

COMMITTEE A

FIRST MEETING

Monday, 19 May 2008, at 17:25

Chairman: Dr F. CICOGNA (Italy)

1. OPENING OF THE COMMITTEE: Item 10 of the Agenda

The CHAIRMAN welcomed participants and introduced Dr W.T. Gwenigale, Dr V. Jaksons, Mr A.A. Miguil and Dr B. Sadasivan, who would attend the Committee's meetings in their capacity as representatives of the Executive Board.¹ He reminded the latter that their role was to convey the views of the Executive Board, not those of their respective national governments.

He drew the Committee's attention to the proposals by the Committee on Nominations for the posts of Vice-Chairmen and Rapporteur.²

Decision: Committee A elected Mr J.O. Da Silva (Timor-Leste) and Dr M.J. Muñoz (Uruguay) as Vice-Chairmen and Dr P.D. Parirenyatwa (Zimbabwe) as Rapporteur.³

2. ORGANIZATION OF WORK

The CHAIRMAN requested participants to limit the length of their statements to three minutes.

Mr JERMAN (Slovenia), speaking on behalf of the Member States of the European Union, requested the Committee to invite the European Commission to attend and participate, without vote, in the deliberations of the meetings of the subcommittees and other subdivisions of the Health Assembly dealing with matters within the competence of the European Community, especially those relating to agenda item 11, Technical and health matters.

It was so agreed.

The CHAIRMAN warned that deliberations might have to be interrupted at some stage in order to take up agenda item 11.6, Public health, innovation and intellectual property: draft global strategy and plan of action, which, as agreed at the first plenary meeting of the Health Assembly, must be dealt with as soon as possible.

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

² See page 255.

³ Decision WHA61(4).

3. TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 11.1 of the Agenda (Document A61/4)

Ms HALTON (Australia), speaking in her capacity as Chair of the Intergovernmental Meeting on Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and other Benefits, described the work done on implementing resolution WHA60.28. The Intergovernmental Meeting in November 2007 had been suspended after four days of positive debate, and a compilation of the work achieved had been submitted to an open-ended working group that had been convened in April 2008. After making good progress, the group had agreed to reconvene in November 2008, before the resumption of the Intergovernmental Meeting some days later. In the meantime, the bureau was keen that every country concerned contribute to the documents being prepared for the resumed meeting. A first draft of a Chair's text would be completed during the ensuing two weeks, then translated into the five other official languages and sent to Member States. They would have one month to submit their comments. The second draft would be translated and returned to Member States for consideration before the open-ended working group reconvened in November. The ample opportunities for participation, and the questions raised, would provide the strongest possible starting point for the Intergovernmental Meeting.

Dr ALLAH KOUADIO (Côte d'Ivoire), speaking on behalf of the African group of Member States, said that foci of H5N1 infection had been found in seven African countries during 2006–2007. In recent years, the African Region had enhanced its capacity to combat pandemic influenza through, inter alia, laboratory networks, surveillance systems and intersectoral epidemic management. Challenges remained, however, including weak epidemiological surveillance, inadequate supplies of antiviral medicines and limited capacity of laboratories and health systems. Oseltamivir was priced beyond the reach of most African countries, and many had been unable to build up stocks as recommended by WHO. There was urgent need of an international solidarity mechanism that would give all countries access to antiviral medicines and training in their use.

He welcomed the launching of the interim traceability mechanism, the fair and transparent sharing of viruses, and especially vaccines, and the benefits of sharing viruses with WHO collaborating centres. Those benefits should also include the establishment of innovative financing mechanisms, increased access to medicines and vaccines at affordable prices, and technology transfer and technical cooperation in identifying and characterizing H5N1 and other influenza viruses that would meet WHO requirements for the designation of reference laboratories and collaborating centres in Africa.

Dr LUKITO (Indonesia) noted that all Member States were seeking a fairer, more transparent mechanism for virus-sharing and asked to what extent the mechanism had been used for that purpose since its launch in January 2008.

Dr WANNA HANSHAOWORAKUL (Thailand) said that the pandemic influenza action plan to increase vaccine supply required commitment by manufacturers and Member States. She welcomed support from WHO to build capacity for vaccine development. Her country had resolved to produce 10 million doses per year and would prefer self-reliance, although development was difficult as vaccine manufacturers were still reluctant to transfer vaccine technology to Thailand.

Thailand had extended the coverage of seasonal influenza vaccination to people aged over 65, and intended to include patients with chronic diseases.

She urged the Intergovernmental Meeting to reach an outcome on the sharing of influenza viruses and access to vaccines and other benefits as otherwise Member States would seek bilateral agreements on virus-sharing to the detriment of an equitable approach and to the advantage of the vaccine manufacturers. Global security would be endangered by a lack of vaccines in the event of

pandemics. The Intergovernmental Meeting should concentrate on fair and equitable sharing of benefits, including stockpiling of pre-pandemic vaccines and a protocol for vaccine allocation during a pandemic. That would also encourage virus-sharing among Member States.

WHO should continue support for vaccine procurement in developing countries and the transfer of vaccine-development technology to those with the potential and commitment. Collaboration among developing countries for vaccine procurement and manufacturing should be encouraged.

Dr VOLJČ (Slovenia), speaking on behalf of the European Union and its Member States, said that the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Bosnia and Herzegovina, Montenegro and Serbia, and Armenia, Moldova and Ukraine aligned themselves with his statement. The European Union was committed to ensure a transparent and effective multilateral system for the timely sharing of viruses and viral sequence data under the auspices of WHO, as well as to improving the transparency and efficiency of the WHO Global Influenza Surveillance Network.

He commended measures outlined in the Interim Statement of the Intergovernmental Meeting. Progress had been made in establishing a traceability system for all shared H5N1 and other potentially pandemic human viruses, that provided full disclosure of information on transfer and movement of viruses. The European Union supported the establishment of an advisory mechanism for the virus traceability system and any increased transparency. He asked for details of the timetable of that mechanism.

He supported the proposal of the Chair of the Intergovernmental Meeting to draft a Chair's text for submission, after consultation with Member States in July, to the next Intergovernmental Meeting in November 2008. That meeting would be the final one and result in a collectively satisfactory agreement.

The meeting rose at 18:05.

SECOND MEETING

Tuesday, 20 May 2008, at 09:15

Chairman: Dr F. CICOGNA (Italy)

TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 11.1 of the Agenda (Document A61/4) (continued)

Mr CHAUDHRY (India) said that, despite the progress made, the world remained unprepared for a pandemic. Preparedness could be jeopardized if some countries did not match the efforts of others, hence the need for coordinated global action. He welcomed the fact that the Intergovernmental Meeting had set up an open-ended interdisciplinary working group to establish a fair, transparent and equitable framework. Tools and knowledge were needed for local and indigenous production of vaccines and antiviral medicines. The ability to produce adequate vaccines was crucial for pandemic preparedness.

He welcomed the recognition by the group that had met in April 2008 that, although a virus tracking system had been initiated, refinements and standard terms and conditions for virus sharing were still needed. He supported the establishment of an advisory mechanism, based on equitable representation of WHO regions and affected countries. The timelines set by the Intergovernmental Meeting must be respected in order to resolve the issue of virus sharing and sharing of benefits. In overcoming the virus, there was no time for protracted negotiations.

Mrs NGUYEN THI MINH CHAU (Viet Nam), affirming her country's commitment to sharing samples of influenza virus type A (H5N1) with WHO collaborating centres and Member States' laboratories, stressed the issue of patents for H5N1 virus strains when they were used in the development and production of H5N1 vaccines. Countries affected by H5N1 virus outbreaks and able to share virus strain samples required internationally agreed policies that provided checks and balances governing the use of samples and the equitable sharing of benefits. She expressed appreciation for the work of the Intergovernmental Meeting.

Procedures for transporting influenza virus samples to WHO collaborating centres and laboratories in Member States should include biosafety measures to prevent accidental release and transmission of viruses in transit.

Viet Nam was developing its capacity to produce H5N1 vaccines, both for the prevention of current human infections and for use during a potential influenza pandemic caused by an H5N1 virus strain. She requested support from other Member States and the Secretariat and for research, production and testing of H5N1 vaccines developed in Viet Nam.

Dr AYDINLI (Turkey) said that WHO should coordinate and monitor international surveillance of seasonal influenza viruses and viruses with pandemic potential. Member States should increase vaccine supply and access to pandemic influenza vaccines.

An outbreak of H5N1-type influenza in Turkey in January 2006 had been eliminated with the support of WHO. Lessons from Turkey's experience had been shared globally, in particular with Afghanistan, Iraq, Sudan, the Syrian Arab Republic, Turkmenistan and Yemen. Rapid clinical and epidemiological investigations of human infections, shared findings and transparency were all vital.

Mr ASLANYAN (Canada) stressed the need for effective, tangible sharing of samples by all Member States to mitigate and respond to pandemic threats. WHO's progress in establishing an

interim system for virus sample sharing would help to define the features of an international stockpile of H5N1 viruses. Canada would host a consultation later in 2008 to explore permanent and advanced mechanisms for influenza virus traceability.

Dr HARPER (United Kingdom of Great Britain and Northern Ireland) highlighted the seriousness of global health security. Without rapid sharing with WHO and analysis of influenza viruses, the risks increased considerably. In addition, manufacturers needed viruses to prepare vaccines.

Recognizing the imbalance in the distribution of benefits, especially vaccines, the United Kingdom had contributed £2 million to WHO's global pandemic influenza action plan in November 2007 through increased vaccine supply. He called on other Member States to make donations to the plan. The 50 million doses of H5N1 vaccine donated by the manufacturing industry to WHO's stockpile in 2007, while most welcome, represented only one third of the 150 million recommended by the WHO Strategic Advisory Group of Experts.

Following much progress, the session of the Intergovernmental Meeting to be held in November 2008 could be final and swiftly resolve remaining issues through the continued energy and effort of Member States.

Dr VIOLAKI-PARASKEVA (Greece) said that Greece was following the recommendations of both WHO and the European Union in its preparedness activities. She stressed the importance of transparency in the movement of viruses and access to vaccines and other benefits.

Dr LANGE (United States of America) highlighted the undiminished threat of a global influenza pandemic. Timely access to epidemiological data and clinical samples was critical to protecting global health security, and in that respect the WHO Global Influenza Surveillance Network had served the international community well. He recognized the concerns of some regarding access to vaccines and the desire of all for more equitable benefits. His country had provided funding support for the next phase of the virus tracking mechanism.

Endorsing the view that the November 2008 session of the Intergovernmental Meeting should be its last, he stressed the need to move quickly. In a pandemic, pharmaceutical interventions alone would not be sufficient, as it would take several months before vaccines became available. He urged all Member States to adopt measures, in addition to virus and sample sharing, to mitigate the effects of a pandemic in their communities, such as by "social distancing". His country's Centers for Disease Control and Prevention had formulated guidance in that area and made it available on its web site.

Dr KAMOTO (Malawi) welcomed the interim traceability mechanism for H5N1 influenza viruses and the agreement reached to share viruses and samples within the WHO system. She looked forward to a framework for the sharing of viruses and their benefits.

Malawi's emergency preparedness plans included task forces, technical committees and regional response teams to plan and coordinate activities and mobilize resources. Ministry of Health officers had undergone training organized by WHO. Remaining challenges included limited resources, inadequate laboratory capacity, medical supplies and infrastructure, and insufficient trained personnel.

The threat of a pandemic was real; outbreaks had already occurred in African countries. The Health Assembly needed to put in place a mechanism to ensure equitable access to medicine and vaccines for all, including support for the transfer of technology for vaccine manufacture.

Dr MELNIKOVA (Russian Federation) endorsed the Secretariat's actions to enhance the influenza pandemic preparedness of Member States and those of the WHO Global Influenza Surveillance Network and its activities in virus and sample sharing, information exchange, technical assistance and consultation. Diagnostic and virological research was continuing at the State Scientific Centre for Virology and Biotechnology in Novosibirsk, a WHO collaborating centre for the countries of the Commonwealth of Independent States and Central Asia.

The interim results from the Intergovernmental Meeting did not make it possible to evaluate the progress made on establishing stocks of vaccines and antiviral medicines, mobilizing resources, preparing reports on patent issues, setting up a consultative mechanism, or establishing an interdisciplinary working group. She stressed the need for equitable and transparent international mechanisms to ensure that all countries had access to vaccines and other medicines.

Ms JAJULA (South Africa) said that, although no case of influenza resulting from H5N1 viruses had been reported in South Africa, the country supported the sharing of data, biological specimens and research, and was active in the Global Influenza Surveillance Network. The Intergovernmental Meeting must conclude its work in order to resolve the issues of sharing of viruses and access to vaccines and other benefits. She expressed support for the interim traceability mechanism for all H5N1 viruses and the appointment of an advisory group.

Dr ST JOHN (Barbados) said that her country had implemented an avian influenza plan, formulated with assistance from the poultry industry. It included monitoring of wetlands for dead birds, controls on importation of suspect agricultural products, and control measures on poultry farms to halt the spread of avian influenza. National influenza preparedness plans had been drafted and would be presented to nongovernmental organizations and the private sector for evaluation and revision. The Ministry of Health had also drafted a manual for community polyclinics.

PAHO had provided support to various Member States, including Barbados (as one of seven Caribbean countries selected), in order to strengthen surveillance of acute respiratory infections. Barbados had adapted a regional protocol for influenza surveillance to its national needs. Since training and surveillance at Barbados' Queen Elizabeth Hospital had started in January 2008, no case of severe acute respiratory infection had been identified.

A supply of 40 000 doses of oseltamivir, with an expiry date of 2010, had been secured for use in the event of a pandemic. The national draft plan included measures for public health containment and education. Barbados had integrated PAHO's training in risk communication into its preparedness planning.

Dr GEBRESELASSIE (Ethiopia) noted that the outbreaks of avian influenza due to the H5N1 virus had already caused great losses in the poultry industry, especially in Asia and in some African countries. Adaptation of the extremely pathogenic virus to the human host, increasing human-to-human transmissibility, would pose a grave risk for a human pandemic. Ethiopia's health emergency preparedness and response system was almost complete and two facilities had been selected as sentinel sites in order to capture the spectrum of respiratory illnesses. Training of personnel would begin in a few months with assistance from the Centers for Disease Control and Prevention in the United States of America, and from WHO.

He urged the Committee to examine the current level of global preparedness. Countries must raise their level of pandemic influenza preparedness in test plans and procedures before an actual outbreak. He welcomed the launching of the interim traceability mechanism for influenza viruses, and urged the Secretariat to expedite the appointment of the advisory group.

Dr TEY (Singapore) recalled that, during the crisis caused by severe acute respiratory syndrome, Member States had come to understand the difficulties in dealing with transnational health threats. On that basis, countries should continue to share information on pandemic preparedness plans in order to be ready for a possible human influenza pandemic arising out of the current H5N1 avian influenza outbreaks. Singapore favoured free and open sharing of virus samples in order to facilitate risk assessments and the timely development of vaccines and antiviral agents.

Singapore's pandemic preparedness plan had been tested in July 2006 and involved all levels of government. In 2008, a comparable exercise had tested the readiness of hospitals to manage suspected avian influenza patients and to validate the concept of a dedicated infection control response team.

Dr RAFIQUE (Bangladesh) noted that, although there had been no reported human case of avian influenza in Bangladesh, in March 2007 the H5N1 avian influenza virus had been found in 284 poultry farms spread across about two thirds of the districts of the country. Bangladesh had established an avian and human influenza preparedness plan, a risk communication strategy and a multisectoral task force. Antiviral medicines and related equipment had been stocked, isolation units in key hospitals were operational, and 3700 medical personnel had been trained. Bangladesh was sharing influenza virus and sequence data with the Centers for Disease Control and Prevention, and was ready to share such data with other WHO reference laboratories throughout the world.

WHO should increase stockpiling of antivirals and vaccines, establish procedures for placement and deployment options, and further strengthen national laboratory capacity for risk assessment.

The CHAIRMAN proposed that, as agreed during plenary, discussion of the item should be suspended to enable discussion of item 11.6.

It was so agreed.

(For resumption of the discussion, see below.)

Public health, innovation and intellectual property: draft global strategy and plan of action:
Item 11.6 of the Agenda (Document A61/9)

Mr OLDHAM (Canada), speaking in his capacity as Chair of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, reported on the progress of the task assigned to the Working Group by resolutions WHA59.24 and WHA60.30. At their meeting on 28 April – 3 May 2008, Member States had made considerable progress and the last difficult issues could be resolved through the wisdom of the present Health Assembly. Thus a global strategy, and implementation of the essential part of the plan of action to be agreed, could begin.

The CHAIRMAN proposed that an informal drafting group be established to take the discussion forward, under the chairmanship of Dr Viroj Tangcharoensathien (Thailand).

Ms BAQUERIZO GUZMÁN (Ecuador) expressed support for the work done by the Working Group under the leadership of Mr Oldham.

The CHAIRMAN said that it was his intention that Member States should give comments after the drafting group had reported back to the Committee.

It was so agreed.

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

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 11.1 of the Agenda (Document A61/4) (resumed)

Dr BAI Huqun (China) said that China would continue to support the influenza virus tracking system and to develop vaccines to counteract pandemic influenza. There had to be fair sharing of viruses and of the public health and economic benefits stemming from this sharing. Greater support should be given to developing countries in areas such as surveillance, and they should be encouraged to cooperate in the relevant research, of which the influenza virus traceability mechanism was an essential component.

Dr EL GABALY (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, noted a high level of political commitment to increasing national preparedness as a new strain of the virus might emerge, resulting in an influenza pandemic in countries that lacked diagnostic capabilities.

The countries of his Region lacked laboratory and epidemiological capacity, which could impede an effective response to a pandemic. International cooperation, channelled through WHO, was needed to establish infrastructures and produce vaccines. Insufficient cooperation among collaborating centres in the provision of clinical strains of the viruses could threaten world health security. It was important to take into account the benefits accruing to countries from virus exchanges, and transparent procedures should be set up, leading to the fair and timely provision of vaccines at affordable prices.

Dr SANTÍN PEÑA (Cuba) noted that reports of cases of influenza in humans arising from the H5N1 virus would indicate a grave danger of increased viral recombination and consequently exchanges of viruses and strains should be accelerated. The interim traceability mechanism for all influenza viruses would make location data available for each virus and for subsequent use in the development of vaccines. Rapid agreement on a procedure for transparent exchange of viruses, and accessible vaccines for all, was vital to preventing a future pandemic.

Dr SUGIURA (Japan) said that, as pandemic influenza preparedness measures must be implemented on a global scale, his country was providing human and financial resources to WHO, technical and human resources support to Asian countries, and support in the stockpiling of anti-influenza medicines for 1.5 million people in ASEAN countries.

Grave risks would arise if influenza viruses were not shared globally in the near future. Although the Intergovernmental Meeting had not yet made sufficient progress, Japan supported the work of the open-ended working group. The WHO Global Influenza Surveillance Network and the influenza virus tracking system would contribute to effective preparedness worldwide, and Japan looked to WHO to give strong leadership in that important global issue.

Professor MWAKYUSA (United Republic of Tanzania) said that his country's avian influenza preparedness plan included two sentinel surveillance sites for avian influenza, media, public and schools awareness campaigns, a national influenza centre, established in collaboration with the Centers for Disease Control and Prevention, distribution of personal protective equipment, and trained rapid response teams.

Mr LEWIS (Saint Vincent and the Grenadines) pointed out that viruses did not choose whom they attacked. Sharing of influenza viruses and access to vaccines and other benefits were vital to small vulnerable States such as his, which lacked resources to engage in research and relied on the corresponding WHO mechanisms, notably in surveillance and traceability. As pandemic influenza was a global threat, the decision by the Health Assembly the previous day to deny even observer status to Taiwan excluded 23 million people from the "health for all" principle of WHO.

Dr MOHAMMED (Oman) commended the Secretariat's ongoing coordination in the field of pandemic influenza, especially with regard to the exchanges of information and of virus samples and strains through collaborating centres. Such activities must be collective, as must their benefits. The vaccines required in the event of an outbreak must be provided by the Organization to all who needed them, as the benefits and interests of global society as a whole should take into account national and regional concerns.

Mr MENESES (Mexico) said that preparedness for a potential influenza epidemic required a network of information on circulating virus strains, essential to countries carrying out research, and for producing vaccines rapidly. Technical support should be provided to countries that needed to upgrade their research and surveillance capacities. Mexico was strengthening production of vaccines and

enhancing the response capacity of both health personnel and the population. If an epidemic was to be contained, WHO would have to organize and monitor distribution of the different strains of viruses for research purposes. Appropriate documentation and procedures would be essential.

Dr OTTO (Palau) noted that his small country was located in the Asia-Pacific region, which was at risk of an influenza pandemic. Palau was grateful to the WHO Regional Office for the Western Pacific and to all partners for their technical and financial support in setting up its pandemic influenza preparedness plan.

Dr MAOATE (Cook Islands) said that his country had established its plans of action against the threat of pandemic influenza, with support from WHO and partners. He supported the call by Malawi and Palau for the equitable distribution of vaccines and medicines as most small island States could not afford total preparedness for pandemic diseases.

Dr ROHANI JAHIS (Malaysia) expressed concern about the increased threat of H5N1 in view of the recent emergence of avian influenza among poultry, especially in the Western Pacific Region. Malaysia recognized the right of States in regard to biological resources but also supported transparent international mechanisms for the equitable sharing of benefits, including access to diagnostics and treatment. Clinical specimens and viruses should be shared with WHO collaborating centres for pandemic risk assessment, vaccine development, updating of diagnostic reagents and test kits, and surveillance of resistance to antiviral medicines. Malaysia was willing to share influenza viruses but called for equitable sharing of benefits arising from the generation of information, diagnostics, medicines, vaccines and techniques. An innovative financing mechanism was needed to facilitate affordable procurement of pandemic vaccines.

Dr NASIDI (Nigeria) said that the first cases of avian influenza in sub-Saharan Africa had occurred in Nigeria in 2006 and the first human case in February 2007. Response had included the setting up of an intersectoral committee with members from the agriculture, health and information ministries with funding and additional support from the World Bank. The last poultry outbreak had occurred in October 2007, and the committee had established an avian influenza surveillance laboratory, recently qualified as a WHO national influenza centre, three reference laboratories, and a sentinel surveillance service in collaboration with the Centers for Disease Control and Prevention. It had also stockpiled medicines and empowered laboratories to carry out diagnoses locally. Continuous training was being provided for health-care workers. Those achievements had been facilitated by cooperation with the Regional Office and other partners.

Dr ESTEGHAMATI (Islamic Republic of Iran) said that the Intergovernmental Meeting should find a mechanism to ensure equitable access to viruses and benefits. WHO should support developing countries through capacity building and the transfer of technology for influenza vaccine production.

Dr MALEFHO (Botswana) commended the support accorded to countries affected by avian influenza. However, the potential genetic variation of the virus would hinder long-term production of vaccine, and WHO should facilitate equitable access to influenza vaccines as and when they became available.

Ms ACUÑA NAVARRO (Costa Rica) said that her Government favoured health promotion to ensure pandemic influenza preparedness. Immunization was nevertheless the main priority, and mechanisms were needed to allow all countries of the Region equitable access to vaccines. Efficient national laboratories were required for the production of vaccines, based on national and international collaboration, both public and private.

Dr DROPPERS (OIE) said that, in 2005, FAO and OIE had established a joint network of expertise on avian influenza to promote monitoring and control of infection in poultry and other bird species and to share biological material and information for vaccine development. The network collaborated with WHO's influenza network on public health matters. The current epizootic was a global problem, requiring a strategy supported by the latest scientific exchange and analysis of biological material and data in the network. Such collaboration was also vital for timely preparation of human influenza vaccines. Scientific data provided indicators for control strategies and early warnings such as drug resistance or increased virulence. Withholding information could threaten the health and welfare of both people and animals. Therefore, all OIE reference laboratories were mandated to gather, process, analyse and disseminate relevant data. Scientific data and biological materials were exchanged through the network. Laboratories had to actively encourage the sharing of materials and data, and deposit genetic data into a public database within three months of receiving an isolate. Countries reporting outbreaks of avian influenza were responsible for sharing materials and data through the network without delay. OIE and FAO continuously communicated with the media on the subject. To enhance cooperation and transparency, countries that submitted biological material or data must be acknowledged in subsequent publications and be seen as partners.

