9 of document A58/43 Rev.1.

The draft resolutions were approved.²

6. STAFFING MATTERS: Item 19 of the Agenda

Human resources: annual report: Item 19.1 of the Agenda (Document A58/34)

Recruitment strategy integrating gender and geographical balance: progress report: Item 19.2 of the Agenda (Document A58/35)

Dr OSMAN (Representative of the Executive Board) noted that the sixth annual report provided complete data on the WHO staffing profile as at 31 December 2004, including information on overall numbers, gender and geographical balance, age and length of service, temporary staff, the distribution of the workforce by occupational group, internal and external recruitment, and national professional officers.

Mr MACPHEE (Canada) noted with pleasure the progress made in some areas, and particularly that five previously unrepresented or underrepresented countries were within their desirable range of representation and that, in 2004 32 appointments to the professional category had involved nationals of such countries. Although the percentage of women in the professional category had increased since the last report, it was still short of the goal of gender balance, and he encouraged continued efforts in that direction, bearing in mind that merit should always be the primary criterion in the selection of personnel.

He voiced concern that nurses accounted for only a small percentage of professional medical staff, and that that figure had declined since 2001. Some 630 staff members were due to retire in the next five years. That situation should be monitored closely, as it offered potential for the development of a human resource strategy.

A summary of any efforts made by the Organization not covered by the largely statistical presentation given in the report would be welcome.

Dr QI Qingdong (China) welcomed the efforts made to increase diversity among staff. However, he noted that the total number of staff at P.4 level and above had been increasing year by year, and far exceeded the number of staff at lower levels. Would that situation have financial repercussions? Furthermore, only 16.7% of appointments to the professional category had been from unrepresented or underrepresented countries, which was a long way from the goal set by the Health Assembly. What action would be taken to remedy that situation? Was there any long-term strategy to achieve a balance between permanent and temporary staff?

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA58.7.

² Transmitted to the Health Assembly in the Committee's first report and adopted as resolutions WHA58.8, WHA58.9, WHA58.10 and WHA58.11, respectively.

Dr ENAMI (Japan) said that the annual report showed that many countries were still unrepresented or underrepresented. He strongly urged that steps be taken to improve that situation.

Mr HENNING (Human Resources Services) thanked the delegate of Canada for his advice. In reply to the delegate for China, he said that there had been an increase in the number of fixed-term appointments during 2003-2004 and in the number of staff at P.4 level and above, pursuant to an earlier Health Assembly decision on regularization of staff positions through contract reform. Some additional increases were expected before the completion of the regularization exercise due by the end of the year.

Concerning geographical distribution, the report showed that improvements had been made. Increases in the number of institutions, both governmental and nongovernmental, in which WHO vacancies were circulated should start showing results in late 2005 and 2006. In addition, the Director-General had given precise instructions on how the various offices should increase representation of unrepresented and underrepresented countries and attain 60% of recruitment from developing countries, as well as reaching gender targets.

On the point raised by Japan, he said that the recruitment strategy noted by the Board the previous year, and which aimed at increasing diversity, should soon start to show results.

Mr STRØMMEN (Norway) said that, to fulfil its role as the global community's centre of excellence for health, WHO depended on having the highest calibre of staff. Like other United Nations organizations, however, the Organization needed to take into account gender and regional balance. The report in document A58/35 showed that WHO was taking seriously the request by the Health Assembly in resolutions WHA56.17 and WHA56.35 on gender balance and representation of developing countries. Progress had been made, but the results did not appear to match the efforts undertaken. The annual report on human resources (document A58/34) indicated that 32 of 192 new appointments to the professional category in 2004 were nationals from underrepresented countries: how many were filled through nominations and how many through vacancy announcements? Nominations generally favoured recruitment by managers of persons they had already worked with, thus reinforcing the tendency to recruit from countries already represented. In addition to the negative impact on regional balance, that tendency contributed to a lack of diversity. WHO should in general recruit professional-category staff through vacancy announcements, and look at the practice in other United Nations organizations with regard to new appointments, particularly at D.1 level and above. He sought more transparency, and encouraged the Secretariat to publish and update regularly its organizational chart, as the current lack of information hindered representation of Member States on WHO's staff, albeit unintentionally.

The Committee noted the reports.

The meeting rose at 12:20.

SECOND MEETING

Thursday, 19 May 2005, at 15:00

Chairman: Dr J. WALCOTT (Barbados)

1. STAFFING MATTERS: Item 19 of the Agenda (continued)

Amendments to the Staff Regulations and Staff Rules: Item 19.3 of the Agenda (Resolution EB115.R17)

Dr YOOSUF (Maldives, Representative of the Executive Board) said that at its 115th session the Executive Board had confirmed amendments to the Staff Regulations and Staff Rules made by the Director-General, including an increase of 1.88% in the base/floor salary scale for the professional and higher categories based on the recommendation of the International Civil Service Commission to the fifty-ninth session of the United Nations General Assembly (September 2004). The adjustment implied similar adjustments to the salaries of staff in ungraded posts and of the Director-General. In accordance with Article 3.1 of the Staff Regulations, the Board recommended that the Health Assembly adopt the draft resolution on salaries of staff in ungraded posts and of the Director-General contained in resolution EB115.R17.

Mr HOHMAN (United States of America) said that at the 115th session of the Executive Board his delegation had requested WHO to harmonize its practice on education grants for internationally recruited staff living and working outside their home countries with that of other United Nations bodies. Contrary to his expectation, however, the issue had not been addressed, and he therefore asked for updated information to be provided at the 117th session of the Executive Board in January 2006.

Mr HENNING (Human Resources Services) said that, in the course of the review carried out in response to that request, it had been discovered that the criteria used by the United Nations to determine entitlement to education grants would be equally applicable to other expatriate entitlements. The work involved in the review was therefore considerably wider in scope than had been expected. A start had been made, however, and a proposal on education grants and other related entitlements would be submitted to the Board at its 117th session.

The draft resolution was approved.¹

Report of the United Nations Joint Staff Pension Board: Item 19.4 of the Agenda (Documents A58/36 and A58/36 Corr.1)

The Committee noted the report.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA58.12.

Appointment of representatives to the WHO Staff Pension Committee: Item 19.5 of the Agenda (Document A58/37)

The CHAIRMAN invited the Committee to appoint one member and one alternate member to the WHO Staff Pension Committee, in accordance with the rotational schedule explained in the report. In the absence of objections he took it that the Committee wished to convey the following draft decision to the plenary:

Decision: The Fifty-eighth World Health Assembly nominated Mrs R. Veerapen of the delegation of Mauritius as a member, and Mrs C. Patterson of the delegation of Australia as an alternate member, of the WHO Staff Pension Committee for a three-year term until May 2008.

The draft decision was approved.¹

2. PROPOSAL FOR ESTABLISHMENT OF WORLD BLOOD DONOR DAY: Item 20 of the Agenda (Resolution EB115.R15; Document A58/38)

Dr YOOSUF (Maldives, Representative of the Executive Board) said that the Board considered universal access to safe blood to be an essential part of health-care systems and an effective strategy in HIV prevention. At its 115th session, it had expressed strong support for the establishment of an annual World Blood Donor Day as part of a global strategy to promote voluntary blood donation, which was crucial in ensuring the safety, quality and availability of blood and blood products. The goal of eliminating paid blood donation should be pursued, especially as few countries had achieved that goal more than 25 years after resolution WHA28.72 had urged Member States to work towards it. The Board had recommended that the Health Assembly adopt the draft resolution contained in resolution EB115.R15.

Dr SANGALA (Malawi) said that the first global world blood donor day had been celebrated in his country on 14 June 2004. The event had been attended by more than 500 blood donors and its theme had been the formation of Malawi's "Club 25", a WHO initiative undertaken with European Union funding. The project, which was designed to mobilize young people between the ages of 16 and 25 to become safe and committed regular blood donors, was well established. The initiative had been welcomed enthusiastically by young people in Malawi, who were responsible for at least 40% of the donated safe blood. He supported the draft resolution.

Dr KONATE (Côte d'Ivoire) commended WHO's efforts to establish adequate blood transfusion services worldwide. To ensure wide coverage with safe and tested blood and blood products his country had set up a national and three regional blood transfusion centres and 64 blood banks. All blood donations were voluntary, and the strategy for recruitment was based on education of the population to encourage and motivate donors.

He proposed that in subparagraph 3(7)(a) of the draft resolution the words "quality-control systems" should be replaced by "quality-management systems". The resolution should also urge the inclusion of the subject of the clinical uses of blood in the curriculum of medical schools, and the education of children in the concept of voluntary blood donation. He thanked WHO for its support to Côte d'Ivoire in the area of blood transfusion and fully supported the draft resolution.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as decision WHA58(9).

Dr SHANGULA (Namibia) commended the proposal to establish World Blood Donor Day. Blood transfusion constituted an integral part of the clinical management of patients, but donors were becoming increasingly scarce. Celebrating the event would ensure that more people were sensitized and encouraged to become donors. He therefore supported the draft resolution.

Dr LEPAKHIN (Assistant Director-General) thanked delegates for their support for the establishment of World Blood Donor Day as an annual event. It was important to reduce the percentage of family replacement and paid donations, as they were often unsafe. World Blood Donor Day should increase the number of countries achieving a 100% rate of voluntary, unpaid donations.

In response to a request by Mr HOHMAN (United States of America) for clarification, Dr KONATE (Côte d'Ivoire) explained that the term "quality-control systems" would cover only laboratory analysis, whereas "quality-management systems" would cover both quality control and quality guarantees. He would not press for an amendment in regard to his other suggestion.

The draft resolution, as amended, was approved.¹

The meeting rose at 16:00.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA58.13.

THIRD MEETING

Friday, 20 May 2005, at 10:00

Chairman: Dr J. WALCOTT (Barbados)

1. DRAFT FIRST REPORT OF COMMITTEE B (Document A58/53)

Mr YEE Ping Yi (Singapore), Rapporteur, read out the draft first report of Committee B.

Dr SHANGULA (Namibia) expressed disappointment that the External Auditor would not be submitting his interim report to the Health Assembly until the following week, by which time many ministers would have been obliged to leave Geneva. The External Auditor had known for a year that he was required to report to the Health Assembly, and it was reasonable to expect him to have adjusted his schedule accordingly. Ministers were accountable to their constituencies on the use of funds, including those paid to WHO. By depriving them of the opportunity to discuss the report, the External Auditor was showing an unacceptable lack of respect, and he asked the Director-General to bring the matter to his attention. He wished his comments to be placed on record and to be recalled during consideration of the appointment of the next External Auditor.

Dr KEAN (Governance), in reply, said that, in both the preliminary daily timetable for the Health Assembly agreed by the General Committee and that presented to the Executive Board at its 115th session, agenda item 17 had been scheduled for Monday, 23 May. The External Auditor had, accordingly, made plans to travel from his home country for that date. That was the reason why he could not be present if the item were to be brought forward.

The report was adopted.¹

2. HEALTH CONDITIONS OF, AND ASSISTANCE TO, THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE: Item 15 of the Agenda (Documents A58/24, A58/INF.DOC./2, A58/INF.DOC./4 and A58/INF.DOC./5) (continued from the first meeting, section 3)

Mr SUMIRAT (Indonesia), making a point of clarification, said that in the previous discussion on the draft resolution on health conditions in the occupied Palestinian territory including East Jerusalem and in the occupied Syrian Golan, in expressing support for the draft resolution he had omitted to ask for Indonesia to be added to the list of sponsors.

¹ See page 355.

3. IMPLEMENTATION OF MULTILINGUALISM IN WHO: Item 21 of the Agenda (Document A58/39)

Dr YOOSUF (Maldives, Representative of the Executive Board), introducing the item, said that the Executive Board had been presented at its 115th session with the clarifications requested at its 114th session, informed of the progress made in improving multilingualism in WHO and shown the recently launched new version of WHO's multilingual web site. The Board had welcomed progress made but said that more needed to be done, such as the translation of *The world health report* in all official languages, providing simultaneous interpretation in meetings of regional groups, and drawing up a plan for longer-term measures on multilingualism, which would include cost implications. A plan of action with quantifiable targets had been requested.

Mr RECINOS TREJO (El Salvador), speaking on behalf of the Latin American and Caribbean Group, attached great importance to multilingualism in the Organization, given the multilingual nature of the region, in which three of the official United Nations and WHO languages were spoken. His Group defended and promoted the equal use of those languages, without discrimination, within the Organization. Although he welcomed the progress made on multilingualism, further improvements were necessary, particularly with regard to the availability of simultaneous interpretation services for the consultation and coordination meetings of the regional groups, the meetings of the governing bodies, and the meetings of expert groups; the Group had experienced problems with meetings during the Health Assembly for that reason. Acknowledging that promoting multilingualism was a long-term endeavour that required the allocation of resources, he said that the task force on multilingualism should take into account his Group's concerns relating to interpretation in the medium-term measures it would be proposing.

Ms LANTERI (Monaco), endorsing the importance of multilingualism and the need to ensure its implementation, said that interpretation in meetings, both formal and informal, and the translation of documents into WHO's six official languages were essential not only for the full participation of Member States in the Organization's work but also to ensure general access to knowledge and information, particularly by health workers. At the 114th session of the Executive Board, the Director-General had undertaken to increase the volume of documents translated and make provision for the training of WHO staff in the official languages. She welcomed the progress made – although it was still not enough – and the establishment of a task force to draw up a strategic plan. Its proposals should be submitted at the latest at the next Health Assembly for consideration.

Dr QI Qingdong (China) commended WHO's progress in the area of multilingualism – particularly in promoting the use of the six official languages – and suggested three possible improvements. First, the promotion of the six official languages, which had been successful at headquarters, should be extended to regional and country offices. Secondly, the timeliness of translations needed to be improved; there had been a lag of several months, for example, between publication of the English version of *The world health report 2005*¹ and the Chinese version, thereby reducing its effectiveness. Other important news, such as that concerning disease outbreaks, also needed to be rapidly translated. Thirdly, it was necessary to allocate funds to translation in order to ensure a balance between the six official languages. Referring to paragraph 8 of the report, he asked why there was no provision for the Chinese language in relation to the Health InterNetwork Access to Research Initiative (HINARI), and whether there was a plan to introduce it, since that would facilitate access to health information for one quarter of the world's population.

¹ *The world health report 2005: Make every mother and child count*. Geneva, World Health Organization, 2005.

Mr KOCHETKOV (Russian Federation), commending the Director-General's strengthening of multilingualism, observed that the report did not provide a strategy for reaching that goal but merely commented on projects under way. Like other delegates, he requested the establishment of a valid strategy on multilingualism in WHO, not just translation of the web site or publications, incorporating the experience of other United Nations organizations. ITU had adopted a resolution on funding all languages on an equal basis. Such an example could be useful to WHO.

Mrs LE GUEVEL (France) also endorsed the importance of multilingualism and commended WHO's work in translating the documents on its web site. However, further progress was required since only top-level content was available in the six official languages and many information documents were only translated at the last minute, if at all. She expressed regret that some meetings were still held without interpretation, including some presentations of the programme budget, which was unacceptable in view of their importance and technical content. She maintained that improving multilingualism must remain a priority for WHO, including at regional level. That was in the interest of both Member States and the Secretariat, given that multilingualism was the best way to reach a broad audience and thus contribute to improving health for all.

Dr EL ISMAILI ALAOUI (Morocco) welcomed the efforts made to improve multilingualism in order to optimize the Organization's work. Regrettably, the lack of interpretation for certain meetings handicapped some countries in following that work. Also, delays occurred in the translation of documents that were of the utmost importance for improving health conditions in certain countries. He therefore asked for further efforts to be made in the translation of documents in the six official languages.

Dr ABDULLA (Sudan) commended the important report, which reflected WHO's desire for dialogue with all peoples of the world. Improving multilingualism would ultimately improve the health of the populations at large, which was the Organization's main concern. He encouraged the use of the six official languages for communication and translation, and regretted that many documents were still not translated. Targets had not been met in that area, and he asked WHO for more financial support to that end. He also called for documents to be translated not only into the six official languages but also into all local languages, especially in those areas where health conditions could be improved, and asked for his request to be conveyed to WHO's regional and local offices.

Mr MOLCHAN (Belarus) welcomed WHO's efforts on multilingualism, but joined other delegates in expressing concern that the speed, coverage and quality of translation – including that of information and methodological materials – into all six official languages and their distribution in print still needed to be improved.

Dr STEIGER (United States of America), speaking in Spanish, commended the report with regard to improving interpretation and translation services and the extension of multilingual services to all of the Organization's work. He regretted, however, that interpretation services had not been extended to informal groups or to negotiating groups during the Health Assembly, as all countries should have the right to participate in those groups in their national language or in the official languages of the United Nations system.

Dr AL-HUSSEIN (Saudi Arabia) acknowledged the Secretariat's work in the area of multilingualism. He endorsed the suggestion of other delegates that a clear action plan should be drawn up for the broader use of languages and the translation of documents into all languages in order to attain WHO's objectives.

Mr MACPHEE (Canada) commended WHO's progress, particularly the improvements made to the web site, and he hoped that would continue. As a bilingual country, Canada had always been

strongly in favour of increased multilingualism and respect for the official working languages within WHO, especially the use of the French language.

Dr BEHBEHANI (Assistant Director-General), responding to comments, said that in 2005 *The world health report* had been translated into all six official languages for the first time. With regard to the delay mentioned by the delegate of China, he would try to improve the timeliness of publication the following year. In response to the observation that Chinese was not included as a language for training in the use of the HINARI system, he recalled that HINARI had been made available to more than 70 countries free of charge. He would consider making such training material available in Chinese, if so requested. Responding more generally to other issues raised, he said that following the concerns expressed by the Executive Board at its 114th session a task force had been established under a special coordinator to review multilingualism in WHO and to identify problems and obstacles in its implementation. The task force would make its recommendations and suggest medium- and long-term measures, together with the appropriate budget, to the Board at its 117th session. He would take into account all the other observations made regarding the further progress that needed to be made.

The Committee noted the report.

4. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (referred from Committee A)¹

Cancer prevention and control: Item 13.12 of the Agenda (Resolution EB114.R2; Document A58/16)

Dr OSMAN (Representative of the Executive Board) said that at its 114th session the Executive Board had examined a report on the prevention and control of cancer and had supported the need to develop and integrate adequate national programmes into existing health systems.² It had also stressed the importance of dealing with all the components of cancer control – prevention, early detection, treatment and palliative care – in a balanced way. The need to explore appropriate mechanisms for adequate funding of cancer prevention and control programmes, especially in developing countries, had also been raised. Emphasis had been placed on the need to establish innovative partnerships and appropriate networks to reduce the cancer burden. The Board had adopted resolution EB114.R2 on cancer prevention and control which recommended a draft resolution to the Health Assembly for adoption.

Dr MIZUSHIMA (Japan) said that his country was greatly concerned at the rapid increase in cancer cases, in view of its ageing society, and had therefore prioritized the strengthening of cancer control and research. In 2004, Japan had launched its third 10-year strategy plan for cancer control and in 2005 had established a task force for cancer prevention and control within its Ministry of Health to promote cancer-control measures. The quality of medical care should be improved through ensuring access to information on cancer and information-sharing among medical institutions. Japan was currently developing a fibre-optic network between its national cancer centre and local cancer centres to facilitate case-study meetings. His country had developed effective measures to prevent and control cancer, which included a mass screening programme, particularly for gastric and colon cancer. Japan

¹ See summary record of the first meeting of Committee A, section 1.

² Document EB114/3.

wished to contribute to such efforts internationally, in cooperation with WHO and IARC, and to learn about successful measures that other Member States had implemented.

The draft resolution rightly emphasized the need for health system infrastructures to be strengthened for the effective implementation of cancer prevention and control programmes. He supported its general thrust, but considered it ambitious. He asked to be informed of its cost implications, bearing in mind Financial Regulation XV on resolutions involving expenditures.

Ms OLLILA (Finland), speaking on behalf of the five Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, said that, with increasing life expectancy and less healthy lifestyles, chronic diseases, including cancer, posed a major threat to health in developing countries. Although much could be done through effective treatment and rehabilitation, WHO should prioritize disease prevention and health promotion, and reallocate resources accordingly. Prevention was far more effective and economical and reduced avoidable suffering. It required collaboration among all sectors of society, with primary health care, including health education and screening, playing a key role.

More research into etiology and pathogenesis was needed, but there was firm evidence of the success of prevention measures. Current evidence on the etiological role of tobacco use, diet, physical inactivity and harmful use of alcohol supported the concept of prevention of noncommunicable diseases and the need for integrated (rather than disease-specific) prevention programmes that aimed to reduce social inequity and emphasize primary health care, health promotion and national intersectoral policies. Certain carcinogenic infectious agents and occupational hazards, such as asbestos, should be appropriately controlled. Globally, prevention depended on successful implementation of the WHO Framework Convention on Tobacco Control and the Global Strategy on Diet, Physical Activity and Health, and cancer organizations should therefore actively support their aims. All Member States had to have access to information on the high-quality international research that was coordinated by IARC.

Ms VALDEZ (United States of America) recalled that, at the 114th session of the Executive Board, all members had urged the Secretariat to help them to make cancer prevention, detection and treatment a higher priority. Members had also spoken of the need for a strong political movement. Cancer was the second leading cause of death in the United States, responsible for one in four deaths. In 2001, the Government had set a goal of eliminating the suffering and death caused by cancer by 2015. Although research was crucial to cancer-control programmes, prevention should not be underestimated: the adoption of healthier lifestyles could significantly reduce a person's risk for cancer.

WHO had recognized the essential role of sustained partnerships in reducing cancer mortality and morbidity. Examples included IAEA's work with WHO on radiation treatment for cancer, and IARC's leadership and focus on screening. Reducing cancer morbidity and mortality required early detection, diagnosis and treatment methods to be tailored to available resources. Breast cancer was the leading global cause of cancer deaths among women; the Breast Health Global Initiative brought together international health-care organizations, nongovernmental organizations and the private sector to establish best practice guidelines for care in limited-resource settings. The International Tobacco and Health Research and Capacity Building Program, sponsored by WHO and the United States National Institutes of Health, provided research and training grants to combat the growing incidence of tobacco-caused illnesses and death in the developing world, including those related to cancer. The Secretariat's report highlighted the growing need to expand palliative care for cancer patients and for support mechanisms for their families. The Secretariat and the International Narcotics Control Board might consider joint sponsorship of workshops to review the unmet need for opioids.

In view of the threat posed by cancer, particularly in ageing societies, and the expected future rise in cancer mortality rates in many countries, she supported the draft resolution but proposed that the preambular paragraph beginning "Recognizing the importance" and subparagraphs 1(9) and 2(13) should be amended by the addition of "and palliative care" after "control". In subparagraph 1(8), "and palliative care" should be added after "options". To reflect the progress made since the 114th session

of the Executive Board, the words “a programme of action for cancer therapy” in the last preambular paragraph should be changed to read “the Programme of Action for Cancer Therapy”.

Dr SOMBIE (Burkina Faso) welcomed the draft resolution. Prevention was the best strategy, particularly in developing countries. Once people were taken ill, most of them did not have access to adequate treatment; the minority of people who did then faced difficulties in obtaining follow-up treatment, which led to relapses. Burkina Faso was in the process of setting up a system of cancer prevention.

Dr SOLOMON (Kenya) reported that Kenya had seen rapidly rising incidence rates of cancer among groups 10 to 15 years younger than in other developing countries; the five major cancers were cancer of the cervix, breast, oesophagus and prostate and Kaposi sarcoma. Colorectal and hepatocellular carcinomas were linked to consumption of alcohol and exposure to aflatoxins, and non-small cell lung cancer was associated with tobacco smoke. Non-Hodgkin lymphoma, squamous cell carcinoma and Kaposi sarcoma were related to HIV infection.

Owing to lack of knowledge, of political will and of national capacity in policy development and programme implementation, primary prevention, early detection and palliative care were too often neglected in favour of treatment-oriented approaches, regardless of whether the latter were cost-effective or improved the patient's quality of life. Strategies had been established to raise community awareness of cancers, expand cancer screening, early detection, treatment and palliative care, and establish hospices. A noncommunicable disease division in the Ministry of Health to deal with cancers and a cancer technical working group had been set up. The Ministry had developed a cervical cancer prevention programme and produced guidelines on the prevention of breast cancer with the support of WHO, and cervical cancer screening was being provided in several districts. Hospice centres had been set up in several cities.

Kenya had to deal with low awareness of cancer, inadequate screening facilities and funding, and a paucity of radiotherapy and chemotherapy units. It intended to strengthen health-care delivery services to improve screening coverage and early detection; establish a cancer-control programme, including a cancer registry; and emphasize cancer prevention, care seeking, early detection, treatment options and palliative care in community health care. He supported the draft resolution.

Ms TEZEL AYDIN (Turkey) said that most cancer cases were preventable or curable, and that the population could be protected from one third of new cancer cases through tobacco control and another one third through changes in nutritional behaviour; early detection strategies for some cancers were also successful. The number of new cancer cases was expected to treble over the next 20 years and the developing countries would account for 70% of that increase. She supported the draft resolution.

Dr YAN Jun (China) said that, faced with the severe challenges posed by noncommunicable diseases such as cancer, China had had to adapt its health strategies and focus on prevention, with an emphasis on early detection, primary prevention and palliative care. Developing countries, in which health resources were often limited, needed to adopt comprehensive prevention strategies, and the experience gained by his country in cancer prevention could provide a valuable example for others.

He proposed that the draft resolution should be amended by the insertion, after the existing paragraph 1(11), of a new subparagraph that would read, “to spread and popularize the appropriate technologies for the diagnosis and treatment of cancer, in order to promote its early diagnosis and treatment, especially in developing countries;”.

Mrs WAUTERS (Belgium) said that in Belgium cancer was the second leading cause of death and a common cause of morbidity, with significant implications for quality of life. Many cancers were preventable, but primary prevention activities were still often insufficient. She therefore welcomed the emphasis on integrated strategies for disease prevention and health promotion in the draft resolution,

following up on earlier Health Assembly resolutions such as those on the WHO Framework Convention on Tobacco Control and the Global Strategy on Diet, Physical Activity and Health. She also commended WHO's normative work in cancer prevention and screening, and IARC's research.

In subparagraph 1(6) of the draft resolution, she proposed that the words "traditional and herbal medicine" be amended to read "traditional medicines and therapies, including for palliative care", and that subparagraph 1(14) be amended to read, "to ensure, where appropriate, the evidence-based safety and efficacy of the available traditional medicines and therapies".

Ms WILSON (Canada) strongly supported the draft resolution. She commended WHO's cooperation with IARC in the publication of the IARC handbooks on cancer prevention and the *World cancer report*.¹ Canada was currently implementing a national strategy for cancer control by means of a partnership between government, nongovernmental organizations and research and community-based institutions, as well as an integrated chronic disease-prevention strategy. It wished to encourage technology transfer and sharing of best practices between countries suffering cancer epidemics, and to that end was hosting the first International Cancer Control Congress (Vancouver, British Columbia, 25-28 October 2005).

Professor IVANOV (Bulgaria) said that programmes had been launched in his country for control of breast, uterine and cervical cancers and prevention of prostate and lung cancers, and a national programme for colon and rectal cancers was in preparation. Those programmes emphasized prevention, with particular regard to lifestyle and environmental factors, and a ban on smoking in public places had been introduced. For the past three years, cancer diagnostics and treatment had been carried out on the basis of evidence-based medicine. National standards for surgery and general and clinical pathology had been formulated and enforced, and standards for radiation treatment and oncology were in process of adoption. Guidelines for the diagnostics, treatment and tracing of patients with stomach cancer had been in force since 1991. All cancer patients, irrespective of the stage of the disease, the cost of the treatment, and their economic status, received free medication. A national cancer registry had been established in 1960 and was included in the International Association of Cancer Registries. There was active cooperation between Parliament, the Government, professional associations and nongovernmental organizations in cancer prevention and control.

He strongly supported the draft resolution.

Dr BLOOMFIELD (New Zealand) said that in his country a cancer-control strategy and accompanying action plan had been developed over the past three years. The strategy included primary prevention, screening, early detection, treatment, support, rehabilitation, palliative care and research. It aimed to reduce cancer morbidity and mortality and reduce inequalities in outcomes, and had been formulated in partnership with the Ministry of Health, nongovernmental organizations, the health sector and consumer organizations. It had enabled cancer control to be considered holistically, so that adequate emphasis could be given to preventive measures, in particular tobacco control, improved nutrition, and research and evaluation. He supported the draft resolution.

Dr YOT TEERAWATTANANON (Thailand) said that the draft resolution was asking too much of Member States; the actions called for should be prioritized, especially when resources were limited. He proposed addition of a new subparagraph 1(1), reading "to set priorities based on national burdens of cancer, resource availability and health system capacity for cancer prevention and control programmes;".

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that, in Cuba, cancer was the second leading cause of death for all age groups, representing 23.9% of all deaths. However, according to WHO, 43% of

¹ Stewart BW & Kleiheus P, Eds. *World cancer report*, Lyon, France, IARC Press, 2003.

cases would be preventable by lifestyle change, at least a third would be curable if diagnosed early and treated using current methods, and a further third would at least have a greater chance of survival and an improved quality of life through effective and appropriate treatment.

There was an imbalance between the resources allocated to basic research and those allocated to prevention and control, treatment-based approaches being favoured in some cases to the detriment of primary prevention and early detection. If two thirds of cases could be prevented or treated, research into etiology and the evaluation of prevention, treatment and control strategies should be intensified. A system of monitoring, which would include cancer registries, was crucial both for research and for the planning and evaluation of control programmes. He supported the draft resolution.

Dr SHANGULA (Namibia), expressing support for the draft resolution, urged an integrated approach to cancer prevention and control in order to maximize the impact of interventions. It was good that the draft resolution recognized the involvement of IAEA in cancer control, treatment and research, and he proposed that some reference should be made in the operative part to the need for close collaboration between the Secretariat, IAEA and Member States. He would submit his amendment in writing.

Mrs VEERAPEN (Mauritius) said that cancer was a significant public health problem in Mauritius, where about 1500 new cases were diagnosed and 900 deaths from the disease occurred each year. With assistance from WHO, a national cancer registry had been established in the 1990s, which had shown that cancer was the second most common cause of death. A study in 1989-1996 had shown a marked predominance of breast, uterine and cervical cancers, and accordingly mammary and cervical screening had been included in noncommunicable disease screening services from 2001. A report on cancer incidence and mortality for the period 1997-2000 had been published, and a report on data from 2001 to 2003 was being produced using customized IARC software.

To deal with the current alarming incidence rate of cancer, legislation prohibiting smoking in, inter alia, public buildings, hospitals and health-care centres had been introduced; higher excise duties had been levied on tobacco products; health education on the dangers of tobacco use had been undertaken through the mass media and in primary and secondary schools; balanced diet and physical exercise were being promoted; and mass screening was being carried out for cervical and breast cancer. She supported the draft resolution as amended.

Mr SOLANO ORTIZ (Costa Rica) said that in his country cancer was a public health priority; it was the second leading cause of death, the most frequent forms being cervical and breast cancer in women and prostate and lung cancer in men, although lung cancer was increasingly affecting women, mainly owing to tobacco consumption. It was important for WHO to give cancer a prominent place on its agenda. His country had adopted many national strategies, relating to disease prevention, promotion of healthy lifestyles, diagnostics, treatment, cancer registries, research, strengthening of health services and the development of palliative care; a national cancer institute had also been established.

He proposed that subparagraph 1(12) of the draft resolution should be amended by the addition of the words "taking into consideration the recommendations made by the Second Global Summit of National Hospice and Palliative Care Associations, held in Seoul, Republic of Korea, in March 2005;".

Mr WANGCHUK (Bhutan) welcomed the emphasis given in the draft resolution to prevention, early detection and treatment, healthy lifestyles, risk factors, human resources and infrastructure development. He commented that cancer incidence in Bhutan was increasing rapidly, and that a focus on the Millennium Development Goals might cause cancer management and prevention issues to be neglected. He therefore fully supported the draft resolution.