Dr NABARRO (Senior United Nations System Coordinator for Avian and Human Influenza) commended the efforts of many Member States to develop, test and revise pandemic preparedness plans. Many regional organizations had also contributed, especially the Asia-Pacific Economic Cooperation, ASEAN, the South Asian Association for Regional Cooperation, the European Union, the African Union and the Central Asia Regional Economic Cooperation. He commended WHO's leadership and direction at all levels, and the contributions of other international, nongovernmental and private organizations that had participated in pandemic preparedness. Further efforts remained essential.

Dr HEYMANN (Assistant Director-General) expressed appreciation of the support and comments by Member States, especially those that had experienced outbreaks of avian influenza in poultry but had avoided human transmission, thus demonstrating control of the disease in human populations. The Secretariat was continuing to improve pandemic influenza preparedness, by reaching consensus on surveillance, clinical management and non-pharmaceutical interventions, through rapid response activities, outbreak investigations and the transfer of vaccine technology. As mentioned, WHO's Strategic Advisory Group of Experts had recommended that WHO maintain stockpiles of H5N1 vaccine for rapid containment of an early phase-4 epidemic and, if necessary, to support countries in treating essential populations. Discussions were continuing on how to keep stockpiles up to date. The Secretariat continued to work with countries in designating collaborating centres and establishing national influenza centres. It was also collaborating with FAO, UNICEF and OIE on shifting the emphasis from detection of the virus in humans to its earlier detection in animals with a view to preventing human infection. Canada would host a technical meeting in September 2008 in preparation for a coordination mechanism. An interim tracing mechanism for virus sharing had operated since January 2008. Three out of four countries with cases of avian influenza in humans had shared viruses in 2008, as compared with four out of nine in 2007. The Secretariat was working with countries to strengthen risk communication capacity and placing data on clinical trials of H5N1 vaccine on WHO's web site. It would continue to support the Intergovernmental Meeting to ensure international solidarity for improved public health security.

Dr KEAN (Executive Director, Office of the Director-General) said that the Working Group meeting in March had recommended that the Director-General establish an 18-member advisory mechanism. The Director-General was consulting Member States through the bureau of the Intergovernmental Meeting to establish such a group, with satisfactory geographical and scientific balance. States should consult with their member of the bureau so that membership and procedures of the advisory mechanism could be announced as soon as possible.

The Committee noted the report.

Poliomyelitis: mechanism for management of potential risks to eradication: Item 11.2 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R1, and A61/5)

Dr SADASIVAN (representative of the Executive Board) said that the Secretariat's report and a draft resolution on eradication of poliomyelitis had been considered by the Board at its 122nd session. The report summarized progress towards eradication and measures for managing the long-term risks associated with polioviruses once transmission of the wild virus had been interrupted globally. Given the progress made, the Board had agreed on the need to intensify eradication efforts in remaining poliomyelitis-infected areas and to discuss the establishment of an international coordination mechanism to manage long-term risks. The Board had considered the Secretariat's summary of the long-term risks and their management, including the option of establishing an annex to the International Health Regulations (2005). The Board had revised the draft resolution on the basis of amendments proposed by Member States, including a request to the Director-General to renew the fight to eradicate poliomyelitis, drawing on operations, research and the experience of regions where the disease had been eradicated, and to submit to the Board a proposal for mechanisms to mitigate the risk of reintroduction of poliovirus. The Board had agreed that the International Health Regulations (2005) should not be amended and that no other binding mechanism should be introduced.

Professor HOVI (Finland) commended the report and the success of affected countries in limiting the number of new cases due to wild type 1 poliovirus. Rapid completion of the initiative was important for every Member State, since every additional year before the goal was reached could jeopardize high-coverage vaccination and surveillance in countries free of wild poliovirus. The risk of reintroduction from countries that were still affected and of outbreaks due to vaccine-derived poliovirus persisted. It was of great concern that the number of cases caused by type 3 poliovirus had increased in India in 2007, and type 1 poliovirus still caused many cases in Africa. He encouraged the Secretariat, the affected countries and Member States to achieve final eradication as soon as possible and improve immunization programmes in problem regions, perhaps by using both oral and inactivated poliovirus vaccines. He supported the resolution but proposed two amendments: the last preambular paragraph should read "Noting that planning for such international consensus must begin as soon as possible in order to be ready for implementation without delay after transmission of wild poliovirus is interrupted globally", and subparagraph 2(3), beginning "to achieve rapidly", should be placed first.

Dr MUKONKA (Zambia) said that his country was implementing the four strategies of WHO's poliomyelitis eradication initiative. Its African Regional Certification documentation had been accepted. Poliomyelitis eradication had strengthened surveillance in the Expanded Programme on Immunization and other disease control activities. Surveillance of acute flaccid paralysis had consolidated implementation of the disease surveillance strategy in Zambia. Shortages in human resources remained a problem.

Dr AL-MADWAKHI (Yemen) said that his country's efforts to eradicate poliomyelitis had been complicated by regional conflicts and new cases had been recorded in September 2007. A vaccination campaign had been launched but conflicts made it difficult to gain access to children. The Regional Office was pursuing its efforts to contain the virus. He supported the draft resolution as proposed.

Dr ZARAMBA (Uganda) said that his Government was sustaining high immunization coverage with oral poliovirus vaccine and continuing surveillance in order to meet the requirements for certification of eradication. Challenges remained, such as maintaining high immunization coverage, limited human resources in remote areas and the risks of importation of the virus.

The Health Assembly should consider support for poliomyelitis-free countries in maintaining their certification-standard indicators through surveillance and routine vaccination.

Dr KOMOTO (Japan) noted that the number of cases of poliomyelitis in Nigeria and India so far in 2008 was already higher than in 2007. Eradication efforts were therefore at a critical stage. Control measures and risk management should focus not only on wild type 1 poliovirus but also on types 2 and 3. He urged support for the draft resolution, and the elaboration of a new strategy for poliomyelitis eradication.

He noted that the Western Pacific Region had been declared poliomyelitis-free in 2000 and had maintained that status. Japan had made a large contribution to the global eradication of poliomyelitis.

Dr ROSELL-UBIAL (Philippines) said that, although her country had been free of poliomyelitis for seven years, eradication was still pursued, and routine immunization coverage was greater than 85%. For active surveillance of acute flaccid paralysis the rate was set at 2 cases per 100 000 children under the age of 15 years. Her country was looking forward to results from research on the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis and in order to manage those risks.

Guidelines were needed on phasing in the use of inactivated poliovirus vaccine while phasing out the use of oral poliovirus vaccines in poliomyelitis-free countries. The Secretariat should lead consultations, make recommendations and support low-income countries in that area. She supported the draft resolution.

Dr METAI (Kiribati) supported the draft resolution, in particular with regard to the use of inactivated poliovirus vaccine in routine immunization programmes and the coordination of poliovirus risk management strategies. He urged those countries with sufficient capability to produce more inactivated poliovirus vaccine to be made available and affordable for other countries. Mechanisms to minimize the long-term risks of polioviruses should be established.

Professor AZAD (Bangladesh) said that oral poliovirus vaccination coverage in his country stood at 93%. Bangladesh was poliomyelitis-free, despite sporadic imported cases due to wild poliovirus. It had maintained certification-standard surveillance for acute flaccid paralysis since 2000.

His country had conducted 16 national immunization days but requested WHO to relax the obligation to continue them as the cost was around US\$ 15 million. The country enjoyed good immunization coverage through the Expanded Programme on Immunization, and there were other pressing investment needs. A method of exempting poliomyelitis-free countries from conducting further national immunization days was needed.

Dr SANTÍN PEÑA (Cuba) said that, since the eradication of poliomyelitis in Cuba in 1962, oral poliovirus vaccines had been used, and coverage was greater than 95%. Active surveillance of acute flaccid paralysis had also been maintained. In order to ensure eradication, oral poliovirus vaccine should be replaced by inactivated poliovirus vaccine, which was, however, about 10 times more costly, and more funding would be required to guarantee coverage of 95% in the poorest countries. His country's research on inactivated poliovirus vaccine (and notably the patterns of conversion and doses), in collaboration with PAHO, would be useful to developing countries that were changing to use of inactivated vaccines. Collaborative work was being carried out in Angola on the interruption of transmission of imported viruses. High-security laboratories were necessary to ensure that wild polioviruses were contained.

Technical support and funding should be provided to poorer countries to ensure biocontainment in the event that poliovirus was detected in poliomyelitis-free areas.

Dr BAI Huqun (China) said that his country had strengthened acute flaccid paralysis surveillance and long-term biocontainment of poliovirus and in 2000 had reached the target for minimizing the long-term risk of reintroduction of poliovirus or the re-emergence of poliomyelitis. Immunization with oral poliovirus vaccine had been maintained and cases of wild poliovirus registered.

China had been poliomyelitis-free for eight years. Its current concerns therefore involved the long-term risks, such as the occurrence of vaccine-related cases, and also the transfer of technology for vaccine production and the bulk production of vaccine. China wished to continue cooperating with WHO in those areas and to receive financial and technical support for the global eradication of poliomyelitis.

Professor MWAKYUSA (United Republic of Tanzania) said that his country had adopted the four strategies for global eradication of poliomyelitis and had attained oral poliovirus vaccine coverage of 80%, with national immunization campaigns since 1996. Vaccination was free for all children, and acute flaccid paralysis surveillance, established in 1994, ensured that all cases were reported and investigated. Since 1988 the number of cases reported had decreased by 99%.

Challenges to be met included a shortage of trained personnel and the risk of importation of wild poliovirus through people from neighbouring countries in which the disease was endemic. He urged the international community to maintain support for the eradication of poliomyelitis.

Dr VIOLAKI-PARASKEVA (Greece) proposed three amendments to the draft resolution. Words to the effect of “recognizing the risk of inadvertently introducing wild poliovirus” should be added as a last preambular paragraph. In subparagraph 2(1), the word “rapidly” should be replaced by the words “promptly and identify”, and in subparagraph 3(4) the word “affected” should be inserted after “remaining”.

Mrs RIZZO (Italy) agreed on the importance of strengthening acute flaccid paralysis surveillance and on implementing the mechanisms for management of risks to poliomyelitis eradication. Greater efforts and efficient coordination of all partners were needed. Italy would continue to support WHO with financial contributions and technical collaboration. She supported the draft resolution.

Dr AYDINLI (Turkey) said that, although his country was poliomyelitis-free, surveillance for acute flaccid paralysis continued. Turkey was at risk of importation of poliovirus, and routine vaccination and other measures were still necessary.

Turkey had been active in poliomyelitis eradication in Afghanistan, and supported the activities of WHO and the Organization of the Islamic Conference in that country.

Dr FORRESTER (Jamaica) said that the last case of poliomyelitis in her country had been reported in 1992; since then, acute flaccid paralysis surveillance had been established and strengthened. However, vaccination coverage had declined to 85% in 2007.

Her country's concerns included inadequate supplies of oral poliovirus vaccine, achieving at least 95% vaccination coverage in each birth cohort, ensuring the surveillance and investigation of suspected cases, maintaining high levels of immunization among susceptible persons and eliminating cases of vaccine-associated paralytic poliomyelitis, secure biocontainment in order to prevent use of wild poliovirus by bioterrorists, dealing effectively with antivaccination groups through sustained public communication, and managing transition from oral to inactivated poliovirus vaccines once certification of global eradication had been achieved.

She supported the draft resolution but recommended some amendments. The last preambular paragraph should state that planning for international consensus should begin immediately and not after global interruption. In subparagraph 2(2), the time frame for containment should be 6–12 months after detection of the last case of poliomyelitis caused by a circulating wild poliovirus. Subparagraph 3(3) should set a date for cessation of use of oral poliovirus vaccine and should consider adult booster doses.

WHO should support countries in dealing with antivaccination groups, raise public awareness about vaccine safety, lobby for political and funding support in countries affected by the disease, continue negotiations with vaccine manufacturers for adequate supplies of vaccines, and set a new target date for interruption of poliomyelitis transmission globally.

Dr MELNIKOVA (Russian Federation) noted that endemic transmission of wild poliovirus persisted in some countries. Her country's commitment to the global poliomyelitis eradication initiative plan included acute flaccid paralysis surveillance, 95% vaccination coverage of children and a strengthened laboratory network for biological security and containment.

Mr ABDOO (United States of America) said that poliomyelitis eradication was feasible but the challenges faced by the remaining four countries in which the disease was endemic made it unlikely that that goal would be reached in 2008. The focus in the draft resolution on managing long-term risks after the interruption of transmission was appropriate; however, Member States should allocate adequate resources to poliomyelitis eradication, adhere to the International Health Regulations (2005), including immediate notification of poliomyelitis, and remain vigilant against import of wild polioviruses. He commended WHO's approach to reducing the risks associated with ceasing the use of oral vaccine and looked forward to the proposed mechanism to mitigate the risk of reintroduction of poliovirus that did not involve amending the International Health Regulations (2005) or drawing up another binding instrument. He supported the draft resolution.

Ms JAJULA (South Africa) said that laboratory containment of wild polioviruses was a problem in both the public and the private sectors; surveillance of acute flaccid paralysis must be strengthened, and certification-standard surveillance maintained in order to reduce transmission of imported viruses. The international community should support the use of new vaccines in developing countries.

She supported the draft resolution, but suggested that subparagraph 2(3) be amended to read: "to achieve and maintain routine immunization coverage against poliomyelitis at a level greater than 80% of the childhood population and set country specific target dates", as the poliomyelitis eradication target had not been achieved by some countries. She urged increased support to countries that experienced wild poliovirus importations.

Dr WANNA HANSHAOWORAKUL (Thailand) said that her country had been free from poliomyelitis since 1998, and oral vaccine was provided only for routine immunization and national immunization days. National experts favoured use of oral vaccines, which produced gut immunity, were cheaper and easier to administer than inactivated vaccines. More evidence was needed on the budgetary and sustainability implications of using inactivated poliovirus vaccines. The international community had an ethical responsibility to stop the transmission of poliovirus in endemic areas, and prevent its reintroduction into poliomyelitis-free countries by ensuring immunization. She welcomed the draft resolution with no amendment.

Dr MOHAMMED (Oman) said that the re-emergence of poliovirus in 27 previously disease-free countries was a sobering lesson for the international community. National authorities should redouble their efforts to conduct routine immunization, re-vaccination and epidemiological studies. The re-emergence of poliomyelitis, as seen in 2003, must not occur.

Dr YUSHARMEN (Indonesia) said that his country had a well-established poliomyelitis eradication and surveillance infrastructure. In 2005, an outbreak of imported poliomyelitis in West Java had been immediately contained, with support from WHO and other partners; 305 cases had been reported. No new case had been reported since 2006. He urged countries where wild polioviruses continued to circulate to take immediate steps, with the support of WHO, to prevent transmission.

Mr SHIRALIYEV (Azerbaijan) said that, after the disintegration of the Union of Soviet Socialist Republics, the prevalence of poliomyelitis in his country had been reduced through immunization campaigns. Since October 1995, there had been no reported case. Immunization coverage was being increased in order to contribute to global eradication.

Dr ASSOGBA (Benin) said that his country had achieved immunization coverage of 95%. Surveillance of acute flaccid paralysis was good in 10 of the 12 provinces, and no case of wild poliovirus had been reported since 2005. Benin would achieve pre-certification status in 2008. He supported the draft resolution.

Dr SADRIZADEH (Islamic Republic of Iran) said that his country remained at high risk of poliovirus importation, as it shared a border with two of the four remaining countries in which the disease was endemic. It would continue to fund campaigns until the disease had been eradicated. The dramatic drop in cases due to type 1 poliovirus in Asia in 2008 was encouraging. However, the uncontrolled transmission of poliomyelitis in Nigeria threatened global poliomyelitis eradication if it continued and spread to neighbouring countries. He supported the draft resolution, but proposed that a new operative paragraph be inserted, highlighting the risk posed by that outbreak and requesting urgent control activities in Nigeria so that all children were vaccinated with oral poliovirus vaccine.

Dr NASIDI (Nigeria) said that his Government recognized the resurgence of wild poliovirus type 1 and the reintroduction of poliovirus types 1 and 3 into states of southern Nigeria and the recent cases of vaccine-derived poliomyelitis. His Government's 2008 budget had allocated funds for a more effective immunization programme and improved communication. He thanked his Government's partners for their support and urged continued efforts. He supported the draft resolution, with the amendments proposed by South Africa.

Mr MENESES (Mexico) noted with deep concern that the *Wild Poliovirus Weekly Update* of 13 May had reported that three times as many cases due to wild poliovirus had already occurred in 2008 than in 2007. Mexico's last reported case of poliomyelitis due to wild poliovirus had been in 1990. He supported the draft resolution but suggested that any new strategy to fight poliomyelitis could include implementation of immunization weeks in countries affected by the disease, and which had proved to be a cost-effective strategy in his country.

Dr DANKOKO (Senegal) said that his country had been certified poliomyelitis-free in June 2004 but detection, response and containment continued, given the risks of importation of wild poliovirus in Africa. He supported the draft resolution.

Mrs VIREM (France) commended the initiative to provide inactivated poliovirus vaccines at an affordable price after the eradication of wild poliovirus. Once the virus had been eradicated, France would be in favour of injectable vaccine. She supported the draft resolution. She asked whether the last detected case of poliomyelitis would be the last case of paralytic poliomyelitis confirmed virologically, which was the current basis for surveillance, or the last clinically confirmed case of poliovirus infection, including non-paralytic conditions such as meningitis, pharyngitis and diarrhoea.

Dr AMANKWAH (Ghana) said that Ghana's achievement of no reported case of wild poliovirus since 2003 resulted from political commitment, community participation, national immunization days, routine immunization and effective surveillance. Ghana had been certified poliomyelitis-free in 2007. Remaining challenges included maintaining surveillance, timely response to imported wild poliovirus, long-term use of poliomyelitis vaccine, and biocontainment of infectious material. He supported the draft resolution.

The meeting rose at 12:20.

THIRD MEETING

Tuesday, 20 May 2008, at 16:00

Chairman: Dr F. CICOONA (Italy)

TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

Poliomyelitis: mechanism for management of potential risks to eradication: Item 11.2 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R1, and A61/5) (continued)

Dr MALEFHO (Botswana) outlined his country's management of the potential risks to poliomyelitis eradication, including acute flaccid paralysis surveillance in all districts, monitoring re-emergence of poliovirus and laboratory containment, immunization campaigns, strengthening of outreach services, and provision of cold-chain equipment. Poliomyelitis surveillance was coordinated by several committees with efforts to improve immunization in all 24 districts. No case due to wild poliovirus had been recorded. A nationwide survey in 2007 had shown that 92% of children under one year old were fully immunized with no recorded case of vaccine-derived paralysis. Survey findings identified and strengthened interventions in priority areas. With WHO's support, Botswana had improved vaccine procurement and logistics, and would continue to maintain its poliomyelitis eradication status until the African Region was certified poliomyelitis-free. He supported the draft resolution.

Dr KAMOTO (Malawi) said that the African Region remained at risk of importation of wild poliovirus as illustrated by recent events in Angola, Chad, the Democratic Republic of the Congo and Niger. Endemic wild poliovirus transmission persisted in northern Nigeria and remained the greatest threat to eradication in Africa. Malawi appreciated that Nigeria had cut the number of cases due to wild poliovirus from 1122 in 2006 to 286 in 2007. However, in order to implement the intensified plan for 2008–2009, all the estimated budget of US\$ 1306 million would be needed. Malawi was committed to maintaining its poliomyelitis-free status, certified in 2005: the last case had been reported in 1992. Malawi maintained routine immunization coverage of more than 80% and had ensured high-quality surveillance since 2000.

WHO should continue support to affected countries and sponsor research into the risk of reintroduction of poliovirus in the long term and re-emergence of poliomyelitis after interruption globally. A new strategy was needed for eradicating poliomyelitis from the remaining countries in which it was endemic, drawing on experience and research from regions having already eradicated the disease. Consensus was needed on the long-term use of poliomyelitis vaccine and biocontainment of infectious and potentially infectious materials.

Professor DJONA (Chad), speaking on behalf of the Member States of the African Region, recalled resolution WHA60.14, in which the Health Assembly had called on Member States to strengthen their active surveillance of acute flaccid paralysis and prepare for the long-term biocontainment of wild poliovirus, and had requested the Director-General to submit proposals to the Sixty-first World Health Assembly for minimizing the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis. Those countries where poliomyelitis was still endemic should seek out families refusing poliomyelitis vaccination for their children and intensify active surveillance of acute flaccid paralysis. Countries at risk from poliomyelitis must implement with urgency the intensified eradication plan for 2008–2009. Cross-border campaigns and routine vaccination were effective in eradicating the scourge. He urged synchronized vaccination activities to reach all children, particularly those of insular, nomadic refugees and displaced families, in border areas. He called on

the delegates of Cameroon, Niger and Nigeria, whose countries bordered on Lake Chad, to coordinate their activities. All the political, traditional and religious stakeholders must be mobilized and relevant information provided to local communities.

He called for continued international strengthening of the African countries' vaccination programmes and invited support for the draft resolution.

Dr PALAU (Honduras) said that the last confirmed case of poliomyelitis in Honduras dated back to 1972 and eradication had been certified in 1976 following a vaccination campaign covering more than 95% of children. Vaccination continued and coverage exceeded 85%. Her country maintained active surveillance of acute flaccid paralysis and investigated its causes. In 2005, one case of vaccine-derived flaccid paralysis had been reported. Those poorer countries that had eradicated poliomyelitis should be supported through access to safe and effective vaccines. Honduras would continue its efforts to keep itself and the world free of poliomyelitis. She supported the draft resolution, particularly paragraph 3.

Ms JOHRI (India) said that eradicating poliomyelitis was the single largest programme in the Indian health sector and her Government was proposing to allocate some US\$ 998.5 million to it during the 11th Five Year Plan. In 2008, it had allocated US\$ 267 million from domestic resources. About 2.75 million people were engaged in vaccinating some 172 million children during one nationwide round. Regional immunization days covering the endemic states were held almost every month. Partners, including WHO, UNICEF and Rotary International, had been involved in the Pulse Polio Programme at every stage. The India Expert Advisory Group made recommendations on the choice of vaccine, number of rounds, geographical areas and immunization strategy, which were followed meticulously.

Intensified immunization and the use of monovalent vaccine had contained poliovirus circulation in a limited geographical area. Out of 35 states and union territories, only two continued to experience indigenous viral circulation. The migratory population from both inside and outside the endemic states was being tracked and immunized in vaccination booths in railway stations, trains, bus terminals, road crossings and religious premises. In the endemic areas, operations were launched upon detection of poliovirus, in addition to the regular monthly rounds. With WHO's support for surveillance of acute flaccid paralysis, cases were detected immediately. Surveillance reported through some 30 000 sites. In the core endemic areas, often the source of an outbreak, as many as 93% of households were immunized.

In India, the Director-General had met the Prime Minister and the chief ministers of the two endemic states, Uttar Pradesh and Bihar, and had seen the efforts being made to eradicate poliomyelitis. In line with the recommendations of the Inter-Agency Expert Review Group on the Millennium Development Goals, India was using monovalent oral poliomyelitis vaccines types 1 and 3 in the endemic areas. The strategy was to first sequentially target the type 1 poliovirus and try to contain the type 3. With the former mainly being used, cases of type 3 poliovirus were still numerous. However, type 1 cases had been reduced from 520 in 2006 to 21 in 2007, with only four cases reported so far in 2008. The seven core endemic districts of Uttar Pradesh had not reported any cases of type 1 poliovirus since November 2006.

She suggested revisiting use of the bivalent vaccine against both types 1 and 3 poliovirus, and development of monovalent vaccines based on the Indian strains of types 1 and 3 poliovirus for greater effectiveness. India's sustained efforts to eradicate poliomyelitis would surely bear fruit soon.

Mr FOWLER (Canada) commended the recent successes of the Global Polio Eradication Initiative, including the 84% reduction in the number of cases of type 1 poliovirus between 2006 and 2007, the halving of diagnostic times and the official eradication of poliomyelitis in Somalia. It would continue to support eradication efforts in the remaining four endemic countries. Canada was also exploring integrated approaches to the eradication of poliomyelitis and ongoing surveillance.

He supported the draft resolution and, noting the paragraph concerning Nigeria, proposed the addition of a paragraph that specifically recognized the progress made in Afghanistan, India and Pakistan towards eliminating type 1 poliovirus and urged these countries to carry out large-scale mop-up activities.

Dr BALVINDER SINGH GILL (Malaysia) commended WHO's strong leadership in the global effort to eradicate poliomyelitis and efforts to mobilize financial support for countries in which poliomyelitis was endemic. Collaboration with other global organizations should be sustained. Malaysia supported the draft resolution and would be introducing inactivated poliomyelitis vaccine into its immunization programme. Countries declared free of wild poliovirus should not be complacent since the risk of importation was still high.