Dr SANGALA (Malawi) said that cancer was a serious problem in Malawi, in particular cervical cancer among women, Burkitt lymphoma among children, and Kaposi sarcoma in people with HIV infection. Aside from surgery, no other intervention was available to such patients, and when

funds were available they were referred to neighbouring countries for treatment. Because of the increasing number of cases, an oncology centre, including a radiotherapy unit, was being established, and in that connection Malawi had applied for membership of IAEA, which had shown willingness to assist. Technical assistance would also be sought from WHO. He supported the draft resolution.

Mr BELOT (South Africa), supporting the draft resolution, said that primary health-care facilities should be the first point of contact with the health system for people with cancers, and the provision of information and education for patients and their families at that stage should reduce late presentation of cancers. In South Africa patient compliance was problematic in chronic disease management, and following the identification of some of its causes a Therapeutic Patient Education programme had been set up; a training manual for behavioural change in both health professionals and patients was being developed. Appropriate information and education would help patients to understand and manage their condition in partnership with health professionals.

The issues of primary prevention and reducing exposure to risk factors had been tackled by introducing tobacco legislation and by formulating appropriate guidelines for identifying modifiable risk factors. Guidelines for cervical cancer screening and prostate cancer testing and information documents on breast and testicular cancers had also been prepared, and a healthy lifestyle strategy and generic risk assessment tool were being developed.

Tertiary-level cancer-treatment centres had been identified. Palliative-care guidelines had been developed for adults and children, covering pain management, drug and other therapy, referral and legal and ethical issues. Partnerships between individuals, the community, government, not-for-profit and community-based organizations and the private sector were essential. The most important issues remaining were availability of opioids at community level, reliable information, models to enhance health-seeking behaviour and the minimum resources needed to implement a successful programme.

Mr CROITOR (Republic of Moldova), speaking on behalf of the GUAM countries (Georgia, Ukraine, Azerbaijan and the Republic of Moldova), said that the increasing incidence rates of oncological illness and death in those countries reflected a global trend. The cancer epidemic was also characterized by the neglect of a significant number of patients diagnosed with the disease, a large number of whom died within a year of diagnosis. High treatment costs placed a heavy burden on national health budgets in the four countries, and the governments understood the need to integrate preventive measures into national programmes. Health professionals were indispensable to cancer control; family doctors had a significant role in explaining risk factors.

Breast cancer, the main cause of cancer-related deaths among women in the GUAM countries, was given high priority in national reproductive-health agendas. As treatment was more effective in the early stages of the disease, breast cancer was being targeted by means of a complex set of primary and secondary preventive measures, tackling such risk factors as alcohol use, physical inactivity, obesity and poor nutrition. Programmes were being developed to improve knowledge among health professionals regarding early cancer detection, and greater emphasis was being placed on improving public awareness of the role of healthy lifestyles in preventing cancer.

He thanked the Regional Office for Europe for its work on the European strategy on noncommunicable diseases, and urged the countries involved in its further development to ensure that it contained adequate measures for cancer prevention. Given the importance of partnerships at national, regional and global levels in cancer prevention, he welcomed the efforts to establish links with other organizations working in the field. The GUAM countries supported the draft resolution.

Mr DELVALLEE (France) commended the report on basic intervention strategies that took into account risk factors related to the environment, socioeconomic conditions and infectious agents. He welcomed the focus on primary prevention, screening and health education, three areas which formed the basis of France's new cancer plan. The development of partnerships was undoubtedly the best way of making progress, and France was pursuing that objective by actively participating in the excellent

work of IARC. He encouraged those countries that had expressed an interest in that work to join its Governing Council.

He fully supported the draft resolution, and proposed that a new subparagraph 2(14) should be added, to read as follows: “to examine jointly with the International Narcotics Control Board the feasibility of a possible mechanism to aid effective pain control via opioid analgesics”. That amendment would take account of the fact that in March 2005 the Control Board had invited WHO to participate in a feasibility study on the subject.

Dr ELSAYID (Sudan) expressed strong support for the draft resolution. Cancer prevention and control was a fundamental area that needed support both technically and financially, since incidence of the disease had significantly increased in all countries. According to *The world health report 2002*,¹ cancer was one of the 10 leading causes of death; the situation was worsening and the case-load based on risk had increased 20-fold in the previous 30 years. Dealing with the burden of cancer was beyond the capacities of the health facilities and personnel in Sudan, and its treatment was one of the most costly for patients and families.

Cancer screening and early detection were challenges that had still to be overcome, and newly established cancer centres were suffering from shortages of medical supplies for radiotherapy and chemotherapy and financial resources for training. Human resource development in areas such as cancer epidemiology, radiation and medical oncology, clinical haematology and medical surgery was necessary to support cancer control, and further priorities included a cancer registry, palliative care and pain relief.

Mr RYAZANTSEV (Russian Federation) said that the disease was the third most common cause of death after cardiovascular diseases and accidents, poisoning and trauma in the Russian Federation which accordingly placed strong emphasis on prevention and early detection. Legislation aimed to reduce risk factors, and to that end several federal laws governing treatment and prevention had been adopted. He welcomed the efforts being made by the international community to determine optimum ways of reducing cancer morbidity and mortality. A national cancer programme, developed on the basis of WHO and IARC recommendations, would be one such means, and the Russian Federation had collaborated successfully with WHO in that connection. It would also be useful to establish a specific mechanism whereby scientific advances could be incorporated into working practices, accumulated experience evaluated, and recommendations on primary prevention developed. He supported the draft resolution.

Dr SEALEY-THOMAS (Antigua and Barbuda), speaking on behalf of the Member States of the Caribbean Community, said that cancer was among the 10 leading causes of death in many countries in the region. The most common cancer sites were the colon and prostate among men and the breast and cervix among women; the estimated incidence of cervical cancer in the Caribbean was among the four highest subregional rates in the world. Previous attempts to establish cancer-control programmes in the region had not been sustained. Currently many countries were working with PAHO and the Caribbean Epidemiology Centre to develop a Caribbean cervical-cancer prevention and control programme, and many had also developed national strategic plans and guidelines for cervical cancer control.

She supported the draft resolution, which would not only strengthen current efforts for cervical-cancer prevention and control, but support countries in developing plans for other cancers seen in the region.

¹ *The world health report 2002. Reducing risks, promoting healthy life*. Geneva, World Health Organization, 2002.

Dr AL-HUSSEIN (Saudi Arabia) supported the draft resolution, but proposed that the words “to give technical support to countries for treatment programmes and methods” should be added after “control” in subparagraph 2(7).

Dr CHAOUKI (Morocco) said that in recent years Morocco had undergone an epidemiological transition. In addition to having to deal with communicable diseases, it was also facing the growing problems posed by noncommunicable diseases, in particular cancer. Several chronic diseases had common but avoidable lifestyle-related risk factors. Prevention was linked to the promotion and adoption of healthier lifestyles. One core element of the strategy for control of noncommunicable diseases, and cancer in particular, should be implementation of the WHO Framework Convention on Tobacco Control at national, regional and global levels. Cancer registries, which were the principal tool for epidemiological surveillance, should be established in all countries to enable them to assess the magnitude of the cancer burden, and WHO should redouble its efforts to assist them.

He fully supported the draft resolution as amended by the delegate of France, and stressed the need for it to include a reference to palliative care.

Mr AL-LAWATI (Oman) said that Oman was demonstrating its determination to combat cancer by making the necessary preparations for implementation of the WHO Framework Convention on Tobacco Control. In 1976, Oman, with the cooperation of WHO and IARC, had established a cancer registry, and cancer patients were able to receive appropriate treatment.

He supported the draft resolution and proposed the following amendments: the inclusion in the eighth preambular paragraph of wording relating to palliative care; the inclusion in subparagraph 1(4) of a reference to the negative effects of tobacco use; the inclusion in subparagraph 1(13) of wording advocating the provision of opioid analgesics to patients in clinical treatment; and the inclusion in subparagraph 2(8) of a reference to guiding principles on palliative care for cancer patients, including ethical aspects.

Dr KAMUGISHA (Uganda) said that, with an estimated 20 000 cases annually, cancer was becoming an increasing cause of morbidity and mortality in Uganda. As a resource-poor country, Uganda was unable to offer adequate access to treatment. HIV/AIDS had exacerbated the situation; among some 1.2 million people living with HIV/AIDS, about 200 000 were at risk of developing cancers, such as Kaposi sarcoma, Burkitt lymphoma and other opportunistic tumours. The Government recognized the serious threat of cancer, and the health ministry had undertaken to reduce the burden it represented by a multisectoral approach focusing on palliative care and primary prevention (including vaccination against hepatitis B under the Expanded Programme on Immunization), legislation on tobacco control, health education, risk-factor surveillance, and alcohol- and substance-abuse programmes. The Uganda Cancer Institute had long experience of cancer management through its research on Burkitt lymphoma and other tropical cancers. Plans were being prepared to expand and improve radiotherapy centres, establish chemotherapy centres at selected regional referral hospitals and increase the number of trained cancer-management and palliative-care personnel.

He supported the draft resolution, and proposed the addition in the operative part of the following wording: “Given the close association between cancers and HIV/AIDS and the fact that some of them respond to chemotherapy, and given that the drugs concerned are very expensive, WHO is requested to negotiate with the pharmaceutical companies with a view to reducing the price of anti-cancer drugs and to consider placing those drugs on the WHO Model List of Essential Medicines, as is the case for other drugs used in the treatment of opportunistic conditions”.

Dr SINGH (India) expressed his support for the draft resolution. He proposed the following amendments: the inclusion in subparagraph 1(5) of “and oral” between “cervical” and “cancer”; the insertion after subparagraph 2(5) of an additional subparagraph to read “to support research on cost-effectiveness studies on different strategies for prevention and management of various cancers”;

and the insertion after subparagraph 2(6) of an additional subparagraph to read “to support research on development of an effective vaccine against cervical cancer”.

In resource-constrained developing and least developed countries with large populations, mass population screening might not be feasible but screening for at-risk populations might be explored. There was also a need for appropriate legislation and policies to ensure that morphine was readily available for palliative care.

Dr AZIZ (Pakistan) said that, like many other countries, Pakistan was facing a double burden of disease, and cancer, an increasing cause of morbidity and mortality, represented a significant portion of the noncommunicable disease burden. Sufficient insight existed into cancer etiology, prevention, early detection, treatment and palliative care; the extensive research by IARC over the past 40 years had revealed that tobacco use, unhealthy diet, alcohol consumption, inactive lifestyles and infections were responsible for most cancers. Pakistan appreciated WHO's efforts to create a framework for an integrated mechanism for control and prevention of noncommunicable diseases, including cancers, and acknowledged the adoption of the WHO Framework Convention on Tobacco Control and the Global Strategy on Diet, Physical Activity and Health as landmarks. In establishing its national cancer prevention and control programme, Pakistan was following WHO's recommendation that it should be outcome oriented. He supported the draft resolution.

Mr SZTWIERTNIA (Poland) said that cancer prevention and control were among WHO's most important activities. Poland had introduced a national programme for cancer control, whose main aim was to reduce the incidence of cancer among middle-aged people, and a new research programme on applications of new molecular technologies in oncological diagnosis and treatment. The latter programme was funded by the Government with additional support from nongovernmental organizations and the private sector and, if successfully implemented, it should result in a 5% reduction in cancer cases within 10 years.

Dr ZAHER (Egypt) said that the Egyptian health ministry regarded combating cancer as a priority, and had established a cancer-control project that involved awareness-raising, measures to facilitate the provision of appropriate treatment, and performance evaluation. In Egypt, breast cancer accounted for 33% of all cancer cases and affected 48% of women; 65% of cases reached the third or fourth stage before they were detected, which underscored the need for much earlier diagnosis. The project should have a positive impact and enable the desired objectives to be achieved.

Professor GHODSE (International Narcotics Control Board), speaking at the invitation of the Chairman, said that WHO and the Control Board had collaborated closely to ensure adequate provision of drugs for medical purposes while preventing their diversion into illicit channels. The Board had also been working towards attaining the targets for increased access to affordable essential medicines in developing countries in relevant Millennium Development Goals. The consumption of narcotic drugs had increased significantly, but the benefits often did not accrue to populations in developing countries. Opioid analgesics, for example, were still in short supply, particularly in developing countries, which accounted for only about 6% of the global morphine consumption despite representing about 80% of the world's population. The shortage prevented governments from providing adequate care to thousands of cancer and AIDS patients. If availability did not improve, lack of access to opioid analgesics would cause much unnecessary pain and suffering. The situation became even more grave during crises. Essential medicines should be available when needed, in adequate amounts and in the appropriate dosage forms to satisfy the health-care needs of the majority of the population. By developing a strategy to integrate the availability of opioid pain medication into palliative care for HIV/AIDS, cancer and other chronic diseases, WHO was already working towards achieving that goal. The Control Board would also work with WHO to develop guidelines on the use of opioids for the management of opioid dependence. The Commission on Narcotic Drugs, at its latest

session in March 2005, had adopted a resolution requesting the Board and WHO to consider the feasibility of an assistance mechanism to facilitate adequate treatment of pain.

He called for adoption of the draft resolution. The key to ensuring the appropriate use of controlled medicines and preventing their illicit use lay in educating health professionals in the rational use of drugs in general and psychotropic drugs in particular.

Mrs BLONDEAU (International Union against Cancer), speaking at the invitation of the Chairman, said that her Union was the only nongovernmental organization dedicated solely to all aspects of cancer control worldwide. She underlined the need for concerted action between international organizations, governments, public and private institutions and individuals to apply current knowledge in order to prevent cancers by eliminating known risk factors, implementing prevention strategies, such as the hepatitis B vaccination, and applying comprehensive tobacco-control policies – cost-effective interventions that had benefits beyond cancer. Also, where treatment was available, access to early detection and appropriate treatment could increase chances of survival and improve quality of life. In low-resource settings, developing and implementing appropriate screening methods, for example, for cervical cancer, could prevent malignancy and improve lives. For certain malignant cancers, such as acute childhood leukaemia, advances in treatment had greatly improved outcomes and increased the survival rate. The use of affordable treatment, coupled with research and development of new, less expensive technologies, would bring real benefits. The need was particularly acute in developing countries, where about 80% of cancer patients had late-stage incurable disease when they were diagnosed. Effective relief from pain and other symptoms should be an integral part of cancer management plans.

Controlling cancer in different environments required strategies tailored to make the most effective use of available resources. National cancer-control strategic plans encompassed prevention, early detection and treatment. Cancer claimed twice as many lives as AIDS and was a growing problem worldwide. The draft resolution was a step in the right direction and should be adopted.

Dr LE GALÈS-CAMUS (Assistant Director-General) affirmed that cancer was a matter of increasing concern but added that a growing body of knowledge was contributing to the development of more reliable prevention techniques. The draft resolution presented clear and comprehensive strategic orientations, of which the foremost was prevention. WHO had already launched initiatives aimed at prevention through tobacco control and the Global Strategy on Diet, Physical Activity and Health, which were being implemented at national level. Although cancer prevention represented a major line of attack in the fight against cancer, WHO also had a duty to ensure that all those who were currently suffering from cancer had access to safe, efficacious and affordable treatment. WHO would continue to make every effort to ensure that palliative care was safely made available to everyone who needed it. Replying to the delegate of Japan, she said that the draft resolution was closely linked to other technical programmes and would therefore have a significant effect on much of WHO's future work and funding allocations.

The battle against cancer required the formation and strengthening of partnerships, for example, to extend the scientific knowledge base, which was a prerequisite for the development of efficacious programmes. The relationship between WHO and IAEA exemplified the type of productive working arrangement that needed to be developed in order to successfully combat cancer.

The meeting rose at 12:50.

FOURTH MEETING

Friday, 20 May 2005, at 15:10

Chairman: Dr J. WALCOTT (Barbados)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Cancer prevention and control: Item 13.12 of the Agenda (Resolution EB114.R2; Document A58/16) (continued)

Dr YOUNES (Secretary) read out the amendments to the draft resolution that had been proposed at the previous meeting.

Dr LARIVIÈRE (Canada) welcomed the presence of the Director of IARC, as cancer prevention and control was at the core of the Agency's mandate, and congratulated IARC on its 40th anniversary. The draft resolution acknowledged the Agency's superb contribution to research on cancer in the 40 years of its existence.

He said that he could endorse the proposed amendments, which would make the draft resolution more solid and comprehensive. The resolution was extremely ambitious, and its implementation would require close collaboration between Member States, the Secretariat, IARC and other multilateral bodies.

Dr AL-HUSSEIN (Saudi Arabia) noted that traditional and herbal medicine were unregulated in many countries of the world. He therefore suggested adding to the relevant paragraph of the draft resolution a reference to the need for documented and scientific evidence in that regard.

Dr YOT TEERAWATTANANON (Thailand) proposed the addition of a new subparagraph after subparagraph 2(2), reading "to provide technical support to Member States in priority-setting for cancer prevention, control and palliative care".

Dr KAMUGISHA (Uganda) said that he could accept the resolution as amended, but proposed the addition to paragraph 2 of a further subparagraph requesting the Director-General to report on the matter regularly to the Health Assembly.

Mr ESCUDERO MARTÍNEZ (Ecuador) proposed that subparagraph 1(11*bis*) should be re-worded to read: "to improve access to appropriate technologies, with support from WHO, for the diagnosis ...". Supported by Ms VALDEZ (United States of America), Mr FERRER RODRÍGUEZ (Cuba) and Dr QI Qingdong (China), he asked for a copy of the amended text to be distributed.

The CHAIRMAN said that an amended text would be produced for consideration the following day. The item would therefore remain open for discussion.

Dr BOYLE (Director, IARC) welcomed the expansion of WHO's cancer-control activities as outlined in the report and the draft resolution. IARC, which celebrated its 40th anniversary in 2005, was part of WHO, and was devoted to research on cancer etiology and prevention worldwide and to providing evidence for cancer-control policy. It had worked for 40 years in establishing techniques and cancer registries worldwide, and during its existence the number of States in which cancer

incidence data were available had risen to more than 60, many of which had obtained their registries with the assistance of the Agency. Currently 16 Member States contributed to funding its work.

One major programme was on the identification of causes of human cancers; so far, 900 chemicals and environmental and lifestyle exposures had been evaluated for carcinogenicity. IARC had played a strong role in the scientific evaluation of cancer-prevention strategies and approaches, such as healthy diet, population screening and physical activity. Globally, it conducted research into lifestyle and genetic causes of cancer, with an increasing focus on low- and medium-resource countries, where most new cases currently arose, and was undertaking three of the largest-ever screening studies for cervical and oral cancers in Africa and India. IARC estimated that some 11 million new cases of cancer would be diagnosed in 2005, and owing to the age of the population worldwide that figure was likely to rise to 25 million by 2030 unless action was taken. IARC was prepared to do everything possible to work with Member States to identify ways of reducing the global burden of cancer.

(For approval of the draft resolution, see summary record of the sixth meeting, section 4.)

Disability, including prevention, management and rehabilitation: Item 13.13 of the Agenda (Resolution EB114.R3; Document A58/17)

Dr OSMAN (Representative of the Executive Board), introducing the draft resolution contained in resolution EB114.R3, said that various measures could considerably improve the lives of people living with disabilities, including the provision of devices such as wheelchairs, prostheses or hearing aids, facilitation of access to education and employment, and the addressing of discrimination. The Executive Board had discussed the importance of the role of the public health sector in that connection. Members had expressed concern about the rapid increase in the number of people with disabilities as a result of chronic diseases, injuries, malnutrition, and HIV/AIDS, as well as growth in the ageing population. They had stressed the importance of the issue and welcomed a more active role by WHO, particularly in the area of data collection and in the development of a world report on disability and rehabilitation.

Dr QI Qingdong (China), commending the report, noted that developing countries bore a heavy burden of disability, which not only caused mental and physical suffering but also adversely affected the family of the patient and society as a whole. WHO's work on treatment and rehabilitation made an important contribution to helping disabled persons to find a place in society and to obtain work. The draft resolution did not sufficiently stress the role that could be played by prevention. Many causes of disability went beyond WHO's remit, but the health sector could do more to cooperate with relevant government services to make society more aware of the crucial nature of prevention. He proposed that after paragraph 1(1) a new subparagraph 1*bis* be added, to read "to increase awareness of the public at large of the importance of the issue of disability and to coordinate efforts of all sectors of society to participate in disability prevention activities". A new subparagraph 2(9) should also be added, to read: "to support Member States in taking the necessary steps to reduce risk factors that lead to disabilities".

Dr AL-HUSSEIN (Saudi Arabia) pointed out the importance of minimizing risk factors that might lead to disability. He proposed adding a subparagraph on provision of medical care to people with special needs, with a view to facilitating their access to treatment, and also that reference should be made to disabilities in children, especially in the context of inherited diseases sometimes caused by intermarriage. He advocated premarital testing to forestall such diseases, with family counselling and discussions in schools to raise awareness of such problems.

Dr TRAN TRONG HAI (Viet Nam) welcomed the inclusion of disability on the agenda particularly as his country had experienced the catastrophic effects of 30 years of war. His Government had for the past 20 years been implementing a nationwide programme, covering 45 out of

64 cities, and had recently introduced legislation expanding the provision for disability prevention and management and for rehabilitation. He strongly supported the draft resolution.

Mrs VIREM (France) supported the draft resolution, particularly the improvements that had been made to the text to cover prevention, accidents at work and in the home, recognition of the handicapped as a resource for society, and, above all, the need to coordinate programmes on incapacity and ageing in the light of increased life expectancy. France was reviewing how to promote and integrate fully the rights and dignity of the disabled into society. Her Government had recently passed a law to guarantee equality of rights and opportunities for handicapped persons. The draft resolution should stress the need for improving access to home care and giving greater consideration to the quality of life of the chronically sick, not only by research on morbidity, mortality and risk factors, but also by education designed to achieve better professional and social integration of the handicapped and their families.

Dr NABLI (Tunisia) endorsed the principles set forth in the report and thanked the Secretariat for helping Member States to develop their strategies. She proposed that wording should be included in the draft resolution to cover legislation on screening for disabilities at birth, in view of the crucial importance of prevention and management. Premarital testing and national counselling programmes were crucial to reduce the risk of childhood disability. Disabled people should be fully integrated into society, and her Government had launched appropriate programmes to that end.

Dr KAMUGISHA (Uganda) said that disability was a considerable burden in his country, as 10.4% of the population was handicapped. Most of those affected were the rural poor, and major causes included injuries due to armed conflict and landmines, HIV/AIDS, road traffic accidents and malaria. Under his country's Constitution, persons with disabilities had the right to respect and the provision of appropriate measures to ensure that they realized their full mental and physical potential. Standards and guidelines had been developed covering training of health workers, provision of equipment, research, and networking with civil societies. However, there were still challenges to be overcome, such as lack of health personnel trained in gerontology, limited resources, insufficient research, despite a general atmosphere of goodwill towards persons with handicaps.

Dr SOLOMON (Kenya), commending the draft resolution, said that 10% of Kenya's population was disabled and lived mainly in rural areas, where they had difficulty in accessing medical services. The Ministry of Health had set up a rehabilitation programme, which included the training and deployment of appropriate human resources in health institutions, and adopted a strategy to increase awareness of the availability of such facilities and services.

Primary health care was the key approach for the provision of health services geared to vulnerable and underprivileged groups. Achievements included the deployment of physiotherapists to health centres, the initiation of community-based rehabilitation services in some 25 districts, and the adoption of the Disability Act in 2003. A national plan of action was being developed. Continuing obstacles included poor accessibility of services in rural areas and limited supplies of the equipment needed for such services.

Dr CICOONA (Italy), welcoming the report, expressed his concern at the rapid increase in the number of people with disabilities worldwide. Prevention was crucial. The Secretariat's strategy for community-based rehabilitation had proved successful in improving the quality of life of the handicapped and their participation in society. He supported the draft resolution.

Ms BLACKWOOD (United States of America) said that, since the adoption of the Americans with Disabilities Act more than a decade previously, her Government had strengthened its commitment to improving the capacity of persons with disabilities to participate in daily life. In 2001 the President had launched the New Freedom Initiative, which was designed to expand educational

opportunities and to increase the ability of the 54 million Americans with disabilities to integrate into the workforce. High-quality health care was essential for all citizens, but for the disabled it could mean the difference between living independently in a community or living in an institution. She strongly supported the emphasis given to making rehabilitation available to people of all ages, encouraging early identification of disabilities, identifying assistive technology needs, and promoting community-based programmes. Her Government would be pleased to share its experiences with WHO. She supported the draft resolution.

Dr NABAE (Japan) commended the report and expressed support for the draft resolution. The goal of a society in which the rights and dignity of people with disabilities were ensured should be pursued by all nations. Japan had participated actively in the drafting of the international convention to promote and protect the rights and dignity of persons with disabilities, and had contributed to the United Nations Voluntary Fund on Disability. It attached the utmost importance to prevention, management and rehabilitation, particularly in the light of the country's ageing population. As the incidence of strokes increased, more people suffered paralysis, and the increase in osteoporosis meant that more people suffered hip fractures that could make them bedridden. He endorsed the report's conclusion that disability should be seen in a broader context and that Member States should be urged to put in place effective preventive, management and rehabilitation measures. Japan had high expectations of the report on the subject to be produced by the Director-General.

Ms DEL VALLE MATA LEÓN (Bolivarian Republic of Venezuela) proposed that subparagraph 1(3) should read "to promote early intervention and identification of disability, especially during pregnancy and for children,". She also proposed adding a new subparagraph 1(8*bis*), reading "to ensure equality at work, on satisfactory terms for persons with disabilities" and a new subparagraph 2(5*bis*), reading "to promote studies of incidence and prevalence of disabilities as a basis for the formulation of strategies for prevention, treatment and rehabilitation".

Dr CHETTY (South Africa), expressing support for the draft resolution, recalled that one of the objectives of the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities was to facilitate the development of disability policies in all Member States. The rules on medical care, rehabilitation and support services were the most relevant in the health context, and South Africa had made significant strides in implementing them. A national rehabilitation programme set up in 1996 ensured that medical care was available and accessible to people with disabilities, and a disability survey had been undertaken in 1999 to monitor the availability and accessibility of services. In 2003, free health care at the hospital level had been introduced for people with disabilities, giving them access to a whole range of health services, including rehabilitation and the provision and maintenance of assistive devices. Early intervention, identification of disability, and access to information were also being improved. Health workers had been trained in basic sign language to facilitate communication with deaf clients. South Africa was playing a leading role in preparatory work on the drafting of the international convention to promote and protect the rights and dignity of persons with disabilities. In dealing with issues of disability, it gave priority to vulnerable groups such as women and children.

Two important issues that required action were lack of access to everyday services such as transport, environmental obstacles to access to health care, and lack of resources for disability prevention, management and rehabilitation.

Dr SANGALA (Malawi) commended the report and expressed support for the draft resolution. In Malawi, there were between 700 000 and one million people with disabilities, and the number of persons disabled as a result of road traffic accidents was increasing dramatically. In its national health policy document for the year 2020 the Government had committed itself to expanding medical rehabilitation services for those in need, within the limits of available resources, giving priority to prevention and rehabilitation.

Malawi's only rehabilitation training centre had been destroyed by fire, but with assistance from Norway and Sweden a new and better centre had been built and two smaller centres producing prosthetic equipment would soon be operational. A 50-bed orthopaedic hospital had been opened in 2005 and would perform 1000 corrective and reconstructive surgical procedures a year. Malawi had a well-established orthopaedic training programme enabling paramedics to deal with most situations that required surgery. A programme encouraging rehabilitation technicians to do more work at country level had recently been initiated and a physiotherapy school was planned.

He proposed that the words "physical and mental" in the second preambular paragraph of the draft resolution should be deleted, and that "those injured by landmines" should be added after "malnutrition" in the fourth preambular paragraph.

Mr ASPLUND (Sweden), speaking on behalf of the Nordic countries Denmark, Finland, Iceland, Norway and Sweden, said that the objective of their disability policies was to enable persons with disabilities to participate fully in the life of the community. Disability affected all sectors of society and could not be isolated from other areas of policy. It was also a global concern; the entire health care system, and particularly primary health care, should ensure that people with disabilities received the necessary services, and WHO could play an important role by promoting equal access to medical care. The Nordic countries supported the development of specialized rehabilitation services for people with disabilities, including chronic disorders, and the integration of existing rehabilitation services within primary health care, including social support and access to assistive technology.

Both the Secretariat and individual Member States should continue to maintain a disability perspective in all their activities; indeed, all United Nations agencies had a responsibility to include such a perspective in their work. The Nordic countries encouraged the Secretariat to increase its cooperation with international organizations for the disabled, and to continue to focus on gender and child issues in the area of disability and rehabilitation, both internally and in Member States. Follow-up by Member States on the International Classification of Functioning, Disability and Health, a unique tool which took account both of individual capacities and of environmental factors, was also important. The Nordic countries supported the draft resolution.

Mr FERRER RODRÍGUEZ (Cuba) noted the link between disability and problems of development, even though the past two decades had seen improved ways of preventing loss of capacity or aiding its recovery. Advances in genetic research with specific applications to the prevention of growth abnormalities, the increasing availability of vaccines and medicines to prevent diseases leading to disability, and more technologically advanced rehabilitation had made it possible to improve the quality of life of the disabled and to prevent their suffering.

Cuba's health system paid special attention to disability prevention, comprehensive health care and the special needs of the disabled. In addition to having one of the most comprehensive vaccination programmes in the world, Cuba had for several years been developing a network for the early diagnosis of diseases of genetic or metabolic origin. Early diagnosis, medical or surgical interventions, and intensive rehabilitation had made disability-prevention programmes highly effective. In 2002, the Government had undertaken a massive research project into the causes of disability and the living conditions of disabled persons and to propose measures for improved care and prevention. It had also developed a community-based approach to rehabilitation designed to make services more accessible to the public; by the end of the year, each of the country's 444 polyclinics would have a physiotherapy and rehabilitation room. Access to specialized education for all disabled children and young people was guaranteed. In the case of persons with severe disabilities or living alone, the State paid carers to keep them company and to do their housework, while permanent paid leave was granted to mothers or family members caring for children or persons with severe disabilities.

Since the best solution was prevention, Cuba proposed the addition to the draft resolution of a new subparagraph 1(9*bis*), to read "to investigate and put into practice, in their specific conditions, the most effective actions to prevent the appearance of disabilities, with the participation of other sectors of the community".

Mr RYAZANTSEV (Russian Federation) said that disability was a key public health concern. While supporting WHO's policy on disability, he wished to see more emphasis on disabled children. The Russian Federation had 305 specialist centres and 296 rehabilitation units for children with disabilities, but more than 2500 were needed; vocational training and employment for people with disabilities were also strongly emphasized, more than 14 000 training places being provided for them in 259 institutions of further and higher education.

He welcomed the draft resolution, but proposed the addition, in the fifth preambular paragraph, of the words "particularly in the child population", and the addition in subparagraph 1(2) of the words "particularly by encouraging training and protecting employment".

Ms VALLE (Mexico), expressing support for the draft resolution, proposed amendments designed to reflect the progress made on the issue of disability in other forums, in particular the ad hoc committee on the drafting of an international convention to promote and protect the rights and dignity of persons with disabilities. The words "physical or mental" in the third preambular paragraph limited the kinds of disability that had been recognized internationally and should therefore be deleted. The fourth preambular paragraph should include violence, AIDS and environmental degradation among the factors that had contributed to an increase in the number of persons with disabilities. In the seventh preambular paragraph the words "equality of opportunities" should be added after "ensure", the words "for persons with disabilities" should be added after "quality of life" and the words "regardless of disability" deleted. In subparagraph 1(2), the words "and protecting" should be inserted after "promoting", and in subparagraph 1(9) the words "actively and constructively" should be added after "participate" and the words "in order that it may be adopted by the General Assembly" added at the end. A new subparagraph 1(4*bis*) should be added, to read "to contribute to the work of the ad hoc committee responsible for preparing a United Nations comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities".

Dr GAMBOA PEÑARANDA (Costa Rica) said that people with disability should be a priority work area. They suffered prejudice, stereotyping and discrimination, and faced various physical and social obstacles which marginalized them in society. Costa Rica had adopted a law on equal opportunities for people with disabilities and established a special education centre for those with hearing, language or visual impairments, and mental retardation. However, much remained to be done to meet the needs of people with disabilities, and to ensure that they were able to exercise their rights to the full, and Costa Rica was a member of the committee responsible for drafting a United Nations convention for that purpose. WHO needed to build up its work on disability, and to be given the necessary human, technical and financial resources to support States in developing their own policies on disability. He supported the draft resolution, as amended by Mexico and the Bolivarian Republic of Venezuela.