Mr STENHAMMAR (Rotary International), speaking at the invitation of the CHAIRMAN, said that the 1.2 million members of Rotary International were committed to achieving the certification of poliomyelitis eradication. It was gratifying to see the dedication of the world's health leaders to the goal of a world free of poliomyelitis. He thanked the Director-General for her continued support of poliomyelitis eradication, emphasized by her visits to all four remaining countries in which poliomyelitis was endemic in order to review and encourage progress.

The intensified effort to eradicate poliomyelitis had been launched in Geneva in February 2007, with international commitment to overcoming the remaining operational and financial challenges to eradication. Progress had been made, particularly in Asia. Worryingly, there had also been a resurgence of the disease in the last country in Africa in which it was endemic, and sporadic cases in countries previously free of poliomyelitis, particularly in west and central Africa. Urgent commitment from political leaders at all levels was critical to stopping the disease in Africa. He called upon the leaders of the remaining disease-endemic countries – Nigeria, India, Pakistan and Afghanistan – to ensure that all children were reached and vaccinated during the intensified campaigns in 2008–2009.

Rotary International, the largest private sector donor, had joined with the Bill & Melinda Gates Foundation to provide an additional US\$ 200 million over the next three years. It was to be hoped that the private sector commitment would challenge others to provide the resources needed to eradicate poliomyelitis. Globally, the Global Polio Eradication Initiative still faced a funding gap of US\$ 490 million for 2008–2009. He appreciated the international public sector support, particularly in the G8 countries, whose longstanding commitment he further encouraged. Failure to eradicate the disease would result in the paralysis of an estimated 10 million children over the next 40 years, negating the global investment of US\$ 6000 million. The Global Polio Eradication Initiative was the largest health initiative in history, and a model for global health endeavours. With so much at stake, the historic opportunity must be grasped, the investment protected, and a world free of poliomyelitis delivered for future generations everywhere.

Dr HEYMANN (Representative of the Director-General for Polio Eradication) said that the Secretariat appreciated the support of Member States, as they worked with partners to interrupt the transmission of poliomyelitis. Clearly, as long as it was present in any country, poliomyelitis threatened the rest of the world. The consequences of poliovirus importation depended on the routine immunization programmes in the countries concerned: countries with strong programmes required few campaigns to prevent transmission, while weaker programmes required many in order to reach a level of immunity that would interrupt transmission again. Campaigns were necessary in all countries bordering or at risk from poliomyelitis-affected countries. The Director-General's meeting with stakeholders in February 2007 set milestones to monitor the progress of countries towards the interruption of transmission. Intensified efforts using monovalent vaccines were launched. The milestones would be reviewed in early 2009, and their attainment reported to the Health Assembly. Some countries were making progress with type 1 vaccine, and studies showed those to be much more effective than trivalent vaccines, with an up to threefold increase in seroconversion per dose. Solidarity had been shown with infected countries, with instances of technical cooperation between

developing countries. WHO was continuing its research on inactivated poliovirus vaccine and cost-effective strategies for countries that would use poliomyelitis vaccine after eradication. Research was also continuing into the development of Sabin inactivated poliovirus vaccine in order to enable developing countries to participate in its manufacture. Activities continued to minimize the risk of poliomyelitis after eradication, so that the last case, as determined virologically, would indeed be the last. He thanked WHO's partners as they worked together towards eradication, and those countries that were broadening the coverage of their infrastructure for poliomyelitis eradication to other infectious diseases.

After Ms VESTAL (Assistant Secretary) had read out the proposed amendments to the draft resolution, reviewed by the Secretariat, Mr ABDOO (United States of America) requested to see the proposed amendments in writing.

The CHAIRMAN said that the item would remain open and a revised version of the draft resolution, including the proposed amendments, would be issued.

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

Smallpox eradication: destruction of variola virus stocks: Item 11.3 of the Agenda (Document A61/6)

Dr TSHABALALA MSIMANG (South Africa), speaking on behalf of the Member States of the African Region, noted the work undertaken by the WHO Advisory Committee on Variola Virus Research and the considerable research accomplishments outlined in the report. Since the adoption of resolution WHA33.3, declaring the global eradication of smallpox, the Health Assembly had adopted a number of resolutions referring to the temporary retention of variola virus stocks and their ultimate destruction. She sought clarification from the Secretariat on various issues. The Health Assembly had decided that the Advisory Committee would comprise a group of experts from Member States in each of the WHO regions; was that the case?

Noting the update on the legal status of variola virus stocks in the two repositories, she asked the Secretariat to indicate how the challenge of uncertain and variable ownership rights for transferred samples of the stocks in question would be addressed. What were the implications of the new research proposals submitted to WHO, which were still to be evaluated by the Advisory Committee in terms of the time frames set out in resolution WHA60.1? What was the Secretariat doing "to ensure that approved research proposals, research outcomes and the benefits of this research are made available to all Member States", as requested in subparagraph 4(4) of resolution WHA60.1? The Member States of the African Region remained committed to reaching a date for final destruction of the remaining stocks of the variola virus.

Dr GARBOUJ (Tunisia), speaking on behalf of the Member States of the Eastern Mediterranean Region, acknowledged the work under the aegis of the WHO Advisory Committee on Variola Virus Research, particularly the sequencing studies on live variola virus stocks, which furthered understanding of the genetic structure of the virus and facilitated subsequent work on diagnostics. However, it was wrong to continue holding the virus stocks and a date no later than 2010 must be set for their destruction. She supported the request for all Member States to be informed of the results of epidemiological and diagnostic research, particularly with regard to antiviral agents and diagnostic methods. There should be a network of laboratories evenly distributed throughout all regions.

Dr ENDO (Japan) emphasized research on antiviral agents and vaccines, especially in the light of the continuing threat of bioterrorism. WHO should continue to promote wide and equitable access to research outcomes, crucial to public health and which helped to combat other diseases. The Health Assembly must reaffirm that the destruction of live variola virus stocks in laboratories was the ultimate goal of smallpox eradication efforts; and the strains and primary isolates held in the

two repositories in the Russian Federation and the United States of America must remain subject to an annual inventory under a unifying system, with the appropriate safeguards in place. Legal Counsel's advice should be followed on the still unclear legal status of those two collections.

Professor SHCHELKUNOV (Russian Federation) said that variola virus remained a global threat and that, despite new antiviral agents, vaccines and diagnostic tools, research must continue in line with previous Health Assembly resolutions in order to improve prevention and treatment. With none of the world's population under 27 years of age immune to the virus, the international community was right to be concerned about the potentially catastrophic effects of secret stocks, held in places other than the two repositories, falling into the hands of terrorist groups. Destruction of the two official collections would diminish preparedness against a variola virus attack and reduce the number of people who were expert in controlling that dangerous disease. The two repositories remained under the supervision of the Secretariat and the Health Assembly, and the WHO Advisory Committee on Variola Virus Research had leading experts examining their work each year and making any necessary adjustments.

Dr YUSHARMEN (Indonesia), speaking on behalf of the Member States of the South-East Asia Region, said that none of those States had possessed or researched stocks of variola virus since deciding to destroy them in accordance with resolution WHA33.4. The process of destroying remaining stocks must begin immediately, and the Sixty-fourth World Health Assembly should achieve global consensus on the timing of such destruction. Meanwhile, the two countries with repositories must provide other Member States with a transparent annual report on the findings of their research on the virus.

Dr SASIDHORN TANGSAWADEE (Thailand), concurring with the comments by the delegate of South Africa, said that there was much room for research on the use of antiviral agents and vaccines among immunocompromised and pregnant individuals. But the WHO Advisory Committee on Variola Virus Research and the Secretariat must subject all proposals to a thorough review given the serious concerns over the ethical aspects and feasibility of such research.

Mrs VIREM (France), drawing attention to paragraph 11 of document A61/6, was concerned about the need to prevent biological proliferation during the transfer to third parties of DNA fragments from laboratories whose projects had been approved by WHO. Stricter controls were required and the transfers themselves must be stopped at the same time as the destruction of stocks of live variola virus. In the meantime, the laboratories in question must submit regular detailed reports on their activities.

Mr MACPHEE (Canada) fully endorsed the destruction of remaining stocks of variola virus once they had outlived their usefulness for public health research. Canada welcomed efforts towards the 2010 review of past, present and future research leading to global consensus at the Sixty-fourth World Health Assembly on the timing of the destruction of the stocks by examining research proposals, identifying laboratories that researched portions of variola virus DNA, and increasing awareness of the regulations that governed the use and distribution of that DNA, especially to third parties.

Dr HEYMANN (Assistant Director-General) thanked Member States for their continued guidance regarding variola virus stocks and the research to be undertaken before their destruction. The Director-General had increased membership of the WHO Advisory Committee on Variola Virus Research by a third in order to add more public health expertise, as requested, and the 2010 timeframe for review of research remained. Studies still in progress showed promising signs of the development of new antiviral agents and less reactogenic vaccines. WHO would increase vigilance on the transfer of variola virus DNA through multilateral trade agreements.

Mr BURCI (Legal Counsel), taking up the matter of the legal status of the variola virus stocks held in the two repositories, said that despite the Secretariat's efforts to gather records and information from the various countries holding stocks in 1977, the "ownership landscape" remained varied and incomplete, for the reasons set out in the report. However, he stressed that the two collaborating centres had agreed to hold and handle all stocks of the virus as a form of cooperation with WHO under their terms of reference and that, even if the ownership rights issue was uncertain, the stocks remained subject to the safety regulations applicable to infectious substances in the two countries in question.

The Committee noted the report.

Implementation of the International Health Regulations (2005): Item 11.4 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R3, A61/7 and A61/7 Corr.1)

Dr SADASIVAN (representative of the Executive Board), introducing the item, invited the Health Assembly to consider the draft resolution contained in resolution EB122.R3 adopted by the Executive Board at its 122nd session. He drew attention to two amendments to the original draft resolution contained in paragraph 20 of document EB122/8: the first proposed by China, regarding universal application of the Regulations, and the second by Malawi, on behalf of the Member States of the African Region, requesting the Director-General to support Member States with vulnerable health systems to strengthen core capacity requirements for surveillance and response at points of entry, with special emphasis on the sub-Saharan Africa laboratory network.

Dr AYDINLI (Turkey) said that, since under the International Health Regulations (2005) Member States were responsible for early recognition, control and notification of health threats, his country had, with technical support from WHO, held an evaluation meeting in Ankara.

Regarding paragraph 15 of the report, relating to nomination of experts, details of the procedure and timelines for such nominations would be helpful. Regarding paragraph 19, detailed information should also be communicated to Member States. Information flowing from national focal points to WHO should be reciprocated, particularly on activities relating to the Regulations.

Mr HAGE CARMO (Brazil) said that his country was completing implementation of the International Health Regulations (2005), in cooperation with other South American countries.

Reports on implementation of the Regulations should be submitted annually, with the next submitted to the Sixty-second World Health Assembly. Since the adoption of the Regulations at the Fifty-eighth World Health Assembly, Brazil and other South American countries had used the decision instrument in Annex 2 to assess events that might constitute a public health emergency of international concern. Without guidelines relating to a contextual analysis of the events, the decision instrument seemed less likely to identify those real emergencies.

He asked the Secretariat for information on development of the guidelines referred to in resolution WHA58.3, including completion dates and procedures relating to use.

Mr LYSYSHYN (Canada) said that his country would continue to provide technical assistance through the Secretariat as part of its support to Member States for implementation of the International Health Regulations (2005), including legislative tool kits and guidelines for points of entry. Canada was working on border screening and control with its North American neighbours, and would continue to promote best practices with other Member States.

He looked forward to a report from the Secretariat on progress in implementing the Regulations.

Dr VOLJČ (Slovenia), speaking on behalf of the European Union and its Member States, said that the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and the European Free Trade Association country Norway,

member of the European Economic Area, as well as Armenia, Azerbaijan, Georgia, Moldova and Ukraine, aligned themselves with his statement. The European Union fully supported the draft resolution and welcomed the schedule for reporting on the implementation of the International Health Regulations (2005). The Secretariat should continue to develop common practices for implementation, particularly for routine inspections and timely public health measures.

According to strategic objective 1 of WHO's Medium-term strategic plan 2008–2013, policy and technical support would be provided to Member States in order to monitor communicable diseases of public health importance.

He thanked the Secretariat for documentation and support to Member States in implementing the Regulations. He praised the capacity building and training activities of the WHO Lyon Office for National Epidemic Preparedness and Response. The relationships established between contact points in the European Region and the national focal points were appreciated. He welcomed the framework for events to be reported for the prevention and control of communicable diseases. He reiterated the European Union's commitment to full implementation of the Regulations.

Dr LAL (India) noted that the International Health Regulations (2005) provided opportunities to strengthen public health systems. India's Director of the National Institute of Communicable Diseases was the national focal point. Communications had been established with other sectors and all responsible authorities contacted. National capacities had been assessed and a state-based surveillance programme to detect and respond to outbreaks of disease and potential epidemic had been established. Workshops had been held, laws and regulations drafted, and high-security laboratories for surveillance of avian influenza had been identified.

India had provided technical assistance to other countries in the South-East Asia Region and was participating in regional implementation forums. He requested the Secretariat to support Member States in developing legal frameworks, consolidating disease surveillance and strengthening border health management.

India endorsed the requirements set out in Annex 1 of the Regulations to strengthen national capacities at all levels, leading to the decisions called for in Annex 2. Both international and national resource mobilization needed to be expanded.

He reiterated his country's commitment to implementing the Regulations and supported the draft resolution.

Mr ABDOO (United States of America) emphasized that the International Health Regulations (2005) must be universally applied in order to protect all people. The Secretariat had to support Member States in order to develop the implementation capacities required, while Member States needed to be transparent in reporting the information required, as on outbreaks of diseases. Those included the H5N1 strain of avian influenza and other new influenza strains, which were serious threats to global health. Withholding information on outbreaks of H5N1 influenza, including samples of the virus, contravened the spirit of the Regulations.

The United States was willing to share with partners its valuable experience in implementing the Regulations in order to advance global health security. He supported the draft resolution.

Dr METAI (Kiribati) expressed commitment to full implementation of the International Health Regulations (2005) and support for the draft resolution. In 2007, WHO had supported a meeting on the Regulations in order to review the capacity of the Pacific island countries and areas. Those needed to meet core functions, based on the Asia Pacific Strategy for Emerging Diseases, including medical services in the vicinity of airports, regional alert systems, surveillance, laboratory services and communication, with identified national focal points of which his country had five.

Funding was the difficulty for those countries in meeting their implementation targets for 2012. Partner-funded aid programmes had mechanisms for the Pacific Community, but those funds needed to be more accessible. Kiribati had many requirements to meet. He thanked WHO and partners for their support and urged them to maintain it.

Dr DAHN (Liberia), speaking on behalf of the 46 Member States of the African Region, recognized the need to reduce people's vulnerability to acute and cross-border health threats. A revision of the integrated disease surveillance and response guidelines would help, but would have to take place at all levels of the health-care delivery system.

Country preparedness and response capacities differed across the African Region. Therefore a plan to provide the required skills and capacities specific to individual countries should be drawn up and every country able to carry out preliminary diagnosis and even confirmatory diagnosis of diseases. That would reinforce implementation of the draft resolution.

The African Region was a target for the dumping of nuclear waste, with associated health implications. Global surveillance systems should be capable of detecting chemical and radioactive leaks, and international partnerships and response were essential to minimizing those threats.

The African countries remained committed to implementation of the International Health Regulations (2005); however, the Region was challenged in mobilizing additional resources. She looked forward to collaboration with the other Regions in achieving the goals of the Regulations.

Mr HERBERT (Saint Kitts and Nevis) expressed support for the draft resolution, commitment to timely reporting and implementation of the International Health Regulations (2005) and thanks for WHO support. The Office of the Chief Medical Officer had been designated the national focal point. National core capacity would be assessed, before the end of 2008, in conjunction with the Caribbean Epidemiology Centre. He asked WHO to extend support in strengthening that Centre's surveillance and laboratory services.

Dr ST JOHN (Barbados), speaking on behalf of the member countries of the Caribbean Community, said that an intercountry assessment of port health systems in six Caribbean countries in 2004 had revealed inadequacies in port health services, human resources and training, disease surveillance systems and laboratory capacity. PAHO had offered remedial action through training in preparation for the 2007 Cricket World Cup, held in the Caribbean, which had tested countries' readiness to implement the revised Regulations and to develop strategic plans. PAHO's continuing technical cooperation had included a workshop in June 2008 to examine core capacity requirements; the issuance of ship sanitation certificates; and support for surveillance of communicable diseases, including influenza. Country legislation was being harmonized with the Regulations and port health guidelines elaborated. All countries of the Caribbean Community had named focal points. The countries concerned supported the draft resolution.

Dr GHEBRESELASSIE (Ethiopia) said that proper implementation of the International Health Regulations (2005) by all Member States was a matter not of choice but of necessity. Ethiopia was developing a plan for addressing public health emergencies in the framework of the African Regional Strategy for Integrated Disease Surveillance. The centre responsible for prevention, preparedness, detection, response and recovery was preparing training in epidemiological surveillance. WHO should support capacity building in these areas and in the neediest countries. Ethiopia was one such country. He emphasized access to WHO's event information site for national focal points.

Dr SOPON IAMSIRITHAWORN (Thailand) said that Thailand had a five-year plan for implementing the International Health Regulations (2005) by 2012. That only 10% of the 231 public health events in the event management system had been communicated to WHO through national focal points emphasized a need to improve the system and information-sharing among focal points in countries within regions. Accordingly, he proposed that a new subparagraph 4(3) should be added to the draft resolution, to read: "to create a platform for effective communication among National IHR Focal Points concurrent with communications with WHO IHR contact points and to encourage sharing of information on outbreaks in order to facilitate alert and appropriate responses for the prevention and control of infectious diseases across borders". As the International Health Regulations (2005) indicated that the first review of the functioning of Annex 2 should take place no later than one year

after the entry into force of the Regulations, he also proposed that “Sixty-third” in subparagraph 2(3) should be replaced by “Sixty-second”.

Mrs VIREM (France) said that France’s surveillance and response system would fully meet the requirements of the revised Regulations. She welcomed the progress reported and supported the draft resolution. The Secretariat should support Member States by finalizing guides on sanitation in aircraft and ships and preparing a list of countries and areas affected by vectors. She requested clarification of the procedure for transmission of confidential information from national focal points to WHO, on coordination with the contact points in the regional offices, and of the obligations of national focal points with respect to points of entry.

Dr BALVINDER SINGH GILL (Malaysia) said that Malaysia’s implementation of the Regulations included establishment of the national focal point, strengthening core capacities, training of health personnel in use of the decision instrument in Annex 2, and revision of disease control legislation. He supported the draft resolution.

Mrs LANGIDRIK (Marshall Islands) expressed doubt that the International Health Regulations (2005) could be effective as a global regulatory mechanism unless all countries participated. The Secretariat should provide Member States with more technical support for the burdensome compliance with the Regulations.

Dr TEY (Singapore) said that Singapore’s comprehensive alert and response system met the requirements of the Regulations. All countries must inform the global community on public health emergencies of international concern. International health security required the collaboration and trust of all stakeholders.

Ms ALI (Maldives) said that Maldives supported the draft resolution but was under technical and financial constraints in implementing the International Health Regulations (2005). As a country dependent on international tourism and trade, it needed to strengthen health measures at its ports for its citizens and visitors. The Secretariat should continue to support capacity building with Member States and develop a clear mechanism for dealing with non-compliance with the Regulations.

Dr MARQUES DE LIMA (Sao Tome and Principe) expressed appreciation to the Regional Office for Africa for support to Member States in their implementation of the International Health Regulations (2005) by organizing meetings for national focal points, control personnel and in disease prevention. His country was finalizing implementation plans. In order to achieve universal application of the Regulations, information should be transmitted to those countries that had been unable to implement the Regulations independently. He supported the draft resolution.

Dr MINNIS (Bahamas) said that the International Health Regulations (2005) would not be implemented on schedule without greater capacities at every level. As an archipelago, the Bahamas had recognized that strengthened port health surveillance and pandemic influenza preparedness had to be coordinated and integrated. Comprehensive pandemic preparedness had been developed with support from WHO and partners.

A simulation drill had demonstrated the improvements for rapid response and containment needed within the health system. Completion of the regional protocol for port health surveillance would further identify and guide best practices.

Of particular concern to the Bahamas was the required assessment of core country capacities, and it still awaited the Caribbean assessment instrument. The national focal point, established within the Office of the Chief Medical Officer, kept up to date through WHO’s event information site and the reporting mechanisms. He requested more information about WHO reporting requirements in relation to the International Food Safety Authorities Network. He supported the draft resolution.

Dr XING Jun (China) supported the draft resolution. His Government attached great importance to the International Health Regulations (2005) and had established focal points and relevant regulatory bodies. Steps taken included multisectoral coordination; strengthened laws and regulations; training and awareness-raising campaigns for the health and quarantine departments. His Government had invested heavily in the public health system. It had established a direct reporting and disease surveillance network covering 31 provinces, and enhanced its prevention and treatment of avian influenza and its pandemic influenza preparedness. It had also cooperated extensively with WHO.

Effective implementation of the Regulations required: WHO's timely analysis and evaluation of information about public health emergencies and management; further guidance and feedback regarding the instrument suggested in Annex 2; that each region be regarded as a unit for the purposes of training and capacity building, as countries within a region shared characteristics; WHO's strengthened support for building capacity in developing countries; strengthened reporting systems for the Regulations; and enhanced coordination with the International Food Safety Authorities Network.

Mrs CHISTYAKOVA (Russian Federation), focusing on implementing the International Health Regulations (2005), welcomed the Secretariat's support for Member States, the fostering of partnerships and creation of a health security and environment cluster at headquarters. Implementation was being strengthened in her country through the network of laboratories monitoring infectious diseases, mobile emergency response, and intersectoral cooperation. In 2007, it had hosted the eighth inter-State conference on a global strategy against infectious diseases in countries of States Parties of the Commonwealth of Independent States.

The situation concerning outbreaks of infectious diseases needed an annual review. Public health risks of international concern relating to biological or chemical agents, radioactive materials and waste, and other dangerous goods required the development of an algorithm for information exchange between the Secretariat and Member States. Ports entitled to release a vessel from quarantine should be listed. She supported the draft resolution.

Dr MIDZI (Zimbabwe), voicing support for the International Health Regulations (2005), said that Zimbabwe had established intersectoral communication channels and a national focal point, and had held a training workshop to improve capacity in August 2007. Implementation of the Regulations was planned for July 2008, enhancing communication with regional WHO contact points and strengthening surveillance at airports and all land ports of entry. Zimbabwe remained open to any technical and financial support from WHO and other stakeholders.

Dr ESTEGHAMATI (Islamic Republic of Iran) said that full implementation of the International Health Regulations (2005) would require further support to countries in order to improve surveillance of points of entry and strengthen laboratory networks or mobile laboratories. High-quality standard kits for rapid response to health threats should be developed, and regulatory mechanisms for the transparent sharing of data ratified. Uniform software and guidelines could be developed for surveillance and rapid containment of any events constituting a threat to world health. Web pages could be designed for easy public access and rapid data sharing.

Dr MALEFHO (Botswana) commended the Secretariat's support to Member States for implementing the International Health Regulations (2005). Botswana had amended its public health law by adopting the Regulations as law. The authorities responsible for carrying out health measures under the Regulations and relevant focal points had been designated. A port health programme, assessment of needs at points of entry and the development of core capacities had all begun. The Regulations had been incorporated into training materials for health workers as part of the International Strategy for Disaster Reduction. Botswana required technical support for port health training and a code of practice for health screening at points of entry.

Dr HEYMANN (Assistant Director-General) said that the International Health Regulations (2005) had already shown their value on several occasions. A recent outbreak of Rift Valley fever had

been reported by the Sudanese Government through its national focal point. WHO, FAO and OIE had responded, and the focal points in all Member States had been alerted to the significance of the outbreak at a time when cattle were being traded throughout the area, and countries had therefore been able to manage the risk. The focal points for the Regulations had been linked closely with the International Food Safety Authorities Network, and a recent survey of Member States had shown that focal points had been designated in all the respondent countries. Further survey results would be provided to focal points for the Regulations in due course.

With regard to the decision tool in Annex 2 of the Regulations, field testing was in progress and methods of assessing effectiveness would be worked on at an expert meeting. The Regulations remained an invaluable framework for strengthening core capacities, including through the preparation of public health laboratories and epidemiological training. International preparations for outbreaks of avian influenza and other infectious diseases were under way in line with the Regulations. WHO would continue to work within that framework to make it the dynamic and proactive instrument for public health security envisaged by Member States. The WHO regions continued to work with Member States on plans to strengthen core capacity over the next five to seven years. In June 2007, an internal WHO exercise had evaluated communication in the context of the Regulations, and in June 2008 an exercise involving regional offices, country offices and national focal points in the simulation of a pandemic would be undertaken in order to identify what needed strengthening. In June 2008, the United Nations system would be conducting an internal evaluation of its response to a pandemic using the Regulations as a framework; involvement of nongovernmental organizations in the response to such a pandemic would be considered in September.

Dr IVANOV (Assistant Secretary), reading out the amendments proposed during the discussion, recalled that Brazil had suggested replacing “biennially” in subparagraph 2(1) with “annually”, and that Thailand had suggested that “Sixty-third” in subparagraph 2(3) should be replaced with “Sixty-second”. In subparagraph 4(1), Brazil had suggested that “every two years” should be amended to read “every year”. Lastly, Thailand had suggested the addition of a new subparagraph 4(3), to read: “to create a platform for effective communication among national IHR focal points concurrent with communications with WHO IHR contact points, and to encourage sharing of information on outbreaks in order to facilitate alert and appropriate responses for prevention and control of infectious diseases across borders”.

Following a comment from Mr ABDOO (United States of America) on the need for more time to consider the amendments proposed, the CHAIRMAN said that a revised version of the draft resolution would be prepared for subsequent consideration by the Committee.

It was so agreed.

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

The meeting rose at 18:30.

FOURTH MEETING

Wednesday, 21 May 2008, at 09:30

Chairman: Dr F. CICOGNA (Italy)
later: Mr J.O. DA SILVA (Timor-Leste)
later: Dr F. CICOGNA (Italy)

TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

Global immunization strategy: Item 11.7 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R7, and A61/10)

Dr SADASIVAN (representative of the Executive Board) said that the Sixtieth World Health Assembly had noted the achievement of the goal of reducing by half deaths worldwide due to measles by 2005. In resolution WHA58.15 on the global immunization strategy, the Health Assembly had requested the Director-General to report to the Health Assembly every three years on progress towards achieving global immunization targets. At its 122nd session in January 2008, the Executive Board had considered a report on that subject, together with a draft resolution, which it amended and recommended to the Health Assembly in resolution EB122.R7.

Dr GARRIDO (Mozambique) said that vaccines were the most cost-effective method of reducing infant mortality, and could greatly contribute to achieving Millennium Development Goal 4. Remarkable progress had been made recently in vaccine research and development. He thanked WHO, UNICEF and the GAVI Alliance for their support for routine immunization to low-income countries. Mozambique was investigating improved use of underutilized vaccines such as typhoid vaccine. Infant and under-five child mortality rates could be reduced by incorporating all existing and new vaccines into routine immunization programmes within five years of launch and more fully exploit the full potential of immunization. In 2006, for example, 26.3 million children had still not been vaccinated against diphtheria, tetanus and pertussis. Mozambique was increasingly concerned at the high costs of new vaccines for its limited health budget, even with the support of the GAVI Alliance which lacked the funds to help countries to implement fully immunization programmes by 2015. Developed countries should honour the commitment of providing 0.7% of gross domestic product for development assistance.

Speaking on behalf of the Member States of the African Region, he proposed to amend the draft resolution by inserting additional text. A new fifth preambular paragraph would read: "Recognizing the availability of underutilized and new vaccines that could have a significant impact on the health of the peoples of the world, including the achievement of Millennium Development Goal 4". A new eighth preambular paragraph would read: "Concerned by the insufficient level of resources available for the introduction of new vaccines, especially in low- and middle-income countries, which will prevent these countries from achieving Millennium Development Goal 4". In the last preambular paragraph, the phrase "infant mortality" should be replaced by "under-five mortality rates". A new subparagraph 1(3) should be inserted, reading: "to adopt policies ensuring that new life-saving vaccines are introduced into national immunization schedules no later than five years after market availability and expand coverage with these new vaccines to accelerate the achievement of Millennium Development Goal 4". Finally, a new subparagraph 2(4) would read: "to work with UNICEF to build on existing international efforts and partnerships and facilitate the development of a consensus among developing and developed countries for meeting the financial gaps and other requirements for the attainment of Millennium Development Goal 4 through immunization."

Dr EZOE (Japan) commended WHO's leadership in promoting immunization and supported the draft resolution. Improved monitoring of the financial balance and coverage of vaccination programmes, and the incidence of adverse post-immunization events, was needed. Member States should consider using the strong infrastructure established by the Expanded Programme on Immunization, especially the programme for poliomyelitis, in all child health services. He emphasized regular vaccination programmes, while acknowledging the need for new vaccines. He proposed amending subparagraph 1(3) of the draft resolution by inserting the words "while maintaining the efforts to assure regular vaccination programmes" before "for all target populations".

Mr FISKER (Denmark) said that the global immunization strategy could become a major tool in the prevention of infectious diseases, provided that it was resourced and implemented appropriately, and adapted to the needs and priorities of each country. The recent Immunization Week in Europe had highlighted the importance of immunization programmes.

Ms ACUÑA NAVARRO (Costa Rica) said that her country had carried out all the recommended immunization measures backed by a universal and properly funded system of health care with good rates of vaccination coverage. However, incorporating new vaccines into routine immunization was expensive and required sustainable mechanisms for vaccine procurement, such as revolving funds. In seeking to achieve the Millennium Development Goals, Costa Rica was anxious to introduce the new pertussis, rotavirus and pneumococcal conjugate vaccines. The Secretariat's report should have included ways in which the GAVI Alliance could help countries like hers to sustain the introduction of those vaccines.

Dr METAI (Kiribati) supported the draft resolution and the suggestions for amendments. Kiribati was fully committed to the Global Immunization Vision and Strategy 2006–2015, including the reduction of deaths from measles by 90% by 2010. In 2007, Kiribati's immunization coverage had exceeded 95%. Mass campaigns had been more effective than routine immunization in getting vaccines to children, owing to the logistical problems of its islands. It was difficult to get vaccine to neonates within the first 24 hours of birth. Application of the out-of-cold-chain policy for delivery of hepatitis B vaccine might solve the problem. Since 2000, the country had not had any cases of measles, neonatal tetanus, poliomyelitis, pertussis or diphtheria. It would introduce *Haemophilus influenzae* type b vaccine in 2008 with support from the GAVI Alliance and WHO. Kiribati had substantially reduced its under-five mortality rate, but children were still dying from diarrhoea and from nutrition-related and influenza-like illnesses. He would encourage countries able to produce large quantities of vaccines to do so and thereby meet the needs of others. He thanked WHO, UNICEF, the GAVI Alliance and other partners for their support.

Dr BAI Huqun (China) commended the Secretariat's report. In keeping with the Global Immunization Vision and Strategy, Member States were improving immunization rates with reduced under-five mortality, and implementing the WHO/UNICEF strategic plan for reduced measles mortality. In 2006, China had adopted a measles eradication plan for 2006–2012, aimed at reducing the national measles rate to one per million, and eliminating endemic measles by 2012. The plan also included measures on immunization, prevention, disease surveillance, epidemic containment and management of infection sources. China had made significant progress in adapting new and underutilized vaccines. The national immunization plan covered 14 types of vaccine, including those against meningitis and hepatitis A. Central government was responsible for vaccine purchases and injector expenses. Member States needed extra support in their decision-making and funding for the adoption of new vaccines, especially when evaluating the cost-effectiveness of new vaccines and their impact on public health. China was willing to cooperate further with WHO and other partners, in building capacity for immunization and pursuit of Millennium Development Goal 4.

Dr SOPON IAMSIRITHAWORN (Thailand), speaking on behalf of the Member States of the South-East Asia Region, welcomed the report. He commended all stakeholders in reducing measles mortality beyond 50%. Sustaining that level of coverage required effective primary health care and outreach services. The pressure to introduce new vaccines had to be balanced against their cost and sustainable use. His Region commended the “reaching every district” strategy, which promoted equality. It welcomed the child survival packages that included immunization, the vaccination weeks in various regions, and the continuing support of UNICEF and the GAVI Alliance.

The Region was, however, concerned that, despite additional resources for immunization and the strengthening of routine services, the prices of underused vaccines, such as pentavalent and *Haemophilus influenzae* type b vaccines, remained high. The vaccines remained monopoly products, and high prices were not affordable for governments. According to recent research, the epidemiology and disease burden of invasive pneumococcal diseases in Asia were not well established, and because of the high prices, only a few wealthier countries were using pneumococcal conjugate vaccines.

He proposed several amendments to the draft resolution. At the end of the seventh preambular paragraph, the words “middle-income countries” should be followed by, “due to the high cost of these vaccines and the lack of adequate numbers of manufacturers in developing countries of products that are prequalified by WHO”. Subparagraph 1(1) should begin: “to review the national strategy, programme performance and gaps for improvement and”. Subparagraph 1(3) should be amended to read: “to further expand access to, and coverage of, available, affordable and cost-effective new life-saving vaccines of assured quality and desired efficacy, in accordance with the burden of disease and national priorities, for all target populations in order to accelerate the achievement of Millennium Development Goal 4 and to ensure long-term financial and programmatic sustainability”. The following text should be inserted at the end of subparagraph 2(2): “, and to increase the number of manufacturers of WHO prequalified vaccines;”. In subparagraph 2(3), the word “new” should be inserted after “affordable”. The words “establish an integrated surveillance for adverse events following immunization and to minimize unnecessary” should be inserted in subparagraph 2(5) after “in order to”. A new subparagraph 2(8) should be added, as follows: “to accelerate the implementation of the global framework for vaccine-preventable disease surveillance and immunization programme monitoring, especially prospective, time-limited projects to generate comprehensive epidemiological data required to guide immunization programmes and strengthen national capacity for evidence-based policy decisions in adopting new vaccines.”

Mr Da Silva took the Chair.

Dr VIOLAKI-PARASKEVA (Greece) noted that much remained to be done to achieve Millennium Development Goal 4. Although more vaccines would soon be available, countries had financial constraints to consider. Millions of deaths had been prevented through the Expanded Programme of Immunization, itself a gateway for other low-cost interventions, but inequalities persisted.

Supporting the draft resolution, she proposed including two new preambular paragraphs: “Recognizing the immense contribution of immunization made to the control of the common communicable diseases in the countries where it has been effectively applied”, and “Recognizing that continued efforts are also required to strengthen surveillance of communicable diseases and ensure the quality of vaccine production, management and administration”. In subparagraph 2(1), the words “and increase collaboration” should be inserted after “to work”.

Mr HAGE CARMO (Brazil) said that both the report and the draft resolution appeared to imply that the slow rate of introduction of new vaccines was due to decisions made by individual Member States rather than to development complexities, the cost of new vaccines and the intellectual property regime. His country had taken measures towards achieving the Millennium Development Goals, maintaining the elimination of measles and eliminating rubella and congenital rubella syndrome. A rubella vaccination campaign in the current year was intended to immunize around 67 million

people under the age of 40. His country was committed to the global strategy, and he supported the draft resolution.

Dr ROSELL-UBIAL (Philippines) reiterated her country's commitment to reducing child mortality rates through routine immunization coverage. Measures had been introduced in 2007 to eliminate measles and neonatal tetanus, eradicate poliomyelitis and control hepatitis B and other vaccine-preventable diseases. Health sector expenditure would reflect the cost of new vaccines in child health packages. Surveillance and the Expanded Programme on Immunization were being stepped up.

The draft resolution should mention the need for all countries to ensure safe injection practices at all levels of the health-care system, with institutionalized monitoring and a technical checklist to be evaluated periodically. She emphasized the need for continued financial and technical support for low-income countries in logistics, systems management and cold chain equipment.

Dr ZARAMBA (Uganda), speaking on behalf of the Member States of the African Region, said that an average coverage of 82% for three doses of diphtheria-tetanus-pertussis vaccine had been achieved by the end of 2006, with a rate of more than 90% in 15 countries. The Region had made great progress in reducing the measles mortality rate and towards eradicating poliomyelitis, but needed to tackle water and sanitation issues in order to eradicate the latter disease. The "reaching every district" approach would bring about high immunization coverage. Thirty-two of the 46 Member States of the Region had received approval from the GAVI Alliance for the introduction of *Haemophilus influenzae* type b vaccine, already introduced into the routine immunization programmes of many countries. Thirty-eight countries had introduced hepatitis B vaccines, and 18 had expressed interest in introducing pneumococcal vaccines. Many countries had embraced the Regional Child Survival Strategy by integrating immunization, surveillance and other health interventions. Integrated "child days plus" brought together health education, immunization, deworming and vitamin A supplementation. Financial mechanisms, such as advanced market commitments, had increased the global supply of vaccines.

The Region's many challenges included investment for routine immunization, lack of access to immunization for around 8.7 million children, and the cost of new vaccines. Rubella was an emerging problem that would require increased attention.

He noted that the *Haemophilus influenzae* type b vaccine had virtually eliminated the disease in many African countries. The introduction of new vaccines would be necessary to achieving Millennium Development Goal 4. He acknowledged the contribution made by the international community and urged national governments to dedicate greater investment and management in immunization. He supported the draft resolution, with the amendments proposed by the delegation of Mozambique.

Dr SANTÍN PEÑA (Cuba) emphasized improved access to immunization and achieving higher coverage for underused vaccines such as that for hepatitis B. Developing countries should receive financial support for the introduction of new vaccines.

Cuba had pioneered immunization strategies: free immunization had been available to all since 1962 and vaccination coverage exceeded 95%; 13 diseases were covered by routine immunization with 10 vaccines and six of those diseases had been eliminated. Two severe clinical conditions, neonatal tetanus and tuberculous meningitis, had disappeared, and the morbidity and mortality due to the other diseases had been reduced by 95%. Cuba produced eight of its own vaccines. All vaccines were monitored by a regulatory authority. A network of surveillance and diagnostic laboratories provided rapid screening for emerging diseases. Cuba thanked WHO for support in obtaining vaccines. He supported the draft resolution.

Dr GARCIA (United States of America) supported the draft resolution. In many countries, poor, marginalized and unvaccinated children often suffered most from vaccine-preventable diseases. The

success of the global immunization strategy would depend on setting goals for coverage and for reductions in related mortality.

Member States and the Secretariat must collaborate to strengthen the monitoring of immunization coverage, disease surveillance and laboratory networks. Accurate data from vaccination programmes, such as coverage estimates, was essential to monitoring progress and thus strengthening the infrastructure required for new vaccines and technologies. The challenge to all Member States was how to launch new methods and devices, at affordable prices, and introduce them into ongoing immunization programmes. Public-private partnerships such as the GAVI Alliance were valuable, given strong and transparent management.

Dr MELNIKOVA (Russian Federation) noted the success of the WHO/UNICEF Global Immunization Vision and Strategy. Her country had maintained an immunization coverage level of between 96% and 99%. In the past two years, more than 25 million children and adults had been immunized against hepatitis B, and more than 11 million children and adolescents against rubella. Since a mass vaccination programme, very few cases of measles were reported.

Preventive work in any country had to include public information campaigns and efforts to counter negative ideas about vaccination. In her country and the rest of the European Region, population groups outside the mainstream had been reached through the European Immunization Week. It was important to develop and introduce new vaccines and to research the prevalence of vaccine-preventable infections. In 2007, her Government had contributed US\$ 80 million to an advance market commitment for vaccines.

Dr BELAYNEH (Ethiopia) noted that hepatitis B and *Haemophilus influenzae* type b vaccines had been introduced in 164 and 168 Member States, respectively. In March 2007, Ethiopia had introduced pentavalent vaccines, with the support of the GAVI Alliance, and evidence on the burden of rotavirus disease was being gathered.

Countries must be given support in deciding which vaccines to introduce and when. Progress in measles reduction was attributable mainly to activities such as intensified surveillance. Increasing access to immunization, such as the “reaching every district” strategy, had improved global coverage.

In efforts to achieve Millennium Development Goal 4 by 2010, Ethiopia had incorporated the global immunization strategy into its national plan. The African Region accounted for 70% of the global reduction in measles mortality. Ethiopia had improved coverage of routine measles immunization by implementing the “reaching every district” approach, establishing case-based management of measles and by integrated disease surveillance.

Many sub-Saharan countries had introduced national multiyear plans for immunization, with planning and monitoring done at district level and with innovative approaches such as the “reaching every district” strategy. The focus must shift to reaching every child, by targeting those countries and districts with large numbers of unvaccinated children. Ethiopia had established a health outreach programme with extension workers.

Dr MOHAMMED (Oman) said that the Global Immunization Vision and Strategy 2006–2015 had resulted in a significant reduction in mortality, particularly among women and children. It was regrettable that several vaccines were still underused, such as the hepatitis B vaccine, which was reaching only 60% of the population. The GAVI Alliance must review the pricing and affordability of vaccines. Efforts were needed in developing new vaccines for malaria, tuberculosis, HIV/AIDS and noncommunicable diseases.

Dr ROHANI JAHIS (Malaysia) said that international partners and donors should continue their support for the Global Immunization Vision and Strategy 2006–2015. Many countries required guidance from WHO when deciding to introduce new vaccines into immunization programmes. The Secretariat should negotiate with the vaccine companies in order to reduce prices of vaccines. With coordinated and systematic immunization services, Millennium Development Goal 4 would be achievable.

Mr HERBERT (Saint Kitts and Nevis) said that his country's immunization programme had achieved universal coverage against the common vaccine-preventable diseases. Since the early 1990s, there had been no death or case of illness attributable to those diseases and his Government's sustained investment would continue, as would cooperation with Caribbean partners to enhance the Expanded Programme of Immunization. He drew the Director-General's attention to the work of the Caribbean Epidemiology Centre and the need to sustain that vital institution. He supported the draft resolution.

Mr MCKERNAN (New Zealand) said that he supported efforts to implement comprehensive immunization programmes. Progress had been made in vaccinating against measles but much work remained, given the number of children who died from vaccine-preventable diseases. New Zealand had recently adopted an immunization target as one of its 10 health targets and immunization now included human papillomavirus and pneumococcal vaccines. An immunization campaign had been completed against group B meningococcal disease, which had reached epidemic proportions in the country during the previous decade and had been dramatically reduced through a 90% vaccination rate. He supported the draft resolution.

Dr OUAHDI (Algeria) said that his country had achieved significant immunization coverage through the expanded programme. It would not use the vaccines against typhoid fever or hepatitis A, as that could obscure the underlying problems of those diseases: unsafe drinking water and poor hygiene. The funds allocated to those vaccines should be used to make safe drinking water and sound hygiene accessible to all. The draft resolution should recognize the limitations of those vaccines and emphasize the need to secure safe drinking water and proper sanitation for all as the best way to eliminate all water-borne diseases. Algeria was willing to share its experience in preventing those diseases through improved public hygiene and universal access to safe drinking water.

Mr CLARKE (Barbados) said that his country had introduced child health days and vaccination weeks. It had also achieved significant results and recognition by the Caribbean Epidemiology Centre and PAHO for its work in combating vaccine-preventable diseases. In 2007–2008, the country had no case of poliomyelitis, neonatal tetanus, measles, rubella or yellow fever.

He supported the targets set in the Global Immunization Vision and Strategy 2006–2015. The Secretariat should support countries in obtaining high-quality vaccines, encourage the development of vaccines for neglected diseases, and support Member States in decision-making, monitoring, and reporting on progress in their immunization campaigns. He supported the draft resolution.

Dr TEY (Singapore) said that her country supported the introduction of new and underused vaccines. However, given the rising emergence and re-emergence of infectious diseases and the rapid advances in the research and development of new vaccines, the Organization should work with vaccine manufacturers and funding agencies to ensure that life-saving vaccines were affordable and accessible for countries in need.

Dr OTTO (Palau) said that his country had achieved zero measles mortality and an overall immunization coverage rate of more than 95%. Thus it had met both the targets set for those indicators in the Global Immunization Vision and Strategy 2006–2015 and Millennium Development Goal 4. He thanked WHO and UNICEF for support in establishing an effective immunization programme and partners for financial resources, vaccine supplies and technical assistance. Supporting the draft resolution, he suggested inserting the words "and intergovernmental" in subparagraphs 2(2) and 2(3) after "to collaborate with international", in order to include intergovernmental partners such as the Secretariat of the Pacific Community.

Dr HAFIZ (Pakistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that measles mortality had been significantly reduced. Overall immunization coverage had increased from 79% in 2000 to 87% in 2006. By 2007, 21 countries had introduced hepatitis B

vaccine and 15 had introduced *Haemophilus influenzae* type b vaccine. However, several poorer countries and those experiencing complex emergency situations needed more support in order to increase routine immunization and vaccination coverage and introduce new life-saving vaccines. He supported the draft resolution.

Mr MENESES (Mexico) said that in his country immunization coverage was good and equality of access to vaccination was improving. New and pentavalent vaccines were being introduced, and surveillance of vaccine-related adverse events had been strengthened. The campaign to eradicate congenital rubella had achieved a coverage rate of more than 98%. Under the universal immunization programme, vaccination teams went into the community on an ongoing basis, and vaccination weeks aimed for coverage of all children, and especially to eradicate poliovirus. He supported the draft resolution.

Dr RAMATLAPENG (Lesotho) said that her country's routine immunization coverage had been satisfactory, except for measles. The threat of a measles outbreak had led to supplementary immunization activities in October 2007, and a coverage rate of 92%. With technical support from the Regional Office for Africa, pentavalent vaccine had been introduced, with vitamin A supplementation, albendazole treatment, and treatments for HIV/AIDS. The "reaching every district" strategy had developed microplans that tackled pockets of low coverage, the decentralization of services was continuing and community health workers had been given incentives.

Reducing the disease burden should incorporate injection safety, for both immunization and therapeutic care, given that more than 20 blood-borne pathogens could be transmitted through contaminated needles, including HIV. Vaccine injections were currently delivered with auto-disable syringes and bundled with safety boxes for disposal. The guidelines governing immunization should be applied in the administering of other injections. Together with other African States, Lesotho had agreed on a comprehensive injection safety resolution, and she called on the Health Assembly to support universal safe injection practices. She supported the draft resolution, suggesting the inclusion in subparagraph 1(4) of a reference to monitoring compliance with safe injection.

Dr Cicogna took the Chair.

Ms DLAMINI (Swaziland) said that her country's slight decline in immunization coverage had been reversed by implementing the "reaching every district" strategy. National child health days had extended immunization coverage to marginalized populations. Child survival interventions, including vitamin A supplementation and deworming, had been integrated into the routine immunization programme. She requested support from the Organization in implementing cross-border immunization and inclusion on the list of beneficiaries in the GAVI Alliance.

Mr NIBLETT (United Kingdom of Great Britain and Northern Ireland) said that his Government's support for the Global Immunization Strategy included significant grants to the GAVI Alliance, the International Finance Facility for Immunization over 20 years, and poliomyelitis eradication, as well as an advanced market commitment to develop new pneumococcal vaccines. That support intended to deliver the widest range of vaccines through effective health systems, and bring new vaccines to market in low-income countries. There was a need to extend the safe injection practice for vaccines to all injections in order to prevent the spread of HIV and hepatitis B virus by that route.

Dr OJHA (Nepal) said that Nepal's immunization programme, covering all districts, had reduced infant and under-five morbidity and mortality and was making progress towards meeting the objectives of Millennium Development Goal 4. Vaccine-preventable diseases were routinely reported, and outbreak response and integrated surveillance had been established for acute flaccid paralysis, measles, neonatal tetanus and Japanese encephalitis. He thanked WHO and all partners for their support.

Immunization coverage for diphtheria-tetanus-pertussis vaccine, measles vaccine and BCG vaccine stood at 89%, 85% and 90% respectively, and all-antigen coverage at 83%. Nepal aspired to achieve and sustain a coverage rate in excess of 90% for diphtheria-tetanus-pertussis vaccine by 2008, and for all antigens by 2010; and to attain poliomyelitis-free status in collaboration with its neighbours. It aimed to expand those programmes and to step up control of other vaccine-preventable diseases by introducing new vaccines.

Dr BAE Geun-ryang (Republic of Korea) emphasized the reported achievements of WHO's Expanded Programme on Immunization. His country had been declared measles-free in 2006, and maintained measles immunization coverage at more than 95%, but in 2007 it had experienced a nosocomial outbreak of the disease, which was still endemic in neighbouring countries, highlighting the need for region-wide commitment to communicable disease control. Plans included expanded immunization by improved access to medical services and enhanced monitoring and assessment through nationwide immunization registers.

His country fully supported the policy of WHO and would work with other Member States and international organizations to improve vaccination coverage and ensure stable supplies of vaccines.