Mrs AREEKUL PUANGSUWAN (Thailand) welcomed the support to Member States in framing appropriate policies on disability and in encouraging community involvement, as well as the strategy for community-based rehabilitation. Such strategies should be culturally sensitive, to fit each country's context. People with disabilities should be recognized as social capital, and sufficient resources should be invested in comprehensive rehabilitation services, to enable them to become productive to the full extent of their capacities. She strongly supported the draft resolution.

Dr EL ISMAILI ALAOUI (Morocco), welcoming the draft resolution, said that since 1956 Morocco had provided assistance for people with disabilities. The ministry responsible for the family, children and handicapped persons provided services of the kind specified in the draft resolution. A national survey had been conducted into the prevalence and distribution of disability, which was more frequent in rural than in urban areas, and into types of disability, their causes and severity, and the nature of the activities engaged in by people with disabilities. The findings would be used to develop a

national programme for disability, to be implemented by all government departments and by civil society and other partners.

Dr ZAHER (Egypt) said that in Egypt considerable emphasis was placed on the special needs of people with disabilities. Her country had implemented a treatment programme for thyroid diseases in newborn infants and was monitoring the incidence of thyroid diseases. Efforts were being made to extend its programme for those suffering from hereditary diseases to all regions of the country. Special provision was made for those with hearing and visual impairments.

Dr SOMBIE (Burkina Faso) suggested including in the preamble of the draft resolution a mention of disability caused in childhood by accidents while playing, such as disabilities resulting from injuries to the knee, which could result in precocious gonarthrosis, or to the eyes, which could lead to cataract and secondary glaucoma. Better strategies were needed to prevent disability from such causes.

Mr VOIGTLÄNDER (Germany) commended the Secretariat's efforts in the area of disability and rehabilitation and welcomed the draft resolution. It was, however, important to refer to the terminology used in the International Classification of Functioning, Disability and Health. He therefore proposed the addition, after the preambular paragraph beginning "Recalling the United Nations' Standard Rules ..." of a paragraph that would read, "Recalling the International Classification of Functioning, Disability and Health, officially endorsed by the Fifty-fourth World Health Assembly in 2001;".

Ms BAQUERIZO (Ecuador) said that, as all people who lived with disabilities needed at least one other person to look after them, disability affected some 25% of the world's population. The area of disability should therefore be prioritized at national and international levels, and tackled at the global level. In Ecuador, a law concerning people with disabilities had been passed and general and sectoral policies adopted. A national plan was being implemented through the national council on disability. A survey of the prevalence of disability and its geographical distribution, the individual profiles of those with a disability, public awareness of the risk factors for disability, and the characteristics of successful integration of persons with a disability had revealed that 13.2% of the population had some kind of disability. Prevention and treatment of disability, and the rehabilitation of people with a disability, were priorities. She supported the draft resolution and endorsed the amendments proposed by Mexico. She suggested that the reference to "violence" in the third preambular paragraph should be followed by a mention of domestic violence, which often resulted in disability for the victims. Subparagraph 1(9) should call for the United Nations convention on disability to be adopted as rapidly as possible, to reflect the resolutions adopted in other United Nations forums, such as the Commission on Human Rights.

Dr BELLO DE KEMPER (Dominican Republic) said that vulnerability to disability was greater in the developing countries because of the prevalence of accidents and chronic disease. The rights of people with disabilities needed to be promoted and protected. She endorsed the draft resolution and proposed, in the fourth preambular paragraph, after "growth", insertion of the words "growth of the ageing population" and addition of the words "AIDS, environmental degradation," after "violence". She supported the proposals by the delegates of Mexico and the Bolivarian Republic of Venezuela and that of the delegate of Cuba for a new subparagraph 1(9*bis*).

Ms WILSON (Canada), supporting the draft resolution, said that Canada was committed to advancing the full integration of persons with disabilities in Canadian society, and to guaranteeing their access to quality health care, rehabilitation services and disability supports. Each year, Can\$ 7500 million were invested in providing benefits and programmes for people with disabilities. The most recent budget had also increased tax relief for persons with disability and their caregivers.

Canada played an active part in the working group engaged in drawing up a United Nations convention to promote and protect the rights and dignity of persons with disabilities, which specifically mentioned adequate and equitable access to primary health care and rehabilitation services.

Mrs SIBANDA (Zimbabwe) supported the draft resolution. In Zimbabwe, the Ministry of Health and Child Welfare was responsible for coordinating rehabilitation services throughout the country. Unfortunately, Zimbabwe had lost a number of trained physiotherapists, occupational therapists and rehabilitation technicians, just as it had lost other health workers. Rehabilitation was offered at both public and private health facilities; the poor, children under five and persons over 65 were exempt from payment. In Zimbabwe, a major cause of disability was road accidents. Everything possible was being done to integrate disabled children with their peers in school.

Dr AHMED (Pakistan) said that most people living with disability lived in poor countries and lacked access to basic services, including rehabilitation services. Moreover, their numbers were increasing day by day because of injuries resulting from armed conflict, landmines, accidents, and ageing. The reminder to Member States and the international community of their duty to provide equal opportunities and to promote the human rights of people with disabilities was timely. He acknowledged WHO's assistance in implementing the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities. The health and rehabilitation of persons with disabilities took top priority in Pakistan's national health programme. His country also had a community-based rehabilitation programme which it was implementing with the assistance of its international partners. In view of the magnitude of the health and rehabilitation needs of disabled persons, he strongly supported the draft resolution.

Mr AL-LAWATI (Oman) suggested that a reference be included to the *World report on road traffic injury prevention*.¹ Paragraph 9 of document A58/17 mentioned the provision of assistive devices such as wheelchairs and prostheses for people with disabilities. In the draft resolution, he wished to see included a mention of equipment to enable people with disabilities to drive their own vehicles, and subparagraph 1(3) should also urge Member States to provide such prostheses and equipment for people with disabilities.

Mrs CAMPBELL (Nicaragua) supported the draft resolution and endorsed the amendments suggested by the delegate of Mexico. In the fourth preambular paragraph, instead of the reference to "war", she proposed "war wounded" and "landmines and violence".

Dr LE GALÈS-CAMUS (Assistant Director-General) said that she had been struck by the frequent mention by delegates of road traffic accidents, the theme of World Health Day in 2004, which were increasingly a cause of disability. WHO was currently working with other organizations to prevent such injuries. Disabilities affected every age group, and she had noted the concern at the increase of disability among the younger population. WHO was working closely with UNICEF and other organizations to develop an efficient strategy to prevent trauma in children, which often caused death and disability. It was the duty of WHO to ensure that the prevention of disability and the question of access by people with disabilities to high-quality care and rehabilitation remained at the heart of its work. WHO would continue to contribute to the development of the United Nations comprehensive and integral international convention on protection and promotion of the rights and the dignity of persons with disabilities.

¹ Peden M et al, Eds. *World report on road traffic injury prevention*. Geneva, World Health Organization, 2004.

The CHAIRMAN suggested that the agenda item should remain open until a later meeting, when a new version of the draft resolution incorporating the amendments proposed would be considered.

It was so decided.

(For approval of the draft resolution, see summary record of the sixth meeting, section 4.)

International Plan of Action on Ageing: report on implementation: Item 13.15 of the Agenda (Resolution EB115.R7, Document A58/19)

Dr OSMAN (Representative of the Executive Board) said that the Executive Board at its 115th session had discussed the report on implementation of the International Plan of Action on Ageing adopted in 2002. Members had agreed with WHO's focus on a holistic approach to policies on active and healthy ageing and the importance of primary health care for health and well-being, in addition to highlighting emerging issues such as the older person caring for family members with HIV/AIDS and the issue of abuse of older people. The Board had adopted resolution EB115.R7 on strengthening active and healthy ageing recommending a draft resolution for adoption by the Health Assembly.

Dr MORICONI (Italy) agreed that priority should be given to access to primary health care for elderly people and supported WHO's projects focusing on the provision of integrated health-care systems for ageing populations. He supported the draft resolution which was well balanced and reflected the interventions needed to ensure healthy ageing for all populations.

Dr AMIN (Bahrain) said that his country gave special attention to helping its ageing population to remain active. Its national plan on ageing was based on the Madrid Political Declaration. Bahrain, like other countries in the Eastern Mediterranean Region, was currently experiencing demographic changes, and the proportion of the elderly in the population was projected to increase from 35% to 50%. WHO needed to play a pioneering role, by encouraging the countries of the Region to set up the health systems that would enable them to respond to the changing age structure. That would require financial resources, but the Programme budget 2006-2007 did not appear to make any additional funding available for activities to help the aged. WHO should give priority to preparedness and appropriate response to the needs of older people and to enabling Member States to implement the resolution. He supported the draft resolution, on condition that the necessary funds were provided to enable attainment of the objectives.

Dr ST JOHN (Barbados) said that her country had been working with the public and private sectors, civil society, nongovernmental and international organizations and older people to formulate a national policy on ageing. Already, 12% of its population was aged 60 years or more. The six leading causes of death were chronic diseases, which disproportionately affected older people. People should be encouraged to make healthier life choices, and governments should provide supportive environments. Barbadians of 65 years and over received free services and medicines. A gerontology clinic, established in collaboration with PAHO, would be opened in 2005, and further clinics would follow. The Government also provided chronic-care facilities. Collaboration between the public and private sectors had resulted in the placement of people with chronic conditions in private nursing homes near their community of origin, thus alleviating the problem of relatives refusing to care for older people suffering from ill-health, and a regulatory body ensured that private facilities met legal requirements. Other actions had included construction of a senior citizen's complex, establishment of a network of centres for day activities and an intergenerational programme, and provision of home help and district nurse services. The traditional extended family structure still existed, but younger women needed to work and older women were becoming less productive because of chronic disease. It

was to be hoped that the policy framework and legislation would reverse the tide of injustice, which was often even meted out by relatives. The retirement age had recently been extended to 65 and a new pension structure had been introduced. Tax incentives to encourage savings and education on active healthy ageing were provided. She supported the draft resolution.

Mr INFANTE CAMPOS (Spain) said that in 2003 his Government had developed an action plan for the elderly for 2003-2007, in pursuance of the International Plan of Action on Ageing, and had recently submitted a white paper on dependence. Dependency in carrying out everyday activities affected people of all ages, but in Spain one third of people over 65 suffered from that problem, and his Government therefore planned to introduce legislation on social benefits for dependency. He supported the draft resolution.

Mrs YOUNG (Jamaica) said that Jamaica was one of the 12 countries implementing WHO's project to formulate an integrated approach to primary health-care services for the elderly. Communicable diseases had decreased in Jamaica and in other countries of the Caribbean Community, but noncommunicable diseases had increased. People were living longer (in Jamaica life expectancy for men was 71 years and for women 75 years) and their quality of life was being affected by noncommunicable diseases and situations relevant to their social welfare. Her Government had instituted a national council for senior citizens 20 years previously and the national health insurance scheme covered hospitalization and tests for the elderly, and the provision of free treatment for chronic diseases for the elderly had recently been increased. She strongly supported the resolution.

Mrs GUSTIN (Belgium) said that her country attached great importance to the subject of ageing and to health care for the elderly. She supported the draft resolution, but suggested two minor amendments: in subparagraph 1(4), the words "the family" should be replaced with "their family" in order to give the concept of family a broader significance; and in subparagraph 3(3) "economy" should be replaced with "community", so that the wording was in keeping with subparagraph 1(4), which should refer to "their family and community".

Dr EL ISMAILI ALAOUI (Morocco) said that his country was experiencing a demographic shift, with a markedly falling fertility index, lengthening life expectancy, and increasing numbers of older people. Morocco had participated in the work of the United Nations Second World Assembly on Ageing and had drawn up a report on ageing, which would serve as a basis for developing a national strategy, action plan and follow-up measures for the elderly. Elderly people were often cared for by their children, but society was changing and that type of family solidarity was on the wane, often because of a lack of resources. In the draft resolution, he proposed the introduction of a new subparagraph after paragraph 1(4), to read "to take measures and to provide incentives designed to ensure that are resources for those caring for the elderly".

Dr NISHIJIMA (Japan) said that his country had taken various measures designed to help it cope with its ageing society and ensure that the elderly were able to lead a dignified life. The long-term care insurance system begun in 2002, for instance, systematically ensured the basic right of the elderly to select the care service which they wanted. Domestic violence against the elderly was a problem that should receive full attention; while it was difficult to assess the extent of the problem, it was nevertheless essential to provide support for victims. Japan fully supported WHO's ageing-related activities and the draft resolution.

Mr HARTOG (Netherlands) stressed the importance of the International Plan of Action on Ageing as a framework for the implementation of age-sensitive actions in a world where population ageing was a matter of growing concern. Referring to his country's recent sponsorship of a WHO project on integrated primary health care for older persons in low-income countries, he suggested continued implementation of similar projects and emphasized the significance of ageing activities in

the context of the United Nations, as articulated in the draft resolution. WHO should pursue its commendable efforts to keep ageing on the international agenda.

Mr HOHMAN (United States of America) said that his country had suggested inclusion of the current item on the agenda in view of the increased attention given to active ageing and its belief that WHO programmes should accord higher priority to ageing issues. WHO's technical cooperation should include the development of policies and programmes in support of healthy and active ageing, and the promotion of research and exchange of best practices on the two critically important issues of older persons and HIV/AIDS and prevention of elder abuse. Continuing improvement in the lives of older citizens was a priority of his Government, as demonstrated by the focus of its ageing-related programmes. The International Plan of Action on Ageing was a blueprint for the development of such programmes and policies. Its effective implementation by all Member States and United Nations agencies, including WHO, was therefore important, to which end the draft resolution would serve as a guide for future action and reinforce the collective efforts to support public health policies and programmes that focused on the growing numbers of older people in both developed and developing countries.

Mrs HESSEL (Denmark) welcomed the priority given to healthy ageing, as illustrated in the draft resolution. With increasing numbers of elderly people, the preparation of age-friendly societies posed such challenges as the efficient management of chronic diseases. She was therefore pleased to note WHO's strong emphasis on primary health care and urged WHO to support the efforts of Member States to strengthen and broaden the primary health sector.

Dr CHETTY (South Africa), after expressing her support for the draft resolution, said that her country had instituted policies, strategies and guidelines that were designed to promote healthy and active ageing. Emphasis was placed on the provision of primary health-care services and special efforts were made to include older persons in community-based care programmes, despite the already heavy burden of AIDS patients. The integration and coordination of such sectors as health and welfare were essential to the success of those programmes. Other important issues to be highlighted were the negative impact of HIV/AIDS on the economic, social and health status of older persons, the increased abuse of the elderly, and the inclusion of geriatric medicine in the training curricula for health-care professionals.

Mrs AREEKUL PUANGSUWAN (Thailand) said that progress in implementing the International Plan of Action on Ageing had been impressive. Preparation was the key to ensuring that ageing citizens remained active and healthy. Elderly persons had a valuable contribution to make to society, to which end appropriate work opportunities should remain available to them. Those in need, however, should receive special support and care, in which context she commended the WHO age-friendly primary health-care project aimed at reducing the barriers to the provision of such care.

Professor PEREIRA MIGUEL (Portugal), after welcoming the draft resolution, said that considerable work had been done at the regional level on the provision of community-based primary health care to growing numbers of older people. Within Europe, common challenges and shared solutions for the maintenance of a healthy, active and productive society had been discussed. His Government had instituted a national health programme for the elderly, to whom it afforded high priority by building capacity in such settings as the family, health centres, hospitals and community services. He shared WHO's views on the importance of a holistic life-course approach to ageing in which due attention was paid to the determinants of health and emphasis placed on a continuum of health and social care services with a view to ensuring that older people remained healthy and productive. He also supported WHO's efforts to integrate ageing issues into policies and programmes for attainment of the Millennium Development Goals.

Mr DE CASTRO SALDANHA (Brazil) expressed his strong support for the draft resolution, which was fundamental to raising awareness of the challenges posed to society by ageing. It was vital to renew the commitments spelt out in the International Plan of Action on Ageing and stress the need for WHO to prioritize the issue of active and healthy ageing as a matter of urgency. Allocation of the requisite financial resources for that purpose was thus imperative.

Dr DELAVAR (Islamic Republic of Iran) said that disease-prevention and health-promotion programmes should be started early in life in order to prevent chronic disease and disability in older persons, thus guaranteeing a better quality of life. Strengthening healthy ageing programmes, which covered all aspects of well-being, could change the process of implementing vertical disease-prevention programmes. The integration of interventions for service providers and clients would be more cost-effective for the developing countries in particular. He fully supported the draft resolution, but provision for the activities concerned should be made in WHO's budget allocation plan.

Mr RYAZANTSEV (Russian Federation) supported the initiatives for the development of a new sectoral approach to ageing, in partnership with intergovernmental, governmental and community organizations. In that regard, the Madrid Political Declaration and International Plan of Action on Ageing provided a guideline for work, in the context that respect for the elderly remained a mark of civilization. His country supported the draft resolution and would join in further international cooperation on ageing-related matters.

Mr ASPLUND (Sweden) said that the fact that people were living longer and more autonomous lives was not only a major achievement but also testimony to the success of comprehensive and multisectoral actions for health and social development. Disease prevention and health promotion among the elderly were also particularly important, as were systemic interventions such as good eating habits and physical exercise, which could even be introduced later in life with positive effect. With that in mind, he proposed that, in subparagraph 3(4) of the draft resolution, the words "strategies, policies and interventions" should be inserted after the phrase "health promotion and disease prevention".

Mrs INGÓLFSDÓTTIR (Iceland) said that the ageing of the world population raised three major issues: increasing numbers of active older people demanding new social structures and opportunities; increasing numbers of disabled older people requiring new interventions and improved health and social care, which had economic implications; and resolving the complex economic, technological, organizational and social problems posed by the ageing of society. Innovative social, organizational and technical responses were therefore needed. The draft resolution, which Iceland supported, would have a positive impact on the promotion of healthy ageing and on the quality of life and independence of older people.

Mr LANGAT (Kenya) said that the proportion of older people in the population in Kenya was set to rise well above the current figure of 4% by 2050. Already, the increase in demand for health services by older people suffering from chronic disease or disability was unprecedented. In order to address that problem and the other hardships faced by older people, Kenya had implemented several strategies in the three years since the adoption of the International Plan of Action on Ageing, covering such areas as community advocacy, food security, nutrition and primary health-care services. Achievements included the development of support groups for older people, the drafting of a national social health insurance bill and training for health personnel in the health problems of older persons. Challenges included lack of comprehensive and coherent policies and programmes for older persons, poverty and lack of sustainable livelihood, the large dependent population and lack of resources for the creation of an enabling environment for older persons. Further strategies for the next three years were also planned with a view to, inter alia, strengthening primary health-care services for older persons, establishing community structures for the support and care of older persons and introducing a

comprehensive social security scheme for those over 60 years of age. He supported the draft resolution.

Dr SINGH (India) said that India, as a country that recognized the welfare of older persons as an issue of crucial concern, endorsed the draft resolution. The availability and accessibility of health-care facilities were important determinants of the present and future health of the elderly, who were frequently unable to reach medical centres without assistance and lacked the resources needed to meet their various health care needs. Training medical officers and multipurpose health workers about risk factors for illness among the elderly would therefore make a significant contribution to management of the major chronic diseases. He endorsed a multipronged approach in the field of gerontology with a view to preventing or delaying the onset of such diseases. He also recommended the inclusion of geriatric medicine in medical curricula and research into the health status of older women, with particular reference to such conditions as dementia, osteoarthritis and osteoporosis.

The meeting rose at 18:05.

FIFTH MEETING

Saturday, 21 May 2005, at 09:00

Chairman: Dr J. WALCOTT (Barbados)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

International Plan of Action on Ageing: report on implementation: Item 13.15 of the Agenda (Resolution EB115.R7; Document A58/19) (continued)

Dr SEVER (Israel) said that in most countries older people were considered to be a weak population group lacking the political power to claim the basic human rights they deserved, including the right to good health and well-being and to live in proper relief conditions. He regretted that governments did not give high priority to geriatric care and healthy ageing. He praised the Secretariat's efforts in that area, particularly its encouragement of health ministries to improve the situation of older people by promoting comprehensive health action plans in the fields of prevention, medical care for acute and chronic diseases, rehabilitation and nursing care. However, he queried how the Secretariat could be expected to advance its healthy ageing policy without any budget; without the necessary financial resources, its discussions on the subject would never have any tangible purpose or outcome.

Dr YAN Jun (China) commended the report. China was a developing country with an increasingly ageing population, which created a public health issue, and it was therefore adjusting its social security system to provide primary health care for older people living in the community with a view to promoting healthy ageing. Its health-promotion activities included training health professionals in the care of the elderly. Risk factors should be addressed in order to prevent accidents, and support should be given to older people so that they might live independently and remain active.

HIV/AIDS placed a heavy burden on older people, especially in developing countries; older people not only suffered from the loss of their children, but also bore the responsibility of bringing up their orphaned grandchildren when they themselves needed care. WHO should play a key role in coordinating health and social security systems to help older people in families affected by HIV/AIDS. The abuse of older people should not be neglected. Regardless of the varying cultural definitions of abuse, the international community should uphold the importance of respecting older people, and legislation to protect their rights was needed to solve the problem. She supported the draft resolution.

Ms VALLE (Mexico), speaking on behalf of the Group of the Americas, supported all global efforts to address the care of older people, particularly when they focused on primary health care and preventing physical and mental abuse, because all countries were increasingly facing an ageing population. She recognized that continued efforts were needed to ensure that the growing population of the elderly enjoyed the highest possible level of health and well-being, and therefore firmly supported the draft resolution.

Mrs TAFA (Botswana) commended both the report and the Secretariat's support to developing countries in raising awareness of the challenges of ageing societies and in meeting the health and social needs of older people. Botswana was participating in the project to formulate an integrated response of health-care systems to rapid population ageing, which had provided a unique opportunity to assess the performance of the health system in meeting the needs of older people. The research had

generated important data on the burden of diseases such as diabetes and hypertension. The results would inform policy and programme development in noncommunicable disease control and health-system capacity to meet the specific needs of older people. The preliminary findings had recently been given to key stakeholders in Botswana. The study had also provided useful information on deficiencies in the current health facilities in relation to the health needs of the elderly. She looked forward to using the findings of the WHO age-friendly primary health-care project to improve their primary care services. She also looked forward to WHO's support in implementing the STEPwise approach to surveillance and control of noncommunicable diseases in order to reduce the burden of those diseases on older people. She supported the draft resolution.

Mr RAMOTSOARI (Lesotho) recognized the importance of the International Plan of Action on Ageing. Older people in Lesotho still fulfilled important traditional roles, such as birth attendance. However, homes for the elderly and orphanages, which were not part of traditional African culture, were becoming more common because of increasing poverty, and the provision of such services needed special attention. The increasing responsibility placed on grandparents to raise their orphaned grandchildren as a result of HIV/AIDS was also cause for concern. He fully supported the draft resolution.

Ms LIODAKI (Greece) recognized the importance of training health workers at all levels and teaching geriatric medicine as a specialized subject. It was also important to integrate care for the elderly into the primary health-care sector of existing national health-care systems. Any society that mistreated children and older people should be criticized.

She supported the draft resolution, subject to two minor amendments. In subparagraph 1(5), she proposed adding the word "economic" and a comma after "eliminate". A new subparagraph should be inserted between paragraphs 1(8) and 1(9) that would read: "to develop health care within the existing national health-care systems for primary health care;".

Mrs VEERAPEN (Mauritius) said that, within 25 years, 20% to 25% of the population in Mauritius would be over 60 years of age, owing to reduced fertility rates and longer life expectancy. Her Government had formulated a national policy on the elderly that included programmes to strengthen preventive care at the primary health-care level and to fast-track older people at all levels of the health-care system in order to meet their specific needs. Capacity building in gerontology and geriatrics among health-care providers had also been strengthened and a community-based rehabilitation programme was in place for older people with physical disabilities. Existing physiotherapy, occupational therapy and speech therapy services were being strengthened and decentralized in order to cope with the specific health needs of older people. Mauritius provided the elderly with food supplements, glasses, prostheses and transport at reduced rates, and vaccinated people aged over 60 against influenza. She strongly supported the draft resolution.

Dr ELSAYID (Sudan) said that Sudan too was facing an increasingly aged population: the proportion of older people was projected to rise from 5% in 1999 to 8% by 2025. Although extended families in Sudan traditionally took care of older people, ensuring the highest attainable standards of health and well-being for the country's older citizens was a challenge. Sudan's national health policies included appropriate support mechanisms for older people. They should be regarded as contributors to development rather than consumers, which required both technical and financial support. She endorsed the draft resolution.

Dr GEZAIY (Regional Director for the Eastern Mediterranean) said that a regional strategy for the health care of older people had been in place since 1992. His Region had been among the first to deal with the problem of ageing and had emphasized better use of extended families in taking care of older people. Some governments provided direct support to families in the form of a government-

funded worker to assist in caring for older people at home rather than in hospital or hospices. Interregional activities were also being undertaken which were supported but not initiated by WHO.

Dr LE GALÈS-CAMUS (Assistant Director-General) thanked delegates for their positive comments and suggestions on ways to further WHO's work on active and healthy ageing. Despite limited resources, WHO would continue its efforts to implement the International Plan of Action on Ageing, focusing in particular on promoting health and well-being among older people. Its active-ageing policy framework would guide its activities both at the global level, particularly in its collaboration with other United Nations organizations, and at the regional level, in its technical assistance to Member States.

Dr YOUNES (Secretary) read the amendments proposed: an additional subparagraph should be inserted after subparagraph 1(3), to read: "to adopt measures and incentives aimed at providing resources on behalf of persons responsible for the elderly;". In subparagraph 1(4), the words "the family and community" should be replaced with "their family and the community". In subparagraph 1(5), the word "economic" and a comma should be inserted after "eliminate". An additional subparagraph should be inserted after subparagraph 1(8), to read: "to develop health care of older people within the existing national health-care systems for public health care;". In subparagraph 3(3), the word "economy" should be replaced with "community". In subparagraph 3(4), the word "health" should be inserted before "research" and the words "strategies, policies and interventions" inserted after "disease prevention".

Mr HOHMAN (United States of America) proposed the following amendments: in the proposed additional subparagraph to be inserted after subparagraph 1(3) replace the word "elderly" with "older persons" and in subparagraph 1(4) replace the word "family" with "families". In subparagraph 3(3), he suggested that the reference to the economy should be retained as older people could make a contribution in that regard.

Mrs MEULENBERGS (Belgium) agreed to that proposal but requested that the reference to community should also be retained.

Dr EL ISMAILI ALAOU (Morocco) amended the wording of the additional subparagraph to be inserted after subparagraph 1(3) that he had proposed earlier to read: "to adopt measures and incentives aimed at ensuring resources for persons, be they physical or moral, who are responsible for the elderly;".

Ms WILSON (Canada), referring to the proposed insertion in subparagraph 3(4) of the word "health" before "research", expressed concern that, by specifying health research in the resolution, WHO might exclude other useful forms of research, such as economic modeling for the care of older persons or provisions for caregivers that might enhance the research agenda.

Ms BAQUERIZO (Ecuador) asked whether the new subparagraph 1(4) included a reference to both moral and physical persons; she would support the inclusion of such a reference.

Dr YOUNES (Secretary) re-read the proposed amendments to the draft resolution.

Mr HOHMAN (United States of America) requested further clarification regarding the amendment to include the words "moral and physical care" in the additional subparagraph proposed by the delegate of Morocco for insertion after subparagraph 1(3).

Ms BAQUERIZO (Ecuador) repeated her support of the proposed inclusion of the words "physical and moral persons caring for older people".

Mr HOHMAN (United States of America) said that, while he understood the difference between physical care and having legal responsibility for care, the legal aspect was not captured by the word “moral”.

Ms BAQUERIZO (Ecuador) explained that the word “moral” had been introduced because of an earlier confusion regarding the terminology used for physical and legal persons.

Dr YOUNES (Secretary) proposed the following wording: “to take steps and encourage measures to ensure resources for persons who take physical care or who have legal responsibility for older persons;”.

Ms BAQUERIZO (Ecuador) said that the proposed new wording sought to distinguish between individuals and legal entities, such as organizations or foundations, that took care of older people.

Dr YOUNES (Secretary) suggested that the following wording would express the intended meaning: “to take steps and encourage measures to ensure resources for persons or legal entities who take care of older persons;”.

Ms BAQUERIZO (Ecuador), supported by Dr BELLO DE KEMPER (Dominican Republic), endorsed that proposal.

The draft resolution, as amended, was approved.¹

Public health problems caused by harmful use of alcohol: Item 13.14 of the Agenda (Resolution EB115.R5; Document A58/18)

Dr OSMAN (Representative of the Executive Board) recalled that the Board had reached a consensus on the need to address the medical, social and economic consequences of the harmful use of alcohol. The Organization’s efforts in that area had been supported, but different views had been expressed regarding the potential recourse to a strategy similar to that used for tobacco control, namely, an international legal framework for regulating alcohol, as well as in relation to the role of the alcohol industry. In that context, the beneficial effects of alcohol consumption on health as demonstrated in some studies and the dangers associated with illicit alcohol production and consumption had been mentioned. Some members had stated that the Secretariat must ensure transparency, impartiality and a balanced regional and gender representation in the selection of experts on advisory panels for technical consultation on alcohol and its activities. The need to include the following specific measures to control alcohol-related harm had also been emphasized: the dissemination of scientific information on, and increasing awareness of, the effects of alcohol use; the introduction of taxation and the licensing of alcohol sales; the targeting of advertising agencies and the media to ensure the de-glamorization of drinking; addressing the marketing of alcoholic beverages under free trade agreements; the promotion of mental health and the empowerment of individuals, families and communities against external pressures to consume alcohol; tackling domestic violence associated with alcohol consumption; the promotion of education on healthy lifestyles and a responsible attitude towards alcohol; and the need to strike an appropriate balance when addressing alcohol-related issues with a focus on public health problems induced by alcohol. The Board had adopted resolution EB115.R5 containing a draft resolution recommended to the Health Assembly.

Mrs SCHLEDER-LEUCK (Luxembourg), speaking on behalf of the Member States of the European Union, the acceding countries Bulgaria and Romania, and the candidate countries Croatia

¹ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA58.16.

and Turkey, reiterated their support for the draft resolution contained in resolution EB115.R5, of which they had been cosponsors. The Board at its 115th session had engaged in an intense debate and had reached a balanced compromise which should be acceptable to all Member States, and she urged them to adopt the draft resolution.

Mr RYAZANTSEV (Russian Federation) said that the report justifiably placed the harmful use of alcohol among the world's worst health risk factors. It was a major cause of concern in the Russian Federation. More than two million people were currently receiving treatment for the effects of alcohol use and more than two million new cases of alcoholism were recorded each year. Beer consumption among young people and adolescents was widespread and a matter of particular concern. People were therefore being informed of the dangers of alcohol use. The advertising of alcoholic beverages other than beer was illegal and it was expected that the legislation would be extended to cover beer. Anyone caught driving under the influence of alcohol could have their licence withdrawn for up to two years. People suffering from the harmful effects of alcohol had access to medical institutions, although the treatment available was not particularly effective and needed to be improved. The Russian Federation supported the Secretariat's proposed work on alcohol and the development of recommendations to reduce the alcohol-related burden. While he supported the draft resolution, he observed that there was no satisfactory equivalent in Russian for the English phrase "harmful use of alcohol". He therefore proposed using the phrase "alcohol consumption with harmful consequences".

Dr THAKSAPHON THAMARANGSI (Thailand) said that alcohol was the third most dangerous health risk factor in Thailand. More than 25% of mental health problems were caused by alcohol, and drinking and driving contributed to the high morbidity and mortality from traffic accidents. Alcohol consumption by young people had also led to violence, drug addiction, teenage pregnancy, unsafe sex and HIV infection. In 2000, Thailand had been classified as one of the 10 countries with the highest level of alcohol consumption. The Government had passed legislation restricting the duration and the content of television advertising of alcoholic beverages. The 10 best practices that had been selected from a wide range of policy options and were listed in the report would assist countries in their choice of effective strategies. Since alcohol, unlike illegal drugs, was freely available, countries needed effective alcohol policies to reduce both consumption and the harm it caused.