Dr SHARBAWI (Brunei Darussalam) said that her country provided immunization free of charge to children of any nationality. Immunization was mandatory, and coverage rates were well above 95%. A 2007 survey had reported 100% coverage of infants aged between 12 and 24 months. Children received their second dose of measles, mumps and rubella vaccine at three years of age. By reducing the interval between the two doses, coverage of up to 99% could be achieved in the shortest possible time, thereby preventing future outbreaks or epidemics. High coverage rates and the falling mortality rate among children under five reflected the high-quality immunization services. She supported the draft resolution.

Dr MARQUES DE LIMA (Sao Tome and Principe) observed that the laudable progress made in measles immunization had already proved the worth of the strategies applied. No case of measles had been reported in his country since 1993. Member States and financial partners should redouble their efforts to promote new and underused vaccines. His country intended to introduce several such vaccines by 2012 and looked forward to the arrival of vaccines against diseases such as malaria, dengue fever and tuberculosis, which were significant causes of morbidity and mortality.

He expressed concern that, according to paragraph 17 of the report, certain countries were ineligible for funding from the GAVI Alliance to strengthen vaccination capacity. Steps should be taken to ensure that children in those countries were entitled to immunization.

He proposed that a new subparagraph 1(5) be inserted into the draft resolution, to read: "to strengthen surveillance of vaccine-preventable diseases and monitoring of vaccination programmes".

Dr URBINA (El Salvador), expressing concern about the potential impact on human health of climate change, food shortages and other future scenarios, said that it was completely unjustifiable that a child or adult should die anywhere in the world from vaccine-preventable diseases. El Salvador's immunization programme had achieved coverage of more than 95%, eradicating poliomyelitis and bringing diphtheria, tetanus, pertussis, measles, rubella and tuberculosis under control. Funding had been increased for coverage against hepatitis B, influenza and rotavirus disease. There had been no death from rotavirus disease or pneumonia in the past two years. She supported the draft resolution and urged all countries to adopt an integrated, community approach.

Dr GHOLBZOURI (Morocco) reaffirmed her country's commitment to reducing infant and child morbidity and mortality. Morocco's immunization strategy had achieved 90% coverage since 1995 and routine vaccination was carried out against poliomyelitis, which had been eradicated in 1987. Vaccines were provided free of charge through mobile and static health-care services. Having introduced the *Haemophilus influenzae* type b vaccine in 2006, Morocco aimed to introduce rotavirus

vaccine and pneumococcal conjugate vaccine. Attention was also being paid to the issue of injection safety. She thanked all partners. Technical and financial support would help in maintaining optimal and regular immunization coverage with epidemiological surveillance.

Dr RAFIQUE (Bangladesh) outlined his country's plan for reduced measles mortality 2006–2010. Measles surveillance activities had received support from WHO and only four measles outbreaks had occurred in 2007. Routine immunization had resulted in coverage rates in 2006 of 82% for diphtheria, tetanus and pertussis vaccine, 93% for measles and 98% for BCG, with 82% of children being fully immunized. A "reaching every district" strategy was used to plan and evaluate activities under the WHO Expanded Programme on Immunization.

The period 2003–2005 had seen the introduction of hepatitis B vaccine and auto-disable syringes, which had become the only means of delivering routine immunizations and could be produced locally. A pentavalent vaccine including *Haemophilus influenzae* type b was planned for introduction in 2008, and pneumococcal conjugate vaccine would be introduced if availability permitted. Having developed its capacity in vaccine coverage, Bangladesh looked forward to building capacity in vaccine production, for which technical assistance and support would be needed from WHO.

Dr MHLANGA (Zimbabwe) said that his country's oral poliomyelitis vaccine coverage had met the target of 80% in 2006, although recent reports indicated a slight decline. The "reaching every district" strategy, introduced in 20 districts, had improved programme management and would be extended to cover the whole country in 2008 with financial support from WHO and other partners. Child health days, conducted in June and November 2007, had included measures to guard against the risk of imported poliomyelitis.

Dr HOMASI (Tuvalu), expressing support for the draft resolution, said that, although Tuvalu enjoyed high immunization coverage for all vaccine-preventable diseases, there was concern about adult populations who had never been vaccinated. The high prevalence of hepatitis B among the adult male population, in particular seafarers, required a "catch-up" vaccination programme, but Tuvalu lacked the necessary expertise and finance, for which he requested support from WHO.

To highlight the role of breastfeeding in immunization, he suggested inserting a new subparagraph 1(5) to read: "to strengthen efforts to protect, promote and support breastfeeding".

Mr JAFFAR (Iraq) said that the effectiveness of immunization was demonstrated by decreased mortality rates. He emphasized international partnership, given that infectious diseases knew no borders. Iraq had successfully implemented routine and targeted immunization campaigns. Its last case of poliomyelitis had been reported in December 2000, and child mortality rates were falling. New vaccines had also been introduced.

The security situation in the country had affected immunization rates, despite the dedication of health personnel, many of whom had become victims of the violence. An international framework was needed so that immunization could continue in areas of conflict, insecurity or disaster, and thus prevent the spread of vaccine-preventable diseases in affected regions.

Dr AMANKWAH (Ghana) said that the Global Immunization Strategy was yielding immense benefits. Yellow fever vaccine had been included in Ghana's routine immunization programme since 1992; hepatitis B and *Haemophilus influenzae* type b vaccines in 2002; and pneumococcal conjugate vaccine was planned for 2010. High immunization coverage rates had been achieved through the "reaching every district" approach. Of 588 suspected cases of measles in 2007, only six had been confirmed, and no deaths reported for five years. He requested support for cold chain facilities, which would enhance immunization programmes, particularly in developing countries. He supported the draft resolution.

Mrs LANGIDRIK (Marshall Islands) said that her country had learnt hard lessons from an outbreak of measles five years previously. Immunization coverage had been boosted to 60%. Rotavirus vaccine and pneumococcal conjugate vaccine would be introduced during 2008 and she thanked partners for their support. The geography of the Marshall Islands presented many challenges for the country's immunization programme, in particular the high cost of fuel.

Mr TOURAB (Djibouti) said that, with the help of WHO, UNICEF, the GAVI Alliance and other partners, progress had been made in protecting all children in his country from vaccine-preventable diseases with improved vaccination coverage in the most inaccessible areas. Hepatitis B and *Haemophilus influenzae* type b vaccines had been introduced in 2007, and rotavirus and pneumococcal conjugate vaccines would follow in 2008. The eradication of measles through increased immunization coverage required continued support from its partners, and from WHO, which should also strive to keep down the cost of vaccines and to encourage countries to produce their own.

Dr PÉREZ SIERRA (Bolivarian Republic of Venezuela) said that her country aimed to establish a preventive programme of vaccination for all, to be compulsory for certain vaccine-preventable diseases. Following significant investment, the programme had 14 vaccines.

The campaign to eradicate measles in October 2007 had achieved a coverage rate of 97% immunization. Vaccination Day in the Americas aimed to cover more than one million people. Venezuela was contributing to PAHO's Rotating Fund for purchasing vaccines and syringes, funding vaccine cold chain management teams, introducing new vaccines in Latin America and the Caribbean, and, through WHO, supporting the eradication of poliomyelitis in Africa and Asia. She supported the draft resolution.

Dr MUKELABAI (UNICEF) noted that many countries had achieved high rates of routine immunization coverage. Measles mortality rates had decreased by more than 70% in many countries, contributing to reducing the under-five mortality rate and achieving the Millennium Development Goals. Combining measles vaccination campaigns with the distribution of insecticide-treated bed nets and vitamin A supplementation had helped to reduce deaths related to malaria and other childhood infections. However, many countries still needed to sustain routine immunization coverage of 90% or more. The "reaching every district" approach, and child health days or weeks, could boost immunization coverage rapidly. Poliomyelitis immunization campaigns should be used to strengthen routine immunization infrastructure. The introduction of new vaccines was strongly recommended.

He thanked WHO, Rotary International and partnerships for their support for countries in eradicating poliomyelitis. UNICEF continued to support the enhancement of routine immunization coverage throughout the world. He supported the draft resolution.

Ms ELDER (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, applauded the global reduction in measles mortality, the millions of lives saved and the progress made in reaching the most vulnerable communities, and ultimately the Millennium Development Goals. Her Federation's worldwide base of community volunteers were ready to support countries in the Measles Initiative to attain the highest coverage levels in routine and supplementary immunization, reduce vaccine-preventable morbidity and mortality and alleviate suffering. In 2007, it had supported measles campaigns in 35 countries. In 13 of those, more than 20 000 volunteers had mobilized their communities by educating the public in the importance of immunization. Work would continue with WHO in order to achieve the target of reducing measles mortality by 90% by 2010. She urged all Member States to work together with their national Red Cross and Red Crescent Societies.

Ms ARENDT LEHNERS (International Lactation Consultation Association), speaking at the invitation of the CHAIRMAN, quoted from an article in *The Lancet* referring to the immunostimulant properties of breast milk. According to recent data, more than one million infant deaths could be

prevented through breastfeeding which, as the first freely available form of immunization, should be mentioned in the global immunization strategy. In that light, she welcomed the amendment proposed by the delegation of Tuvalu to the draft resolution.

Ms MAFUBELU (Assistant Director-General), acknowledging the contribution by Member States, thanked UNICEF and the International Federation of the Red Cross and Red Crescent Societies for their outstanding work in partnership with WHO in the area of vaccine-preventable diseases. She congratulated Member States, in particular with respect to measles: deaths had fallen by 68%, and by 91% in Africa, so achieving the 2012 goal four years ahead of time. The same success could be achieved with other vaccine-preventable diseases.

Financial support was important in achieving success, particularly in low-income and middle-income countries. She would convey that message to the Board of the GAVI Alliance, so that it might revisit its eligibility criteria. She encouraged country representatives on that Board to do likewise. The prices of pentavalent vaccines reflected an almost monopolistic situation. However, UNICEF expected a fall in prices from 2010 onwards, with more producers from developing countries coming onto the market. With regard to data quality, gaps had been identified by countries through quality audits and surveys. A data management workshop on global immunization had been held in February 2008, and its recommendations were being implemented. She undertook to make future reports on data quality analysis.

The Secretariat would collaborate with Member States and other partners in order to ensure and sustain high immunization coverage, and promote new and underutilized vaccines. The Secretariat would follow up on the issues and requests voiced in the discussions. Immunization efforts must continue to reduce under-five mortality.

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 eighth meeting.)

Polio myelitis: mechanism for management of potential risks to eradication: Item 11.2 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R1, and A61/5) (continued from the third meeting)

The CHAIRMAN drew attention to a revised version of the draft resolution contained in resolution EB122.R1, incorporating amendments proposed in the third meeting, reading:

The Sixty-first World Health Assembly,

Having considered the report on poliomyelitis: mechanism for management of potential risks to eradication;¹

Recalling resolution WHA60.14, which urged Member States in which wild poliovirus is still present, especially the four countries in which poliomyelitis is endemic, to intensify poliomyelitis eradication activities in order rapidly to interrupt all remaining transmission of wild poliovirus;

Recognizing the need to make rapidly available the necessary financial resources to eradicate poliomyelitis;

¹ Document A61/5.

Recognizing the need to ~~and~~ minimize the long-term risks of **inadvertent** reintroduction of poliovirus and re-emergence of poliomyelitis after interruption of wild poliovirus transmission [Greece];

Recognizing the need for international coordination of the strategies to minimize and manage the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis after interruption of wild poliovirus transmission globally;

Noting that planning for such international consensus must begin **now** ~~as soon as possible~~ [Jamaica] **in order to be ready for implementation without delay** [Finland] after transmission of wild poliovirus is interrupted globally,

1. URGES all remaining poliomyelitis-affected Member States to engage all levels of political and civil society in order to ensure that every child is consistently reached and vaccinated during every supplementary immunization activity against poliomyelitis, so that all remaining transmission of wild poliovirus is interrupted rapidly;

2. URGES Nigeria to reduce the risk of international spread of poliovirus by quickly stopping the outbreak in northern Nigeria through intensified eradication activities that ensure all children are vaccinated with oral poliomyelitis vaccine [Iran (Islamic Republic of)];

3. URGES Afghanistan, India and Pakistan to implement the large-scale mop-up activities now needed to interrupt their final chains of poliovirus transmission, given the very low levels of type 1 poliovirus now present in these countries [Canada];

2.4. URGES all Member States:

(~~1~~) (2) [Finland] to strengthen active surveillance of acute flaccid paralysis in order to detect **and identify promptly** ~~rapidly~~ [Greece] any circulating poliovirus and prepare for certification of poliomyelitis eradication;

(~~2~~) (3) [Finland] to complete the activities outlined in phase I of the WHO global action plan for laboratory containment of wild polioviruses¹ and prepare to implement appropriate long-term safeguards and biocontainment conditions for remaining wild polioviruses within ~~at most 6 to~~ [Jamaica] 12 months after detection of the last case of poliomyelitis caused by a circulating wild virus;

(~~3~~) (1) [Finland] to achieve ~~rapidly~~ and ~~to~~ maintain routine immunization coverage against poliomyelitis at a level greater than 80% of the childhood population **and set country-specific target dates** [South Africa];

(4) to make available rapidly the necessary financial resources to eradicate poliomyelitis and minimize the risks of reintroduction of poliovirus and re-emergence of poliomyelitis after interruption of wild poliovirus transmission;

3. 5. REQUESTS the Director-General:

(1) to continue to provide technical support to the remaining countries affected by poliomyelitis in their efforts to interrupt the final chains of transmission of wild poliovirus;

(2) to assist in mobilizing the financial resources necessary for full implementation of the intensified eradication effort and for ensuring that the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis are minimized;

¹ Second edition, document WHO/V&B/03.11.

- (3) to undertake the necessary research to characterize fully the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis, ~~and~~ to develop appropriate strategies and products for managing these risks, including safer processes for production of inactivated poliovirus vaccine and affordable strategies for its use, **and to set, if and when appropriate, a date for the eventual cessation of use of oral poliomyelitis vaccine use in routine immunization programmes** [Jamaica];
- (4) to develop a new strategy for renewed fight to eradicate poliomyelitis from the remaining **affected** [Greece] countries drawing on experience from regions where poliomyelitis is eradicated and on operations research in order to determine the most efficient and cost-effective interventions;
- (5) to report to the Health Assembly when she determines that transmission of wild poliovirus type 1 is likely to have been interrupted globally, and to submit with that report a proposal or proposals for review by the Executive Board for a mechanism to mitigate the risk of the reintroduction of poliovirus that does not involve amending the International Health Regulations (2005) or developing another binding instrument.

The CHAIRMAN invited the Committee to consider the draft resolution, as amended.

The draft resolution, as amended, was approved.¹

Implementation of the International Health Regulations (2005): Item 11.4 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R3, A61/7 and A61/7 Corr.1) (continued from the third meeting)

The CHAIRMAN drew attention to a revised version of the draft resolution contained in resolution EB122.R3, incorporating amendments proposed in the third meeting, reading:

The Sixty-first World Health Assembly,
Having considered the report on implementation of the International Health Regulations (2005);

Recalling resolution WHA58.3 on revision of the International Health Regulations, which decided that the Sixty-first World Health Assembly would consider the schedule for the submission of further reports by States Parties and the Director-General on the implementation of the International Health Regulations (2005) and the first review of their functioning, pursuant to paragraphs 1 and 2 of Article 54 of the Regulations;

Underscoring the importance of establishing a schedule to review and evaluate the functioning of Annex 2, pursuant to paragraph 3 of Article 54 of the International Health Regulations (2005);

Mindful of the request to the Director-General in resolution WHA59.2 on application of the International Health Regulations (2005) to report to the Sixtieth World Health Assembly and annually thereafter on progress achieved in providing support to Member States on compliance with, and implementation of, the International Health Regulations (2005);

Recognizing the need to rationalize reporting on all aspects of implementation of the International Health Regulations (2005) in order to facilitate the work of the Health Assembly,

1. REAFFIRMS its commitment 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 of the Regulations;

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA61.1.

2. DECIDES:

- (1) in accordance with paragraph 1 of Article 54 of the International Health Regulations (2005), that States Parties and the Director-General shall report to the Health Assembly on the implementation of the Regulations ~~biennially~~ **annually** [Brazil], with the next report to be submitted to the Sixty-~~third~~**second** [Brazil] World Health Assembly;
- (2) in accordance with paragraph 2 of Article 54 of the International Health Regulations (2005), that the first review of the functioning of the Regulations shall be made by the Sixty-third World Health Assembly;
- (3) in accordance with paragraph 3 of Article 54 of the International Health Regulations (2005), that the first review and evaluation of the functioning of Annex 2 shall be submitted to the Sixty-~~third~~**second** [Thailand] World Health Assembly for its consideration;

3. URGES Member States:

- (1) to ensure that the contact details of the centre that has been designated as the National IHR Focal Point are complete and up to date and to encourage relevant staff within the centre to access and use the Event Information Site on the WHO web site;
- (2) to take steps to ensure that the national core capacity requirements specified in Annex 1 to the Regulations are developed, strengthened and maintained, in accordance with Articles 5 and 13 of the International Health Regulations (2005);
- (3) to designate an expert, if they have not already done so, for the IHR Roster of Experts, in accordance with Article 47 of the International Health Regulations (2005);
- (4) to continue to support each other and collaborate with WHO in the implementation of the International Health Regulations (2005), in accordance with resolution WHA58.3 and relevant provisions of those Regulations;

4. REQUESTS the Director-General:

- (1) to submit every ~~two years~~ **year** [Brazil] a single report, including information provided by States Parties and about the Secretariat's activities, to the Health Assembly for its consideration, pursuant to paragraph 1 of Article 54 of the International Health Regulations (2005);
- (2) to provide support to Member States with the most vulnerable health systems in strengthening core capacity requirements for surveillance and response at airports, ports and ground crossings, paying special attention to the sub-Saharan Africa laboratory network;
- (3) **to encourage the efforts to ensure effective communication between National IHR focal points concomitant with the communications with WHO IHR contact points and encourage the sharing of information on the state of actual outbreaks in order to facilitate alert and appropriate response activities for the prevention and control of infectious diseases across borders.** [Thailand]

Dr VOLJČ (Slovenia), speaking on behalf of the European Union, proposed replacing the words “to create a platform of ...” in subparagraph 4(3) by “to continue efforts to ensure ...”.

Dr XING Jun (China) said that he agreed in principle, but believed there was already adequate provision for exchanging information. A new system might make reporting by Member States more difficult. He suggested instead that the effective communication be “encouraged”.

Mr HAGE CARMO (Brazil) reiterated his request that the Secretariat provide information about the estimated date of completion and the procedures proposed, in regard to the guidelines referred to in resolution WHA58.3 for implementing and evaluating the decision instrument contained in the International Health Regulations (2005).

Dr OJHA (Nepal), speaking on behalf of the 11 Member States of the South-East Asia Region, expressed his support for the draft resolution.

Ms MURPHY (Australia) said that she supported any proposals to improve communication that would strengthen prevention and the response to outbreaks of communicable disease across borders. She supported the amended wording of subparagraph 4(3), beginning: “to create a platform of ...”.

Professor HOUSSIN (France) supported the draft resolution. However, before proposing any kind of “platform”, he preferred to wait for the results of the current analysis of information flows between headquarters, regional offices and focal points.

Dr VOLJČ (Slovenia), speaking on behalf of the European Union, said that the International Health Regulations (2005) already represented a platform on which to build effective communication. Certain means of doing so had already been created. He was, however, prepared to withdraw his amendment.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) said that it was not possible to await the result of the analysis being carried out by WHO, because it was vital to share information among Member States in the event of potential pandemics. He proposed that subparagraph 4(3) should begin “to encourage the efforts to ensure effective communication ...”.

Dr VOLJČ (Slovenia), speaking on behalf of the European Union, and Ms MURPHY (Australia), supported the new amendment proposed by the delegate of Thailand.

Dr ISLAM (Secretary) read out the amended text of subparagraph 4(3): “to encourage the efforts to ensure effective communication between National IHR focal points concomitant with the communications with WHO IHR contact points and encourage the sharing of information on the state of actual outbreaks in order to facilitate alert and appropriate response activities for the prevention and control of infectious diseases across borders;”.

The CHAIRMAN invited the Committee to consider the draft resolution, as amended.

The draft resolution, as amended, was approved.¹

The meeting rose at 12:25.

¹ Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA61.2.

FIFTH MEETING

Wednesday, 21 May 2008, at 14:40

Chairman: Dr F. CICOONA (Italy)

TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

Female genital mutilation: Item 11.8 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R13, and A61/11)

Dr SADASIVAN (representative of the Executive Board) said that the report of the Secretariat to the Executive Board at its 122nd session in January 2008 had outlined action taken towards eliminating female genital mutilation since the adoption of resolution WHA47.10 in 1994. Members had highlighted the gravity of that practice, noted that it violated human rights, and favoured enhanced work towards its elimination. They had strongly supported the draft resolution, which had built on the interagency statement on eliminating the practice. Most amendments to the draft resolution proposed by Members had been agreed upon, but some bracketed text remained where no consensus had been reached. The reference in the draft resolution to the resolution of the United Nations Commission on the Status of Women on ending female genital mutilation should be amended to refer to the final version (document E/CN.6/2007/L.3/Rev.1), from which some of the contentious wording in the draft resolution had been taken. The Health Assembly was invited to consider the draft resolution on female genital mutilation.

Mr FISKE (Denmark), speaking on behalf of the Nordic countries, said that the Americas Group, the European Union, Andorra, Canada, the Libyan Arab Jamahiriya, Monaco and New Zealand aligned themselves with his statement. Female genital mutilation, as outlined in the report, must be eliminated. It was violence against women and girls that seriously impeded their human rights, including their right to the highest standard of health. He complimented WHO on its research, advocacy and training, and approved the launch of the interagency statement. However, action had been limited, resources scarce and results modest. He urged the Director-General to make increased, more systematic efforts and to take coherent action. Near universal support for the draft resolution, as amended, should convince the Health Assembly to overcome the few remaining differences. Comprehensive action was needed at all levels in those countries in which female genital mutilation took place to bring about elimination, at the latest within one generation.

Ms SELAO (South Africa) said that South Africa was one of 16 countries in Africa to have taken steps to criminalize female genital mutilation. Beyond legislation, educational programmes must target practising communities. The countries of Africa should come together, oppose the practice and restore the dignity and honour denied to the girls and women subjected to it. She supported the draft resolution and urged WHO to monitor all forms of female genital mutilation.

Dr SHIMIZU (Japan) affirmed that eliminating female genital mutilation was crucial to attaining the Millennium Development Goals, as well as to realizing gender equality and promoting women's health. The results of research into the economic impact of female genital mutilation should influence the efforts of WHO and international agencies. WHO must combat the increasing trend of female genital mutilation carried out by health professionals. He supported the draft resolution.

With regard to the bracketed text in the third preambular paragraph, he would prefer the paragraph to begin with the words "Reaffirming the goals and commitments contained in", as that was less ambiguous, and to add "and related reports" later in that same paragraph. In subparagraph 1(6),

since the commitment should be concentrated on the victims, he preferred the phrase “care and services including those for sexual and reproductive health, in order to assist women and girls who are subjected to this violence”. Japan would be hosting two international meetings on African development, including the health-related Millennium Development Goals, during 2008: the Fourth Tokyo International Conference on African Development (Yokohama, 28–30 May 2008); and the G8 summit (Toyako, 7–9 July 2008). He looked to WHO’s leadership for better health in Africa.

Ms KANIKA BANTERNJIT (Thailand) supported the statement made by the delegate of Denmark. She was concerned that the unacceptable incidence of female genital mutilation was continuing despite international efforts. Although it had never been practised in Thailand, the international community was morally obliged to respect the rights of women and girls at risk from the health implications of the practice. The carrying-out of female genital mutilation by medical professionals should be prohibited. Family, societal and cultural attitudes presented major obstacles, and socioeconomic and demographic factors were also influences. The scientific community should contribute to greater understanding of the cultural dimensions of the practice and conduct community-based research intended to discourage it. Universal access to education and health care for women and girls in the developing world would eliminate female genital mutilation.

With regard to the bracketed text in subparagraph 1(6) of the draft resolution, she had a slight preference for the second option, but would join consensus with others for the sake of immediate approval of the draft resolution.

Dr DANKOKO (Senegal) said that his country’s legislation prohibited female genital mutilation, which had receded, although areas remained where it was carried out covertly. According to a 2005 demographic health survey, 28% of women between the ages of 15 and 45 had undergone the procedure, with the proportion rising to 34% in rural areas. The State had demonstrated commitment through statements by the President, a law prohibiting the practice, educational activities throughout the country, and the formulation of a national action plan, supported by WHO, UNICEF and other partners, aiming to eliminate female genital mutilation by 2015. Senegal supported the draft resolution.

Dr BELAYNEH (Ethiopia) said that the report showed the gravity and extent of the situation of female genital mutilation. In Ethiopia, a survey in 1997 had shown the prevalence of the practice to be 61%, while a follow-up in 2007 had shown a reduction to 47%. Ethiopia acknowledged the rights of women and understood the impact of the practice on maternal and neonatal health. National legal provisions against harmful traditional practices had been strengthened over the past decade. However, harmful traditional practices were deeply rooted and significant change could not be expected fast. Constant education of the public and law enforcement were required. Health institutions had to provide information on female genital mutilation, but implementing policies in communities, with their traditional laws and norms, required innovative approaches in communication. The practice was closely related to cultural and ethnic identity, and targeted interventions based on studies should be considered in priority areas. The underlying causes of female genital mutilation were underdevelopment, poverty and the low status of women. Ties should be strengthened with those working in similar fields in order to hasten socioeconomic development in general and to empower women in particular.

Dr JALLOW (Gambia) said that female genital mutilation was practised by six of her country’s eight ethnic groups and affected 70% of its female population. However, vigorous advocacy by the Government and nongovernmental organizations had encouraged almost half of all practitioners to switch to initiation rites that did not involve cutting, and to become active agents of change. Gambia had ratified the United Nations Convention on the Elimination of All Forms of Discrimination against Women and the United Nations Convention on the Rights of the Child; it had formulated policy on the advancement of Gambian women; and its health policy prioritized reproductive health and rights relating to gender-based violence and female genital mutilation. That was such a deep-rooted

sociocultural practice that legislation had to be sensitive enough to prevent it from going underground. Nevertheless, awareness-raising on informed choice was making significant progress.

Dr XING Jun (China) expressed strong opposition to female genital mutilation. Regardless of any cultural reasons for continuing the practice, it was detrimental to the physical and mental health of girls and women, many of whom had even died of the resulting diseases, and it was a violation of their human rights. Its elimination would require the support of men and of local leaders, cooperation at every national and international level, elaboration and application of guidelines, and adoption of measures to provide the victims with health care and psychosocial support. Female genital mutilation could be eliminated. China pledged active support to the Secretariat to encourage all Member States to formulate and enforce legislation that would protect girls and women from all such forms of violence.

Dr CUYPERS (Belgium) said that female genital mutilation violated the human rights of the many millions of girls and women who had undergone the practice, and in many instances their right to life. It increased both the likelihood of complications for women during childbirth and the rate of perinatal mortality among their babies. Thus it directly impaired efforts to achieve Millennium Development Goals 4 and 5. Health services must provide treatment and care to deal with the health effects of female genital mutilation, including infant health care, reproductive health counselling, psychosocial counselling, prevention and treatment of sexually transmissible diseases, and programmes for traditional midwives. Belgium supported the draft resolution.

Dr SANGARE (Guinea), speaking on behalf of the 46 Member States of the African Region, approved the report. Female genital mutilation was a secular tradition detrimental to the health of women and children, which had been practised in Africa for 3000 years. Excision of the clitoris and labia minora was the most common form and infibulation the most extreme. Family members were subjected to the practice for socio-religious, hygienic or psychosexual reasons. The consequences ranged from severe pain, infections, haemorrhage and shock, through vaginal stenosis and urinary incontinence, to complications in labour and childbirth, diseases such as hepatitis B and HIV/AIDS and, ultimately, death. Despite the consensus reached at The Fourth World Conference on Women in Beijing in 1995 on the need to abolish female genital mutilation, most African countries had been slow to legislate. Ghana, Guinea, Mali and Senegal had introduced measures criminalizing the practice. Guinea and Mali had officially declared every 6 February to be Female Genital Mutilation Zero Tolerance Day. But merely enforcing laws and punishing the practitioners was not enough to abolish ancestral practices. The law must complement education and awareness-raising programmes, and budgets must be made available for retraining the practitioners. The Member States of the African Region invited the Health Assembly wholeheartedly to adopt the draft resolution.

Dr AL ABASSI (Sudan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that those States had enhanced procedures to eliminate the physically and psychologically damaging practice of female genital mutilation. Adoption of the draft resolution should have a positive effect. Tangible progress depended on support provided by the Secretariat to Member States, on their rejection of such harmful practices and on their enforcement of legislation. At a time when much emphasis was being placed on family values, the efforts of religious scholars must be taken into account. He suggested introducing a new subparagraph 2(6) into the draft resolution in order to enhance research into the psychological effects of injuries to the genital organs and to provide the victims with appropriate support.

Mr MARTIN (Switzerland) supported the draft resolution. The preambular paragraphs should refer to previous decisions taken by the international community and the operative paragraphs should mention rehabilitation measures and the role of men; the role of local stakeholders must be stressed.

Dr MALEFHO (Botswana) said that his country encouraged fellow Member States to abandon female genital mutilation. He requested WHO to strengthen national, regional and international efforts to eliminate that harmful practice.

Dr SHARBAWI (Brunei Darussalam) said that her country recognized that female genital mutilation violated the human rights and rights to health of girls and women. The rights described in the United Nations Convention on the Elimination of All Forms of Discrimination against Women and the United Nations Convention on the Rights of the Child should be protected by law. Her country supported the call by WHO for the elimination of practices causing extreme injuries and leading to serious illness and increasing maternal morbidity and perinatal mortality.

However, it had reservations about the definition in the report of the type I procedure: “excision of the prepuce, with or without excision of part or all of the clitoris”. Brunei Darussalam was an Islamic country where circumcision was a religious requirement as much for girls as for boys. But it involved removal of the prepuce only, which did not have health consequences; those caught practising more extreme forms of excision would be convicted under the national penal code. As male circumcision was not termed male genital mutilation, she requested that the definition of the type I procedure in the document be amended so as to allow for the removal of the prepuce in female circumcision without any excision of the clitoris, partial or otherwise.

Dr GARCIA (United States of America) said that the elimination of female genital mutilation through a culturally sensitive approach, conducted mainly by local groups, would reduce female and newborn morbidity and mortality in countries where it was practised. WHO could raise global awareness that female genital mutilation was a medically unacceptable practice from which health-care providers must refrain. Its first step in setting standards and building capacity was to work at country level and maintain surveillance of that serious public health problem.

Dr BUSUTTIL (Malta) said that, although female genital mutilation did not directly affect Malta, he fully supported efforts to eliminate the degrading and dangerous practice and to alleviate the many complications that affected women subjected to it.

Malta agreed with the substance of the draft resolution, and favoured the version of subparagraph 1(6) reading “to develop or reinforce social and psychological support services and care and to take measures to improve health, including sexual and reproductive health care, ...”. That wording would be in line with paragraph 12 of resolution E/CN.6/2008/L.2/Rev.1 on ending female genital mutilation, adopted at the 52nd session of the United Nations Commission on the Status of Women in February 2008. The sixth preambular paragraph of the draft resolution should be amended to refer to the Commission’s resolution.

Mrs CAMPBELL (New Zealand) emphasized greater and faster progress towards eliminating female genital mutilation, a violation of the rights of women and girls and violence against them. New Zealand supported the statement made by the delegate of Denmark. The final resolution needed to be consistent with the wider context in which WHO worked against female genital mutilation, and the Health Assembly must not appear to be undermining international efforts in that regard. Consensus on the wording of the resolution must be achieved.

Dr MUKABI (Kenya) said that female genital mutilation was indisputably a harmful practice. In Kenya the practice was prevalent in about a quarter of the country, with a rate of up to 90% in some communities. Kenya’s remedies had included legislation to punish parents or guardians who forced their children into mutilation.

The Secretariat’s report should have emphasized the role of men, government and other stakeholders in controlling female genital mutilation. With regard to the bracketed text in the second preambular paragraph of the draft resolution, Kenya favoured the second option: “Reaffirming the goals and commitments contained in ...”. For subparagraph 1(6), it favoured the version reading

“to develop or reinforce social and psychological support services and care and to take measures to improve health, including sexual and reproductive health care, ...”.

Dr KROMA (Liberia) reaffirmed her country’s commitment to eliminating female genital mutilation, which was nonetheless deeply rooted in the culture of Liberia, being practised by 14 of its 16 tribes. That made intervention very difficult, particularly since political leaders seeking votes sometimes thwarted local or international efforts to eliminate the practice.

The act itself was a gross violation of the rights of young women. Its elimination would require greatly increased resources, together with coordination and cooperation among Member States. Elimination of the practice would reduce maternal complications at birth. WHO should consider targeting politicians in seeking to end female genital mutilation.

Dr AL-RAIBI (Yemen) said that female genital mutilation was a deeply rooted practice in her country. It remained a form of violence against girls and women; it had serious physical and psychological consequences and reflected discrimination. It had been brought to Yemen by African immigrants, and thus was found in the coastal areas or among families that had moved inland. A decree prohibited the barbarous practice but social customs declared it a religious precept. Despite official efforts, it was still practised clandestinely.

Studies had shown female genital mutilation to be particularly common among illiterate women, notably in areas where the illiteracy rate reached 70% in women and 30% in men. Changing attitudes to the practice would require that people be made aware of its health implications, for which more studies were therefore needed, especially on mortality and morbidity levels.

Ms ST LAWRENCE (Canada) said that Canada strongly supported the efforts of WHO to end the practice of female genital mutilation, which was illegal in Canada and viewed by her Government as both violence against women and a violation of their human rights. Canada was heartened by all efforts to eliminate the practice, having recently supported African countries in achieving a consensus resolution on the issue at the 51st and 52nd sessions of the United Nations Commission on the Status of Women in 2007 and 2008. The draft resolution should be updated to reflect the work of that 52nd session. Canada welcomed the draft resolution and supported the statement made by the delegate of Denmark and sought consensus.

Dr RAHIMY (International Pediatric Association), speaking at the invitation of the CHAIRMAN, said that his organization represented the voice of some one million doctors and paediatricians. They were deeply concerned about female genital mutilation, generally performed on girls of around 10 years of age, or even on infant girls. The harmful procedure could result in numerous immediate or long-term health consequences, sometimes fatal. It raised many human rights issues, including reproductive rights, protection from violence, women’s rights and especially children’s rights.

His members and especially the Union of National African Pediatric Societies and Associations, in collaboration with WHO and UNICEF, were intent on improved understanding at country level of the cultural beliefs underlying female genital mutilation in order to help protect the two to three million girls and women at risk each year.

Ms DELORME (World Medical Association), speaking at the invitation of the CHAIRMAN on behalf of the World Health Professions Alliance, which also included the FDI World Dental Federation, the International Council of Nurses and the International Medical Federation, said that the Alliance represented national associations in more than 150 countries and the collective views of over 25 million health professionals. Female genital mutilation was a gross form of violence to women and girls, a cause of serious physical and mental harm and a violation of their fundamental rights. The Alliance was alarmed at the report’s reference to the increased practice of female genital mutilation by physicians and other health professionals, whose codes of ethics were absolutely opposed to it.

Health professional associations must develop educational programmes that reflected the acute dangers of female genital mutilation for women and girls, raise awareness of a practice that severely violated women's human rights and which no health professional should undertake, and encourage health workers to inform women, men and children about the dangers involved. The Health Assembly should adopt a strong resolution condemning female genital mutilation and urging Member States to intensify action towards abolishing such practices.

Ms MAFUBELU (Assistant Director-General) expressed appreciation for the comments of Member States and of the nine United Nations specialized agencies that had joined WHO in the interagency statement on eliminating female genital mutilation. The commitment of countries to ending that harmful practice, which also violated the human rights of girls and women, was encouraging. Speakers had stressed the need to enact laws and policies and to ensure that those were actually enforced. The role played by empowerment of women and girls in respect of their socioeconomic status and education could not be overemphasized, and she encouraged the efforts of Member States to improve those aspects. She stressed the need to condemn the medicalization of female genital mutilation.

With regard to definitions of female genital mutilation, especially concerning type I, the Secretariat had consulted widely with partners and medical specialists, the conclusions of which were reflected on page 24 of the interagency statement, where the different forms of type I were recognized. The Secretariat would continue to work with partners to eliminate the practice of female genital mutilation within one generation, ending the suffering to which three million girls were exposed every year.

The CHAIRMAN noted that the draft resolution had enjoyed strong support from all speakers. As there were still two bracketed parts, he endorsed the suggestion from Denmark that interested countries, coordinated by Denmark, should discuss the points of disagreement and bring their results to the Committee the next day or the day after.

It was so agreed.

(For approval of the draft resolution, see summary record of the tenth meeting.)

Health of migrants: Item 11.9 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R5, and A61/12)

Dr GWENIGALE (representative of the Executive Board) recalled that the Government of Portugal had proposed inclusion of the agenda item for the purpose of reviewing the health situation of migrants and preparing a series of public health principles for responding to the challenges in terms of both health determinants and health systems. The Secretariat's report contained a series of recommended principles and policies to be implemented both by Member States and by the Secretariat.

The Executive Board, in adopting resolution EB122.R5, recommended a draft resolution for adoption by the Health Assembly.

Dr ALOUWED (Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the report and the draft resolution. Migration had economic and social consequences and placed a heavy burden on health services. Recruiting and training health-care providers from migrant populations encouraged a culturally sensitive approach to care, and fostered stability and better health in migrant communities.

His country had endeavoured to provide health care free of charge for a massive influx of Iraqi migrants, a consequence of the war. Resources were limited and continued provision would require assistance. He thanked WHO for launching an appeal in 2007 for increased support for countries hosting Iraqi refugees, with little response. He urged WHO to launch another appeal.

Dr AYDINLI (Turkey) said that Turkey was a transit country for migrants, who received free health services at seven shelter centres. Vulnerable groups, including migrants suffering from trauma, elderly persons, orphans, unaccompanied children and women, also received psychological and social services. A bill under consideration in Turkey's Parliament would give migrants and asylum-seekers the same health benefits as Turkish citizens. By 2010, six reception centres for migrants would provide primary health care and health education. Turkey supported the draft resolution.

Dr VOLJČ (Slovenia), speaking on behalf of the European Union and two European Free Trade Association countries, Switzerland and Norway; the candidate countries Croatia and The former Yugoslav Republic of Macedonia; the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro, Serbia, as well as Ukraine, Moldova and Armenia, said that migrant health was important and also linked to attainment of the Millennium Development Goals. In all European Union countries, legal migrants had the same access to health services as citizens, and undocumented or irregular migrants had access to emergency care. The European Union supported the draft resolution.

He emphasized the need for coordination among United Nations agencies, including WHO, the taking into account of related work in other international forums, migrant-sensitive policies that accorded with each country's law and practices, intersectoral and multidisciplinary approaches to health care in multicultural societies, and the inclusion of gender and child-oriented perspectives.

Dr DANKOKO (Senegal), speaking on behalf of the Member States of the African Region, said that Africa was both a sender and recipient of migrants. In countries where wars, natural disasters and economic crises had resulted in massive displacements of people, the effectiveness of overburdened health systems had been reduced in the prevention and management of communicable diseases.

He welcomed related initiatives such as the high-level dialogue on migration and development held during the sixty-first session of the United Nations General Assembly in 2006, and the adoption by the Sixtieth World Health Assembly of the Global Plan of Action on Workers' Health, a solid basis for improving the health of migrant workers.

The draft resolution stressed health policies that would enable migrants to access comprehensive health services suited to their needs. The African countries welcomed the draft resolution but wished to propose several amendments. As it was currently drafted, subparagraph 1(2) might have the effect of reducing migrants' access to health services owing to limitations imposed by national laws and practices, and it should therefore be amended to read: "to review or amend their current laws and practices as needed in order to enable migrants to access health benefits and services on an equal footing with the host population". Subparagraph 2(4) should be amended to read: "to devise mechanisms for improving the health of all populations, including migrants, by, inter alia, identifying and rectifying gaps in health service delivery".

Ms ACUÑA NAVARRO (Costa Rica) said that Costa Rica was a destination for many migrants from other Central American countries. Most were illegal, which hindered their access to health care, although her Government sought to provide that. The international community needed to find universal, equitable and affordable access to health services for all populations, including migrants. She supported the draft resolution.

Dr PHUSIT PRAKONGSAI (Thailand) said that Thailand attached a high priority to protecting the health of its two million migrants, most of whom were workers contributing to the Thai economy. Health-care coverage was provided for documented migrants under two public insurance schemes. Basic health services were offered on a humanitarian basis to undocumented migrants, displaced persons, refugees and other vulnerable groups. Migrant-sensitive health services were being provided by volunteers recruited from migrant communities, a communicative approach that had proved successful.

He supported the report's four basic principles of a public health approach to migrant health, but the broad definition of migration therein encompassed too many different categories of migrants. Policies on specific groups of migrants would be more effective and more financially and politically feasible than broad policies covering all categories.

Thailand supported the draft resolution, with the following amendments: in the eighth preambular paragraph, the words "experience increased health risks" should be replaced by "are vulnerable to occupational health risks"; in subparagraph 1(2) the words "disease prevention" should be added after "health promotion"; in subparagraph 1(3) "to establish health information systems" should be added before "to assess and analyse ..."; subparagraph 1(9) should be deleted as it was too broad and did not specifically address the health of migrants. In subparagraph 2(6) the words "and information" should be added after "data"; and in subparagraph 2(9) "civil society organizations" should be added after "academic institutions".

Mr WATERBERG (Suriname) supported the draft resolution, with the addition of a new subparagraph 2(11), to read: "to promote exchange of health information nationally, regionally and internationally on migrants, making use of modern communications technologies".

Dr ZHOU Jun (China) said that in a globalized world, the movement of populations, particularly from developing to developed countries, was a trend that could not be reversed. Host countries faced challenges in ensuring that migrants had access to essential health services and could enjoy the right to health. China supported the draft resolution. Developed countries which were a destination for many migrants should be the first to take effective measures to protect the health of migrants.

Dr VIOLAKI-PARASKEVA (Greece) said that a large proportion of migrants in Greece moved through legal channels but their epidemiological profile could be associated, in certain cases, with negative health implications and social difficulties. She supported the draft resolution, which might be improved by the addition of a new preambular paragraph, reading "Noting that migration requires humanitarian responses", the addition of the words "and secure" after "to promote" in subparagraph 1(2), and the addition of a new subparagraph 1(11), to read "to provide basic occupational health services and rehabilitation schemes for occupational diseases or injuries".

Dr NOHNO (Japan) welcomed WHO's efforts to improve the health of migrants in cooperation with UNHCR, the International Organization for Migration and others. Globalization, and increasing numbers of disasters and conflicts, added significance to international migration and the public health of migrants, matters fundamental to attaining the Millennium Development Goals. The report clearly defined migration, clarified the conditions of vulnerable migrants, highlighted the need for promoting migrant health and disease prevention, and recommended the workplace as an entry point for delivering health services to migrant workers and their families. More detailed information was needed on measures with regard to female migrants, and to regions with large numbers of vulnerable migrants. He supported the draft resolution and looked forward to WHO's leadership on the issue.

Dr CHITUWO (Zambia) said that Zambia had received thousands of refugees and migrants from its eight neighbours, and had, with support from UNHCR and partners, looked after them to the best of its ability. Semi-permanent and permanent refugee camps with basic facilities including water, sanitation, shelter, schools and health centres, had been set up in northern, north-eastern and north-western provinces. The displacement of populations had negative effects from a political, economic and also public health perspective, with outbreaks of diseases and human rights abuses having been reported. Nevertheless, comprehensive and free health services were provided. The policy of the Zambian Ministry of Health was to provide cost-effective, affordable health services as close to the family as possible. He supported the draft resolution.

Mr NICOLA (Portugal) said that the global issue of migrants' health merited its discussion at the Health Assembly and deserved more attention at local, national, regional and international levels. It should be viewed from a public health perspective: promoting the health of migrants promoted health for all. If the draft resolution was adopted, WHO should conduct a broad global consultation with Member States on its implementation.

Mrs CHISTYAKOVA (Russian Federation) said that the report, although welcome, should have given more information about the effects of mass migration, particularly through illegal channels, on the spread of infectious and parasitic diseases. In the Russian Federation, legislation was being drawn up on access of migrants to health services and on health insurance and medical care for migrants. Requirements were also being established concerning the preventive and treatment measures for foreign citizens with infectious diseases. Financial protection mechanisms should be considered for migrants, who were economically vulnerable, including the provision of continuous health insurance between countries of origin and destination. She supported the draft resolution.

Dr GARCIA (United States of America) said that his Government supported efforts to improve the health of migrants in his country. Community and migrant health centres were a vital part of the health-care safety net, providing primary care to uninsured, low-income families and individuals, regardless of their ability to pay. Civil society also provided health care to many needy migrant communities; targeted interventions were also provided. All migrants, regardless of their immigration status, had access to emergency health care. He urged the Committee to respect the fragile consensus that had been reached by the Board in resolution EB122.R5, and not to reopen discussion of the text. He supported the draft resolution as it stood.

Mrs LASPINA (Ecuador) said that about 20% to 25% of Ecuadorians had migrated to escape poverty and the country's financial crisis at the end of the 1990s. WHO must ensure that the report's four strategies for improving the health of migrants were implemented. The right to health was a basic human right that should be guaranteed anywhere in the world. She commended WHO's efforts to eliminate the obstacles that prevented migrants' equitable access to health services. Ecuador would support an international public health strategy for migrants based on all aspects of human rights.

Mr HERBERT (Saint Kitts and Nevis) said that, over the previous decade, his country had observed significant inward migration. The new migrants had been absorbed and their acute health needs met, but if that migratory trend continued it would place huge demands on national resources. While respecting human rights, he emphasized the link between population movements and the demands placed on taxpayers in the host countries. Movement of people was also linked to movement of disease agents such as malaria and multidrug-resistant tuberculosis and to sexually transmitted infections. Concern for the health needs of migrants should take into account the absorptive capacity of receiving nations. He supported the draft resolution, in particular the call for increased advocacy at the highest political level. Attention should be paid to the work required to reduce the known causes of population movement and to support countries whose absorptive capacities were strained by the influx of migrants.

Dr MOHAMMED (Oman), speaking on behalf of the countries of the Gulf Cooperation Council, said that between 10 and 15 million workers from other countries were employed as contract workers in his region. He therefore proposed that both the terms "migrants" and "contract workers" be used in the text of the draft resolution.

Dr ROSELL-UBIAL (Philippines) emphasized concern for the health of migrant workers rather than other categories defined in the draft resolution. She welcomed the report, as the number of overseas Filipino workers, most of whom worked in the health and service sectors, had increased to an estimated 8.2 million in 2007. She urged Member States to support the strategies set out in the report

for improving the health and well-being of migrants. Her Government was formulating a framework of social safeguards that would include the health of migrants. The Secretariat's report provided useful guidance.

The Secretariat should support countries in cooperative strategies that would develop medical care and services for sick and injured migrant workers, and, when medically possible and acceptable to the migrant, mechanisms for repatriation.

Professor AZAD (Bangladesh) welcomed the overall goals stated in the draft resolution and drew attention to subparagraph 1(4), which dealt with provision of improved health of all populations, including migrants. The formulation "subject to national laws and practice" in subparagraph 1(2), however, was a cause for concern, as it could have an adverse effect on the health care offered to legal and illegal migrants, because of lack of insurance or legal status. That would contradict WHO's principle of health for all. The subparagraph should be rephrased to avoid any possibility that the right to health of migrants was neglected or undermined.

Dr MOOSA (Maldives) expressed support for the draft resolution. The issue of migrant health, however, raised potential problems with regard to language. She supported the amendment proposed by Suriname to include a paragraph on the exchange of information on migrant health at national, regional and global levels.

Mrs UREÑA (Bolivia) said that WHO had an obligation to take into consideration the health of migrants, who numbered about 175 million. Most had no assured access to health services, in contravention of their human rights under international law. She therefore supported the draft resolution, with the amendment to subparagraph 1(2) proposed by other delegations in order to ensure equitable access of migrants to health care.

Mr MENESES (Mexico) said that the health of migrants was a priority in his country. He stressed that, in view of the extensive discussions that had been held by the Executive Board at its 122nd session in January, the draft resolution should be adopted without amendment.

Dr VOLJČ (Slovenia) said that the European Union concurred with the statement by the United States of America that the draft resolution should be adopted without amendment in view of the work that had already been done by the Executive Board. Any proposed amendments would have to be presented in writing before the European Union could accept them.