Resolution WHA36.12 on alcohol consumption and related problems, which had identified the topic as a theme for a World Health Day, had been adopted 22 years ago but not implemented. He therefore requested that the topic be designated as the theme for World Health Day in 2010. He strongly supported the draft resolution and looked forward to its wide implementation. He proposed the following amendments: the replacement at the beginning of the first preambular paragraph of "Recalling" with "Reaffirming"; and the addition in subparagraph 1(1) of a footnote after "strategies" to read, "for example, the '10 best practices' as described in the report contained in document A58/18".

Mr GUNNARSSON (Iceland), speaking on behalf of the Nordic countries, underlined the importance they attached to the draft resolution. Alcohol-related problems accounted for a major share of the global burden of disease. If WHO was to maintain its authority as the global leader in health, it must urgently take steps to address such a serious health risk. Reaching consensus on the text of the draft resolution had been challenging, given the many divergent views of members. The current text represented the best achievable outcome, and he therefore urged delegates to adopt it with the two amendments proposed by Thailand.

Dr SINGH (India) supported the draft resolution and proposed the following amendments: the insertion after subparagraph 1(1) of an additional subparagraph to read: "to consider provision of a cess on the sale of alcohol and the revenue generated to be used for programmes for the prevention of alcohol abuse and treatment of dependent individuals", and after subparagraph 2(5) of a further

subparagraph to read: “to produce a report on linkages between alcohol consumption and high risk behaviour including the spread of HIV/AIDS and methods to reduce the risk”.

Mr DE CASTRO SALDANHA (Brazil) strongly supported the draft resolution, which highlighted the impact of alcohol use on public health and the need to include it as a main priority area in the global health agenda. His Government had implemented a national programme on alcohol in order to extend the medical coverage available to alcohol and drug users and their relatives and to accelerate their rehabilitation and social insertion. It was essential to implement health promotion activities in schools, workplaces, health centres and communities to undermine the stereotypical images associated with alcohol use. The health ministry was developing a plan to prevent the harmful use of alcohol. Given the scale of the problem and the damage it caused, it was crucial to involve society as a whole in order to gain support for public policies on alcohol use.

Mr RECINOS TREJO (El Salvador), speaking on behalf of the Latin American Group, said that its countries were well aware of the health problems associated with the harmful use of alcohol and therefore had actively participated in the drafting of the resolution. The draft resolution, which the Group supported, represented a delicate balance between a number of different positions and he therefore urged its adoption as it stood.

Mr LANGAT (Kenya) said that about a third of the global population consumed alcohol and the harmful effects were of serious concern, not least in Kenya. A recent national health survey had shown that alcohol consumption was one of the major health risk factors and that it had serious implications for HIV infection, particularly among young people. Kenya had been addressing the problem by raising awareness among the public and by enforcing the rules on alcohol advertising and other forms of substance abuse. It had established a national campaign to inform and educate the public, but its activities were hampered by a lack of funding. The consumption of illicit alcohol was a major concern as it had been the cause of many hundreds of deaths in recent years. Counselling centres were currently being set up to tackle the problem. Kenya supported the draft resolution.

Mr VAN DER HEIDEN (Netherlands) said that the harmful use of alcohol contributed substantially to the global burden of disease, and for that reason his country had been a sponsor of the draft resolution. Although Member States were ultimately responsible for implementing the necessary measures, WHO had a vital role to play at the global and regional levels in providing the necessary information, an area in which the Netherlands would be willing to provide support within the framework of a joint partnership. WHO should also begin discussions with all the relevant authorities and stakeholders, including the alcohol industry.

Dr MATHESON (New Zealand) commended WHO's leadership role, given the significance of alcohol as a risk factor for noncommunicable diseases and injuries. Alcohol use was responsible for 4% of the global burden of disease, a similar proportion to that attributed to tobacco use. A key principle informing New Zealand's position on the issue was the balance between the benefits and harms associated with alcohol use. For some groups and in some contexts, even small amounts of alcohol carried a risk of harm. Similarly, the current evidence suggested that for some noncommunicable diseases, such as breast cancer, the risk increased in proportion to consumption with no apparent safe lower limit. Given the increasing impact of alcohol use, New Zealand supported the draft resolution, together with the amendments proposed by Thailand.

Mrs YOUNG (Jamaica) said that, although alcohol use continued to be a problem in Jamaica, there had been a steady reduction in consumption rates. The prevention strategies implemented were in line with those outlined in the report. She was not in favour of the introduction of taxation, which was outside the remit of health ministries, preferring to focus on education and health-promotion programmes, which in Jamaica had led to reduced consumption by all age groups. She supported the

draft resolution, thanked the Nordic countries and Thailand for their work, and endorsed the idea of basing the theme of World Health Day 2007 on the title of the draft resolution.

Mr WANGCHUK (Bhutan), commending the report, recorded his concern at the significant, and rising, rates of disease, injury, disability and premature death related to alcohol in Bhutan. Considerable resources were allocated to that problem, which had a significant social and economic impact. He welcomed WHO's holistic approach to dealing with alcohol-related problems, and its focus on policies to restrict consumption and on effective health-promotion strategies, particularly those aimed at young people. He supported the draft resolution, as amended by Thailand.

Dr BELBEISI (Jordan) said that Islam prohibited alcohol consumption, which had dire health consequences, both directly and indirectly, for example, through the increased propagation of HIV related to unsafe sex. Jordan had adopted several policies, including the setting of a minimum age of 18 for the purchase of alcohol, the levying of heavy taxes on alcohol, a total ban on alcohol-impaired driving and on alcohol advertisements, and the provision of rehabilitation programmes for alcoholics. He therefore fully supported the draft resolution.

Professor PEREIRA MIGUEL (Portugal) commended the report and, in line with the European Union position, expressed his support for the draft resolution. The Secretariat should support Member States in monitoring alcohol-related problems in order to reinforce the scientific and empirical evidence of the effectiveness of policies, such as those to prevent alcohol-impaired driving, alcohol consumption during pregnancy and alcohol consumption by young people. Portugal had high rates of alcohol consumption and alcohol-related problems, and had established a national action plan to combat them, under which various projects on health promotion, education and legislation had been set up. Data were currently being gathered on alcohol-related problems. Training programmes were being designed for health professionals on hazardous and harmful drinking, and a task force had been set up to coordinate national action in that area. Portugal was also involved in the Primary Health Care European Project on Alcohol and the International Network on Brief Interventions for Alcohol Problems, and he looked forward to collaborating with the Secretariat in furthering that work.

Dr YAN Jun (China), welcoming the report, said that insufficient attention was paid to the disease burden related to alcohol use, especially in developing countries. The problem of excessive alcohol use existed in China, where nearly 100 million people drank, 21% of whom were young people over the age of 15 (especially males), and treatment interventions were therefore being planned. China would be actively participating in WHO's future work on alcohol problems, and wanted to receive technical guidance from the Secretariat. WHO should step up research on the impact of the harmful use of alcohol on health and the disease burden, in order to provide evidence to support the formulation of relevant strategies. She fully endorsed the draft resolution, as amended by the delegate of Thailand.

Ms DEL VALLE MATA LEÓN (Bolivarian Republic of Venezuela) said that the legal measures being implemented in her country to tackle health problems related to harmful alcohol consumption included the introduction of a minimum legal age to buy alcohol, restrictions on hours of sale of alcohol, taxation of alcohol, and restrictions on alcohol-related advertising. However, the extent of alcohol-related problems was greater than the scope of the measures implemented, which had therefore not had the desired effect. The problem was exacerbated by the cultural phenomenon of social drinking in the country. A policy for the prevention of alcohol consumption should be introduced for people who blatantly transgressed social norms, with punitive or financial sanctions, in order to encourage health-oriented behaviour. She supported the draft resolution.

Dr CHETTY (South Africa) expressed in advance her support of the statement that would be made on behalf of Member States of the African Region. Her country was experiencing alcohol-

related public health problems in line with those described in the report. Alcohol misuse was implicated in a range of chronic health problems and contributed significantly to the increase in mortality and morbidity from injuries, road fatalities, fetal alcohol syndrome, and crime and violence. South Africa had set up a surveillance system on the nature and extent of alcohol abuse. A recent survey of risk behaviours in young people had provided valuable information on which to base policies and programmes. Substance abuse-prevention training had been provided in schools, complemented by a policy on the prevention and management of substance abuse. Regulations had been drafted on the labelling of all alcohol containers. She supported the draft resolution as amended by Thailand.

Mr HOHMAN (United States of America) said that alcohol abuse was a complex problem that caused significant public health problems. Prevention held the key to solving that and other substance-related problems and more research was needed to find ways of increasing the age of first alcohol use. WHO's work on alcohol-abuse issues in the past had not been transparent and had not engaged all relevant stakeholders, an approach that would reduce the efficiency of any programmes developed. He welcomed the assurance given at the 115th session of the Executive Board that the Secretariat would embrace transparency and its promise to work collaboratively with the alcohol industry.

The following principles should frame WHO's future work on alcohol: full disclosure of the scientific and epidemiological studies on which its findings and conclusions were based, and willingness to accept peer review of those studies; willingness to accept scientifically rigorous data generated by industry, or financed by it, as was the case with the food, chemical, pharmaceutical and other industries, as long as there was full disclosure of funding sources; transparency to ensure that Member States and relevant stakeholders were fully informed of WHO's activities and initiatives in that area; impartiality in the selection of experts for technical consultations on alcohol, expert reviews of evidence relating to the health effects of alcohol, and expert advisory committees for policy recommendations; and willingness to engage and consult with all relevant stakeholders, including the beverage alcohol industry, in the elaboration of alcohol policy.

He did not endorse the amendments proposed to the draft resolution, including the Thai proposal on the inclusion of a footnote relating to best practices, which were not, in his Government's view, evidence-based. Nevertheless, if a consensus emerged to accept that amendment, he would not go against it. However, he was unable to accept the amendment proposed by the delegate of India.

Dr AL-HUSSEIN (Saudi Arabia) commended the report and draft resolution. In view of the negative effects of alcohol consumption on health, he proposed an amendment whereby "harmful" be deleted from the phrases "harmful use of alcohol" and "harmful alcohol consumption" occurring in the operative paragraphs and the title of the draft resolution. Also, he asked for the words "and distributors of alcoholic beverages" to be deleted from subparagraph 2(8). With those small amendments, he would support the draft resolution.

Professor KINDE-GAZARD (Benin), speaking on behalf of the Member States of the African Region, affirmed that the public health problems associated with the consumption of alcohol, as described in the report, had reached alarming proportions; it had become the primary risk to health in developing countries. Alcohol was often used as a way of escaping from day-to-day problems; hence the rate of alcoholism was frequently high among young people. She consequently favoured the setting up of databases to monitor developments in that area.

The African Region was aware of the public health challenges involved. The various problems it faced included lack of appropriate alcohol-treatment centres, the invasion of African countries by alcoholic products of dubious quality, and aggressive publicity for alcoholic beverages. The Region, which was already gravely affected by endemic diseases such as malaria, HIV/AIDS and tuberculosis, nonetheless reaffirmed its commitment to the health of mothers and children. It consequently

encouraged WHO's strategies to combat alcohol abuse and its effects, including prenatal screening and help for the victims of alcoholism. She supported the draft resolution.

Dr SINGH (India) suggested that WHO should study the issues that he had raised earlier and expressed his willingness to withdraw his proposed amendments.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the report had shown that issues linked to alcohol consumption constituted an important public health risk. In the Region of the Americas, there had been an increase in alcohol consumption during the 1980s, owing to greater financial means and availability of alcohol on the market. In Cuba, a prevention programme had already produced results, including a halving of alcohol consumption. Hence it was important to decrease the availability of such products and propose other solutions to dependent people, conducive to a change in their lifestyle. His country had developed strategies to identify high-risk groups and to involve all stakeholders in the health field, particularly in primary health care. He supported the draft resolution, but asked for the amendment proposed by the delegate of Thailand to be submitted in writing.

Dr NABAE (Japan) also supported the draft resolution and expressed his appreciation for the Secretariat's commitment to furthering the work carried out by Member States. Problems caused by the harmful use of alcohol extended well beyond health issues, to encompass a wider social sphere including crime, violence in the family and unemployment. His country relied on WHO to provide assistance, on the basis of scientifically well-founded schemes, through the collaborating centres in various Member States.

Dr AKBARI (Islamic Republic of Iran) recognized that the consumption of alcohol affected the four essential aspects to health, namely biological, psychological, social and spiritual well-being. He proposed the following amendments to the draft resolution: in the fourth preambular paragraph, the word "particularly" should be added after the word "consumption"; in the sixth preambular paragraph, the phrase "and violence" should be added at the end; the word "harmful" should be deleted throughout the text; in subparagraph 1(2), the words "religious figures" should be inserted after the word "including" in the second line; subparagraph 2(2) should be replaced by the following text: "to convene an expert group with the aim of drafting a convention or legal instrument such as the Framework Convention on Tobacco Control to restrict production, distribution, marketing and consumption of alcohol;".

Mr RAMOTSOARI (Lesotho) welcomed the report. In his country, wide abuse of alcohol had led to a deterioration of social life, such as an increase in the divorce rate and abuse of children. It also caused significant public health problems, including traffic accidents. Consequently it was important that WHO should continue to engage all stakeholders, particularly alcohol manufacturers, in order to involve them in problem-solving. He favoured the adoption of a scientific and transparent approach by WHO in that connection. His Government had already studied concrete programmes to address alcohol abuse, in conjunction with brewing companies. He urged adoption of the draft resolution.

Dr CHITUWO (Zambia) said that his country had experienced an increase in road traffic accidents, violence against women, and HIV infections. Before the commercialization of alcohol, alcoholic beverages had been consumed only in a cultural context such as weddings. However, owing to aggressive advertising, especially on television, alcohol consumption had come to be regarded as fashionable. He therefore welcomed WHO's strategies to reduce harmful use of alcohol, which should be incorporated in the wider context of campaigns to reduce poverty. He consequently supported the draft resolution.

Dr MACHATINE (Mozambique) said that alcohol misuse was a matter of public concern in her country, owing to the consequences such as domestic violence, road accidents and physical disorders, especially among young people. She supported the draft resolution.

Dr ST JOHN (Barbados) also supported the draft resolution and welcomed WHO's work in the area. At the national level, governments were able to enforce appropriate nondiscriminatory policies to protect public health and, in her country, such a control programme had produced excellent results. Its underlying principles were collaboration between all stakeholders, the government, nongovernmental organizations and the private sector. The alcohol industry in Barbados had demonstrated its commitment to positive interaction with WHO by promoting drink-driving prevention, as part of the World Health Day 2004 focus on road safety. Consideration had also been given to sponsorship of an international conference on best practices in industrial self-regulation. Policy in her country was geared to advocating responsible use of alcohol, the inclusion of prevention strategies in primary health-care promotion services, such as the adolescent education programme, the introduction of substance abuse cessation programmes, and public awareness campaigns, as well as control measures for reducing road accidents, introducing seat-belt legislation and breathalyser use.

Ms GILDERS (Canada) said that Canada fully supported the resolution as drafted, and particularly the language that had been strengthened to underscore the importance of collaboration with various stakeholders, including industry, on initiatives to reduce the harmful effects of alcohol use. She affirmed the delicate balance on the wording negotiated in discussions at the 115th session of the Executive Board. In November 2004, the Canadian Addictions Survey had revealed that most Canadians aged 15 and over drank in moderation and without harm, but the increase in heavy drinking among young people that had also been identified by the Survey gave cause for concern, and there was a need for awareness and prevention campaigns targeting that age group.

Canada welcomed the report and the initiative taken by the Board, and looked forward to the adoption of the draft resolution by the Health Assembly. In the interests of consensus, Canada could accept the minor amendments proposed by Thailand and thanked India for the flexibility it had shown.

Dr NABLI (Tunisia) expressed support for the draft resolution. She proposed that the limits of harmful and non-harmful use of alcohol should be defined and that the international exchange of information on harmful alcohol use, as well as implementation of strategies targeting young people, should be strengthened, as such strategies were new in countries such as hers. All strategies for preventing at-risk behaviour generally and the consumption of psychoactive substances in particular should be integrated into a single programme, for instance a mental health programme, and made part of primary health care in order to rationalize use of existing resources. Consideration should be given to the advisability of drafting a framework convention to combat the harmful use of alcohol, along the lines of the WHO Framework Convention on Tobacco Control.

Dr DAHL-REGIS (Bahamas) said that she shared most of the concerns expressed about alcohol misuse, a problem that contributed significantly to the disease burden in the Bahamas and showed no sign of abating. She agreed with the delegate of Zambia that the issue should be considered in the context of poverty reduction and of advertising that targeted young and poor people. She supported the appeals for consensus. She shared the concern of the delegate of the United States of America regarding the derivation of best practices, and supported the draft resolution as currently worded.

Dr ABDULLA (Sudan) strongly supported the draft resolution. The report stated that low or moderate consumption of alcohol had a protective effect on the heart, but that was not a scientific fact and ignored the findings of other valid research, conducted in cooperation with WHO, which had reached completely different conclusions. For instance, the 2001 European Comparative Alcohol Study conducted in 15 European countries had concluded that there was no evident benefit to heart health.

With regard to policy development, there was need to draw up evidence-based policies, making use of the mass of high-quality international research available on the subject. Such policies must be formulated and implemented at both national and local levels in such a way as to be mutually supportive, and they should not focus purely on extreme cases. There was also need to develop nationwide plans with specific timeframes; existing regional and multinational plans could be used as guidance for that process. National plans must be adapted to local conditions, and WHO's technical expertise would be needed to assist countries in that regard.

Mr VOIGTLÄNDER (Germany) said that greater emphasis should be given to prevention of excessive alcohol consumption by young people, notably by encouraging a critical attitude towards excessive drinking patterns. That was not an easy task, but it was necessary because young people were sometimes aggressively targeted by marketing and advertising strategies. As a result, support should be given to integrated approaches aimed at increasing a sense of responsibility among all social groups. There was also a need for more training of health professionals in counselling patients whose alcohol consumption posed risks.

When implementing the WHO strategy, all relevant stakeholders, including the alcohol industry, must assume their share of responsibility for the development of effective methods for reducing harmful drinking patterns. He welcomed the announcement that a report on evidence-based strategies and interventions to reduce alcohol-related harm was to be submitted to the Sixtieth World Health Assembly. The German Government and the German Federal Centre for Health Education were willing to cooperate in implementing a comprehensive alcohol-prevention strategy both nationally and internationally.

Dr SANGALA (Malawi) expressed appreciation of the report. An aspect of particular importance to his Government was road traffic accidents, which in Malawi were reaching epidemic proportions and having enormous economic and social consequences. The Ministry of Health had been forced to open new trauma units in referral hospitals to cope with the growing numbers of patients, further loading an already overburdened health-delivery system. He therefore suggested that a new subparagraph should be inserted between subparagraphs 2(4) and 2(5), to read: "to assist and support Member States with technical information on appropriate breathalyser technology for use by medical personnel and law-enforcement agents".

Dr CICOGLA (Italy) commended the draft resolution, which reaffirmed earlier commitments, gave a clear picture of the situation, and identified priority action to be taken; he urged delegations not to upset the delicate balance achieved. Flexibility, goodwill and common sense were needed to reach a consensus on a text that had been very difficult to draft. The issue was far too important to risk a lack of consensus. The draft resolution should be adopted with the two minor amendments proposed by Thailand.

Dr AL-HUSSEIN (Saudi Arabia) said that he could support the draft resolution, provided that a reference to those involved in the trade in alcoholic beverages was included in subparagraph 2(8).

Mrs NADAKUITAVUKI (Fiji) said that alcohol consumption in the Pacific region was one of the key risk factors for ill-health and premature death related to noncommunicable diseases. It had serious economic and social consequences and could lead to violence, including domestic violence, motor vehicle accidents, and suicides. In Fiji, alcohol and substance abuse was an emerging public health problem; according to a survey in 2002, 45% of the population had used alcohol and 24% were currently using it, binge drinking being most common in the 35-44 year age group for both men and women. The Government had established an Alcohol and Substance Abuse Council. Taxes on alcohol rose yearly and the minimum age for buying alcohol was to be raised from 18 to 21 years. Drinking hours were restricted and alcohol sales were prohibited on Sundays and public holidays, with heavy penalties imposed on bootleggers. Positive results of random breathalysing of motorists by police

could lead to suspension of driving licences and heavy court penalties. Given the increasing burden of noncommunicable diseases and HIV/AIDS and their links with alcohol consumption, the Ministry of Health had drawn up a strategic plan for noncommunicable disease control in cooperation with such bodies as the National Road Safety Council. Alcohol control legislation should be in place by later in the year, and education on the subject via schools and the mass media was ongoing. The National Centre for Health Promotion, in conjunction with WHO, had recently held a workshop for health workers on screening and intervention in cases involving alcohol problems. Efforts were also under way to set up support groups on the lines of Alcoholics Anonymous. She strongly supported the draft resolution.

Dr EL ISMAILI ALAOUI (Morocco) also strongly supported the draft resolution. Alcohol use was a complex phenomenon. For instance, what was meant by “harmful” use, and what were its quantitative limits? The issue was also complicated by religious, cultural, traditional, social and economic factors. He therefore suggested that WHO should act through its regional offices to conduct research aimed at a better understanding of the phenomenon and the development of appropriate strategies to deal with it. The fact that Morocco was a Muslim country did not mean that it did not face problems of alcohol misuse.

Mr AL-LAWATI (Oman) said that he could support the draft resolution provided that the word “harmful” was deleted throughout. There was no scientific evidence for the concept of “harmfulness” and he agreed with the delegates of the Islamic Republic of Iran and Tunisia that such a concept needed to be defined more clearly. He urged the Director-General to hold consultations with a view to arriving at a legally meaningful term and establishing a framework for alcohol use worldwide.

Mrs TAFA (Botswana) said that her Government was particularly concerned about the contribution of alcohol consumption to high mortality and morbidity rates as a result of road traffic injuries, interpersonal violence, especially violence against women and children, and irresponsible sexual behaviour that could result in the spread of HIV and other sexually transmitted diseases.

She strongly supported the draft resolution and suggested that emphasis should be placed on assistance to Member States in developing multisectoral frameworks to address the problem of alcohol misuse. A greater effort should also be made to educate young people about alcohol-related problems as part of school health programmes.

Ms VALLE (Mexico) said that her country had some national programmes for combating harmful use of alcohol. It was strongly committed to developing educational programmes and policies on alcohol, and to researching fetal alcohol syndrome. Its National Panel on Addiction was working on patterns of alcohol consumption.

She said that the text of the draft resolution, which struck a careful balance between extreme positions, should not be renegotiated. She looked forward to implementation of the resolution, and to receiving a report on progress at the Sixtieth World Health Assembly. She fully agreed with the comments made by the delegate of Italy. Further amendments would jeopardize the adoption of a resolution of great importance for public health.

Dr SANGALA (Malawi) endorsed the comments made by the delegate of Italy, and said that in the interests of achieving consensus he was willing to withdraw his earlier amendment. He also requested the Secretariat to produce a report for the Sixtieth World Health Assembly in order to assist countries in devising their own policies.

Ms BAQUERIZO (Ecuador) said that she had no wish to renegotiate the resolution. The discussions leading to its adoption by the Executive Board had been difficult enough, and the resulting consensus text was well-balanced and reflected the positions of all the participating countries.

Dr RAJALA (European Commission) said that Europe had the highest alcohol consumption in the world, and binge drinking by young people was a cause of special concern. In 2001 the Council of Ministers had adopted a set of recommendations to Member States to undertake to reduce alcohol consumption among the young. The Commission was preparing a European Union strategy to combat alcohol-related harm, and was in the process of consulting widely on the draft strategy with experts from the Member States and stakeholders, with a view to its adoption in early 2006. The European Policy Centre had initiated a round table on alcohol policy in an effort to obtain a consensus. One especially important stakeholder was the alcoholic drinks industry itself. The European Commission had asked members of the industry numerous questions, seeking its agreement to devising benchmarks for good practice which could be independently verified and adjusted if necessary. He looked forward to reporting on the outcome of that exercise, and hoped that the results would prove to be applicable internationally.

The CHAIRMAN proposed that the meeting be suspended to enable delegations to make progress in reaching a consensus on the draft resolution.

The meeting was suspended from 11:55 to 12:40.

Mr GUNNARSSON (Iceland) said that consensus had been elusive but, given extra time, it might prove achievable. Supported by Dr SUWIT WIBULPOLPRASERT (Thailand) and Ms GILDERS (Canada) he suggested that the Committee postpone further consideration of the item until the next meeting.

Mr HOHMAN (United States of America) also favoured postponement. He requested that, in the meantime, the Secretariat should prepare a statement on the implications of the draft resolution for both the current programme budget and the Programme budget 2006-2007, together with the implications of the proposed amendments. It should be borne in mind that the costs associated with developing a convention would be significantly greater than those incurred in developing the WHO Framework Convention on Tobacco Control, owing to inflation and exchange rate fluctuations.

The CHAIRMAN suggested that the item be taken up again at the next meeting.

It was so agreed.

(For continuation of the discussion, see summary record of the sixth meeting, section 4.)

International migration of health personnel: a challenge for health systems in developing countries: Item 13.21 of the Agenda (Resolution WHA57.19; Document A58/23)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Algeria, Benin, Botswana, Burkina Faso, Cameroon, Central African Republic, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Nigeria, Senegal, Seychelles, South Africa, Swaziland, Zambia and Zimbabwe, which read as follows:

The Fifty-eighth World Health Assembly,
Having examined the report on international migration of health personnel: a challenge for health systems in developing countries;¹

¹ Document A58/23, Section F.

Concerned that migration and recruitment of health personnel, particularly highly trained and skilled health personnel, from developing to developed countries continue to be a major challenge for health systems in developing countries;

Recalling the requests directed to the Director-General in resolution WHA57.19, and noting with satisfaction that the Director-General has taken steps to address some of them;

Noting that there are additional areas related to international migration of health personnel, within the context of resolution WHA57.19 that require further attention by the Director-General;

Bearing in mind the high-level debate to be held at the United Nations General Assembly in 2006 on international migration,

1. EXPRESSES GRATITUDE to the Director-General for the steps he has taken to implement some of the requests directed to him in resolution WHA57.19;
2. REQUESTS the Director-General:
 - (1) to intensify his efforts to implement fully resolution WHA57.19;
 - (2) to strengthen WHO's programme on human resources for health by allocating to it adequate resources, in particular financial and human resources;
 - (3) to report on implementation of this resolution to the Fifty-ninth World Health Assembly.

Ms MAFUBELU (South Africa), speaking on behalf of the Member States of the African Region, welcomed the decision of the Health Assembly to consider the question of the international migration of health personnel as a substantive item of its agenda. The African group had taken a leading role in drafting resolution WHA57.19. The issue of human resources for health was a top priority for Heads of State and Government in Africa, which had decided to declare 2004 the "Year for Development of Human Resources in Africa". The Director-General had already responded to some of the requests addressed to him in resolution WHA57.19: she welcomed in particular the appointment of the Special Envoy on Human Resources for Health, and the work being done to compile a minimum database for migration, so as to improve information systems related to human resources for health. Although some work had also been done on multilateral agreements, it was crucial to identify their adverse effects and possible ways of dealing with those. She called on the Director-General to provide information on the progress made in developing a code of practice, as requested in resolution WHA57.19, and asked for details on the education initiative set up to provide support for the rapid production of new health workers in African countries. The choice of the development of human resources for health as the theme for *The world health report* and World Health Day in 2006 was welcome, but that area of work was underfunded, and inadequate resources had been allocated to it in the Programme budget 2006-2007.

She requested the Director-General to inform the Health Assembly of the outcome of consultations with the United Nations and specialized agencies on the possibility of declaring a year or decade of Human Resources for Health Development. What new steps had been taken to help to develop fair practices in the international recruitment of health personnel? The group was awaiting a progress report on the feasibility, cost and appropriateness of an international instrument on the subject, as well as recommendations by the Director-General on ways of offsetting the effects of the loss of health personnel on countries concerned.

A further paragraph should be added to the draft resolution, reading as follows:

3. DECIDES to have "International migration of health personnel: a challenge for health systems in developing countries" as a substantive agenda item during the Fifty-ninth World Health Assembly."

Mr AL KHAILI (United Arab Emirates) noted with pleasure that the subject would be the theme of World Health Day in 2006. While aware that his country attracted health personnel from abroad, he was conscious of the negative impacts of international migration. His country often entered into agreements with certain States to recruit nurses, and the recruitment process was cumbersome, involving examinations, interviews and training in the regulations applicable in local hospitals. However, the incoming personnel often left after a short time to work elsewhere. He could therefore endorse the draft resolution.

Dr AKASHI (Japan) expressed appreciation of the progress made by WHO in implementing resolution WHA57.19. Japan recognized the importance of developing human resources, and was cooperating for that purpose in developing countries. Nongovernmental organizations and the private sector were often important providers of medical services, but, it was important to strengthen public health systems in case donors withdrew by means of fostering human resource development and preventing a “brain drain” of skilled health personnel. Internal migration from the public sector to the private sector, which weakened public health systems, should also be taken into account.

Mr NESVÅG (Norway) said that the global health workforce crisis threatened to undermine efforts to attain health improvement goals and to affect countries’ capacity to fight AIDS and to achieve the Millennium Development Goals. The gross mismatch between financial resources allocated in support of health goals and the personnel necessary to produce practical results undermined the credibility of development partnerships and the whole structure of global health.

Member States needed to come to grips with the situation. They had failed to stem the exodus of health personnel from the developing countries to the rich countries by means of appropriate codes of practice, or to consider the negative impact that exodus had on developing countries that had invested in their training. The challenges were not only technical and financial, but political: appropriate legislation and policy decisions were needed in source countries and host countries alike. Conflicting interests had to be recognized and negotiated, and the Secretariat had to engage in monitoring and brokering and, perhaps most of all, give visibility to the impact of policies that underlay the crisis and forge alliances to overcome it. Even before publication of *The world health report 2006* action was needed. Norway strongly endorsed the draft resolution and wished to be included among its sponsors.

He urged WHO to make full use of its capacities at global, regional and country levels to help solve the problem of migration of health personnel. A special effort was also required to bridge WHO’s work on health and development with AIDS and the impact of AIDS on health systems. He looked forward to the substantive discussion of those issues at the Fifty-ninth World Health Assembly.

Dr BELLO DE KEMPER (Dominican Republic), acknowledging the importance of the subject under discussion, drew attention to paragraph 43 of the report, which stated that the Secretariat was developing evidence-based approaches to strengthening “production” of human resources for health. Human beings should never be considered as merchandise, and she therefore proposed that the word “production” should be replaced by “training”.

Dr SUWIT WIBULPOLPRASERT (Thailand) pointed out that resolution WHA57.19 requested the Director-General to give “top priority” to human resources for health in WHO’s Eleventh General Programme of Work 2006-2015. Analysis of the Programme budget 2006-2007 showed, however, that, while the overall programme budget had increased by 17%, the budget for human resources for health had increased by only 6%. It had been explained that human resources for health were also included in other budget areas, but no proper analysis had been provided. If a solution to the problem of human resources for health was to be found, resolution WHA57.19 must be complied with.

Dr QI Qingdong (China) agreed that the international migration of health personnel was an important issue. He appreciated the efforts made by the Director-General in the past year to implement

resolution WHA57.19 and encouraged their continuation. His country could contribute to progress in the area of human resources development, and he supported the draft resolution.

Mrs AL-SABIRI (Oman) said that the international migration of health personnel was one of the major problems facing health systems worldwide. Shortage of nurses was common to developing and developed countries alike, and it was therefore essential to develop strategies to keep them once they had been recruited. She supported the draft resolution, and welcomed the designation of human resources for health as the theme for World Health Day 2006. She also endorsed the comments made by the delegate of the United Arab Emirates.

Mrs NADAKUITAVUKI (Fiji) said that the shortage of skilled health professionals, especially doctors and nurses, had become a global problem as personnel tended to move from less developed to more affluent countries where conditions of service were more attractive. Fiji had commissioned studies on the impact of skill losses on health services, and had developed a five-year retention strategy plan to mitigate and control those losses. It was also signatory to the Commonwealth Code of Practice for International Recruitment of Health Workers, which had been adopted in 2003. She acknowledged the role played by WHO in that area and fully supported the draft resolution.

Dr ZOTOUA (Côte d'Ivoire) congratulated the Organization on the way it had dealt with an important subject which represented a continuing dilemma for developing countries. In his country only 50 of the 200 doctors trained every year were recruited to the health service, and the remainder were left without employment, resulting in a brain drain, notably to the Nordic countries. He strongly supported the views expressed by the delegate of Oman.

He suggested that a mechanism be set up to collect data on the migration of health personnel, and that a strategy should be developed by WHO, in collaboration with the countries or regions concerned, to support unemployed doctors.

Mrs YOUNG (Jamaica) also supported the draft resolution. The Caribbean region was one of the areas where the migration of health personnel to the developed world significantly affected health services. Jamaica was therefore exploring strategies to increase the numbers trained under "training for export" and "planned migration" schemes, designed to ensure rotation of health staff. As a member of the Commonwealth, her country followed the Commonwealth Code of Practice in that respect. Her region would welcome inclusion in any proposed initiatives to increase the number of new health workers trained.

The Caribbean Community supported the proposed theme of the *The world health report 2006* and World Health Day 2006. She requested that Jamaica be added to the list of sponsors of the draft resolution.

Ms AMIN OUMER (Ethiopia) said that migration of health personnel was a major problem in Africa in general and in the least developed countries in particular, and she strongly supported the view expressed by the delegate of Norway. The problem had become worse and had had a strong negative impact on her country's health strategies. Ethiopia was one of the countries with the highest HIV infection rates, and the emigration of health personnel hindered national and international efforts in that area. She emphasized the importance of the draft resolution, and urged the international community to seek an immediate solution to the problem.

Dr PARIRENYATWA (Zimbabwe) endorsed the statements made by the delegate of Norway. Migration of health personnel was debated in various forums year after year, but the situation continued to deteriorate. It was time for urgent measures to be taken, including compensation to the developing countries and support for their training institutions. He asked what steps had been taken by the Director-General to deal with the issue since the adoption of resolution WHA57.19, and what

progress had been made with the ethical guidelines and the education initiative to provide support for training.

Mrs BLACKWOOD (United States of America) said that, although she recognized the right of individuals to seek better opportunities for themselves and their families, the potential impact of migration on health systems must also be addressed. The Secretariat had acknowledged the need to focus within its own competencies and mandate, and to work with Member States and other relevant partners to produce an evidence-based approach to the recruitment and retention of health professionals. Such collaboration would improve countries' capacity to analyse trends, project human resource needs and identify action to be taken. Collaboration would also ensure optimum use of collective resources. Given the complexities of migration and human resource development, a range of competencies and expertise from outside WHO would be needed.

Dr BOUDIBA (Algeria) said that migration of health personnel was indeed an increasing problem in developing countries, for the success of whose health activities human resources were essential. It was therefore imperative that the problem be solved by concentrating on the setting up of mechanisms for training such personnel in their own countries.

Mrs WIENKAMP-WEBER (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that the shortage of trained health staff had led to a serious crisis in many countries, particularly in those whose health systems were near collapse owing to a large population of HIV patients and a shrinking workforce. Given the shortage of nurses, it was a daunting challenge for those systems to meet WHO targets and attain the health-related Millennium Development Goals. Evidence suggested that most professionals, especially nurses, did not wish to migrate and only did so when strong "push" factors were involved. Patchy statistics indicated that existing pay and working conditions were the main factors underlying the shortage of nurses, in which case emphasis should be put on sound retention measures in both industrial and developing countries. Members of the nursing faculty were in equally short supply. Paradoxically, however, nursing shortages existed in parallel with the unemployment of thousands of nurses, for example in cases where a freeze on new employment was imposed by donors. Moreover, many nurses chose not to work in the health sector; it was therefore vital to create viable work practices, supportive infrastructures and targeted incentives in order to attract them back to work and reduce international demand. Meanwhile, the comparatively poor salaries and lower percentage of allowances received by nurses conveyed the demoralizing message that their work was not valued, leading to high turnover and migration.

The magnitude and nature of migration was, however, frequently unclear owing to the lack of any systematic data collection. Her association therefore strongly supported the establishment of information systems and databases and would work in partnership with WHO to achieve the goal of retaining nurses in active practice.

Dr EVANS (Assistant Director-General) said that scenarios for a code of practice were currently being developed with a view to offering greater feasibility and effectiveness than did the codes of practice already in existence. WHO was working towards the goal of fair practices in recruitment in conjunction with partners including the Caribbean Community, ILO, IOM and the Global Commission on International Migration.

Efforts to compensate for the negative effects of migration should be framed in the larger context of human resources for health. To that end, WHO, in conjunction with partners, had tabled a plan of action at the High-Level Forum on the Health Millennium Development Goals (Abuja, December 2004), following which Norway had hosted a consultation on the subject in February 2005. The imperative of developing comprehensive strategies for human resources for health at country level had thus already been identified. The flow of international volunteers was likely to increase in the short term, which might offset or exacerbate migration. Also consideration could be given to the use of auxiliary and para-professional workers, who could be trained faster and were less likely to migrate.

Efforts were also under way to assess the evidence on the feasibility and effectiveness of strategies to produce more than workforce needs, since the pressures on staff to migrate were set to persist. Investment by major funds with a view to improving workforce conditions was also under consideration.

In reply to the delegate of Japan, he agreed that it was important to strengthen public sector leadership in the context of human resources for health strategies. In the event of a major withdrawal of donor support, however, some public sectors would have difficulty in supporting an expanded workforce, the financing strategies for which were part and parcel of moving forward responsibly.

In response to the delegate of Norway, he confirmed that, across departments and regions, the Secretariat was working with its priority programmes to develop clear strategies for strengthening the workforce that went beyond simply training. Thus far, the engagement of WHO's regional and country offices in that process had been encouraging. Taking into account its strengths, WHO was well positioned to offer guidelines and normative advice, develop technical assistance and strengthen capacities and the evidence base. Such core competencies, however, were not exclusive to WHO, which therefore needed to work effectively with partners in order to fulfil its role.

Replying to the delegate of Thailand, he pointed out that, during the past biennium, there had been no Department of Human resources for health, and the budget calculations in that connection were not therefore as straightforward as they might appear. During the biennium 2006-2007, the Secretariat would for the first time be dedicating an area of its work to human resources for health, in which connection it was also aggressively developing a relevant strategy. Such steps were indicative of a move in the right direction.

The studies mentioned by the delegate of Fiji were crucial and reflected an opportunity to invest in the evidence base. He acknowledged with gratitude the support that had been provided by Australia. Concerning the comments of the delegate of the United States of America, he said that, given its clear but specific role, WHO was required to articulate its response with partners, including ILO, IOM, the World Bank, bilateral and donor parties and professional associations.

WHO shared a responsibility with partners to identify the negative consequences of current fiscal regulations in order to develop fiscal circumstances that were more conducive to rapid expansion of the workforce than was sometimes the case. WHO would also be exploring ways of enhancing the recruitment and deployment capabilities needed in order to cope with workforce expansion.

The draft resolution, as amended, was approved.¹

Achievement of health-related Millennium Development Goals: Item 13.2 of the Agenda (Document A58/5)

The CHAIRMAN said that there were two draft resolutions for consideration under the agenda item. The first, on the achievement of health-related Millennium Development Goals, was contained in paragraph 20 of document A58/5. The second, on working towards universal coverage of maternal, newborn and child health interventions had been proposed by the delegations of Algeria, Angola, Benin, Botswana, Brazil, Burkina Faso, Canada, Cape Verde, Central African Republic, Comoros, Congo, Democratic Republic of the Congo, Denmark, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Japan, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Nigeria, Norway, Pakistan, Portugal, Sierra Leone, South Africa, Swaziland, Uganda, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, Zambia and Zimbabwe, and read as follows:

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA58.17.

The Fifty-eighth World Health Assembly,

Concerned by the high level of maternal, newborn and child morbidity and mortality in the world, the slow pace of progress in improving maternal, newborn and child health, by the growing inequalities between and within Member States, and the continuing need to address gender inequalities;

Alarmed by the inadequate resources for maternal, newborn and child health and by the lack of appreciation of the great impact of maternal, newborn and child health in sustaining socioeconomic development;

Mindful that cost-effective interventions exist to meet the health needs of women, newborns and children;

Aware that care needs to be provided as a seamless continuum both throughout the life-cycle and spanning individuals, families, communities and the various levels of the health system, thus creating an integrated approach to reproductive, maternal, newborn and child health;

Convinced that only through coordinated and concerted action and unprecedented resource mobilization at international and national levels will it be possible to deal with the global crisis that currently affects the health workforce and strengthen health systems in order to end the exclusion of the poor, the marginalized and the underserved;

Welcoming the increased commitment of the international community and WHO to the health of women, newborns and children, and to meeting the development goals contained in the Millennium Declaration and other international development goals and targets;

Recalling resolution WHA56.21 adopting the strategy for child and adolescent health and development and resolution WHA57.12 adopting the strategy to accelerate progress towards the attainment of international goals and targets related to reproductive health and aware of the need for stepping up efforts to achieve international goals for reproductive, maternal, newborn and child health and development;

Reaffirming the outcomes of the World Summit for Children (New York, 1990), the Programme of Action of the International Conference on Population and Development (Cairo, 1994), and the Beijing Platform for Action of the Fourth World Conference on Women (Beijing, 1995);

Recalling also the Delhi Declaration on Maternal, Newborn and Child Health (April 2005);

Welcoming *The world health report 2005: Making every mother and child count* and the guidance offered by the associated policy briefs,

1. URGES Member States:

- (1) to commit resources and to accelerate national action towards universal access and coverage with maternal, newborn and child health interventions, through reproductive health care;
- (2) to establish or sustain national and international targets and monitoring mechanisms for measuring progress towards the achievement of agreed goals;
- (3) to involve all key stakeholders, including civil society organizations and communities, in setting priorities, developing plans and programmes, measuring progress and evaluating impact;
- (4) to adopt and implement, in line with international agreements, the legal and regulatory frameworks to promote gender equality and protect the rights of women and children, including their entitlement to equal access to health care, with special attention for those thus far excluded, particularly the poor, the marginalized and the underserved;
- (5) to ensure that national strategic-planning processes include interventions at political and programme level to strengthen health-care delivery systems for effective and rapid advance towards universal coverage, including:

- (a) realigning the content of programmes for maternal, newborn and child health and nutrition, incorporating their management structures and services, and embedding them in core development processes for health systems in order to ensure that reproductive health and rights are fully integrated;
- (b) addressing the workforce crisis by drawing up national plans for development of human resources for health that include mechanisms for equitable deployment and retention;
- (c) building realistic scenarios, with their costing and budget implications, for scaling up the health systems required for delivering maternal, newborn and child health care;
- (d) building the institutional capacity to move from user fees to prepayment mechanisms and pooling systems, including tax-based and insurance systems in order to ensure universal access and financial and social protection;
- (e) building a national consensus around the need for moving towards universal coverage, with mechanisms for predictable, sustained and increased funding, maternal, newborn and child health at the core of the citizen's health entitlements, and human resources for health as a national priority;
- (f) creating partnerships between government, civil-society organizations, private sector entities and development agencies to maintain the political momentum, overcome resistance to change, and mobilize resources;
- (g) establishing participation mechanisms for not-for-profit civil-society organizations, in order to strengthen accountability mechanisms and systems of checks and balances;

2. REQUESTS the Director-General:

- (1) to strengthen the coordination, collaboration and synergies of WHO's programmes on reproductive, maternal, newborn and child health, its programmes on malaria, HIV/AIDS, tuberculosis and health promotion, and its programme on health systems development, in support of countries;
- (2) to ensure that WHO fully participates in harmonization efforts within the United Nations system, supports efforts of Member States to establish policy coherence and synergies between and within national and international initiatives in maternal, newborn and child health, particularly between those taken by partners within the United Nations system and others;
- (3) to support the efforts of national health authorities to ensure that reproductive, maternal, newborn and child health are systematically included in frameworks for socioeconomic development and plans to ensure sustainability;
- (4) to intensify technical support to Member States for developing their institutional capacity for achieving international goals and targets through universal access to, and coverage of, reproductive, maternal, newborn and child health programmes, in the context of strengthening health systems;
- (5) to mobilize the international community so that it commits the additional resources required to achieving universal access to, and coverage of, reproductive, maternal, newborn and child health care;
- (6) to declare an annual world maternal, newborn, and child health day in order to ensure continued global visibility of the reproductive, maternal, newborn and child health agenda and to provide an opportunity for countries and the international community to reassert their commitment to this issue;
- (7) to report biennially to the Health Assembly on progress towards reducing exclusion and achieving universal access to, and coverage of, reproductive, maternal, newborn and child health care, and on the support provided by WHO to Member States to attain this goal.

A working group would meet to discuss the texts of the two draft resolutions.

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

The meeting rose at 13:40.

SIXTH MEETING

Monday, 23 May 2005, at 09:30

Chairman: Dr M.A. RAHMAN KHAN (Bangladesh)

1. SECOND REPORT OF COMMITTEE B (Document A58/58)

Mr YEE Ping Yi (Singapore), Rapporteur, read out the draft second report of Committee B.

The report was adopted.¹

2. FINANCIAL MATTERS: Item 17 of the Agenda

Unaudited interim financial report on the accounts of WHO for 2004 and comments thereon made by the Programme, Budget and Administration Committee: Item 17.1 of the Agenda (Documents A58/26, A58/26 Add.1 and A58/27)

Dr YOOSUF (Maldives, Representative of the Executive Board), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee (PBAC), said that the Committee had noted the interim financial report for the year 2004, with its improved analytical presentation of financial information, and the significant progress in respect of governance, accountability, income and expenditure trends, and the overall financial stability of the Organization. It had also noted that implementation rates had varied significantly across areas of work. The Secretariat had identified the need for a long-term financing plan and for setting parameters for efficient and effective funding from all sources and for expenditure.

Mr KOCHETKOV (Russian Federation) noted that unpaid obligations from 2003 had increased to more than US\$ 400 million and asked how it was planned to resolve that issue. He also enquired as to the expected results of the first year of the current biennium.

Ms WILD (Comptroller) said that there were two reasons why unpaid obligations had been higher than at the end of the previous biennium. First, there had been an increase in the level of expenditure, hence a higher level of unliquidated obligations was to be expected. Secondly, at the end of the biennium, it was necessary to close down some unpaid obligations, so that the level reflected accounts payable, namely money owed to providers of services and work to the Organization.

Dr NORDSTRÖM (Assistant Director-General) said that comparison of the mid-term figures for 2004 with those of 2002 would provide a better picture of the current status than the end-of-biennium figures.

Replying to the question on expected results, he said that progress had been made in reporting back on each expected result for 2002-2003 in the performance assessment report. For 2004, a medium-term interim report had been presented to PBAC. That work might be carried forward to

¹ See page 356.

2006, so that the next Health Assembly could be presented with the audited financial report and the performance assessment report, although a breakdown by expected result was unlikely to be ready by that date. The Secretariat was moving towards better initial costing and monitoring of costs in order to obtain specific results.

The CHAIRMAN invited the Committee to consider the draft resolution contained in document A58/27.

The draft resolution was approved.¹

Interim report of the External Auditor: Item 17.2 of the Agenda (Documents A58/28 and A58/29)

Dr YOOSUF (Maldives, Representative of the Executive Board), speaking in his capacity as Chairman of PBAC, said that the Committee, having reviewed the interim report, had noted that the audit had been conducted at all levels of the Organization through a consultative process that had resulted in an effective working relationship and optimal use of audit resources. The Committee had noted that more progress was needed to finalize work in respect of recommendations covering several areas, and had recommended that the External Auditor's report for the biennium should include a schedule for implementation of significant recommendations.

Mr MENON (representing the External Auditor) said that the Comptroller and Auditor-General of India had been assigned the audit of the Organization for the financial periods 2004-2005 and 2006-2007. His opinion on the WHO financial statements for the 2004-2005 period would be presented to the Health Assembly in 2006, but the interim report would apprise the current Health Assembly of the results of the external audit in the first year of his assignment, which had begun after the Fifty-seventh World Health Assembly in May 2004.

WHO's complex and highly decentralized structure meant that the auditor had first to develop an understanding of how it functioned through audits at various levels. Hence visits had been made to two country offices and the regional offices for Africa, the Eastern Mediterranean and the Western Pacific, followed by an interim audit at headquarters at the beginning of 2005. The audits had been performed in accordance with the Common Auditing Standards of the Panel of External Auditors of the United Nations, taking a comprehensive approach covering key areas of WHO's activities. Other regional offices and some country offices were to be covered in the remaining portion of the financial period; management reviews would also be conducted on some specific aspects of the Organization's functioning. In addition, the separate accounts of certain trust funds had also had to be examined.

To date, audits had been performed at IARC, the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, the International Computing Centre and UNAIDS. The findings had been communicated to those bodies through separate management letters. Interaction with the Secretariat had been constructive, and a high level of cooperation had engendered an environment that optimized the value of the external audit process. The acceptance by the Director-General of the interim report and its recommendations was indicative of the consensus that had been reached.

Among the significant issues discussed in the interim report was the policy on fraud prevention, which had since been finalized and circulated, and work on the revision of the WHO Manual. In that context, it was essential to have formalized procedures in place when the Global Management System was introduced in 2006. Difficulties had been experienced in operating the budget control and financial accounting system in two locations in the Regional Office for Africa. A comprehensive study of that system had been undertaken and its recommendations reviewed, with a view to establishing a plan of action to implement the proposed changes.

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA58.18.

Some weaknesses persisted in the area of inventory management, which had been addressed by the Secretariat. The current provisions in the WHO Manual relating to the custody and disposal of inventories were to be further refined, and the establishment of a complete set of inventory records should be a priority, if the transfer to the asset module of the Global Management System was to be facilitated. Local cost subsidies and the Fellowship Programme were critical components of the Organization's activities in countries and the submission of the required reports needed further attention. A revised policy laying down principles for funding support to countries was expected to be issued shortly, together with an evaluation of the Fellowship Programme carried out by the Office of Internal Oversight Services. Once management decisions had been taken improvements would follow.

The External Auditor had taken note of the recommendation made by PBAC, and the report for the biennium would contain a schedule on the status of implementation of significant recommendations made by the external audit. The accountability framework would also be significantly strengthened by a drafting mechanism for internal and external audit recommendations. Efforts would continue to be directed towards bringing greater value to the Organization and its stakeholders by means of the external audit process.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland) said that it would be helpful if in future reports the External Auditor prioritized the issues raised. She would also like to see the Secretariat's response to the report, and clear timeframes for resolution of problems identified. The process could be improved by the tracking system for internal and external audit reports included in the appropriations resolution adopted earlier.¹

She asked for an immediate reply about what action would be taken in response to the External Auditor's recommendations regarding the Regional Office for Africa, and why staff appraisals for 2003 had not yet been completed. On travel advances, she had noted the Secretariat's response to PBAC that processing would be improved by the Global Management System; when would that system become operational? She commended the Organization's work on the fraud-prevention policy and looked forward to its early completion.

Mr MCKERNAN (New Zealand) said that he was pleased to note the excellent relationship that had been established between the Secretariat and the External Auditor. Some recommendations concerned basic financial controls that should be customary practice in any large organization, and he supported the introduction of the systems needed to deal with those recommendations. He concurred with the previous speaker about the prioritization of recommendations. Given that an increase of 17% had been approved for the Programme budget 2006-2007, tight financial discipline must be accorded the highest priority to ensure that resources were not wasted.

New Zealand was particularly concerned by the External Auditor's comments regarding staff travel allowances, and urged the Director-General to resolve the matter forthwith. It was also concerned by the comments on the Budget and Finance Unit in the Regional Office for Africa, as that Region was receiving 30% of the total budget and had been allocated the largest budget increase in real terms for the 2006-2007 biennium. He requested an update on the situation and considered it imperative that the External Auditor's recommendations should be incorporated in an action plan to be implemented by the Director-General and the Regional Director.

Ms BLACKWOOD (United States of America) said that all the identified internal weaknesses in allotment and expenditure controls, staff advances, management of short-term staff contracts, local cost subsidies and management of non-expendable equipment needed prompt attention. She concurred with the previous two speakers regarding the importance of establishing a tracking system and timeframes for the resolution of problems. She encouraged the regional committees to look into issues affecting regional or country offices, and looked forward to future progress reports.

¹ Resolution WHA58.4.

Mr KOCHETKOV (Russian Federation) welcomed the practice of interim reporting and endorsed the requests for prioritizing recommendations and scheduling their follow-up. He drew attention to paragraph 27 of the External Auditor's report, which mentioned problems relating to the performance assessment report. He expressed considerable unhappiness that for a long time his delegation had expressed concern regarding those weaknesses which were the main obstacle to assessing the Organization's financial performance. They could only be resolved through cooperation with Member States. He welcomed the efforts by the Secretariat to remedy those weaknesses.

Mr MACPHEE (Canada) viewed the interim report as an essential tool in the implementation of results-based management, and endorsed the suggestions for prioritizing future recommendations and scheduling their implementation. The report recorded some progress in the area of policies and procedures: it would be helpful if the External Auditor could indicate the areas where guidelines would be useful, so that steps be taken to distribute them to all offices concerned. Noting the recommendations made concerning staff evaluations, he emphasized that such evaluations were an integral part of results-based management. The External Auditor should monitor the situation closely so that future reports could show the progress made in reducing the backlog.

Dr NABAE (Japan) agreed with previous speakers about the need for a tracking system, including timeframes, to follow up implementation of recommendations made by the Internal and External Auditors.

Mr MENON (representing the External Auditor) said that he had taken note of the comments made, especially the request that recommendations should be prioritized. They would be complied with in the next report.

Dr NORDSTRÖM (Assistant Director-General) said that a tracking system would be developed to follow up the recommendations of both the Internal Auditor and the Joint Inspection Unit. Some progress had already been made with staff appraisal; an electronic system for processing appraisal of individual performance was being developed, a different system of incorporating competencies was being applied, and training in leadership was being given to all the Secretariat's 380 managers, with special focus on human resources.

The Global Management System should facilitate the issuing of travel advances but, pending its introduction in 2006, the travel policy had been changed to enable staff members to obtain resources before travelling. Travel advances made would be strictly regulated. Efforts were also being made to improve manual handling of claims. An important step had been taken in the implementation of fraud policies: guidelines had been distributed and planning was in progress for training on risk situations.

In regard to the overall increase in the budget, the Secretariat recognized its responsibility to ensure the best possible management of financial resources and was instituting various improvements. On the matter of baselines and indicators in relation to the performance assessment report for 2002-2003, the Secretariat recognized that weaknesses existed. Some major improvements had already been made for the 2004-2005 biennium and further efforts would be made to provide useful input for managers when implementing programmes in the 2005-2006 biennium.

Mr BROMSON (Administration and Finance, Regional Office for Africa) pointed out that there had been a change of management in the Regional Office and that the new Regional Director was reviewing all outstanding audit recommendations relating to policies, procedures, financial monitoring and control, and was committed to tackling all issues in a timely manner. Ways were being considered with the Budget and Finance Unit to strengthen control systems.

Ms WILD (Comptroller), referring to compliance with policy, expressed appreciation for the attention drawn to the matter by both the External and Internal Auditors. Issues concerning allotment and expenditure control, unliquidated obligations and contracts for services arose fairly regularly; they

were not easy to deal with, but constant efforts were being made to encourage improvement. Policies and procedures on non-expendable inventory had been updated and the action recommended by the External Auditor was being taken. Compliance was always difficult for the Secretariat in the area of local costs and fellowships, but it depended on timely and reliable reporting by those to whom local cost payments were made and by participants in the Fellowship Programmes. She therefore welcomed the recommendation made in the report of the External Auditor for improved compliance. The Secretariat was striving to formulate a reporting mechanism on local costs that would be easy for Member States and that would enable the Secretariat better to account to States for the use of funds. Further efforts would be made to improve the situation.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland) welcomed the opportunity for dialogue on issues of concern to her delegation. However, she had not received answers to two of her questions, namely, how many staff appraisals for 2002-2003 were still outstanding and, with reference to the issue of travel advances, when the Global Management System would be in operation. She also reiterated her request for specific timeframes for implementing the external and internal audit recommendations, including those relating to the Regional Office for Africa.

Dr NORDSTRÖM (Assistant Director-General) said that he regretted that he was unable to answer the first question. Because there should be no outstanding appraisals of staff performance, great efforts were being made to improve the appraisal system. Regarding the Global Management System, the aim was that some components would come into operation on 1 January 2006, and it was likely that the travel module might be in use towards the end of that year. The Secretariat was committed to working with the External Auditor to provide replies on the tracking system and the timeframe for completing implementation of recommendations by January 2006.

The Committee noted the report.

Assessments for 2006-2007: Item 17.4 of the Agenda (Resolution EB115.R8; Document A58/30)

Dr YOUNES (Secretary) read out a correction to the draft resolution contained in resolution EB115.R8. In the paragraph adopting the scale of assessments, a comma and the words “reflecting the latest available United Nations scale” should be inserted after “2006-2007”.

Dr YOOSUF (Maldives, Representative of the Executive Board), speaking in his capacity as Chairman of PBAC, said that the Executive Board at its 115th session had considered the proposed scale of assessments for the financial period 2006-2007, and had agreed to recommend that the scale applied in the financial period 2004-2005 should continue to be used. If that scale were approved, there would be no change in the way in which the burden of payment of the regular budget was shared out among Member States compared to 2005.

The draft resolution, as amended, was approved.¹

Amendments to the Financial Regulations and Financial Rules: Item 17.6 of the Agenda (Resolution EB115.R9; Document A58/32)

Dr YOOSUF (Maldives, Representative of the Executive Board) said that the Executive Board at its 115th session had considered the proposed amendments to the Financial Regulations and Financial Rules and had noted that those changes would make use of Organization's financial

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA58.19.

resources more efficient and effective. Transparency in financial reporting of the achievement of the expected results would be improved. The Board had recommended that the Health Assembly should adopt the draft resolution contained in resolution EB115.R9.

The draft resolution was approved.¹

3. REAL ESTATE FUND: Item 18 of the Agenda (Documents A58/33, A58/44 and A58/44 Corr.1)

Dr YOOSUF (Maldives, Representative of the Executive Board), speaking in his capacity as Chairman of PBAC, said that, at its second meeting, held on 14 May 2005, the Committee had reviewed the proposal for construction projects at locations in countries of the Eastern Mediterranean Region such as Iraq, Jordan and Tunisia, where difficulties were encountered in finding suitable accommodation for programme staff. It had noted that WHO did not intend to construct premises where its staff were housed in safe health-ministry premises, where a United Nations house was planned or available, or where accommodation could be rented at affordable prices and construction would not be cost-effective. PBAC had recommended that the Health Assembly should adopt the draft resolution contained in document A58/33, as amended in document A58/44 Corr.1.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland) said that a wider strategy designed to pinpoint problems arising in particular offices in the regions, and any potential problems within the headquarters building, should ultimately be used in order to provide a comprehensive picture of the real estate situation and thus a more coherent basis for decision-making.

Dr ABDESSALEM (Tunisia) fully supported the proposal of the Regional Office for the Eastern Mediterranean concerning the construction of the WHO Representative's office in Tunisia; as early as 1997, it had offered 1700 square metres of land for that purpose. It also hoped that the premises of the WHO Mediterranean Centre for Vulnerability Reduction would be housed at that site and was ready to assist in that regard.

Mr KOCHETKOV (Russian Federation) asked how much funding would be allocated to guaranteeing the safety and security of staff in the locations concerned and whether the retrofitting of buildings included a component to ensure compliance with Minimum Operating Security Standards.

Mr MACPHEE (Canada) agreed that a long-term comprehensive strategy was needed in order to facilitate future decision-making in matters of real estate, not least in view of the trend towards greater decentralization of staff and the devolution of programme responsibility to the regions and country offices. In that connection, the security aspects represented a significant cost factor that should be given careful consideration.

Mr SUNDARAM (Infrastructure and Logistics Services), replying to the delegate of the United Kingdom, said that at its 117th session the Executive Board would receive a progress report on that strategy, including a location-by-location inventory of WHO's current real estate. That inventory would form part of the larger capital master plan in which various safety issues would be addressed. That plan would therefore answer in part the question raised by the delegate of the Russian Federation.

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA58.20.

Dr NORDSTRÖM (Assistant Director-General) said that, as stated in the Programme budget 2006-2007, the overall cost estimate for spending on staff and infrastructure security was US\$ 30 million, of which US\$ 20 million were earmarked for payment into the common system of the United Nations and US\$ 3 million primarily for WHO's headquarters and field security requirements. The remaining US\$ 7 million were allocated to security-specific investments relating to real estate and infrastructure and logistic support functions, which involved improvements in the security of WHO's premises. New investments also comprised a security element, however, and it was therefore difficult to determine a clear-cut figure.

Mr MACPHEE (Canada) pointed out that the overall cost of rebuilding or expanding offices was increased by the security element, which was an integral part of the process. It was to be hoped that the capital master plan would convey a realistic appreciation of the inbuilt security cost as a separate item in order to facilitate the consideration of future work on premises that might be largely dictated by the need to meet Minimum Operating Security Standards.

Dr NORDSTRÖM (Assistant Director-General) confirmed that the security element would be clearly identified as a separate item in the 10-year capital master plan, which would provide a more precise picture of the present situation and of future costs.

The CHAIRMAN invited the Committee to consider the draft resolution contained in document A58/33, as amended in document A58/44 Corr.1.

The draft resolution, as amended, was approved.¹

4. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Cancer prevention and control: Item 13.12 of the Agenda (Resolution EB114.R2; Document A58/16) (continued from the fourth meeting)

The CHAIRMAN drew the Committee's attention to the revised text of the draft resolution contained in EB114.R2, which incorporated the amendments previously proposed by a number of delegations and which read:

The Fifty-eighth World Health Assembly,

Having examined the report on the prevention and control of cancer;

Recalling resolutions WHA51.18 and WHA53.17 on the prevention and control of noncommunicable diseases, WHA57.17 on the Global Strategy on Diet, Physical Activity and Health, WHA56.1 on tobacco control, and WHA57.12 on the reproductive health strategy, including control of cervical cancer, and WHA57.16 on health promotion and healthy lifestyles;

Recognizing the suffering of cancer patients and their families and the extent to which cancer threatens development when it affects economically active members of society;

Alarmed by the rising trends of cancer risk-factors, the number of new cancer cases, and cancer morbidity and mortality worldwide, in particular in developing countries;

Recognizing that many of these cases of cancer and deaths could be prevented, and that the provision of palliative care for all individuals in need is an urgent, humanitarian responsibility;

Recognizing that the technology for diagnosis and treatment of cancer is mature and that many cases of cancer may be cured, especially if detected earlier;

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA58.21.