Mr CAVALERI (Argentina) said that, in dealing with migratory flows, a new model was required that would change the focus of government policy from security and border controls to a legal framework for human rights of migrants that was universally applicable. Thus, migrants and their families would be given the same protection and rights as nationals, as well as equal access to health care and social benefits. He therefore supported the draft resolution in the form in which it had been adopted by the Board.

Ms TIMBERLAKE (UNAIDS) recalled that, since the beginning of the HIV/AIDS epidemic, some governments had prevented people from entering or residing in those countries purely because of their HIV status. Such restrictions had prevented HIV-positive people from travelling for business or personal reasons or for study, labour migration or political asylum. In 1987, WHO had concluded that such screening would not prevent the introduction and spread of HIV infection and that resources would be more effectively devoted to preventing HIV transmission through information, education and support from health and social services. In 2008, 74 countries still imposed HIV-specific restrictions on the entry and residence. Most affected were labour migrants, either barred from entering through a mandatory pre-departure HIV test or deported when required to take a periodic HIV test abroad. Seldom was HIV testing linked to treatment, health care, counselling or support.

In November 2007, the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria had decided not to hold Board meetings in countries that restricted short-term entry of people living with HIV or that required prospective HIV-positive visitors to declare their HIV status on entry. It also encouraged rapid elimination of travel and entry restrictions for people living with HIV. UNAIDS emphasized that HIV-related travel restrictions had not been shown to protect public health and were a discriminatory anachronism in the age of globalization.

She called upon Member States to adopt non-discriminatory laws and regulations and to rescind HIV-specific travel restrictions. Instead, Member States should include mobile populations as part of their commitment to ensuring universal access to HIV prevention, treatment, care and support by 2010 and to achieving Millennium Development Goal 6 by 2015.

Dr MOSCA (International Organization for Migration) said that providing for the physical, mental and social well-being of migrants reflected values such as equity, solidarity and participation and protecting and promoting the health of communities. Diseases and their association with human mobility were challenges to public health systems; they required a response that tackled the underlying social, economic, cultural, structural and environmental determinants of health.

His organization worked with the many sectors involved in managing migration. Health issues depended on the type of migration and therefore had to focus on the vulnerability associated with each migratory pattern. The Global Forum on Migration and Development, to be held in Manila in October 2008, would consider how migrants could best contribute to development in both their countries of origin and host countries when they were protected and empowered socially, economically, and in terms of basic human rights. Health messages must be included in those discussions but more important was implementation of migrants' health programmes.

He welcomed the draft resolution. His organization would support WHO and governments to increase the capacity of their public health systems and to encourage multisectoral debate on the needs of both migrants and their host communities.

Mr EID (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, drew attention to undocumented migrants, who were being denied the same access to health care as residents under existing legislation. Thus, the doctors of tomorrow might be forced to discriminate against some of their own patients, contrary to the principles of medical ethics and the human right to health. The basis of doctors' actions should be the medical needs of patients and not their legal status. Undocumented migrants should be offered the same health care as other residents.

Dr CONROD (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN and also on behalf of the International Council of Nurses, the International Pharmaceutical Federation and the World Medical Association, emphasized that women faced difficulties in accessing health care, including reproductive and antenatal services. Migrants in general tended to suffer from complex and specific psychosocial and health problems that were exacerbated by the living and working conditions in host countries which required collaboration between professionals. All migrants experienced exclusion from essential health services, such as immunization. In some destination countries, health professionals were forced to identify or supply personal details to the authorities about undocumented migrants in violation of patient confidentiality.

Ensuring the social and professional integration of the growing number of migrant health personnel would maximize the potential of care. He encouraged WHO to adopt an approach to the health of all migrants that ensured their rights to the highest standards of health, regardless of status.

Dr DOEBBLER CURTIS (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, said that the draft resolution failed to reflect that health and access to health care were human rights laid down in international law and treaties, including the International Covenant on Economic, Social and Cultural Rights, which had been ratified by most of WHO's Member States.

The international community had also recently adopted the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, which included the right to health.

The resolution being considered by the Health Assembly should include wording that recognized the human rights to health of all migrants. He called on Member States to ensure those rights and requested that WHO promote those rights.

Dr LOPEZ-ACUÑA (Recovery and Transition Programmes) thanked Member States, international organizations and nongovernmental organizations for their contributions to the debate. The large number of interventions showed how central migrants' health was to the public health agendas of Member States and had highlighted the multidimensional nature of the issue. He had carefully noted the experiences and challenges described by Member States. WHO would continue to work in collaboration with partners such as the International Organization for Migration to ensure better health outcomes and improved health protection for all migrants.

The CHAIRMAN said that, as a number of amendments to the draft resolution had been proposed, he would suggest that the Secretariat be asked to prepare a revised text that took account of those amendments and which would be resubmitted to the Committee for its consideration at a later meeting.

It was so agreed.

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

The meeting rose at 17:30.

SIXTH MEETING

Thursday, 22 May 2008, at 09:15

Chairman: Dr F. CICOGNA (Italy)
later: Mr J.O. DA SILVA (Timor-Leste)
later: Dr F. CICOGNA (Italy)

1. FIRST REPORT OF COMMITTEE A (Document A61/42)

Dr PARIRENYATWA (Zimbabwe), Rapporteur, read out the draft first report of Committee A.

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

Strategies to reduce the harmful use of alcohol: Item 11.10 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R2, and A61/13)

Dr GWENIGALE (representative of the Executive Board) said that at its 122nd session the Executive Board had considered a draft resolution on strategies to reduce the harmful use of alcohol, which expressed deep concern about the extent of public health problems associated with the harmful use of alcohol and called for a draft global strategy to be prepared and submitted to the Sixty-third World Health Assembly. The draft resolution had received broad support during the debate, with many members stressing the need for each country to respond to the issue according to its economic, social, religious and cultural contexts and its resource capabilities, as the global strategy needed to reflect differences in national circumstances. The Board had adopted resolution EB122.R2 recommending adoption of the draft resolution therein to the Health Assembly.

Dr BAI Huqun (China) said that the strategy report was important for a transparent and evidence-based analysis and estimation of the current epidemiological situation and the hazards caused by the harmful use of alcohol. She endorsed measures that would reduce the incidence of drink-driving and prohibit the sale of alcoholic beverages to minors. She supported policies to reduce the illicit or substandard production of alcohol.

Her country would enhance surveillance of alcohol use and exchange of information in cooperation with WHO. A strategy on intervention methods and research should be strengthened in order to provide direct evidence and support for establishing policy and regulations.

Mrs CARDOSO (Cape Verde), speaking on behalf of the 46 Member States of the African Region, stated that the effects of the harmful use of alcohol on the health of individuals and communities had been well documented as had its impact on diseases such as tuberculosis and HIV/AIDS, as well as traumas caused by road traffic injuries or domestic violence. In the African Region, it led to 3.4% of deaths among men and 1% of deaths among women, serious consequences during pregnancy, resistance to some medication, such as antiretroviral therapies, and was also a major

¹ See page 256.

determinant of poverty. Although alcohol consumption was culturally and socially tolerated, levels of consumption per capita were high in many African countries. Action was imperative to counter the economic, medical and social implications of harmful use of alcohol.

The African Region had already initiated strategies to assist those countries facing increased alcohol consumption among young people. Many countries had taken such steps as introducing legislation to prohibit the sale of alcohol to people under 18 years of age, providing psychiatric care to individuals suffering from alcoholism, preparing action plans to counter alcoholism, and launching information campaigns. Each country in the Region needed to establish multisectoral measures, with the active participation of communities, in order to convince people that the scourge of harmful use of alcohol could be overcome.

Mrs BAQUERIZO GUZMÁN (Ecuador), speaking on behalf of the Group of the Americas, stated that its Member States were continuing work on measures to reduce the harmful use of alcohol, which affected public health and had become a leading cause of mortality. In working on strategies to counter the problem, the strengthened role of WHO was fundamental in national and regional capacity building, taking account of each country's public health needs, and such matters as drink-driving and alcohol-related violence. Advances had been made towards reducing the harmful use of alcohol. He stressed the importance of reaching consensus in order to approve the draft resolution.

Dr VOLJČ (Slovenia) said that he was speaking on behalf of the European Union and the European Free Trade Agreement country Switzerland, and the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Ukraine, Moldova and Armenia, which aligned themselves with his statement. Expressing strong support for the resolution, he observed that a comprehensive alcohol strategy would highlight concerns in that area, despite national and regional differences, and would extend existing strategies for reducing the burden of alcohol-related diseases.

The European Region had the highest level of alcohol consumption per capita leading to numerous health, social and economic problems, particularly among young people, repercussions on both communicable and noncommunicable diseases as well as problems of road safety and alcohol-related violence. The European Union had adopted a strategy in 2006 to support its Member States in reducing alcohol-related harm. There had been recognition of differences between countries, not only in the extent of their problems but also in their capacities to counter them, and of the consequent need for better exchange of experience and support for effective measures.

Mr KÖKÉNY (Hungary) said that the draft resolution provided balanced solutions for reducing the harmful use of alcohol. His country was not proud of its high level of alcohol consumption. Stronger measures against drink-driving and illegally produced alcohol might help but improved health systems were also needed throughout Europe. Hungary favoured non-preferential tax policies, increased controls on the marketing of alcohol to young people, an integrated health response against alcohol, tobacco and illicit drug use, and a balanced approach that was neither too liberal nor too restrictive. The WHO strategy report and the European Union statement represented a step forward.

Dr FORRESTER (Jamaica) noted the varied social and cultural contexts of countries and the different roles and responsibilities of those involved in reducing the harmful use of alcohol. Issues for consideration included increasing public awareness of the matter, including its relation to violence and crime and lower life expectancy, and the need to enforce laws and regulations to curb alcohol advertising, sales and consumption. Jamaica was legislating to lower blood alcohol limits from 0.35 mg/dl to 0.12 mg/dl and the Government was considering the earmarking of taxes on alcoholic beverage sales for health care.

Dr KARAMAN (Turkey) said that the harmful use of alcohol produced toxic, psychological and addictive effects, particularly among vulnerable groups such as adolescents, on whom strategies must focus. Health workers must raise public awareness on the issue, as everyone was entitled to objective information on the effects of alcohol on health, families and society.

Scientific research showed that no blood alcohol level was safe for driving. Each country must therefore consider various medical and social factors when setting blood alcohol limits. Some countries placed restrictions on licensing hours for the sale of alcohol but control mechanisms were also needed to prevent the illegal production and marketing of alcoholic beverages. In that context, technical support and cooperation between organizations would be necessary and WHO should lead the way in awareness-raising and tangible measures.

Dr ESTEGHAMATI (Islamic Republic of Iran), noting that alcohol consumption was a major risk factor for neuropsychiatric disorders and other noncommunicable diseases and that related public health problems were increasing globally, stated the need for collaboration among all Member States. He emphasized primary rather than secondary preventive measures against alcohol consumption.

Dr BLOOMFIELD (New Zealand) observed that discussions at the Sixtieth World Health Assembly had been wide-ranging with regard to reducing the harmful use of alcohol, and the need for a strategy agreed. Member States should show restraint and reach consensus on the draft resolution for the sake of action regarding that important public health issue.

Following discussions with other delegations, he proposed a change in wording to the draft resolution: the beginning of subparagraph 2(4) should be amended to read “to collaborate and consult with Member States, as well as consult with intergovernmental organizations”.

Dr JAYATHILAKA (Sri Lanka), speaking on behalf of the 11 Member States of the South-East Asia Region, stated that alcohol consumption in South-East Asia had increased significantly in the previous two decades, owing in part to economic growth and social development, along with alcohol-related problems and concern about public health improvements. That had been compounded by the absence of effective alcohol-related policies.

The WHO Regional Committee for South-East Asia resolution adopted on “Alcohol Consumption Control – Policy options”¹ had played an important part in preparing for resolution WHA58.26. A global strategy was urgently needed to reduce the harmful use of alcohol and he requested WHO to convene a working group consisting of three Member States from each Region, representing developed and developing countries, as well as experts and policy workers, in order to prepare a global strategy and plan of action. His Region also proposed adding a new subparagraph to the resolution to consider an appropriate date for a World No Alcohol Day.

Dr ESTWICK (Barbados) highlighted the adverse socioeconomic and health effects of the harmful use of alcohol in the Caribbean region, where hypertension, diabetes and coronary artery disease were the top three causes of mortality and morbidity. Alcohol had a negative impact on many vulnerable groups, including the young, women and the poor. Barbados’s legislation prohibited the sale of alcohol to minors. Excessive alcohol consumption caused pain and suffering through violence and accidents and was related to psychiatric and psychological illnesses, which often required long-term care. The Ministry of Health supported the responsible use of alcohol, while realizing the ills of excessive use.

Barbados, a small island economy, derived significant income from the sugar cane industry, in which many people were involved, and alcohol production, refining, distribution and sales. The

¹ Resolution SEA/RC59/R8.

Ministry of Health had held discussions with representatives of alcohol producers in the country and region, who were supportive of the responsible use of alcohol.

The influences of alcohol on society would be weighed carefully, with the Ministry of Health responsible for information on and protection against its harmful effects. He supported the draft resolution, with its balanced approach and respect for each country's right to implement strategies which took account of national circumstances.

Mrs REITENBACH (Germany) said that her country had one of the highest alcohol consumption rates in the world and the Ministry of Health's Drug Commissioner was drawing up an alcohol action plan. A range of preventive and legislative measures would aim to reduce overall consumption of alcohol and target all forms of high-risk consumption, especially among young people. Special attention would go to alcohol consumption in pregnancy and the prevention of fetal alcohol syndrome, and the self-regulation system for alcohol advertising would be improved. Germany had introduced an alcohol ban for drivers who had not completed a two-year probationary period or were under 21, thereby contributing to the European Union's Road Safety Action Programme, which sought to halve the number of road accident victims by 2010.

Mr SEGURA (Dominican Republic) recalled that the consultation process on the harmful effects of alcohol on health had begun in 2005 and had resulted in the draft resolution, which should be approved as submitted, allowing the Secretariat to elaborate a global strategy to reduce the harmful effects of alcohol. To reopen the debate and shut out economic operators, as had been suggested by the representative of New Zealand on behalf of several other countries, would be a backward step and upset the consensus. Economic operators were part of the solution to the problems of harmful alcohol use, which could only be solved through a joint approach.

Ms JAJULA (South Africa) said that the public health problems caused by excessive alcohol consumption warranted global, regional and national action. Drinking and high-risk behaviour were linked, and alcohol use was a significant factor in road traffic accidents, injuries and causes of death. She highlighted the challenge to child health and development posed by fetal alcohol syndrome. The social and economic implications of alcohol use threatened the health and safety of poor people and young people in developing countries.

South Africa aimed, through intersectoral strategy, to galvanize all sectors to do more to combat the harmful use of alcohol. The health sector focused on creating public awareness and mobilizing society against alcohol misuse under a healthy lifestyles programme. From February 2009, alcoholic beverage containers in South Africa would by law carry messages highlighting the ills of alcohol consumption. Public awareness measures were intensified during festive periods.

Supporting the draft resolution, she stressed that WHO should consult all stakeholders but should not collaborate with the alcohol industry; she hoped that such was not the intended meaning of subparagraph 2(4). The envisaged global strategy should provide recommendations on addressing, in particular, the link between alcohol advertising and increased alcohol consumption.

Dr AL-THANI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed support for the draft resolution, the global strategy it envisaged, and its balanced approach. It resulted from cooperation and recent scientific research. A global strategy should improve cooperation among all countries and take account of particular national and regional considerations.

The harmful effects of alcohol consumption were perhaps less evident in his Region than elsewhere, partly owing to predominant religious views. Nonetheless, alcohol was consumed and those groups most susceptible to its harmful effects should be targeted, in particular young people. The Health Assembly had previously stressed the need to raise awareness of the harmful use of alcohol and its consequences. He requested the Secretariat to formulate recommendations for both global and regional action.

He highlighted the links between the harmful use of alcohol and the harmful use of psychotropic substances: the former should be addressed in the context of drug addiction in general. The Secretariat's report might usefully have made reference to the fact that some States prohibited the use of alcohol altogether, as it made parts of the report inapplicable to the States concerned.

Dr VIOLAKI-PARASKEVA (Greece), praising the report's analysis of policy options for reducing alcohol-related harm, said that her Government had prepared an action plan, with specific measures to address harmful alcohol consumption among young people. While expressing full support for the draft resolution, she suggested that in subparagraph 1(2) the words "and give emphasis to" be inserted after "develop".

Mr MABUZA (Swaziland), welcoming the draft resolution and the strategies recommended, said that more than half the injuries treated in emergency departments in his country were related to inappropriate use of alcohol. The risk of HIV/AIDS and other sexually transmitted diseases being passed on during alcohol-related unsafe sexual intercourse required special attention. Swaziland was finalizing a national alcohol policy and its traffic legislation would incorporate harsher penalties for alcohol-related offences. He requested the Secretariat to provide technical assistance so that national policies could be aligned with WHO recommendations.

Mrs CHISTYAKOVA (Russian Federation) emphasized the importance for her country, where harmful alcohol use had significant adverse effects on the health of the population, of a WHO global strategy which took into account the complexity of the relationship between individuals and society. It should cover the negative health effects and social consequences of the harmful use of alcohol. Her country was keen to implement the measures proposed in the report and in the form of a national programme to combat the harmful use of alcohol. The Russian Federation would support international efforts in that area and fully supported the draft resolution.

Mr HERBERT (Saint Kitts and Nevis), acknowledging the toll taken by the harmful use of alcohol, said that the reference to "harmful use" was clear and unambiguous. Although health systems advocated against substance misuse and abuse, alcohol was widespread and had religious, culture and social uses. Factors making for harmful use of alcohol included its prominence in social settings, adolescent peer pressure and shrewd marketing by industry. Since some people also found refuge in alcohol use, it was necessary to focus on building resilience, especially among the young, through health and mental health promotion, and working with regional partners on demand reduction programmes. In his country's strategic health plan, demand reduction was primarily a mental health item and he looked forward to cooperation with PAHO to build capacity in mental health promotion and strengthen prevention and treatment programmes for substance use.

Professor PUSKA (Finland) said that the draft resolution formed an excellent basis for WHO to lead work to solve the range of health, social and economic problems caused by alcohol consumption. Rigorous implementation of measures and policies combining research, prevention, brief intervention, treatment and rehabilitation could reduce alcohol-related harm. Interventions acknowledged to be effective should be carefully considered in the proposed global strategy.

Expressing support for the draft resolution, he called on all Member States to support the Secretariat and the regional offices in their work to reduce the harmful use of alcohol. The issue had been discussed many times but little progress had been made and the situation was worsening. He urged the Committee to approve the resolution so as to allow WHO to develop a draft global strategy.

Dr MORI (Japan) said that every Member State must respond to its domestic problems of harmful alcohol use by adopting cost-effective policies, taking account of national circumstances. Information exchanged at international meetings, such as basic data on consumption, problems and

solutions, could serve that process. He supported the draft resolution and emphasized the importance of adopting it during the current Health Assembly.

Dr OTTO (Palau) highlighted his country's concern about rising alcohol consumption among young people in secondary schools and elsewhere, and pointed to aggressive marketing that targeted young people. Paragraph 14 of the report was therefore particularly welcome.

He supported the draft resolution and the amendment proposed by the representative of New Zealand, and echoed the importance of approving the text. In the seventh preambular paragraph the word "possible" should be deleted, as the links between alcohol consumption and certain diseases were proven, and the phrase "with particular focus on marketing practices in order" inserted after the words "integrated approach" in subparagraph 1(1).

Mr FISKER (Denmark) referred to the alarming trends in alcohol consumption seen in his country – high overall and the highest among young people in Europe. The prevalent drinking culture had many adverse effects, including violence, unwanted and unsafe sexual intercourse, police involvement, poisoning, and repercussions on school work and social life. Unfortunately, new alcoholic products were often designed to appeal to the young. Denmark tried to protect its population through regulations on alcohol advertisement, age limits and other measures.

His country's national strategy also focused on harm caused to others, including unborn babies and children who lived with parents with alcohol problems and were at greater risk of later developing alcohol or drug problems themselves. A change was needed in the alcohol culture that created so many innocent victims. He looked forward to the development of a global strategy to reduce harmful use of alcohol and endorsed the comments made by the delegate of New Zealand on the importance of reaching agreement.

Mr KAYITAYIRE (Rwanda), emphasizing that reducing the harmful use of alcohol was a priority, highlighted concerns of alcohol abuse in the workplace, and the production and consumption of illicit and informally produced alcohol. More coordination was needed between the stakeholders trying to prevent, reduce and combat the adverse effects of alcohol abuse. Global measures combined policies that took account of national, religious and cultural factors, together with the health problems, needs and priorities of each country and States' differing resources and capacities.

When traditional alcohol consumption was taken into account, some African countries had some of the world's highest consumption rates, and studies had shown worrying consumption trends among women and adolescents. The health and economic consequences could not be ignored. In Africa, significant proportions of neuropsychiatric disorders and accidental injuries were attributable to alcohol consumption. Links were increasingly apparent between alcohol use and infection with HIV or other sexually transmitted pathogens, failure to follow antiretroviral treatment programmes, and tuberculosis.

He supported the draft resolution, as submitted, and urged the Committee to approve it by consensus. It would be difficult to draw up a global strategy that took account of regional and national differences, but doing nothing was not an option. Member States, the private sector and intergovernmental and nongovernmental organizations must be given a starting point for negotiating a common strategy to combat the harmful use of alcohol.

In the interests of consensus, Ms DAMIGOU (Greece) and Dr OTTO (Palau) withdrew their delegations' proposed amendments to the draft resolution.

Mrs CHOTA (Uganda) said that Member States and the Secretariat should advocate for resources for mass public education on harmful alcohol use. Mechanisms should be considered whereby Member States could identify and educate local communities on viable alternatives for sustainable livelihoods, as crude alcohol was brewed locally for commercial purposes and consumed in large quantities.

Dr MALEFHO (Botswana) believed that alcohol abuse, compounded by public health problems, bore heavy social costs, particularly on developing nations. Many sub-Saharan countries were experiencing an increase in alcohol abuse, particularly among young people, which also contributed to higher rates of HIV infection. His country's strategies, in collaboration with other stakeholders, had involved young people in the drive to educate the public about alcohol use and abuse. He supported the draft resolution.

Ms CHASOKELA (Zimbabwe) said that despite her country's efforts to reduce the harmful use of alcohol, the greatest challenges were policing the laws in force and tackling the illicit brewing of alcohol. She supported the draft resolution.

Dr THAKSAPHON THAMARANGSI (Thailand) stated that there was no risk-free drinking as there was no threshold effect for many diseases, which made effective policy all the more important. The Secretariat should fully support implementation of the recommendations made by the Expert Committee on Problems Related to Alcohol Consumption.

The tobacco and alcohol industries based their approaches on the need to protect and sustain their profits at society's cost, by calling for a role in policy-making and working to undermine it. He encouraged participation by the alcohol industry, but only to the extent that policy might be truly applied; in all other cases, the direct conflict of interest was detrimental to well-formulated policy. He referred to Recommendation No. 9 in the report of the Expert Committee on Problems Related to Alcohol Consumption¹ in that regard. Clear evidence of negative involvement could be seen in developing countries where the alcohol industry had led the framing of national alcohol policy, which consequently fell far short of what had been proven to be effective.

He supported the draft resolution, as amended by New Zealand.

Dr MAOATE (Cook Islands) referred to the continuing harmful effects of alcohol in his country, particularly on young people and to the new improved strategies that had been introduced. He agreed with the delegate of Thailand and urged Member States to consider alcohol in the same light as tobacco: strategies should be consistent on both issues and a similar approach through legislation, resource allocation and leadership should be adopted.

He supported the draft resolution, as amended by New Zealand.

Ms NURM (Estonia) emphasized intensified measures against excessive alcohol consumption. Protecting young people, particularly through legislation, should be a priority since the younger they started drinking the greater their risk of alcohol dependence and alcohol-related harm. Young people were particularly susceptible to alcohol advertising, and evidence showed that it did much to determine the age at which young people started drinking and how much they drank.

She supported the draft resolution, and looked forward to participating in the drafting of a global strategy.

Dr MUKONKA (Zambia) emphasized the framing and application of alcohol-related policies, strengthened legislation regulating the sale and use of alcohol and the setting up of national multisectoral bodies to advocate against the harmful use of alcohol and other drugs.

He supported the draft resolution.

Dr MUSTAFA (Sudan) said that WHO's experience in combating the harmful effects of tobacco use would be important in its bid to combat those of alcohol use.

¹ WHO Technical Report Series No 944, 2007.