Recognizing that tobacco use is the world's most avoidable cause of cancer and that control measures, such as legislation, education, promotion of smoke-free environments, and treatment of tobacco dependence, can be effectively applied in all resource settings;

Recognizing that among all cancer sites cervical cancer, causing 11% of all cancer deaths in women in developing countries, has one of the greatest potentials for early detection and cure, that cost-effective interventions for early detection are available and not yet widely used, and that the control of cervical cancer will contribute to the attainment of international development goals and targets related to reproductive health;

Recognizing the value of multidisciplinary management and the importance of surgery, radiotherapy, chemotherapy, **palliative care** and other approaches in the treatment of cancer;

Recognizing the contribution of IARC, over 40 years, to research on cancer etiology and prevention, providing evidence on global cancer prevalence and incidence, the causes of cancer, mechanisms of carcinogenesis, and effective strategies for cancer prevention and early detection;

Mindful of the need for careful planning and priority-setting in the use of resources in order to undertake effective activities to reduce the cancer burden;

Recognizing the importance of adequate funding for cancer prevention, ~~and control and~~ **palliative-care** programmes, especially in developing countries;

Encouraged by the prospects offered by partnerships with international and national organizations within the Global Alliance for Cancer Control, and other bodies such as patient organizations;

Recognizing the support given by IAEA to combat cancer, and welcoming the initiative of the Agency to establish ~~the programme~~ **Programme of action** for ~~cancer~~ **Cancer therapy**, and research efforts of national cancer institutes in various Member States,

1. URGES Member States:

(1) to collaborate with the Organization in developing and reinforcing comprehensive cancer control programmes tailored to the socioeconomic context, and aimed at reducing cancer incidence and mortality and improving the quality of life of cancer patients and their families, specifically through the systematic, stepwise and equitable implementation of evidence-based strategies for prevention, early detection, diagnosis, treatment rehabilitation and palliative care, and to evaluate the impact of implementing such programmes;

(1bis) to set priorities based on national burden of cancer, resource availability and health system capacity for cancer prevention, control and palliative-care programmes;

(2) to integrate national cancer-control programmes in existing health systems that set out outcome-oriented and measurable goals and objectives for the short-, medium- and long-term, as recommended in the Annex to the present resolution, to identify evidence-based, sustainable actions across the continuum of care, and to make the best use of resources to the benefit of the entire population by emphasizing the effective role of primary health care in promoting prevention strategies;

(3) to encourage and to frame policies for strengthening and maintaining technical equipment for diagnosis and treatment of cancer in hospitals providing oncology and other relevant services;

(4) to pay special attention to cancers for which avoidable exposure is a factor, particularly exposure to chemicals **and tobacco smoke** in the workplace and the environment, certain infectious agents, and ionizing and solar radiation;

(5) to encourage the scientific research necessary to increase knowledge about the burden and causes of human cancer, giving priority to tumours, such as cervical **and oral** cancer, that have a high incidence in low-resource settings and are amenable to cost-effective interventions;

- (6) to give priority also to research on cancer prevention, early detection and management strategies, including, where appropriate, traditional **medicines and therapies, including for palliative care and herbal medicine**;
- (7) to consider an approach in the planning, implementation and evaluation phases of cancer control that involves all key stakeholders representing governmental, nongovernmental and community-based organizations, including those representing patients and their families;
- (8) to ensure access to appropriate information in relation to preventive, diagnostic and treatment procedures and options, especially by cancer patients, **and to palliative care**;
- (9) to develop appropriate information systems, including outcome and process indicators, that support planning, monitoring and evaluation of cancer prevention, ~~and control~~ **and palliative-care** programmes;
- (10) to assess periodically the performance of cancer prevention and control programmes, allowing countries to improve the effectiveness and efficiency of their programmes;
- (11) to participate actively in implementing WHO's integrated health promotion and prevention strategies targeting risk factors for noncommunicable diseases, including cancer, such as tobacco use, unhealthy diet, harmful use of alcohol and exposure to biological, chemical and physical agents known to cause cancer, and to consider signing, ratifying, accepting, approving, formally confirming or acceding to the WHO Framework Convention on Tobacco Control;
- (11bis) to improve access to appropriate technologies, with support from WHO, for the diagnosis and treatment of cancer, in order to promote its early diagnosis and treatment, especially in developing countries;**
- (12) to determine cost-effective minimum standards, adapted to local situations, for cancer treatment and palliative care that use WHO's strategies for nationwide provision of essential drugs, technologies, diagnostics and vaccines, **taking into consideration in the case of palliative care the recommendations of the Second Global Summit of National Hospice and Palliative Care Associations (Seoul, 2005)**;
- (13) to ensure the medical availability of opioid analgesics according to international treaties and recommendations of WHO and the International Narcotics Control Board and subject to an efficient monitoring and control system;
- (14) to ensure, where appropriate, **the documented, scientific, evidence-based safety and efficacy of available traditional medicines and therapies** ~~availability of safe and efficacious traditional and herbal medicine~~;
- (15) to develop and strengthen health system infrastructure, particularly related to human resources for health, in order to build adequate capacity for effective implementation of cancer prevention and control programmes, including a cancer registry system;
- (16) to accord high priority to cancer control planning and implementation for high-risk groups, including relatives of patients and those having experienced long-duration and high-intensity carcinogen exposure;

2. REQUESTS the Director-General:

- (1) to develop WHO's work and capacity in cancer prevention and control and to promote effective, comprehensive cancer prevention and control strategies in the context of the global strategy for the prevention and control of noncommunicable diseases, the Global Strategy on Diet, Physical Activity and Health, and resolution WHA57.16 on health promotion and healthy lifestyles, with special emphasis on less developed countries;
- (1bis) to provide technical support to Member States in setting priorities for cancer prevention, control and palliative-care programmes;**

- (2) to strengthen WHO's involvement in international partnerships and collaboration with Member States, other bodies of the United Nations system and actors from a wide variety of related sectors and disciplines in order to advocate, mobilize resources, and build capacity for a comprehensive approach to cancer control;
- (3) to continue developing WHO's strategy for the formulation and refinement of cancer prevention and control programmes by collecting, analysing and disseminating national experiences in that regard, and providing appropriate guidance, upon request, to Member States;
- (4) to contribute to drawing up recommendations on early diagnosis of cancer, especially in order to define and reach the target populations that should benefit from such diagnosis;
- (5) to consider allocating additional resources so that the knowledge provided by research is translated into effective and efficient public-health measures for cancer prevention and control;
- (5bis) to support research on cost-effectiveness studies on different strategies for prevention and management of various cancers;**
- (6) to promote and support research that evaluates low-cost interventions that are affordable and sustainable in low-income countries;
- (6bis) to support research on development of an effective vaccine against cervical cancer;**
- (7) to support the further development and expansion of a research agenda in IARC and other bodies that is appropriate to the framing of integrated policies and strategies for cancer control **and to promote and support technical and medical programmes in cancer treatment;**
- (8) to promote ~~guidelines on the~~ **guiding principles on palliative care for cancer patients, including ethical aspects** ~~care of patients with terminal cancer;~~
- (9) to provide adequate resources and leadership support to the International Programme on Chemical Safety for its active role in international multisectoral mechanisms for chemical safety, including support for capacity building in chemical safety at country level;
- (10) to support and strengthen mechanisms to transfer to developing countries technical expertise on cancer prevention and control, including surveillance, screening and research;
- (11) to advise Member States, especially the developing countries, on development or maintenance of a national cancer registry containing the type, location of the cancer and its geographical distribution;
- (12) to collaborate with Member States in their efforts to establish national cancer institutes;
- (13) to explore appropriate mechanisms for adequately funding cancer prevention, ~~and control~~ **and palliative-care** programmes, especially in developing countries;
- (14) to initiate the development of a joint programme between WHO – Member States and Secretariat – and IAEA for cancer prevention, control, treatment and research;**
- (14bis) to examine jointly with the International Narcotics Control Board the feasibility of a possible assistance mechanism that would facilitate the adequate treatment of pain using opioid analgesics;**
- (14ter) to explore all opportunities to improve the accessibility, affordability and availability of chemotherapy drugs, particularly in developing countries, for the treatment of HIV/AIDS-related cancers;**
- (14quarto) to report regularly on the implementation of this resolution to the Health Assembly.**

ANNEX

**NATIONAL CANCER CONTROL PROGRAMMES:
RECOMMENDATIONS FOR OUTCOME-ORIENTED OBJECTIVES**

National health authorities may wish to consider the following outcome-oriented objectives for their cancer control programmes, according to type of cancer:

- preventable tumours (such as those of lung, colon, rectum, skin and liver): to avoid and reduce exposure to risk factors (such as tobacco use, unhealthy diets, harmful use of alcohol, sedentariness, excess exposure to sunlight, infectious agents, including hepatitis B virus and liver fluke, and occupational exposures), thus limiting cancer incidence;
- cancers amenable to early detection and treatment (such as oral, cervical, breast and prostate cancers): to reduce late presentation and ensure appropriate treatment, in order to increase survival, reduce mortality and improve quality of life;
- disseminated cancers that have potential of being cured or the patients' lives prolonged considerably (such as acute leukaemia in childhood): to provide appropriate care in order to increase survival, reduce mortality and improve quality of life;
- advanced cancers: to enhance relief from pain and other symptoms and improve quality of life of patients and their families.

Ms BLACKWOOD (United States of America) proposed the following additional amendments to the draft resolution: in subparagraphs 2(5*bis*) and 2(6*bis*), replace the word "support" with "promote", and in subparagraph 2(14) replace the word "initiate" with the phrase "explore the feasibility of initiating" and delete the phrase "Member States and Secretariat".

Dr YOUNES (Secretary) read out the proposed amendments.

The draft resolution, as amended, was approved.¹

Disability, including prevention, management and rehabilitation: Item 13.13 of the Agenda (Resolution EB114.R3; Document A58/17) (continued from the fourth meeting)

The CHAIRMAN drew the Committee's attention to a revised version of the draft resolution contained in resolution EB114.R3, which incorporated the amendments proposed by several delegations, and which read:

The Fifty-eighth World Health Assembly,
Having considered the report on disability, including management and rehabilitation;²
Noting that about 600 million people live with ~~physical and mental~~ disabilities of various types;
Aware of the global magnitude of the health and rehabilitation needs of persons with disabilities and the cost of their exclusion from society;

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA58.22.

² Document A58/17.

Concerned by the rapid increase in the number of persons with disabilities as a result of population growth, **growth of the ageing population** ~~ageing~~, chronic conditions, malnutrition, **those injured by landmines**, war, violence, **especially domestic violence**, **AIDS**, **environmental degradation**, road-traffic, domestic **injuries**, **injuries caused by games** and occupational injuries, and other causes often related to poverty;

Stressing that 80% of people with disabilities, **particularly in the child population**, live in low-income countries and that poverty further limits access to basic health services, including rehabilitation services;

Recognizing that people with disabilities are important contributors to society and that allocating resources to their rehabilitation is an investment;

Recognizing the importance of reliable information on various aspects of disability prevention, rehabilitation and care, and the need to invest in health and rehabilitation services required to ensure **equality of opportunities** and good quality of life **for persons with disabilities** ~~regardless of disability~~;

Recalling the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;¹

Recalling the International Classification of Functioning, Disability, and Health (ICF) officially endorsed at the Fifty-fourth World Health Assembly in 2001;

Recalling also the United Nations World Programme of Action concerning Disabled Persons,² indicating inter alia that the sphere of responsibility of WHO includes disability prevention and medical rehabilitation;

Noting the African Decade of Disabled Persons (2000-2009), the Asian and Pacific Decade of Disabled Persons (1993-2002), the New Asian Pacific Decade of Disabled Persons (2003-2012) and the European Year of People with Disabilities (2003);

Recalling the United Nations General Assembly resolutions 56/168 of 19 December 2001, 57/229 of 18 December 2002, and 58/246 of 23 December 2003;

Mindful that the internationally agreed upon development goals as contained in the United Nations Millennium Declaration would not be achieved without addressing issues related to the health and rehabilitation of persons with disabilities;

Recognizing the importance of the early conclusion of the United Nations comprehensive and integral international convention on protection and promotion of the rights and dignity of persons with disabilities,³

1. URGES Member States:

(1) to strengthen national programmes, policies and strategies for the implementation of the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;

(1bis) to increase awareness of the public at large of the importance of the issue of disability and to coordinate efforts of all sectors of society to participate in disability prevention activities;

(2) to develop their knowledge base with a view to promoting **and protecting** the rights and dignity of persons with disabilities and ensure their full inclusion in society, **particularly by encouraging training and protecting employment;**

(2bis) to take all necessary steps for the reduction of risk factors conducive of disabilities during pregnancy and childhood;

(3) to promote early intervention and identification of disability, **especially during pregnancy and especially** for children, and full physical, informational, and economic

¹ Adopted by United Nations General Assembly resolution 48/96.

² United Nations General Assembly resolution 37/52.

³ United Nations General Assembly resolution 56/168.

accessibility in all spheres of life, including to health and rehabilitation services, in order to ensure full participation and equality of persons with disabilities;

(3bis) to implement family counselling programmes including premarital confidential testing for diseases such as anaemia and thalassemia along with prevention counselling for intra-family marriages;

(4) to promote and strengthen community-based rehabilitation programmes linked to primary health care and integrated in the health system;

(5) to facilitate access to appropriate assistive technology and to promote its development and other means that encourage the inclusion of persons with disabilities in society;

(6) to include a disability component in their health policies and programmes, in particular in the areas of child and adolescent health, sexual and reproductive health, mental health, ageing, HIV/AIDS, and chronic conditions such as diabetes mellitus, cardiovascular diseases and cancer;

(7) to coordinate policies and programmes on disability with those on ageing where appropriate;

(8) to ensure gender equality in all measures, with special attention to women and girls with disabilities, often subject to social, cultural and economic disadvantages;

(8bis) to ensure equality at work, on satisfactory terms, for persons with disabilities;

(9) to participate **actively and constructively** in the preparatory work for the United Nations comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities,¹ **in order that it may be adopted, as soon as possible, by the General Assembly as a matter of priority;**

(9bis) to investigate and put into practice, under their specific conditions, the most effective actions to prevent the appearance of disabilities, with the participation of other sectors of the community;

(10) to ensure provision of adequate and effective medical care to people with special needs and to facilitate their access to such care including to prostheses, wheelchairs, driving aids and other devices;

(11) to research and implement the most effective measures to prevent disabilities in collaboration with communities and other sectors;

2. REQUESTS the Director-General:

(1) to intensify collaboration within the Organization in order to work towards enhancing quality of life and promoting the rights and dignity of persons with disabilities inter alia by including gender-disaggregated statistical analysis and information on disability in all areas of work;

(2) to provide support to Member States in strengthening national rehabilitation programmes and implementing the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;

(3) to support Member States in collecting more reliable data on all relevant aspects, including cost-effectiveness of interventions for disability prevention, rehabilitation and care, and in assessing potential use of available national and international resources for disability prevention, rehabilitation and care;

(4) to further strengthen collaborative work within the United Nations system and with Member States, academia, private sector, and nongovernmental organizations, including organizations of people with disabilities;

¹ United Nations General Assembly resolution 56/168.

(4bis) to contribute to the work of the Ad Hoc Committee responsible for preparing a United Nations comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities;

(5) to organize a meeting of experts to review the health and rehabilitation requirements of persons with disabilities;

(5bis) to promote studies of incidence and prevalence of disabilities as a basis for the formulation of strategies for prevention, treatment and rehabilitation;

(6) to produce a world report on disability and rehabilitation based on the best available scientific evidence;

(7) to promote a clear understanding of the contributions that people with disabilities can make to society;

(8) to report on progress in implementation of this resolution to the Sixtieth World Health Assembly, through the Executive Board;-

(9) to support Member States in taking the necessary steps to reduce the risk factors that lead to disabilities.

Ms YUAN (United States of America) proposed that, in subparagraph 1(2bis), the words “conducive of” should be replaced with “contributing to”. Subparagraph 1(8bis) should be deleted or combined with subparagraph 1(2) since it repeated the idea of protecting employment and quality of work, which was contained in the latter paragraph. In subparagraph 1(9bis), the phrase “the appearance of” should be deleted because its meaning was unclear. In subparagraph 2(4bis), “appropriately,” should be inserted after “to contribute” and subparagraph 2(8) should be moved to become the last subparagraph.

Dr BLOOMFIELD (New Zealand) proposed that subparagraph 1(3bis) should be amended by the insertion of a comma and the words “as appropriate,” after “to implement”.

Dr YOUNES (Secretary) read out the paragraphs with the proposed amendments, noting the proposal to delete subparagraph 1(8bis).

Mr HILMERSON (Sweden) proposed that subparagraph 1(9) should be amended by the deletion of “as soon as possible”, in order to keep to the wording of the Health Assembly’s resolution on the work of the Ad Hoc Committee. Moreover, the phrase “as a matter of priority” conveyed the idea of urgency.

The CHAIRMAN took it that the Committee approved the draft resolution as amended.

The draft resolution, as amended, was approved.¹

Public health problems caused by harmful use of alcohol: Item 13.14 of the Agenda (Resolution EB115.R5; Document A58/18) (continued from the fifth meeting)

Mr GUNNARSSON (Iceland) explained that different countries viewed alcohol differently, according to their particular cultures. As delegates had expressed widely divergent views on the subject, he requested that more time should be allowed for informal discussions.

The CHAIRMAN proposed closing the meeting early for that purpose.

The meeting rose at 12:05.

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA58.23.

SEVENTH MEETING

Monday, 23 May 2005, at 15:00

Chairman: Dr M.A. RAHMAN KHAN (Bangladesh)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Public health problems caused by harmful use of alcohol: Item 13.14 of the Agenda (Resolution EB115.R5; Document A58/18) (continued)

The CHAIRMAN said that, before the Committee resumed its consideration of the draft resolution, the Secretariat would respond to delegates' comments.

Dr LE GALÈS-CAMUS (Assistant Director-General), referring to alcohol use and HIV infection, said that WHO had recently published a report on the link between alcohol consumption, substance abuse, high-risk behaviours (including unsafe sex) and HIV/AIDS. Training modules had also been prepared for primary health care professionals on management of the comorbidity caused by HIV/AIDS, depression and alcohol consumption. A programme on gender and alcohol consumption was being implemented in three countries which mainly involved the screening and treatment of young women for alcohol problems. The link between road accidents and the harmful use of alcohol was a priority area for all the United Nations organizations concerned, and the Secretariat would work in accordance with the mandate conferred on it by the United Nations General Assembly in April 2004.

The likely cost of drawing up an international convention on alcohol was estimated to be US\$ 33 million, based on the example of the WHO Framework Convention on Tobacco Control and the discussions that had been held in the Executive Board and the current Health Assembly. However, the figure was conservative, as it seemed likely that an instrument to regulate alcohol use would require longer and more difficult negotiation than the Framework Convention.

Mr GUNNARSSON (Iceland) said that, in an attempt to reach a consensus on the draft resolution, he had volunteered to find a text that would be as broadly acceptable as possible. Some delegates had wanted the text to remain unchanged. Others had approved of the first of the two amendments proposed earlier by the delegate of Thailand, namely to replace the word "Recalling", at the start of the first preambular paragraph with "Reaffirming"; there had been less support, however, for adding a footnote to subparagraph 1(1) making reference to the 10 best practices as described in document A58/18. An important amendment to emerge from his consultations had been the addition of a new, last preambular paragraph, to read: "Taking due consideration of the religious and cultural sensitivities of a considerable number of Member States with regard to consumption of alcohol, and emphasizing that use of the word 'harmful' in this resolution refers only to the public health effects of alcohol consumption, without prejudice to religious beliefs and cultural norms in any way". Further proposed amendments were to insert the word "particularly" after the phrase "in the context of" in the fourth preambular paragraph; to reword the start of subparagraph 2(2) so that it read: "to consider intensifying international cooperation ..."; to add a new subparagraph 2(2*bis*), to read: "to consider also conducting further scientific studies pertaining to different aspects of the possible impact of alcohol consumption on public health"; and to replace the word "distributors" in subparagraph 2(8) with the expression "trade sectors".

Dr YOUNES (Secretary) re-read the proposed amendments to the draft resolution.

Mr HOHMAN (United States of America) requested that the amendments should be distributed in writing, so that delegations could consult with their governments.

Mr RECINOS TREJO (El Salvador) said that the Group of the Americas, on whose behalf he was speaking, was not in favour of the amendments proposed, particularly the insertion of a reference to best practices, and wanted further discussion. He therefore endorsed the request by the previous speaker and asked for the discussion to be postponed until the following day.

Mr SHEIKH (Pakistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, endorsed the request for the amendments to be distributed in writing. He asked delegates submitting to their respective governments the proposed amendment referring to religious and cultural sensitivities to recall the clear sensitivities about alcohol consumption in that Region and the fact that the amendment was designed to make it easier to reach a consensus on the draft resolution.

Ms MAFUBELU (South Africa) reiterated her support for the amendments proposed by the delegate of Thailand, in particular the reference to the 10 best practices. She endorsed the request for a written version of the amendments.

The CHAIRMAN said that a revised text would be issued the next morning. The agenda item would be left open.

(For approval of the draft resolution, see summary record of the eighth meeting, section 3.)

The meeting rose at 15:45.

EIGHTH MEETING

Tuesday, 24 May 2005, at 09:15

Chairman: Professor J. PEREIRA MIGUEL (Portugal)

1. THIRD REPORT OF COMMITTEE B (Document A58/59)

Mr YEE Ping Yi (Singapore), Rapporteur, read out the draft third report of Committee B.

The report was adopted.

(For correction of the report, see summary record of the tenth meeting, section 1.)

2. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 22 of the Agenda (Document A58/40)

The CHAIRMAN invited the Committee to consider the report by the Secretariat and the following draft resolution on the United Nations reform process and WHO's role in harmonization of operational development activities at country level proposed by Algeria, Argentina, Australia, Belgium, Denmark, Finland, France, Guatemala, Israel, Jordan, Monaco, Netherlands, Norway, Romania, San Marino, Senegal, South Africa, Sweden, Switzerland, and the United Kingdom of Great Britain and Northern Ireland which read:

The Fifty-eighth World Health Assembly,

Taking note of the report on collaboration within the United Nations system;¹

Recognizing the primacy of national planning and priorities and, in this respect, the leadership of national governments for coordination of development activities;

Mindful of the crucial importance of the United Nations reform process related, inter alia, to operational activities for development launched by the United Nations Secretary-General and aimed at both ensuring a better coordination of field level activities and delivering services in a coherent and effective way;

Recognizing the contributions that WHO makes to such development activities;

Mindful also of the need to ensure that United Nations operational activities for development include focus on the achievement of the internationally agreed development goals, including those contained in the Millennium Declaration;

Mindful in particular of the ongoing exchanges of views among Member States generated by the United Nations Secretary-General's report "In larger freedom: towards development, security and human rights for all", which outlines actions he believes would make the United Nations a more effective and efficient instrument for forging a united response to shared threats and shared needs, including the reforming, restructuring and revitalizing of its major organs and

¹ Document A58/40.

institutions where necessary, to enable them to respond effectively to the changed threats, needs and circumstances of the twenty-first century;¹

Determined to reduce the transaction costs of international cooperation in the field of health for both recipients and providers, and to improve its efficiency, monitoring, and reporting;

Eager to realize the unused potential offered by effective collaboration between organizations of the United Nations system, bilateral donors, global initiatives, and other stakeholders in advancing health development;

Recalling the adoption of United Nations General Assembly resolution 59/250 on the Triennial comprehensive policy review of operational activities for development of the United Nations system (22 December 2004), which calls for better coherence and coordination between United Nations entities at country level and for the simplification and harmonization of their rules and procedures;

Taking note of the Rome Declaration on Harmonisation (2003) and of the Paris Declaration on aid effectiveness, ownership, harmonization, alignment, results and mutual accountability (2005);

Willing to ensure a more effective use of human and financial resources at country level, avoiding in particular duplication of activities within the United Nations development system and the Bretton Woods institutions;

Noting the preliminary work under way at WHO on ownership, alignment, harmonization and results, WHO's active role as a member of the United Nations Development Group, and its efforts to strengthen country-level response in accordance with its mandate and through its country focus policy;

Underlining the importance of applying the "Three Ones" principle launched by UNAIDS and approved in resolution WHA57.14,

1. URGES Member States to ensure that operational development activities are planned and implemented in dialogue with, and under the stewardship of, the national government and in conformity with its priorities, while being aware of the coordinated efforts of bodies of the United Nations system carried in the context of the United Nations Development Assistance Framework;

2. REQUESTS the Director General:

(1) to ensure that WHO continues to implement country-level activities in accordance with Member States' priorities, and to coordinate the activities of WHO with those of other organizations of the United Nations system and, where appropriate, with other relevant actors working to improve health outcomes;

(2) to ensure that WHO staff and programmes at headquarters, and regional and country offices adhere to the international harmonization and alignment agenda, as reflected inter alia in the Rome Declaration and Paris Declaration, and actively participate in the preparation and implementation of the United Nations Development Framework, working closely with other members of the United Nations country team and in close collaboration with the United Nations Resident Coordinator at country level, in order to ensure coherence and efficiency;

(3) to take into account the Triennial comprehensive policy review of operational activities for development of the United Nations system, including gender mainstreaming and the promotion of gender equality, in order to guide WHO actions at country level, and to participate actively in examination of the Triennial comprehensive policy review at the Economic and Social Council and at the United Nations General Assembly;

¹ Document A/59/2005.

(4) in particular, to examine ways and take specific steps to further rationalize procedures and reduce transaction costs as outlined in Chapter 4, paragraph 36, of United Nations General Assembly resolution 59/250;

(5) to submit to the Fifty-ninth World Health Assembly, through the Executive Board, an interim report on progress in implementing this resolution and, to the Sixty-first World Health Assembly, a comprehensive analysis of WHO's contribution to implementation of United Nations General Assembly resolution 59/250, in particular the alignment of WHO's operational development activities at country level with those of the United Nations system and the impact of such a coordination effort on aid effectiveness and its monitoring.

Dr AL KHARABSEH (Jordan) said that coordination with the United Nations system and with other intergovernmental organizations was necessary to avoid duplication in financing and activities. It should not, however, constitute an impediment for WHO or provide a bureaucratic obstacle to the flexibility needed by the Organization to carry out its mandate.

Mr MARTIN (Switzerland), speaking as the coordinator for drafting of the resolution, announced that Canada wished to be added to the list of sponsors and that Algeria wished, with regret, to withdraw from the list.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland) proposed the addition of the words "as agreed by the governing bodies" after "Member States' priorities" in subparagraph 2(1).

Ms RISSANNEN (IAEA) said that the Agency contributed to sustainable development through several programmes and established safety standards, some cosponsored by WHO, for the protection of health against ionizing radiation. IAEA had cooperated since 1959 with WHO on human health activities, was designing its programme on nutrition with WHO assistance and had a long record of providing essential equipment and staff training to diagnose and treat cancer patients safely with radiation technology. In the previous 25 years, it had invested some US\$ 150 million in developing, maintaining and upgrading cancer diagnostic and radiotherapy centres worldwide. It supported cancer-related research and elaborated guidelines for safe and effective use of radiotherapy equipment and all other radiation sources. Through technical cooperation, it supported Member States in meeting their priority needs concerning food and agriculture, human health, water resources and the environment.

IAEA emphasized that cancer treatment should be part of a comprehensive cancer-control programme in developing countries. In 2004, the Programme of Action for Cancer Therapy had been launched to enhance that work, in order to ensure access to radiotherapy. In alliance with Member States, WHO and other relevant bodies, the Programme would provide support to developing countries in needs assessment, planning, design and implementation of comprehensive cancer-control programmes; a core strategy was being formulated and funds raised. A multidisciplinary team was being set up, a core intervention package was being defined, and preliminary site-selection criteria and guidelines were being identified. In the coming year a specific strategy for resource mobilization would be formulated and the foundation laid for key partnerships for the Programme. IAEA looked forward to increased collaboration with WHO to enhance global cancer-care capacity and offered its full support for the implementation of the resolution.

Ms KONGSVIK (Norway) commented on WHO's participation in the United Nations Development Group and the broader United Nations reform agenda for operational activities, and on WHO's follow-up to the Paris Declaration on Aid Effectiveness (March 2005). She commended WHO's active involvement in collective endeavours to make the United Nations' operational work more relevant where it most mattered, at country level, and in particular WHO's key role in facilitating participation by United Nations agencies in national strategies for poverty reduction and sector-wide

approaches. The Organization should take bold steps in that direction, strengthening its role at country level, and must become more proactive on issues such as rationalization of country presence through the establishment of common premises, the joint office model, and shared services. Although disappointed that the report contained no reference to the Paris Declaration on Aid Effectiveness, she expressed satisfaction at WHO's participation in the preparation of that seminal document and at the Director-General's statement on the subject conveying an impression of a United Nations that was determined to apply the principles of ownership, harmonization, alignment, results and mutual accountability.

She had noted with great interest the agreement to amend any legislation, rules and procedures that inhibited the Development Group's agencies from participating in sector-wide approaches and direct budget funding arrangements; to increase support for the development of national capacities for the management of such aid; to simplify programme procedures and make greater use of national systems for sector reporting, monitoring and evaluation, annual performance reviews, progress reports and procurement procedures; and to review staffing and skill mix at country level with a view to strengthening capacity for the provision of high quality "upstream" policy advice in key sectors and across sectors.

She commended WHO's work on elaborating those important commitments and looked forward to a comprehensive report on their implementation for consideration by the Health Assembly in 2006.

Mr MARTIN (Switzerland) proposed a slight amendment to the French version of the draft resolution: the word "*consisteraient*" was unnecessary and should be deleted from the seventh preambular paragraph.

Dr BOUDIBA (Algeria) confirmed that Algeria wished to have its name removed from the list of sponsors as it considered that a reference to the report issued by the Secretary-General of the United Nations in March 2005 should not be included in the draft resolution as that report had not received the endorsement of the international community.

The draft resolution, as amended, was approved.¹

3. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Public health problems caused by harmful use of alcohol: Item 13.14 of the Agenda (Resolution EB115.R5; Document A58/18) (continued from the seventh meeting)

The CHAIRMAN invited the Committee to consider the revised draft resolution, which incorporated a number of proposed amendments:

The Fifty-eighth World Health Assembly,

Recalling~~Reaffirming~~ resolutions WHA32.40 on development of the WHO programme on alcohol-related problems, WHA36.12 on alcohol consumption and alcohol-related problems: development of national policies and programmes, WHA42.20 on prevention and control of drug and alcohol abuse, WHA55.10 on mental health: responding to the call for action, WHA57.10 on road safety and health, WHA57.16 on health promotion and healthy lifestyles and WHA57.17 on the Global Strategy on Diet, Physical Activity and Health;

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA58.25.

Recalling *The world health report 2002*,¹ which indicated that 4% of the burden of disease and 3.2% of all deaths globally are attributed to alcohol, and that alcohol is the foremost risk to health in low-mortality developing countries and the third in developed countries;

Recognizing that the patterns, context and overall level of alcohol consumption influence the health of the population as a whole, and that harmful drinking is among the foremost underlying causes of disease, injury, violence – especially domestic violence against women and children – disability, social problems and premature deaths, is associated with mental ill-health, has a serious impact on human welfare affecting individuals, families, communities and society as a whole, and contributes to social and health inequalities;

Emphasizing the risk of harm due to alcohol consumption, **particularly** in the context of driving a vehicle, at the workplace and during pregnancy;

Alarmed by the extent of public health problems associated with harmful consumption of alcohol and the trends in hazardous drinking, particularly among young people, in many Member States;

Recognizing that intoxication with alcohol is associated with high-risk behaviours, including the use of other psychoactive substances and unsafe sex;

Concerned about the economic loss to society resulting from harmful alcohol consumption, including costs to the health services, social welfare and criminal justice systems, lost productivity and reduced economic development;

Recognizing the threats posed to public health by the factors that have given rise to increasing availability and accessibility of alcoholic beverages in some Member States;

Noting the growing body of evidence of the effectiveness of strategies and measures aimed at reducing alcohol-related harm;

Mindful that individuals should be empowered to make positive, life-changing decisions for themselves on matters such as consumption of alcohol;

Taking due consideration of the religious and cultural sensitivities of a considerable number of Member States with regard to consumption of alcohol, and emphasizing that use of the word “harmful” in this resolution refers only to public-health effects of alcohol consumption, without prejudice to religious beliefs and cultural norms in any way,

1. REQUESTS Member States:

- (1) to develop, implement and evaluate effective strategies² and programmes for reducing the negative health and social consequences of harmful use of alcohol;
- (2) to encourage mobilization and active and appropriate engagement of all concerned social and economic groups, including scientific, professional, nongovernmental and voluntary bodies, the private sector, civil society and industry associations, in reducing harmful use of alcohol;
- (3) to support the work requested of the Director-General below, including, if necessary, through voluntary contributions by interested Member States;

2. REQUESTS the Director-General:

- (1) to strengthen the Secretariat's capacity to provide support to Member States in monitoring alcohol-related harm and to reinforce the scientific and empirical evidence of effectiveness of policies;
- (2) to **consider** intensifying international cooperation in reducing public health problems caused by the harmful use of alcohol and to mobilize the necessary support at global and regional levels;

¹ *The world health report 2002. Reducing risks, promoting healthy life*. Geneva, World Health Organization, 2002.

² For example, the 10 “best practices” as described in document A58/18.

(2bis) to consider also conducting further scientific studies pertaining to different aspects of possible impact of alcohol consumption on public health;

(3) to report to the Sixtieth World Health Assembly on evidence-based strategies and interventions to reduce alcohol-related harm, including a comprehensive assessment of public health problems caused by harmful use of alcohol;

(4) to draw up recommendations for effective policies and interventions to reduce alcohol-related harm and to develop technical tools that will support Member States in implementing and evaluating recommended strategies and programmes;

(5) to strengthen global and regional information systems through further collection and analysis of data on alcohol consumption and its health and social consequences, providing technical support to Member States and promoting research where such data are not available;

(6) to promote and support global and regional activities aimed at identifying and managing alcohol-use disorders in health-care settings and enhancing the capacity of health-care professionals to address problems of their patients associated with harmful patterns of alcohol consumption;

(7) to collaborate with Member States, intergovernmental organizations, health professionals, nongovernmental organizations and other relevant stakeholders to promote the implementation of effective policies and programmes to reduce harmful alcohol consumption;

(8) to organize open consultations with representatives of industry and agriculture and ~~distributors~~ **trade sectors** of alcoholic beverages in order to limit the health impact of harmful alcohol consumption;

(9) to report through the Executive Board to the Sixtieth World Health Assembly on progress made in implementation of this resolution.

Mr GUNNARSSON (Iceland) proposed, to promote consensus, deletion of the footnote in subparagraph 1(1) as a compromise designed to accommodate the persistently differing views on the sensitive issues addressed in the draft resolution.

Dr SUPACHAI KUNARATANAPRUK (Thailand) acknowledged the concerted efforts of Member States, in particular Iceland, to find a compromise. The inclusion of the footnote in question had been proposed by his delegation, with the support of 15 Member States. Thailand, however, was willing to be flexible by withdrawing its amendment, if that would further the possibility of consensus.

Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the Member States of the European Union and the acceding countries, stressed that the draft resolution should be approved by consensus. To that end, she was equally prepared to demonstrate flexibility by supporting the proposal to delete the footnote.

Mr RECINOS TREJO (El Salvador), speaking on behalf of the Group of the Americas, reiterated his preference that the draft resolution should retain the wording contained in resolution EB115.R5. He was, however, prepared to support the amended version, taking into account the new Icelandic proposal. He commended the flexibility shown by the Thai delegation.

Ms BLACKWOOD (United States of America) also expressed her appreciation of that flexibility and voiced her support for the Icelandic proposal.

Ms MAFUBELU (South Africa) agreed with the previous speaker but emphasized that deletion of the footnote concerning best practices did not preclude further work on the subject, the outcome of which should be reported at future sessions of WHO's governing bodies.

Mr SHEIKH (Pakistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, praised the spirit of compromise, and expressed particular gratitude to the delegate of Iceland.

Mr SMITH (Jamaica) said that, although he agreed with the comments of the delegate of El Salvador in support of the draft resolution, he wished to place on record his concern about the proposed amendments to the original text of the draft resolution, which had been adopted by the Executive Board after lengthy discussion. In particular, the proposed change to the fourth preambular paragraph was unhelpful and deeply regrettable; it fundamentally altered the substance of the paragraph, which lost its focus on the harm due to alcohol consumption in the context of the three important elements mentioned.

Dr SUPACHAI KUNARATANAPRUK (Thailand) pointed out that he had favoured consensus by withdrawing his proposed amendment. However, he wished to place on record his deep concern about the need for Member States to choose proven and effective core strategies and measures for reducing alcohol-related harm. He requested that further efforts should be made to explore the effectiveness of such policies and interventions in a broader context; the findings could then be exploited when the recommendations referred to in subparagraph 2(4) were drawn up.

The draft resolution, as amended, was approved.¹

The meeting rose at 10:05.

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA58.26.

NINTH MEETING

Tuesday, 24 May 2005, at 15:20

Chairman: Professor J. PEREIRA MIGUEL (Portugal)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Achievement of health-related Millennium Development Goals: Item 13.2 of the Agenda (Document A58/5) (continued from the fifth meeting)

Dr CHITUWO (Zambia), speaking in his capacity as chairman of the working group, confirmed that agreement had been reached on the two draft resolutions: the achievement of health-related Millennium Development Goals, which was set out in the report, and working towards universal coverage of maternal, newborn and child health interventions. The revised texts would be circulated.

The CHAIRMAN invited delegates to make general comments, deferring discussion of the draft resolutions to a later meeting after the revised texts had been circulated.

It was so agreed.

Dr KAPP-JOEL (Luxembourg), speaking on behalf of the Member States of the European Union, the acceding countries Bulgaria and Romania, the candidate countries Croatia and Turkey, and the countries of the Stabilisation and Association Process and potential candidate countries, Albania, Bosnia and Herzegovina, Croatia, Serbia and Montenegro, and The former Yugoslav Republic of Macedonia, said that sound health systems were a prerequisite for universal access to primary health care, in particular in respect of maternal, newborn, child, and reproductive health. They would also facilitate the fight against AIDS, tuberculosis and malaria. The slow rate of progress towards the attainment of the health-related Millennium Development Goals was a matter of serious concern. The provision of additional resources for health programmes, the improvement of the coordination of all stakeholders, and the integration of health strategies in policies to reduce poverty were needed in order to strengthen health systems and attain the Goals.

The European Union was committed to supporting Member States, especially fragile countries, whose specific needs had to be taken into account. It supported the view that health should be treated as an exception to the rule with regard to public sector reform programmes in developing countries; and that it should benefit from an increase in public spending. The European Union would continue its dialogue with Bretton Woods institutions on the budgetary flexibility required for the fight against HIV/AIDS, tuberculosis, malaria and other health priorities. It was unacceptable that every 30 seconds a child under five years of age died in Africa of an easily treatable disease and that every minute a woman died in pregnancy or childbirth. No region had so far attained the Target relating to infant mortality. The right to good sexual and reproductive health, including contraception, must be recognized, and women's empowerment should be encouraged. The United Nations International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995) had stated that realization of those rights was essential to development and the fight against poverty. Without continued efforts in those areas, progress towards the Millennium Development Goals would be limited; the United Nations General Assembly high-level plenary meeting on the outcome of the Millennium Summit (New York, 14-16 September 2005) was expected

to confirm that link. A technical process to examine the best way to take those objectives and the indicators related to the fifth Millennium Development Goal into account would be a positive step.

The joint European Commission/WHO international conference on Women, Children and Newborn Health (Brussels, 4 May 2005) had already placed reproductive health, related rights and the rights of children at the centre of European Community development policy. The provision of access to information on and services for reproductive health was a vital aim, as recognized by the international community; it would be crucial for achieving the Millennium Development Goals. Questions relating to reproductive health and related rights should therefore be given special attention at the forthcoming high-level plenary of the United Nations General Assembly.

Tobacco use was also an important obstacle to attainment of the Millennium Development Goals and the European Union was therefore pleased that the WHO Framework Convention on Tobacco Control had entered into force.

Professor AKOSA (Ghana), speaking on behalf of the Member States of the African Region, said that five years after the Millennium Summit and 10 years away from the target date for the attainment of the Millennium Development Goals, the picture in the Region was grim; progress towards attainment of the Goals, including those related to health, had been slow and, if current trends continued, the target would not be reached. Urgent action was required to accelerate progress. Existing health interventions must be expanded and investment in the social sector increased. He therefore endorsed the key strategic directions proposed in the report. The draft resolution should be strengthened to ensure that greater attention was given to the crisis in human resources, which had arisen from international migration, the active recruitment of health workers from developing countries and inadequate investment in training to fill the resulting shortages in such countries. Developed countries should strive towards self-sufficiency in human resources and should support developing countries in doing likewise. Health systems in the African Region continued to be underfunded; Member States should be encouraged to fulfil the pledge made in the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases to set a target of allocating 15% of the national budget to health. Moreover, developed countries should strive towards allocating 0.7% of their gross national product towards overseas development support. Member States should continue working towards the ideals of the New Partnership for Africa's Development, including the promotion of good governance, and effective stewardship and use of domestic and international resources. The continued denial to some countries of much-needed funds because of political reasons was worrying. Sufficient resources should be provided by the international community to ensure that the targets were met in 2015.

The concerns of the African Member States in relation to the draft resolutions had been properly taken into account by the working group.

Mrs HESSEL (Denmark) strongly supported the Millennium Declaration and the Millennium Development Goals as the common framework for poverty reduction and the driving force for international development. WHO had an important role to play in the attainment of those Goals, in particular Goals 4, 5 and 6. She expressed appreciation for the focus in *The world health report 2005* on the health of mothers and children and the challenges ahead, especially in sub-Saharan Africa.¹ The report underlined the continued need to place firmly on the health agenda the goals and programme of the United Nations International Conference on Population and Development (Cairo, 1994) and its follow-up conference (New York, 1999), and access to reproductive health services. The report also focused on safe abortion, the large unmet need for contraception, and the need to integrate sexual and reproductive health and HIV/AIDS interventions more vigorously at country level. The WHO strategy on accelerating progress towards the attainment of international development goals and targets related to reproductive health, endorsed in resolution WHA57.12, represented a crucial policy tool and

¹ *The world health report 2005: make every mother and child count*. Geneva, World Health Organization, 2005.

guidance for the Organization's work concerning the goals of the 1994 Cairo Conference and the Millennium Development Goals. She welcomed the strategy's focus on the role of the Organization at the global level, ensuring accountability through the report on progress towards sexual and reproductive health as part of achieving the Millennium Development Goals. Adequate resource allocation by WHO, including regular budget funding, was crucial for timely and full implementation of the strategy. Full implementation of the Programme of Action adopted in Cairo in 1994 was essential to reducing poverty and, therefore, to achieving the Millennium Development Goals. Unfortunately, the Millennium Declaration and the Millennium Development Goals had not adequately reflected the goals of the International Conference on Population and Development in relation to the achievement of good reproductive health and reproductive health rights for all by 2015. Denmark would work with like-minded partners to ensure that population and development matters were once again placed at the centre of poverty eradication efforts.

She supported the proposal made by the United Nations Millennium Project Task Force on Child Health and Maternal Health that a specific target and associated indicators concerning universal access to reproductive health services by 2015 through the primary health care system should be established under Millennium Development Goal 5.

Mr NESVÅG (Norway) welcomed the strategic directions outlined in the report, in particular in relation to human resources for health, equity and gender concerns. Urgent action was needed to engage a full range of health workers and to implement the Programme of Action adopted in Cairo in 1994 and the WHO strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health.

WHO had a crucial role to play with respect to the Millennium Development Goals. At country level, it must move away from vertical disease-specific programmes and strengthen its focus on system-wide issues, providing high-class technical support on more comprehensive approaches to health systems development. WHO could also contribute to the attainment of the cross-cutting Goals, in particular poverty reduction, the promotion of gender equality, the empowerment of women, and building global partnerships for development. To that end, it should be more active in the reform of the United Nations at the global and country levels. Activities concerning the achievement of those Goals in the areas of maternal, newborn and child health, and sexual and reproductive health were seriously behind schedule. All Member States had a responsibility to act on prior commitments in those areas, including those undertaken in connection with the Programme of Action and the International Conference on Financing for Development (Monterrey, Mexico, 2002). Norway supported the proposal by the United Nations Millennium Project Task Force on Child Health and Maternal Health to add the target of universal access to reproductive health services by 2015 to Millennium Development Goal 5. Norway continued to support WHO's work in leading the global health efforts to achieve the Millennium Development Goals.

Dr QI Qingdong (China) expressed appreciation for the efforts WHO had been making to achieve the Millennium Development Goals. Nevertheless, it did not currently seem likely that the health-related Goals would be achieved within the agreed timeframe; there were many challenges, especially concerning developing countries. WHO needed to intensify its policy guidance and support to enable poor countries to formulate guiding principles and action plans that matched their own strategic vision, and to support capacity-building, thus enabling Member States to assume greater responsibility for attaining the Goals. WHO should also take the lead in harmonizing and coordinating technical and financial support among international development partners in health, and should urge other United Nations organizations to honour their commitments. At the country level, the Organization should play a key role in coordinating health-related activities in order to avoid duplication. It was also important to encourage cooperation among the Member States themselves at the national and regional levels with a view to sharing their experiences and measuring progress.

Dr SHANGULA (Namibia) recalled that Namibia's Vision 2030 and the Second National Development Plan incorporated the aspirations of the Millennium Development Goals. The Safe Motherhood Initiative had been introduced in 1991 and improvements had been recorded in relation to Millennium Development Goals 4, 5 and 6. Despite those successes, the HIV/AIDS epidemic in Namibia was being compounded by such factors as poverty, alcohol and substance abuse, cultural practices and ignorance. The prevalence rate of tuberculosis had also increased, rising from 629 per 100 000 in 1996 to 712 per 1000 000 in 2002. Nevertheless, he expressed confidence that Namibia would be in a position to meet most, if not all, of the Goals by the target date, and he urged approval of the draft resolution as revised by the working group.

Ms TANHUA (Finland) stressed two crucial, strategic points that should be the focus of WHO's activities in support of Member States. First, an effective health-care system staffed by enough properly trained health workers was vital to progress in achieving the health-related Millennium Development Goals. Strengthening such systems and supporting Member States' capacity accordingly were central to WHO's responsibilities and mandate as the leading global intergovernmental organization for health. Secondly, commitment to the Goals implied commitment to improving women's rights, in accordance with the 1995 Beijing Platform for Action. Indeed, sexual and reproductive health and rights were critical elements in achieving the three health-related Goals, particularly in relation to maternal health, child mortality and HIV/AIDS; she was therefore concerned at the planned developments involving the core budget. Considered in a disaggregated manner, the Goals could serve as indicators of the health status and level of equity of a country or population, if both health-system aspects and reproductive health and rights were taken into account.

Mr PALU (Australia) supported the key strategic directions outlined in the report, calling in particular for health to be placed within a broad development framework, health strategies to be incorporated in overall public policy, and efforts to be made to improve governance. Health systems had to be strengthened and reformed in order to help countries to improve health outcomes for their populations, and improved policies and institutions – in the health sector and beyond – were needed if progress were to be made. Developing countries required a commitment to sustainable, broad-based economic growth resting on good governance for any significant progress towards the Goals. He welcomed the recognition that development policies should seek gender equality and women's empowerment. He strongly supported the call for more attention on the health needs of people living in fragile States, for declining health status was widely held to be indicative of a country's systemic weakness, and the failure of governments to provide effective basic health services could undermine public confidence in their legitimacy. With Australia committed to helping to achieve the Goals, he endorsed the international consensus that policies and actions were required of both developing and developed countries to achieve them. He further welcomed WHO's commitment to harmonizing its efforts towards achieving the Goals within the United Nations system and to working actively in the context of current United Nations reform to heighten that system's impact and effectiveness.

Ms PEDERSEN (Sweden) said that WHO had a particularly important role to play in achieving those health-related Millennium Development Goals on which the least progress had been made, notably in the areas of maternal health and HIV/AIDS. Implementation of the Programme of Action of the 1994 International Conference on Population and Development was essential for ensuring security of individuals, reducing poverty and achieving the Goals. Since it was more important than ever to safeguard sexual and reproductive health and rights, she regretted that the Millennium Declaration and its associated Goals had not sufficiently reflected those adopted by the 1994 Cairo International Conference. Sweden would therefore strive to ensure that linkages between sexual and reproductive health and rights and socioeconomic development were made central to the global consensus on how to achieve the Goals. She expressed support for the proposal by the United Nations Millennium Project Task Force on Child Health and Maternal Health to establish a specific target and indicators,

under Goal 5, on universal access to reproductive health services by 2015, and urged WHO to contribute to that work.

Dr AZENE (Ethiopia) concurred with the delegate of Luxembourg that, since the major Goals were health-related, greater focus on health was required. Echoing the call from the delegate of Ghana to strengthen the resolution, he said that working towards universal coverage of maternal, newborn and child health interventions was important for Africa as a whole and all developing countries.

Dr AKASHI (Japan) said that, given their purpose of providing appropriate health services and so improving people's health, the Millennium Development Goals must be met. WHO's emphasis on human resources and health system development was welcome, but development partners should also provide technical support for policy-making in that area. Japan had been and would continue supporting sustainable human resource development in maternal and child health and in infectious disease control in many countries.

The period until 2015 had to be used effectively by developing countries, which should draw up a road map for overcoming obstacles to the improvement of human resources and health systems, and should monitor progress. Such countries should therefore improve health administration systems and their capacity to use assistance from development partners to good effect. He stressed the importance of collecting appropriate data for monitoring and evaluating progress to the Goals, and of strengthening national health information systems. Since collaboration with related organizations was a necessity, he supported the idea and aim of the recently launched Health Metrics Network.

Mrs HOMANOVSKA (Ukraine) reiterated her country's commitment to achieving the Millennium Development Goals, particularly those relating to health. Improving health provision was a priority in Ukraine, especially for the poor, and key strategy areas were maternal, child and reproductive health and the fight against HIV/AIDS and tuberculosis. Progress in achieving the Goals depended on the effectiveness of the national health system, which was under reform, and on an organized approach to family health, and priority had been given to training for family doctors. She welcomed cooperation between WHO, UNAIDS and other international organizations on the Goals, and the assistance provided to Member States in that regard.

Mr FERRER RODRÍGUEZ (Cuba) said that, according to the *Human development report 2003*,¹ if global progress continued at the same pace as in the 1990s, only the Millennium Development Goals with targets of halving extreme poverty and the proportion of people without access to safe water stood a realistic chance of being met, although the trends for HIV/AIDS and hunger were in the right direction. Of the health-related Goals, that of reducing child mortality by two thirds was the furthest from being achieved, and under-five mortality would decrease by a quarter rather than two thirds; much the same was true of maternal mortality. There was an almost unbridgeable gap between industrialized and developing countries and between the different regions and countries of the South in meeting all the Goals, with Africa suffering terrible living conditions. Ten million children died each year in the world, almost 99% of them in developing countries, and more than half those deaths were from diseases that were often preventable with a cheap vaccine. More than half a million women died annually from pregnancy-related causes, 99% of them in countries of the South. In monetary terms, 91% of medicines were consumed by 15% of the world's population.

According to *The world health report 2003*,² the rich countries had so far failed to live up to all their responsibilities under the compact, which included establishing fairer international trade policies,

¹ UNDP. *Human development report 2003. Millennium Development Goals: a compact among nations to end human poverty*. New York, Oxford University Press, 2003.

² *The world health report 2003: shaping the future*. Geneva, World Health Organization, 2003.

increasing official development assistance, delivering debt relief and accelerating technology transfer. Ridding the world of its ills called for less selfishness and more solidarity. In one developed country alone, military expenditure was US\$ 500 000 million a year.

Cuba had achieved most of the Millennium Development Goals, particularly those related to health, and was making progress towards achieving others. He noted, for example, that in 2004, the infant mortality rate (5.8 per 1000 live births) had been the lowest in its history, placing Cuba among the 36 countries highest ranked by UNICEF. All Cuban children were vaccinated against 13 diseases, with a coverage of 95%, and the country had eradicated poliomyelitis, diphtheria, measles, whooping cough, rubella, mumps and the severe clinical forms of tuberculous meningitis and neonatal tetanus; several of the vaccines were produced in Cuba. In addition, at 0.05%, the prevalence of HIV infection in the 15-49 age group was the lowest in the Americas and one of the lowest in the world. Nearly 1800 patients received free treatment, involving six generic antiretroviral agents produced in Cuba and seven provided under a cooperation programme financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Dr GRONDIN (International Organization for Migration) supported efforts to develop a global partnership for better health for all and to mobilize collective action to achieve the health-related Millennium Development Goals. That needed consideration of migration and its impact on individual health and health systems. Most public health policies and health system management strategies had failed migrants and mobile populations. Migration of health-care workers had indeed had an impact on health systems in developing countries; the aim should be not to stop migration, but to manage its health implications. Achieving WHO's goals of global partnership and collective action for health demanded a change in behaviour, responsibility, accountability, and a coherent, focused approach.

Well-managed migration had an enormous potential for development, contributing, for example, to reducing poverty by providing opportunities for employment and education. It could also help to promote gender equality: between 49% and 51% of all migrants were women, and although they were more vulnerable to exploitation and the health risks associated with the migration process, that process could empower them by providing opportunities for education, access to health care, work experience and economic independence. Migrants returning home could be an important source of investment, entrepreneurship and experience. Remittances could enable migrants' families to purchase health services and medicines.

Migration of health-care workers compromised the ability of countries, particularly those with a heavy burden of disease, to provide efficient health services and threatened their capacity to fight diseases and to combat malnutrition. That situation had a profound impact on health systems and access to health services, creating a need for a migration management strategy in the context of human resources for health. Her organization was ready not only to work with WHO to implement resolution WHA57.19 on international migration of health personnel, but also to put migration on the global health agenda; to that end, the two organizations had developed protocols as a follow-up to the Memorandum of Understanding they had signed in 1999. Those protocols covered such issues as avoidance of duplication, accountability and programme evaluation, and activities for the period 2005-2007 in the areas of migration of health-care workers, migration in emergency settings, and migration in the context of mental health, communicable diseases, and gender issues.

Mrs WIENKAMP-WEBER (International Council of Nurses), speaking at the invitation of the CHAIRMAN and also on behalf of the International Confederation of Midwives, expressed concern that insufficient progress was being made towards achieving the Millennium Development Goals. Attaining any one Goal depended on progress made towards achieving others. She particularly welcomed the emphasis in *The world health report 2005* on the importance of maternal and neonatal care from pregnancy onwards,¹ with skilled professionals on hand to act immediately when

¹ *The world health report 2005: make every mother and child count*. Geneva, World Health Organization, 2005.

unpredictable complications occurred. Chapter 4 of that report reflected the key message in the joint statement by WHO, her Council and the International Federation of Gynecology and Obstetrics on the critical role of skilled attendants and the need for them to have an enabling environment in which to operate. Midwives and nurses were experienced in the provision of care in a variety of settings but they could not build roads and health facilities, supply clean water, or manufacture and transport necessary drugs and equipment. She called on governments and nongovernmental organizations to work with the Council and the Federation to integrate those elements into a single care package and to ensure that it reached women and their families everywhere; achievement of Millennium Development Goal 8, which highlighted the need for effective partnerships, might be the key to success in those efforts. Both organizations would work with their member associations and others to support national and global initiatives that reflected commitment to progress towards the Goals, and particularly to a broad approach that acknowledged that such efforts were interrelated.

Dr PIRMOAZEN (International Medical Parliamentarians Organization), speaking at the invitation of the CHAIRMAN, drew attention to the fact that in many developing countries one woman died every minute in childbirth or owing to complications in pregnancy. Those deaths could be prevented through appropriate care, treatment and information, and the babies of women who had received prenatal and antenatal care were more likely to survive. In order to save thousands of women dying from unsafe abortions, appropriate services should be made available so that the need for abortion could be avoided. In many developing countries, political decisions could make the difference between life and death: it was for parliamentarians to develop policies that would save lives by increasing access to education and health services. The first step would be to review and develop legislation relating to health and to monitor its implementation.

Medical parliamentarians should work to mobilize resources for health-related issues, either from allocations in the national budget or from official development assistance. Despite the urgent need for reproductive health services, international financial support for them had decreased. Further funding was also required to protect people in developing countries from HIV/AIDS. Most preventable deaths in developing countries resulted from poor reproductive health and that should be included in the Millennium Development Goals, since preventable deaths were socially unjust and impeded economic development.

The challenges demanded cooperation and collaboration, and he urged the international community to join forces in meeting them. Medical parliamentarians, for their part, would work to create the political will needed to improve health-related development, notably in reproductive health.

Ms KEITH (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, welcomed WHO's work in the area of maternal and child health. She urged WHO to formulate standards and regulating principles for disease-selective programmes to ensure that their impact on national health systems could be monitored; financial and technical resources from donors would have to be assured in that connection and impact reports should be shared transparently with all stakeholders.

Well-trained, well-supported and well-motivated health workers were essential to a functioning health system, and her organization would support implementation of resolution WHA57.19. She urged WHO and donors to support developing countries in tackling the crisis by providing long-term predictable financial and technical resources. The Fund's experience, and its research in eastern and central Africa, had shown that paying for health care led the poorest people further into poverty. A Save the Children report had highlighted the impact of such regressive financing measures as user fees, and had called for countries to move towards more pro-poor financial protection measures. She urged national health and finance ministers, WHO and donors to help to ensure that essential health services were free at the point of access. Urgent solutions were needed to support health-service delivery in fragile environments, and her organization would assist in developing the necessary knowledge base, while asking WHO, donors and academics to work with nongovernmental organizations to document best practice in such situations.

Health information systems and reporting on health-related Millennium Development Goals had to be improved, and health-system indicators should be added to that monitoring. Data should be increasingly disaggregated so that other social determinants of health could be more accurately monitored and measured. She asked WHO to clarify the progress made with the equity lens it had agreed to develop at the Fifty-seventh World Health Assembly.

Ms WYKLE-ROSENBERG (Corporate Accountability International), speaking at the invitation of the CHAIRMAN, emphasized the need for the Secretariat to support Member States in monitoring the impact of international trade agreements on public health. Public health policy must be protected from interference by vested commercial interests, since, on issues ranging from tobacco to water to food, the profit motive of transnational corporations could run counter to the human right to health. The WHO Framework Convention on Tobacco Control set a new standard for the global regulation of industries whose products and practices were harmful to public health. Member States had recognized that trade liberalization could contribute to the spread of tobacco addiction, in that trade agreements were used to pressure developing countries to accept tobacco products, and had sought to protect public health over the interests of the tobacco industry.

Access to safe and healthy food and water was essential for life and good health and to meet the Millennium Development Goals. By 2025, some 3000 million people, 80% of them in developing countries, would suffer from water shortage. Water was rapidly becoming a commodity, in some poor communities an unaffordable luxury, with the help of trade agreements, and that trend should be monitored closely for its negative impact on public health, particularly in poor regions that lacked adequate access to water.

For the first time in history, as many people had too much to eat as there were people who did not have enough. The global epidemics of hunger and obesity had led to the adoption of the Global Strategy on Diet, Physical Activity and Health. As global food corporations and their trade associations maintained a hold over the world's food resources and wielded influence over trade agreements and global financial institutions, however, transparency and proper management of conflicts of interest were vital to the strategy's successful implementation.

She urged WHO to monitor trade agreements and financial institutions vigorously to ensure their consistency with the Goals, and recommended that the Secretariat and Member States participate in the process under way in the United Nations Commission on Human Rights further to develop human rights norms for the conduct of transnational corporations as an essential element of healthy, equitable development in the twenty-first century.

Dr LEITNER (Assistant Director-General) said that WHO needed to find the right focus in order to have the greatest possible impact on health development in the context of overall development. It would also have to alternate between focusing on halting and reversing trends in major diseases and on ensuring the existence of robust health systems with well-qualified, motivated health personnel where they were most needed. The need for that focus had not been so clear five years earlier, but one positive outcome of the debate was perhaps that it had helped clarify what strategic interventions were needed to ensure better health conditions for people all over the world.

There had also been recognition of the need for closer coordination of national efforts and international support, and for more partnerships between the public and private sectors. There was clearly a need not only for more investment in health but also for cost-effectiveness in the planning and use of such investment. Implementation must be guided by such considerations as equity and gender equality, with emphasis on vulnerable groups in society.

Mrs PHUMAPHI (Assistant Director-General) said that WHO with its partners had been endeavouring to develop and implement effective policies that respected the regulatory framework of the countries concerned, guided by the Millennium Development Goals, the conclusions of the International Conference on Population and Development (Cairo 1994) and the commitments made at numerous other international conferences and the strategies and resolutions adopted by the Health

Assembly. WHO had sought to collaborate with countries, for example, in developing frameworks to guide its work on HIV/AIDS and reproductive health. It was also formulating strategies for working with major partner agencies to achieve the health-related targets, and for reporting to the global community on the progress made towards attaining Goals 4 and 5. In preparing *The world health report 2005*, the Secretariat had adopted a similar approach based on extensive consultations with Member States and partners, in order to formulate policy briefs that went beyond the technical aspects of countries' health programmes to look at critical components of health systems, such as community engagement, human resources and funding. It had sought to focus on integration and the continuum of care, and on bridging the gaps in areas such as access to reproductive health care and making good the lack of resources, which were largely responsible for the lack of progress towards Goals 4, 5 and 6. It was aware of the need for a shift in focus, to ensure that the people and communities in developing countries derived real benefit from the Organization's work.

Dr CASSELS (Millennium Development Goals, Health and Development Policy) said that many of the points raised would be reflected in the revised versions of the draft resolutions. The Millennium Development Goals touched on a wide range of WHO's activities, and delegates had helped to identify priority areas. Clearly, increased investment was critical, but investment alone, without well-constructed health systems, would not yield the desired results. With regard to the importance of tackling the widespread crisis in human resources, he recalled the draft resolution on the international migration of health personnel (already approved by the Committee), which testified to the importance WHO attached to the issue. Certain countries were lagging behind in terms of attaining the Goals and would require additional support. In order to effectively address the issues, many of the strategies in support of the Goals had to be embedded in a broader public policy. The importance of partnerships across the United Nations system, including the Bretton Woods institutions, and new global partnerships for health had also been emphasized in the context of their potential impact on human resources and health systems. Attention had been drawn to cooperation between countries as a crucial ingredient in achieving the Goals.

(For approval of the draft resolutions, see summary record of the tenth meeting, section 3.)

The meeting rose at 16:55.

TENTH MEETING

Wednesday, 25 May 2005, at 09:25

Chairman: Professor J. PEREIRA MIGUEL (Portugal)

1. THIRD REPORT OF COMMITTEE B (Documents A58/59 and A58/59 Corr.1) (continued from the eighth meeting, section 1)

The CHAIRMAN drew attention to the third report of Committee B, which had been approved at the eighth meeting of the Committee. A typographical error, however, had subsequently been identified in the English version of the draft resolution entitled “Assessments for 2006-2007”, contained in that report. The error had been rectified and the corrected text of the draft resolution was contained in document A58/59 Corr.1.

Ms WILD (Comptroller) apologized for the typographical error, which had arisen between the Board’s 115th session and the Health Assembly. The figures in the document A58/59 Corr.1 corresponded to those in the document¹ submitted to the Board at its 115th session and thus reflected the Board’s recommendations.

The report, as corrected, was adopted.²

2. FOURTH REPORT OF COMMITTEE B (Document A58/61)

Mr YEE Ping Yi (Singapore), Rapporteur, read out the draft fourth report of Committee B.

The report was adopted.³

3. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Achievement of health-related Millennium Development Goals: Item 13.2 of the Agenda (Document A58/5) (continued from the ninth meeting)

The CHAIRMAN invited the Committee to consider the revised text of the draft resolution contained in document A58/5,⁴ which read:

¹ Document EB115/17.

² See page 356.

³ See page 357.

⁴ The Annex on “Health in the Millennium Development Goals” in document A58/5 is not reproduced here.

The Fifty-eighth World Health Assembly,

Having considered the report on achievement of the health-related Millennium Development Goals;¹

Recalling the commitments made in the United Nations Millennium Declaration adopted by the United Nations General Assembly in September 2000² and the United Nations Secretary-General's road map towards its implementation;³

Recognizing that the internationally agreed development goals including all those contained in the United Nations Millennium Declaration, especially the health-related goals, mark a turning point in international development, represent a powerful consensus and commitment between rich and poor nations, and set clear priorities for action and benchmarks against which to measure progress;

Recognizing that health is central to achievement of the internationally agreed development goals, including all those contained in the United Nations Millennium Declaration, and that such goals create an opportunity to position health as a core part of the development agenda and to raise political commitment and financial resources for the sector;

Noting with concern that current trends suggest that many low-income countries will not reach the internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration, that many countries may achieve them only among their richer population groups, broadening the inequalities, and that urgent action is needed;

Recognizing the importance of using applicable human-rights instruments in efforts to achieve the internationally agreed health-related development goals, including those contained in the Millennium Declaration;

Acknowledging that rapid progress will require political commitment and a scaling-up of more efficient and effective strategies and actions, greater investment of financial resources, adequately staffed and effective health systems, capacity-building in the public and private sectors, a clear focus on equity in access and outcomes, and collective action within and between countries;

Recognizing that internationally agreed development goals, including those contained in the United Nations Millennium Declaration, are complementary and synergistic and cannot be achieved in isolation as health is central to the achievement of non-health goals and their attainment will affect health targets, including those for HIV/AIDS, tuberculosis and malaria, and other targets set by the Health Assembly;

Recalling that at its Thirty-eighth session (April 2005) the Commission on Population and Development emphasized: "the importance of integrating the goal of universal access to reproductive health by 2015 set at the International Conference on Population and Development into strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, in particular those related to improving maternal health, reducing infant and child mortality, promoting gender equality, combating HIV/AIDS, eradicating poverty and achieving universal access to primary education";⁴

Recognizing WHO's leadership with the World Bank on the High-Level Forum on the Health MDGs (Abuja, 2004) and the impact this has had in catalysing action and progress on the internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration;

Recalling resolution WHA55.19 which calls on the international donor community to increase its assistance to developing countries in the health sector; and which encourages

¹ Document A58/5.

² United Nations General Assembly resolution 55/2.

³ Document A/56/326.

⁴ Draft resolution E/CN.9/2005/L.5, 11 April 2005, paragraph 3.

developed countries that have not done so to make concrete efforts towards the target of 0.7% of gross national product (GNP) as official development assistance to developing countries, and 0.15% to 0.2% of GNP of developed countries to least developed countries, as reconfirmed at the Third United Nations Conference on the Least Development Countries (Brussels, 2001), and encourages developing countries to build on progress made in ensuring that official development assistance is used effectively to help achieve development goals and targets;

Noting that the Heads of State and Government of the Organization of African Unity at the African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (Abuja, 2001) pledged to set a target of allocating at least 15% of their annual budget to the improvement of the health sector;¹

Noting that many countries have cooperation and partnership mechanisms with civil-society, the broader community, religious organizations and the private sector which cover all levels of the administration (national, regional and district);

Recognizing the importance of action and empowerment for gender equality in bringing about more equitable and effective approaches to national development,

1. REQUESTS Member States:

- (1) to reaffirm the internationally agreed health-related development goals, including those for health development contained in the United Nations Millennium Declaration;
- (2) to develop and implement in the context of existing policy and planning processes nationally relevant “road-maps” on the achievement of the internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration, which incorporate the following actions to accelerate progress:
 - (a) prioritizing the internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration, within national development and health plans, including where appropriate Poverty Reduction Strategy Papers, plans that are led by national governments with support from development partners and civil society, and take into account the overall health priorities of the countries concerned; and ensuring that priorities for health and poverty reduction are reflected in associated budgets and expenditure frameworks;
 - (b) raising the level of funding for effective interventions that address health conditions relevant to the achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration;
 - (c) implementing related Health Assembly resolutions, including resolution WHA56.21 on child and adolescent health, resolution WHA57.12 on reproductive health and resolution WHA57.14 on HIV/AIDS, which are components of a global partnership for development and crucial for attainment of the internationally agreed health-related development goals, including those contained in the Millennium Declaration, and the goal of universal access to reproductive health by 2015 set at the United Nations International Conference on Population and Development (Cairo, 1994); and establishing or sustaining national monitoring mechanisms for measuring progress towards achievement of the agreed goals;
 - (d) strengthening collaboration and partnership among relevant sectors, including ministries of finance, and with the international financial institutions, on investments in the health sector with a view to increasing the share of overall government resources allocated to health and, where appropriate, to revise ceilings on public-sector spending to allow for increases in health spending financed from development assistance;

¹ Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, paragraph 26.

- (e) strengthening the core functions of public or private components of the health system, as appropriate, in line with the Declaration of Alma Ata (1978) so that they contribute to the delivery of better and more equitable health outcomes in areas relevant to the internationally agreed health-related development goals, including those contained in the Millennium Declaration;
- (f) improving health and nutrition information systems, including strengthening of vital registration systems, supported by critical health-systems research, in order to inform policy-making, while avoiding an increase in the reporting burden and emphasizing the need for data disaggregated by age, socioeconomic quintile, sex and ethnicity; and to strengthen monitoring and evaluation systems that promote accountability, empowerment and participation;
- (g) to ensure that health and development policies are underpinned by a gender analysis and to strive for gender equality and women's empowerment;
- (h) to strengthen equity and nondiscrimination in development efforts and to facilitate the empowerment and participation of the population in decision-making processes;

2. CALLS on developed and developing countries to address with shared responsibility the growing crisis of human resources for health; and on developed countries to strive towards self-sufficiency without adversely impacting on the human resource situation in developing countries and to provide support to developing countries to achieve self-sufficiency through planning, training, recruitment and retention of all categories of health professionals;

3. URGES developed countries that have not done so to make concrete efforts towards the target of 0.7% of gross national product (GNP) as official development assistance to developing countries, and 0.15% to 0.2% of GNP of developed countries to least developed countries, as reconfirmed at the Third United Nations Conference on the Least Development Countries (Brussels, 2001);

4. URGES developing countries to continue to build on progress made in ensuring that official development assistance is used effectively to help achieve development goals and targets;

5. URGES those countries which are Members of the African Union to fulfil the commitment made at the African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (Abuja, 2001) to set a target of allocating at least 15% of annual budget to the improvement of the health sector;¹

6. REQUESTS the Director-General:

- (1) to ensure that priority actions to support Member States in accelerating progress towards the internationally agreed health-related goals, including those contained in the Millennium Declaration, are reflected in the Programme budget 2006-2007, in future budgets, and in the Eleventh General Programme of Work; and to develop a coherent and adequately resourced strategy, with clear goals and deliverable products, for advancing work in the areas mentioned below, and to report to the Health Assembly on progress;
- (2) to provide support to Member States, at their request:
 - (a) to develop outcome-oriented and adequately resourced policies and strategies for health development;

¹ Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, paragraph 26.

- (b) to strengthen the capacity of public and private health systems, as appropriate, to deliver equitable outcomes on a national scale, through measures that require interdepartmental collaboration, and to convene and support nationally led teams that work with all local actors in order to facilitate access to all sources of financing; develop the education, recruitment and retention of health professionals; integrate community health workers into overall systems; and implement resolution WHA57.19 on international migration of health personnel;
 - (c) to identify vulnerable groups with specific health needs and to devise appropriate programmes that deliver equitable outcomes;
 - (d) to strengthen intersectoral linkages to address the social and environmental determinants of health;
 - (e) to engage in technical and policy dialogue with international financial institutions, including on the impact of their policies on health-related needs; to lead harmonization and coordination processes among development partners in health; and to ensure alignment of support around country priorities;
 - (f) to use appropriate monitoring and evaluation frameworks, including those related to universal access to reproductive health, that measure progress towards the internationally agreed health-related development goals, including those contained in the Millennium Declaration, in order to determine cost-effective programmes that achieve better health and nutrition outcomes without adding to the reporting burden in countries;
 - (g) to promote research that guides successful implementation of activities to achieve internationally agreed health-related development goals, including those contained in the Millennium Declaration;
- (3) to ensure that due attention is devoted to the particular health problems of countries emerging from conflict and other forms of crisis;
- (4) to support actively and contribute to, in the context of reform of the United Nations system, heightening the impact and effectiveness of the United Nations Country Teams; to simplify further, harmonize and coordinate procedures within the United Nations system and with other partners; and to improve alignment of the United Nations inputs with national priorities;¹
- (5) to promote efforts that increase coherence and coordination in development assistance for health so that resources effectively strengthen broad-based health systems;
- (6) to participate appropriately in the high-level plenary of the United Nations General Assembly on the outcome of the Millennium Summit (September 2005).

Dr CHITUWO (Zambia) proposed that, in the penultimate preambular paragraph, the words “including NGOs,” should be inserted after “civil-society”.

The draft resolution, as amended, was approved.²

The CHAIRMAN invited the Committee to consider the revised version of the draft resolution on working towards universal coverage of maternal, newborn and child health interventions, which incorporated amendments proposed by a working group and read:

The Fifty-eighth World Health Assembly,
Concerned by the high level of maternal, newborn and child morbidity and mortality in the world, by the fact that the maternal mortality ratio worldwide has not changed substantially

¹ See also resolution WHA58.25.

² Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA58.30.

over the past decade, by the slow pace of progress in improving maternal, newborn and child health, by the growing inequalities between and within Member States, and by the continuing need to address gender inequalities;

Alarmed by the inadequate resources for maternal, newborn and child health and by the lack of appreciation of the great impact of maternal, newborn and child health in sustaining socioeconomic development;

Concerned by the inadequacy of vital registration and other data required to produce accurate information on maternal, infant and under-five mortality, on their breakdown by socioeconomic groups, on income quintiles, and on urban rural differentials;

Mindful that cost-effective interventions exist to meet the health needs of women, newborns and children;

Aware that care needs to be provided as a seamless continuum both throughout the life-cycle and spanning individuals, families, communities and the various levels of the health system, including reproductive health care, thus creating an integrated approach to maternal, newborn and child health;

Convinced that only through coordinated and concerted action and unprecedented resource mobilization at international and national levels will it be possible to deal with the global crisis that currently affects the health workforce and strengthen health systems in order to end the exclusion of the poor, the marginalized and the underserved;

Welcoming the increased commitment of the international community and WHO to the health of women, newborns and children, and to meeting the internationally agreed development goals, including those contained in the Millennium Declaration;

Recalling resolution WHA56.21 welcoming the strategic directions for child and adolescent health and development, resolution WHA57.12 adopting the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health and aware of the need for stepping up efforts to achieve international goals for reproductive, maternal, newborn and child health and development, and resolution WHA55.19 which calls for an increase in investment in health in developing countries;

Recalling the goals and objectives of the World Summit for Children (New York, 1990), the Programme of Action of the International Conference on Population and Development (Cairo, 1994), and the Beijing Platform for Action of the Fourth World Conference on Women (Beijing, 1995) and their respective follow-ups; the United Nations General Assembly special session on HIV/AIDS (New York, 2001); the United Nations special session on children (New York, 2002);

Recalling also the Delhi Declaration on Maternal, Newborn and Child Health (April 2005);

Welcoming *The world health report 2005: Making every mother and child count* and the guidance offered by the associated policy briefs,

1. URGES Member States:

- (1) to commit resources and to accelerate national action towards universal access and coverage with maternal, newborn and child health interventions, through reproductive health care;
- (2) to establish or sustain national and international targets, and to establish monitoring mechanisms for measuring progress towards the achievement of agreed goals, particularly the target on universal access to reproductive health care by 2015;
- (3) to involve all key stakeholders, including civil-society organizations and communities, in setting priorities, developing plans and programmes, measuring progress and evaluating impact;
- (4) to improve the quality and completeness of vital registration and other relevant household-survey data, where appropriate, to reflect mortality differentials among mothers, infants and under-fives;

- (5) to adopt and implement, in line with international agreements, the legal and regulatory frameworks to promote gender equality and protect the rights of women and children, including equal access to health care, with special attention for those thus far excluded, particularly the poor, the marginalized and the underserved;
- (6) to ensure that national strategic-planning and budgetary processes include interventions at political and programme level to strengthen health-care delivery systems for effective and rapid advance towards universal coverage, including:
 - (a) realigning the content of programmes for maternal, newborn and child health and nutrition, incorporating their management structures and services, and embedding them in core development processes for health systems in order to ensure that reproductive health care is fully integrated;
 - (b) addressing the workforce crisis by drawing up national plans for development of human resources for health that include financial incentives and mechanisms for equitable deployment and retention, especially for rural primary care, so as to give the poor better access to care;
 - (c) building realistic scenarios, with their costing and budget implications, for scaling up the health systems required for delivering maternal, newborn and child health care;
 - (d) building the institutional capacity to manage appropriate financing reform, inter alia a move from user fees to prepayment mechanisms and pooling systems, including tax-based and insurance systems, in order to achieve the goal of universal access and financial and social protection;
 - (e) building a national consensus around the need for moving towards universal coverage, with mechanisms for predictable, sustained and increased funding; around maternal, newborn and child health at the core of the citizen's health care, including entitlements where appropriate; and around the human-resources-for-health crisis as a national priority;
 - (f) creating partnerships between government, civil-society organizations, private sector entities and development agencies to maintain the political momentum, overcome resistance to change, and mobilize resources;
 - (g) establishing participation mechanisms for not-for-profit civil-society organizations and religious organizations in order to strengthen accountability mechanisms and systems of checks and balances;

2. REQUESTS the Director-General:

- (1) to strengthen the coordination, collaboration and synergies of WHO's programmes on reproductive, maternal, newborn and child health, its programmes on malaria, HIV/AIDS, tuberculosis and health promotion, and its programme on health systems development, in support of countries;
- (2) to ensure that WHO fully participates in harmonization efforts within the United Nations system, supports efforts of Member States to establish policy coherence and synergies between and within national and international initiatives in maternal, newborn and child health, particularly between those taken by partners within the United Nations system and others;
- (3) to support the efforts of national health authorities to ensure that reproductive, maternal, newborn and child health are systematically included in frameworks for socioeconomic development and plans to ensure sustainability;
- (4) to further collaborate with relevant partners to produce information on health status inequalities, such as through UNICEF's Multiple Indicator Cluster Surveys or Demographic and Health Surveys, in order to inform appropriate and specific policy actions by all concerned partners;

- (5) to intensify technical support to Member States for developing their institutional capacity for achieving international goals and targets through universal access to, and coverage of, reproductive, maternal, newborn and child health programmes, in the context of strengthening health systems;
- (6) to mobilize the international community so that it commits the additional resources required to achieving universal access to, and coverage of, reproductive, maternal, newborn and child health care;
- (7) to declare an annual world maternal, newborn, and child health day in order to ensure continued global visibility of the reproductive, maternal, newborn and child health agenda and to provide an opportunity for countries and the international community to reassert their commitment to this issue;
- (8) to report biennially to the Health Assembly on progress towards reducing exclusion and achieving universal access to, and coverage of, reproductive, maternal, newborn and child health care, and on the support provided by WHO to Member States to attain this goal.

Dr YOUNES (Secretary) drew attention to two typographical errors: the final part of the third from last preambular paragraph should read “the United Nations General Assembly special session on children” and the final part of subparagraph 1(2) should read “reproductive health by 2015”.

Mr WIERINGA (Canada), observing that his country continued to support WHO and its partners strongly in their promotion of maternal and child health, commended their initiatives and the focus on the area through *The world health report 2005* and World Health Day 2005. The draft resolution, however, included no recognition of sexual and reproductive health or reproductive rights and failed to reaffirm strongly the goals of the International Conference on Population and Development. As such, it did not appropriately reflect the continuum of care that existed between reproductive health and maternal and child health. While not wishing to block consensus, Canada had therefore decided, with regret, to withdraw its sponsorship of the draft resolution.

The draft resolution, as corrected, was approved.¹

4. FIFTH REPORT OF COMMITTEE B

Mr YEE Ping Yi (Singapore), Rapporteur, read out the draft fifth report of Committee B.

The report was adopted.²

5. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of Committee B completed.

The meeting rose at 09:40.

¹ Transmitted to the Health Assembly in the Committee’s fifth report and adopted as resolution WHA58.31.

² See page 357.

PART II

REPORTS OF COMMITTEES

The text of resolutions and decisions recommended in committee reports and subsequently adopted without change by the Health Assembly have been replaced by the serial number (in square brackets) under which they appear in document WHA58/2005/REC/1. The verbatim records of plenary meetings at which these reports were approved are reproduced in document WHA58/2005/REC/2.

COMMITTEE ON CREDENTIALS

First report¹

[A58/50 – 17 May 2005]

The Committee on Credentials met on 17 May 2005. Delegates of the following Member States were present: Algeria, Benin, Bhutan, Chad, Czech Republic, Honduras, Kiribati, Morocco, Peru, Serbia and Montenegro, Slovakia, Yemen.

The Committee elected the following officers: Dr T. Kienene (Kiribati) – Chairman; Dr D. Yevide (Benin) – Vice-Chairman; Dr A. Al-Rabee (Yemen) – Rapporteur.

The Committee examined the credentials delivered to the Director-General in accordance with Rule 22 of the Rules of Procedure of the World Health Assembly.

The credentials of the delegates of the Member States listed at the end of this report were found to be in conformity with the Rules of Procedure as constituting formal credentials, and the Committee therefore proposes that the Health Assembly should recognize their validity.

The Committee examined notifications from the following Member States, which, while indicating the names of the delegates concerned, could not be considered as constituting formal credentials in accordance with the provisions of the Rules of Procedure. The Committee therefore recommends to the Health Assembly that the delegates of these Member States be provisionally seated with all rights in the Health Assembly pending the arrival of their formal credentials: Brunei Darussalam, Djibouti, Ghana, Iraq, Panama, Paraguay, Republic of Moldova, Sierra Leone, Uruguay.

States whose credentials it was recommended should be recognized as valid (see fourth paragraph above)

Afghanistan, Albania, Algeria, Andorra, Angola, Antigua and Barbuda, Argentina, Armenia, Australia, Austria, Azerbaijan, Bahamas, Bahrain, Bangladesh, Barbados, Belarus, Belgium, Belize, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Canada, Cape Verde, Central African Republic, Chad, Chile, China, Colombia, Comoros, Congo, Cook Islands, Costa Rica, Côte d'Ivoire, Croatia, Cuba, Cyprus, Czech Republic, Democratic People's Republic of Korea, Democratic Republic of the Congo, Denmark, Dominican Republic, Ecuador, Egypt, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Fiji, Finland, France, Gabon, Gambia, Georgia, Germany, Greece, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, Hungary, Iceland, India, Indonesia, Iran (Islamic Republic of), Ireland, Israel, Italy, Jamaica, Japan, Jordan, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Lao People's Democratic

¹ Approved by the Health Assembly at its fifth plenary meeting.

Republic, Latvia, Lebanon, Lesotho, Liberia, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Madagascar, Malawi, Malaysia, Maldives, Mali, Malta, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia (Federated States of), Monaco, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nauru, Nepal, Netherlands, New Zealand, Nicaragua, Niger, Nigeria, Norway, Oman, Pakistan, Palau, Papua New Guinea, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Romania, Russian Federation, Rwanda, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Samoa, San Marino, Sao Tome and Principe, Saudi Arabia, Senegal, Serbia and Montenegro, Seychelles, Singapore, Slovakia, Slovenia, Solomon Islands, Somalia, South Africa, Spain, Sri Lanka, Sudan, Swaziland, Sweden, Switzerland, Syrian Arab Republic, Tajikistan, Thailand, The former Yugoslav Republic of Macedonia, Timor-Leste, Togo, Tonga, Tunisia, Turkey, Tuvalu, Uganda, Ukraine, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America, Uzbekistan, Vanuatu, Venezuela (Bolivarian Republic of), Viet Nam, Yemen, Zambia, Zimbabwe.

Second report¹

[A58/52 – 21 May 2005]

On 19 May 2005, the Bureau of the Committee on Credentials examined the formal credentials of the delegations of the following Member States, who had been seated provisionally in the Health Assembly pending the arrival of their formal credentials: Djibouti, Ghana, Paraguay, Republic of Moldova.

These credentials were found to be in conformity with the Rules of Procedure of the World Health Assembly, and the Bureau therefore proposes that the Health Assembly recognize their validity.

COMMITTEE ON NOMINATIONS

First report²

[A58/46 – 16 May 2005]

The Committee on Nominations, consisting of delegates of the following Member States: Bahamas, Bolivia, Bosnia and Herzegovina, Cameroon, China, Comoros, France, Gambia, Guatemala, Guyana, India, Kuwait, Lithuania, Palau, Paraguay, Russian Federation, Senegal, Seychelles, Timor-Leste, Togo, Turkey, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Viet Nam and Mr Muhammad Nasir Khan (Pakistan) (ex officio), met on 16 May 2005.

In accordance with Rule 25 of the Rules of Procedure of the World Health Assembly and respecting the practice of regional rotation that the Health Assembly has followed for many years in this regard, the Committee decided to propose to the Health Assembly the nomination of Ms Elena Salgado (Spain) for the Office of President of the Fifty-eighth World Health Assembly.

¹ Approved by the Health Assembly at its eighth plenary meeting.

² Approved by the Health Assembly at its first plenary meeting.

Second report¹

[A58/47 – 16 May 2005]

At its first meeting held on 16 May 2005, the Committee on Nominations decided to propose to the Health Assembly, in accordance with Rule 25 of the Rules of Procedure of the World Health Assembly, the following nominations:

Vice-Presidents of the Health Assembly: Mr S. Meky (Eritrea), Dr M. Fernandez Galeano (Uruguay), Dr M. Fikri (United Arab Emirates), Professor Suchai Charoenratanakul (Thailand), Ms A. King (New Zealand);

Committee A: Chairman – Dr B. Sadrizadeh (Islamic Republic of Iran);

Committee B: Chairman – Dr J. Walcott (Barbados).

Concerning the members of the General Committee to be elected under Rule 31 of the Rules of Procedure of the World Health Assembly, the Committee decided to nominate the delegates of the following 17 countries: Bhutan, Brazil, China, Congo, Cuba, Equatorial Guinea, Ethiopia, France, Lebanon, Latvia, Luxembourg, Malawi, Mongolia, Russian Federation, United Kingdom of Great Britain and Northern Ireland, United States of America, Zimbabwe.

Third report²

[A58/48 – 16 May 2005]

At its first meeting held on 16 May 2005, the Committee on Nominations decided to propose to each of the main Committees, in accordance with Rule 25 of the Rules of Procedure of the World Health Assembly, the following nominations for the Offices of Vice-Chairmen and Rapporteur:

Committee A: Vice-Chairmen: Dr H. Ntaba (Malawi) and Pehin Dato Abu Bakar Apong (Brunei Darussalam);
Rapporteur: Dr R. Busuttil (Malta);

Committee B: Vice-Chairmen: Professor J. Pereira Miguel (Portugal) and Dr M.A. Rahman Khan (Bangladesh);
Rapporteur: Mr Yee Ping Yi (Singapore).

¹ Approved by the Health Assembly at its first plenary meeting.

² See summary records of the first meetings of Committees A and B (pp. 19 and 241, respectively).

GENERAL COMMITTEE**Report¹**

[A58/51 – 19 May 2005]

**Election of Members entitled to designate a person
to serve on the Executive Board**

At its meeting on 18 May 2005, the General Committee, in accordance with Rule 102 of the Rules of Procedure of the World Health Assembly, drew up the following list of 10 Members, in the English alphabetical order, to be transmitted to the Health Assembly for the purpose of the election of 10 Members to be entitled to designate a person to serve on the Executive Board: Azerbaijan, Bhutan, Iraq, Japan, Liberia, Madagascar, Mexico, Namibia, Portugal, Rwanda.

In the General Committee's opinion these 10 Members would provide, if elected, a balanced distribution on the Board as a whole.

COMMITTEE A**First report²**

[A58/49 – 19 May 2005]

On the proposal of the Committee on Nominations,³ Dr H. Ntaba (Malawi) and Pehin Dato Abu Bakar Apong (Brunei Darussalam) were elected Vice-Chairmen, and Dr R. Busuttil (Malta) Rapporteur.

Committee A held its first, second, third and fourth meetings on 17 and 18 May 2005 under the chairmanship of Dr B. Sadrizadeh (Islamic Republic of Iran).

It was decided to recommend to the Fifty-eighth World Health Assembly the adoption of one resolution relating to the following agenda item:

- 13. Technical and health matters
 - 13.3 Health action in relation to crises and disasters
 - Health action in relation to crises and disasters, with particular emphasis on the earthquakes and tsunamis of 26 December 2004 [WHA58.1].

¹ See document WHA58/2005/REC/2, verbatim record of the seventh plenary meeting of the Health Assembly, section 2.

² Approved by the Health Assembly at its seventh plenary meeting.

³ See third report of the Committee on Nominations, above.

Second report¹

[A58/54 – 20 May 2005]

Committee A held its fifth and sixth meetings on 19 May 2005 under the chairmanship of Dr B. Sadrizadeh (Islamic Republic of Iran).

It was decided to recommend to the Fifty-eighth World Health Assembly the adoption of one resolution relating to the following agenda item:

- 13. Technical and health matters
 - 13.5 Malaria
 - Malaria control [WHA58.2].

Third report¹

[A58/55 – 23 May 2005]

Committee A held its seventh meeting on 20 May 2005 under the chairmanship of Dr B. Sadrizadeh (Islamic Republic of Iran).

It was decided to recommend to the Fifty-eighth World Health Assembly the adoption of one resolution relating to the following agenda item:

- 13. Technical and health matters
 - 13.1 Revision of the International Health Regulations [WHA58.3].

Fourth report¹

[A58/56 – 21 May 2005]

Committee A held its seventh and eighth meetings on 20 May 2005 under the chairmanship of Dr B. Sadrizadeh (Islamic Republic of Iran).

It was decided to recommend to the Fifty-eighth World Health Assembly the adoption of two resolutions relating to the following agenda items:

- 12. Proposed programme budget 2006-2007
 - Appropriation resolution for the financial period 2006-2007 [WHA58.4]
- 13. Technical and health matters
 - 13.9 Strengthening pandemic influenza preparedness and response
 - Strengthening pandemic-influenza preparedness and response [WHA58.5].

¹ Approved by the Health Assembly at its eighth plenary meeting.

Fifth report¹

[A58/57 – 23 May 2005]

Committee A held its ninth meeting on 21 May 2005 under the chairmanship of Dr B. Sadrizadeh (Islamic Republic of Iran).

It was decided to recommend to the Fifty-eighth World Health Assembly the adoption of two resolutions relating to the following agenda items:

- 13. Technical and health matters
 - 13.4 Sustainable financing for tuberculosis prevention and control [WHA58.14]
 - 13.8 Draft global immunization strategy [WHA58.15].

Sixth report¹

[A58/60 – 24 May 2005]

Committee A held its tenth and eleventh meetings on 23 May 2005 under the chairmanship of Dr B. Sadrizadeh (Islamic Republic of Iran).

It was decided to recommend to the Fifty-eighth World Health Assembly the adoption of one resolution relating to the following agenda item:

- 13. Technical and health matters
 - 13.19 Implementation of resolutions (progress reports)
 - Prevention and control of iodine deficiency disorders
Sustaining the elimination of iodine deficiency disorders [WHA58.24].

Seventh report¹

[A58/62 – 25 May 2005]

Committee A held its twelfth and thirteenth meetings on 24 May 2005 under the chairmanship of Dr B. Sadrizadeh (Islamic Republic of Iran). During the twelfth meeting Pehin Dato Abu Bakar Apong (Brunei Darussalam) later took the chair ad interim.

It was decided to recommend to the Fifty-eighth World Health Assembly the adoption of three resolutions relating to the following agenda items:

- 13. Technical and health matters
 - 13.10 Antimicrobial resistance: a threat to global health security
 - Improving the containment of antimicrobial resistance [WHA58.27]
 - 13.17 eHealth [WHA58.28]
 - 13.9 Strengthening pandemic influenza preparedness and response
 - Enhancement of laboratory biosafety [WHA58.29].

¹ Approved by the Health Assembly at its ninth plenary meeting.

Eighth report¹

[A58/64 – 25 May 2005]

Committee A held its fourteenth meeting on 25 May 2005 under the chairmanship of Dr B. Sadrizadeh (Islamic Republic of Iran).

It was decided to recommend to the Fifty-eighth World Health Assembly the adoption of three resolutions relating to the following agenda items:

- 13. Technical and health matters
 - 13.11 Infant and young child nutrition [WHA58.32]
 - 13.16 Social health insurance
 - Sustainable health financing, universal coverage and social health insurance [WHA58.33]
 - 13.18 Ministerial Summit on Health Research [WHA58.34].

COMMITTEE B**First report²**

[A58/53 – 20 May 2005]

Committee B held its first meeting on 19 May 2005 under the chairmanship of Dr J. Walcott (Barbados).

On the proposal of the Committee on Nominations,³ Professor J. Pereira Miguel (Portugal) and Dr M.A. Rahman Khan (Bangladesh) were elected Vice-Chairmen, and Mr Yee Ping Yi (Singapore), Rapporteur.

It was decided to recommend to the Fifty-eighth World Health Assembly the adoption of eight resolutions and one decision relating to the following agenda items:

- 15. Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine
 - Health conditions in the occupied Palestinian territory including East Jerusalem and in the occupied Syrian Golan [WHA58.6]
- 17. Financial matters
 - 17.3 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution
 - Members in arrears in the payment of their contributions to an extent which would justify invoking Article 7 of the Constitution [WHA58.7]
 - Arrears in payment of contributions: Georgia [WHA58.8]
 - Arrears in payment of contributions: Iraq [WHA58.9]
 - Arrears in payment of contributions: Republic of Moldova [WHA58.10]
 - Arrears in payment of contributions: Tajikistan [WHA58.11]

¹ Approved by the Health Assembly at its ninth plenary meeting.

² Approved by the Health Assembly at its eighth plenary meeting.

³ See third report of the Committee on Nominations, above.

- 19. Staffing matters
 - 19.3 Amendments to the Staff Regulations and Staff Rules
 - Salaries of staff in ungraded posts and of the Director-General [WHA58.12]
 - 19.5 Appointment of representatives to the WHO Staff Pension Committee
 - United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Fund [WHA58(9)]
- 20. Proposal for establishment of World Blood Donor Day
 - Blood safety: proposal to establish World Blood Donor Day [WHA58.13].

Second report¹

[A58/58 – 23 May 2005]

Committee B held its third, fourth and fifth meetings on 20 and 21 May under the chairmanship of Dr J. Walcott (Barbados).

It was decided to recommend to the Fifty-eighth World Health Assembly the adoption of two resolutions relating to the following agenda items:

- 13. Technical and health matters
 - 13.15 International Plan of Action on Ageing: report on implementation
 - Strengthening active and healthy ageing [WHA58.16]
 - 13.21 International migration of health personnel: a challenge for health systems in developing countries [WHA58.17].

Third report¹

[A58/59 and A58/59 Corr.1 – 24 May 2005]

Committee B held its sixth and seventh meetings on 23 May under the chairmanship of Dr M.A. Rahman Khan (Bangladesh).

It was decided to recommend to the Fifty-eighth World Health Assembly the adoption of six resolutions relating to the following agenda items:

- 17. Financial matters
 - 17.1 Unaudited interim financial report on the accounts of WHO for 2004 and comments thereon made by the Programme, Budget and Administration Committee
 - Unaudited interim financial report on the accounts of WHO for 2004 [WHA58.18]
 - 17.4 Assessments for 2006-2007 [WHA58.19]
 - 17.6 Amendments to the Financial Regulations and Financial Rules [WHA58.20]
- 18. Real Estate Fund [WHA58.21]
- 13. Technical and health matters
 - 13.12 Cancer prevention and control [WHA58.22]
 - 13.13 Disability, including prevention, management and rehabilitation [WHA58.23].

¹ Approved by the Health Assembly at its ninth plenary meeting.

Fourth report¹

[A58/61 – 25 May 2005]

Committee B held its eighth and ninth meetings on 24 May under the chairmanship of Professor J. Pereira Miguel (Portugal).

It was decided to recommend to the Fifty-eighth World Health Assembly the adoption of two resolutions relating to the following agenda items:

- 22. Collaboration within the United Nations system and with other intergovernmental organizations
United Nations reform process and WHO's role in harmonization of operational development activities at country level [WHA58.25]
- 13. Technical and health matters
13.14 Public health problems caused by harmful use of alcohol [WHA58.26].

Fifth report¹

[A58/63 – 25 May 2005]

Committee B held its tenth meeting on 25 May 2005 under the chairmanship of Professor J. Pereira Miguel (Portugal).

It was decided to recommend to the Fifty-eighth World Health Assembly the adoption of two resolutions relating to the following agenda items:

- 13. Technical and health matters
 - 13.2 Achievement of health-related Millennium Development Goals
 - Accelerating the achievement of the internationally agreed health-related development goals including those contained in the Millennium Declaration [WHA58.30]
 - Working towards universal coverage of maternal, newborn and child health interventions [WHA58.31]

¹ Approved by the Health Assembly at its ninth plenary meeting.