Mr PETTERSSON (Sweden), observing that no comprehensive resolution on alcohol had been approved in the Health Assembly in the past 20 years, said that his country was fully committed to the framing of a global strategy. Vigorous debate had shown how complex and important the issue was, and it was useful to hear of Member States' specific situations; however, progress was essential and the only way forward was to approve the resolution, as amended by New Zealand, by consensus.

Mrs BAQUERIZO GUZMÁN (Ecuador) reiterated the position of the Americas that the resolution should be approved by consensus without reopening debate. The Americas considered that the proposal by New Zealand brought the English text into line with the Spanish, the language in which the resolution had been drawn up. She thanked those delegations that had withdrawn their amendments and she called on other Member States to show the same flexibility for the sake of having the draft resolution approved.

Dr ANTOINE (Grenada), speaking on behalf of the Caribbean Community, supported the draft resolution, as amended by New Zealand. The Caribbean Community had carried out consultations, leading to a declaration on noncommunicable diseases, that included a regional plan for chronic noncommunicable diseases covering harmful use of alcohol.

He urged the Committee to approve the draft resolution as amended by New Zealand, by consensus, recognizing that it was a skilfully crafted text and that there were larger issues to contend with in combating the harmful use of alcohol.

Mr MARTAKIS (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that alcohol-related harm affecting young people was an important health and social issue, as it was the largest cause of death and a significant contributing factor to violence and unprotected sex among young people. He emphasized partnerships and networks involving community agencies and nongovernmental organizations in order to provide care and support for alcohol addicts, to raise public awareness and to empower vulnerable groups. His Federation, a founding member of the Alcohol Policy Youth Network, was focusing on young people and alcohol, and the role of international nongovernmental organizations. Alcohol abuse and alcohol-related problems were too often neglected in medical curricula which could focus on teaching medical students the skills for preventing, diagnosing and treating alcohol-related problems. He urged the Committee to approve the draft resolution.

Dr ALWAN (Assistant Director-General) thanked Member States for their contributions and acknowledged their concerns about the serious public health problems caused by the harmful use of alcohol and the urgent need for action. Following a consensus reached on the draft resolution, the Secretariat would take immediate steps to develop a global strategy, taking into account all the meeting's contributions as well as the current work being carried out. He noted the proposal of Sri Lanka for a World No Alcohol Day.

He commented on the different views of the meaning of the word "collaborate", referring to WHO's Guidelines for interaction with commercial enterprises to achieve health outcomes, available on the WHO web site. According to the Guidelines, WHO could not collaborate with private or commercial enterprises if such action involved any conflict of interest, in particular in relation to normative functions such as standards or guidelines developed by the Secretariat. He called on the Office of the Legal Counsel to elaborate on the matter.

Mr BURCI (Legal Counsel) said that, in its long history of interacting with stakeholders in industry and commercial enterprises, WHO had always been aware of the need to avoid the perception of conflict of interest and to preserve the credibility and integrity of its normative function. The Guidelines for interaction with commercial enterprises to achieve health outcomes represented a codification of best practices to ensure that WHO's interaction with the commercial sector did not raise real or perceived

conflicts of interest concerning the legitimacy and integrity of its functions. The Secretariat consistently relied on the Guidelines to assess any form of collaboration with the private sector.

The CHAIRMAN asked the Secretary to read out the proposed amendment.

Ms VESTAL (Assistant Secretary) said that the amendments from Greece and Palau had been withdrawn, leaving only New Zealand's amendment to subparagraph 2(4). It read: "to collaborate and consult with Member States, as well as consult with intergovernmental organizations, health professionals, nongovernmental organizations and economic operators on ways they could contribute to reducing harmful use of alcohol".

The draft resolution, as amended, was approved.¹

Climate change and health: Item 11.11 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R4, and A61/14)

Dr GWENIGALE (representative of the Executive Board) said that a draft resolution on climate change proposed by the delegations of New Zealand and the United Kingdom of Great Britain and Northern Ireland and cosponsored by Germany and the Netherlands, had been considered by the Executive Board at its 122nd session. The draft resolution reflected concerns over the growing evidence of the effect of atmospheric greenhouse gases and their potential repercussions on human health, and recognized the joint responsibility of all Member States to address the health impacts of climate change. The draft resolution had been amended and adopted by the Board. It called upon the Director-General to present to the Executive Board at its 124th session a draft workplan for scaling up WHO's technical support to Member States for assessing and addressing the implications of climate change for health and health systems. The Health Assembly was invited to consider the draft resolution.

Dr VOLJČ (Slovenia), speaking on behalf of the European Union and its Member States, said that the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro, Serbia as well as Ukraine, Moldova and Armenia aligned themselves with his statement. He acknowledged that WHO had, in the past 20 years, been working to make public the health risks posed by climate change and he applauded the work done for World Health Day 2008: protecting health from climate change. The Medium-term strategic plan 2008–2013, strategic objective 8, also recognized the need to tackle the causes of environmental threats to health through primary prevention.

WHO had an important part to play in minimizing the impacts of climate change by raising awareness of how it affected health and health systems, and promoting sustainable action to tackle it. The report represented a good start and WHO should, in collaboration with other organizations in the United Nations system, prepare guidance relating to climate change and health. The Secretariat should draft a workplan that would broadly reflect the needs of Member States.

Dr SCHWEPPE (Germany) added that his Government welcomed WHO's commitment to mitigating the effects of climate change on human health, and fully supported the draft resolution. However, discussion should focus not only on mitigating climate change and reducing greenhouse gases but also adapting to it. His Government would provide additional funds to WHO for climate change and health and carry out projects in south-eastern Europe and central Asia with WHO in order to protect health from climate change.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA61.4.

Health adaptation projects aimed to strengthen health systems and build institutional capacity in order to deal with extreme weather events, strengthen surveillance of, and response to, infectious diseases and respiratory diseases, and improve food safety and nutrition. Further aims included research into energy efficiencies and renewable energies for health services. Those projects aimed to foster cooperation with WHO and between developed and developing countries in adapting to climate change.

Mr KÖKÉNY (Hungary) said that climate change and its impact on health should be given high priority. Moreover, the threats posed by climate change to health security and to the economy would require intersectoral cooperation. The Director-General had committed herself to providing technical support to Member States which could take the form of preparedness plans, health impact assessments and testing the cost-effectiveness of the necessary measures. Action was needed, such as surveillance and monitoring systems, in order to assess the effects of climate change. Those instruments could also be used to combat threats such as bioterrorism and pandemic influenza. Further research was needed on the diseases that might emerge or re-emerge as a result of increased temperatures in countries with a continental climate. He welcomed WHO's leadership in that area and supported the draft resolution.

Dr AYDINLI (Turkey) commended the report on climate change and health. Humanity was unquestionably in danger, and as a result of human activities. The emergence of danger could, however, trigger joint action. If the current generation persisted in its unforgivable negligence, the next one would pay the price. He supported the draft resolution.

Ms LANGIDRIK (Marshall Islands) fully endorsed the goals defined in the report. Hers was a small country and highly vulnerable to climate change in the form of devastating floods, drought, typhoons, rising sea levels and increases in climate-related diseases. All such events could have harmful and lasting effects in a country only seven feet above sea level. The country was already feeling the impact of climate change, and was wondering what more it could do to avoid the potentially disastrous impact on health. Greater research was needed, on health systems capable of protecting people's health from climate change, but without further delay, because climate change was already taking place. She urged the fostering of cross-disciplinary partnerships that would respond to the needs of vulnerable developing countries.

Mr LARSEN (Norway) welcomed the high global priority given to climate change. Climate change would increase the risk of disease, reduced food production and major floods and storms. None of the health problems were new, but climate change increased their frequency, making it necessary for WHO to play a greater role. Moreover, the health risks were unequally distributed, both between and within countries. Failure to take action would be detrimental not only to health in general, but also to equality of provision. Public awareness was important for ensuring the necessary action would be accepted. The implications of climate change might be particularly difficult for people to accept in poor countries, where other threats, and sheer survival, might appear more immediate. The health sector had a responsibility to communicate the health consequences of climate change, and WHO should assist Member States in their assessments. The draft resolution was a good foundation for further initiatives.

Dr ST JOHN (Barbados) welcomed the report and supported the draft resolution. Barbados had felt the effects of climate change in many areas, especially water provision, since it was classified as a water-scarce nation. Its water came from aquifers, and climate change had resulted in low rainfall at a time of increasing demand due to development. A WHO global project focused on water scarcity, in which Barbados was included, would develop mechanisms to deal with those challenges. Barbados had also suffered recently from vector-borne diseases, including an outbreak of dengue fever that had caused a number of deaths. It had produced clinical management guidelines and had conducted a workshop to train physicians, nurses and pharmacists. As a result of climate change, the eastern

Caribbean region had been affected by hurricanes, damage to agriculture, disruption of tourism and loss of life. Despite its efforts, Barbados was still insufficiently prepared. It had benefited from Safe Hospital workshops, with PAHO support. Many people lived in flood-prone coastal areas and much of its health infrastructure was vulnerable to storm surges and flooding. Corrective action would take time. Asthma prevalence was high, and recent research had associated it with African dust and high relative humidity. She recommended a document entitled “Climate change and health: why Caribbean countries must act now”, produced by the Caribbean Environmental Health Institute, which explained some of the issues.

Mrs RIZZO (Italy) supported the draft resolution. Climate change was a key challenge to public health, and she welcomed the priority given to it. It would pose new challenges to health systems and professionals, and require innovative strategies covering information, prevention, treatment of chronic diseases, and the training of health professionals. Unfamiliar diseases and problems would emerge, and would require a well-trained health community. WHO needed to expand its awareness-raising activities tailored to the needs and cultures of the countries concerned. Health should be included in the climate change debate and the health sector given its share of the resources made available through the United Nations Framework Convention on Climate Change process and the Nairobi Work Programme. The Conference of the Parties to that Framework Convention in 2009 would be a critical moment. Strengthened evidence and improved understanding of the links between climate change and health, including adaptation and mitigation measures, were needed. Her Government would support financially WHO activities related to climate change and health.

Dr MOOSA (Maldives) spoke on behalf of the 11 Member States of the South-East Asia Region, as well as 13 small island developing States: Antigua and Barbuda, Federated States of Micronesia, Fiji, Jamaica, Kiribati, Marshall Islands, Mauritius, Palau, Samoa, Saint Kitts and Nevis, Tonga, Tuvalu and Vanuatu. The health impacts of climate change disproportionately affected the developing and small island countries by comparison with the industrialized ones, and could jeopardize progress towards achievement of the Millennium Development Goals. Recent events in the Member States, as evidenced by the large number of casualties, morbidities and other suffering experienced by vulnerable population groups, had sounded the alarm for urgent action. Additionally, the negative impact of climate change on food production, causing shortages and rising prices, projected severe effects on the nutritional status of the vulnerable populations. Strengthened preparedness of health systems, and their capacity to monitor and respond to the public health impacts of climate change, was urgently needed.

Welcoming the draft resolution, she noted that it called for action only by the Director-General of WHO, but not by Member States themselves. She therefore proposed the insertion of an additional paragraph:

“2. URGES Member States:

- (1) to develop and integrate health measures to national plans on adaptation to climate change;
- (2) to effectively strengthen the capacity of the health systems for monitoring and minimizing the public health impacts of climate change through adequate preventive measures, preparedness, timely response and effective management of natural disasters;
- (3) to promote effective engagement of the health sector and its collaboration with all related sectors, agencies and key partners at national and global levels to reduce the current and projected health risks from climate change;”.

Dr FORRESTER (Jamaica) commended the report on climate change and health, and welcomed the draft resolution. She endorsed the statement by the delegate of Barbados. Like many other small island States, Jamaica was vulnerable to events induced by climate change, such as hurricanes, rising

sea levels and higher temperatures. It also had a high rate of deforestation and of motor vehicles per capita. In its climate change profile, emphasis was placed on the impact of vector-borne diseases. Climate change had been a contributory factor in recent outbreaks of dengue fever and malaria. As for food security, the recent riots in Haiti had underlined the urgent need for action, since food production in Jamaica had suffered from repeated hurricanes and droughts. Policies for food security and strategies for disaster mitigation response had been developed, with the support of PAHO and international partners. Attention must be paid to improved building design, especially in health infrastructures, to cleaner and safer transportation, to prudent energy policies and to striking a balance between the demands of business and sound environmental and public health practices. Such plans should include mitigation strategies to counter the health impacts of climate change. Primary health care played a role in changing behaviours in the direction of environment-friendly practices and through public awareness. Jamaica was building capacity in public health leadership through the newly established Caribbean Health Leadership Institute and the Public Health Leadership Programme. It welcomed WHO's technical support, and looked forward to the workplan. The theme of the meeting of Commonwealth health ministers in 2009 would be health and climate change. She urged WHO and the Commonwealth Secretariat to work as partners on the subject.

Supporting the amendment proposed by the delegate of Maldives to the draft resolution, she suggested adding the words "and security" after "climate change for human health".

Dr TAKAOKA (Japan), welcoming the report, acknowledged the significant impact of climate change on health. The effects of climate change should be assessed on the basis of scientific evidence. The health of individuals, as well as public health, was affected by patterns of rainfall and water use, so each country should collect its own accurate data on the health effects of climate change. There should also be effective cooperation within WHO. In July 2008, Japan would be chairing the G8 Summit, which had climate change on its agenda. Japan intended creating a framework in which the main emitters of greenhouse gases could participate, with the purpose of setting fair targets for all the participants. The summit would provide an opportunity to consider health and climate change and increase efforts to collect relevant data. He supported the draft resolution.

Mr SOAKAI (Nauru) commended WHO's leadership on climate change. Nauru aligned itself with other Pacific island States that had long drawn attention to the dangers of climate change. The risk of relocation was becoming a reality with consequent social and public health implications. They were highlighted in the draft resolution contained in resolution EB122.R5 on the health of migrants. Nauru thanked partners for support for its health sector development and its efforts to combat the negative effects of climate change. He supported the draft resolution under consideration, as amended by the delegate of Maldives.

Ms WISEMAN (Canada) said that research strongly suggested that changing climatic conditions would increase the risks to human health. She supported the draft resolution. Canada's recent work included an assessment of health risks and vulnerabilities associated with climate change, and was investing in adaptation programmes to assist and protect its own population. It recognized the challenges of climate change for First Nation and Inuit peoples' health and well-being, and was assisting communities in the management of the health impacts. Canada would contribute to the development of a workplan that would increase understanding of health risks, promote adaptation strategies and raise awareness towards necessary action.

Dr BAI Huqun (China) said that global warming was inevitable, a matter of worldwide concern. China's action plan on environment and health gave priority to climate change, and research was being conducted into the impact of climate change on environment-related diseases and the interactions between climate change and air pollution. That research had led to further research on effective measures. The next steps would be to devise departmental workplans based on the response plan to climate change, to coordinate public health interventions and emergency responses, to consolidate

existing resources, and to strengthen response capacity to climate change. A monitoring network would be set up on extreme weather and health. Research would be carried out into climate change and human health, with cost-effectiveness of the measures taken and evaluation. An information campaign would raise public awareness and help the public to protect themselves more effectively. A final aim was to strengthen global communication and cooperation, as part of a joint response to the shared problem of climate change.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) observed that the report showed a scientific consensus that global warming was a reality and was due mainly to the burning of fossil fuels and the release of greenhouse gases, with the emergence of new diseases and adverse effects on food production and water supplies. It would become more difficult to achieve the Millennium Development Goals. The mitigation strategies outlined in the report would be difficult for some developing countries to apply, since wood was often the only source of energy for cooking food. The developed countries were not being asked to cut down the numbers of cars on the road, but to give preference to bicycles or walking. Moreover, it would be difficult to carry out the recommendation to restrict the production and transport of food. In Cuba, average annual temperatures had risen steadily since 1951 and the years since 2000 had been the hottest ever recorded. Climate change had affected the seasonal pattern of infectious diseases, indicating the likelihood of epidemiological variations in acute respiratory infections, diarrhoea, viral hepatitis and other diseases, and increased outbreaks of dengue fever. The effects of global warming on the emergence of new diseases and their seasonable variation must be taken into account. He reiterated the point made that humanity itself was in danger of disappearing because of the rapid degradation of its natural living conditions. Given the information available, WHO should develop an international strategy and plan of action to combat the effects of climate change on health.

Dr AMANKWAH (Ghana) reported that the impact of climate change was already being felt in Ghana. Torrential rains in August and September 2007 had resulted in extensive floods in the north of the country, which in turn had caused loss of life, destruction of property, damage to physical infrastructure including health facilities, the disruption of health service delivery and an upsurge in water-borne and water-related diseases.

He supported the draft resolution, but suggested replacing the word “stratospheric” in the second preambular paragraph by “atmospheric,” and the word “strengthened” in the third preambular paragraph by “improved”.

Dr AL-SHATTY (Kuwait) supported the draft resolution. As a desert country, Kuwait had begun to see rises in temperature throughout the year, with scarce rainfall and more frequent dust storms. He emphasized the man-made factors involved in climate change. It was paradoxical, for example, that food was being used to generate energy by means of biofuels while people in poor countries went short of food. He favoured the use of technology in order to reduce the impact of motor vehicles on the environment.

WHO should step up its cooperation with other organizations, such as ILO, in dealing with the effects of climate change. Human health must have a central place in the decision-making process.

Mr HERBERT (Saint Kitts and Nevis) mentioned the statement issued by the Director-General on 7 April 2008, pointing out that, although climate change was a global phenomenon, its consequences would be unevenly distributed, with developing countries and small island nations being first and hardest hit. Saint Kitts and Nevis faced the real prospect of more frequent and intense hurricanes, rising sea levels, drought and floods. It needed the support of the international community to secure or strengthen its coastal defences, ensure supplies of potable water and food, mitigate the effects of floods and erosion, and establish vector-borne disease surveillance and response. He supported the draft resolution.

Dr SULAIMAN (Malaysia) said that his Government had set up an intersectoral cabinet committee on the key issue of climate change, which needed immediate responses involving both adaptation and mitigation. However, countries would require funding for the tools and technologies needed to minimize the risks and impact of climate change.

In order to integrate health into the mainstream of the debate on climate change, Malaysia was organizing, in September 2008, a conference on the subject for health ministers from Asia and the Pacific. He supported the draft resolution, with the addition proposed by the delegate of Maldives.

Ms SELAO (South Africa) recalled that the theme of World Health Day 2008 had been climate change and health. South Africa had used that event to raise awareness and promote practical strategies such as sun protection practices, recycling programmes, water and sanitation education, and tree planting. Initiatives targeted at industry, particularly manufacturing, were also under way.

She supported the draft resolution, but proposed adding at the end of the sixth preambular paragraph the words “however, industrialized States must take greater responsibility in this regard.” An additional preambular paragraph should read: “to work with United Nations agencies and other parties in examining the feasibility of establishing an international financing instrument to support countries to mitigate the impact of climate change”.

Mr ITALELI (Tuvalu) said that climate change was already affecting the health of people in his country. Warmer weather was resulting in shorter breeding cycles for mosquitoes, causing an increase in vector-borne diseases. More frequent seasonal cyclones and rising sea levels were causing flooding and contaminating the groundwater, causing damage to root crops and staple food supplies. The results were increasing waterborne diseases, eye and skin infections, and nutritional deficiencies.

He endorsed the statement by the delegate of Maldives. He urged WHO’s continued attention to climate change and the serious risks to global health security.

Mr KAYITAYIRE (Rwanda), speaking on behalf of the Member States of the African Region, said that human activities were contributing considerably to climatic changes that were harming numerous communities and ecosystems. The adverse effects of climate change could be categorized, such as temperature-related mortality and morbidity, the impact of extreme meteorological conditions on health, the effects of atmospheric pollution, the impact on health of contaminated water and food, zoonotic and vector-borne disease, ill-health due to increasing exposure to ultraviolet rays, the impact on vulnerable population groups, and the socioeconomic impacts on the health and well-being of communities.

The African Region had already suffered serious droughts and the devastating HIV/AIDS pandemic, its health systems were inadequate and its governance systems unstable. In future, it might be affected by even more serious diseases as a result of climate change and global warming. Climate change and rising sea levels represented a particular danger to Africa’s small island developing States.

The various international and regional initiatives in the field of health and the environment must be supported. A conference on health and the environment, the first of its kind in Africa, would take place in Gabon in August 2008.

The draft resolution called for the preparation of a workplan for scaling up WHO’s technical support to Member States for assessing and tackling the implications of climate change for health and health systems. The Health Assembly should adopt the resolution by consensus.

Professor AZAD (Bangladesh) said that Bangladesh was hit very hard by climate change, for which its people were not responsible. In 2008, there had been two large floods within a month followed by the devastating effects of cyclone Sidr, causing the loss of thousands of lives and the destruction of resources built up over generations. Bangladesh was also suffering an increasing prevalence of malaria, leishmaniasis and dengue fever as a consequence of climate change. Most of the deadliest tornadoes on record worldwide had struck Bangladesh. Its location in the delta of the Bay of Bengal exposed it more than any other country to such natural calamities. It deserved urgent support in warding off the effects of climate change.

He strongly supported the proposal by the delegate of Maldives.

Dr METAI (Kiribati) supported the draft resolution, with the addition proposed by the delegate of Maldives. The severe impact of climate change on Kiribati had become clear in 2000 when sea surges had crossed its smaller islands and resulted in crop failures, leading in turn to nutritional problems. Since the islands were only at most 500 metres across, there was nowhere to run as the coasts were eroded.

Almost the whole of 2007 and the first three months of 2008 had been completely dry, which had destroyed many food crops. The air on the islands was dusty, aggravating respiratory problems. The islanders were now having to boil their drinking and cooking water, with effects on the consumption of firewood and other fuels. Cases of diarrhoea had increased, and caused deaths among children.

There was an urgent need for alternative energy sources to meet the needs of the islands, including desalination plants, and technology to harness energy from the abundant sunlight and wind.

If global temperatures rose too high, the coral would die. The small fish that fed around the coral would die, and then the larger fish that fed on the small ones would die also. The livelihood of coral islanders would then be gone. If sea levels rose a mere 12 feet, the islands themselves would be gone. It was time to move beyond words. Member States must work together to reduce greenhouse gases and the use of chemicals harmful to the ozone layer.

He asked WHO and partners for funding and technical support for a comprehensive assessment of the capacity of small coral island nations such as Kiribati to deal with the health effects of climate change.

Dr Cigogna took the Chair.

Dr PÉREZ-SIERRA (Bolivarian Republic of Venezuela) observed that climate change was having and would have serious effects for all humanity, but especially for poorer people. The present development model, based on individualism and consumerism, must change. As long as hunger, social exclusion and poverty persisted, democracy and the environment would be under threat. According to the principle of shared but different responsibilities, it was up to the developed countries, the principal emitters of greenhouse gases, to provide financial resources and transfer clean technologies to the developing countries in support of measures to mitigate and adapt to climate change. Venezuela was increasing energy efficiency by rationing energy consumption and developing solar and wind power. She supported the draft resolution and emphasized greater cooperation among all United Nations agencies. She called on WHO to support national, subregional and regional initiatives to strengthen systems for monitoring the impact of climate change on health.

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

The meeting rose at 12:40.

SEVENTH MEETING

Thursday, 22 May 2008, at 14:35

Chairman: Dr F. CICOGNA (Italy)

1. ORGANIZATION OF WORK

The CHAIRMAN announced that, as agreed by the General Committee the previous day, the chairmen of the two committees had met with the President to review the progress of work and had decided that items 11.12, Monitoring achievement of the health-related Millennium Development Goals, and 11.14, Progress reports on technical and health matters, should be transferred to the agenda of Committee B. Depending on progress in Committee B, item 11.13, Counterfeit medical products, might also be transferred to its agenda.

Ms BAQUERIZO GUZMÁN (Ecuador) enquired whether decisions regarding the transfer of agenda items should not properly be taken in plenary, as the programme of meetings had been adopted in plenary. She suggested that the meeting be suspended briefly in order to allow delegations to reorganize their participation in the discussions of the two committees.

The CHAIRMAN recalled that the General Committee had agreed that the President would review the work of the two committees and take decisions regarding the transfer of agenda items. The change would be announced both in plenary and in Committee B. He said that Committee B would not take up the transferred items until it had completed its consideration of all other items on its agenda, and delegations would therefore have ample time to confer beforehand.

2. TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

Climate change and health: Item 11.11 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R4, and A61/14) (continued from the sixth meeting, section 2)

Mrs MONDIWA (Malawi) said that her country depended heavily on rain-fed agriculture and on biomass for household energy, and was therefore highly vulnerable to the adverse impacts of climate change and extreme weather events. The situation was exacerbated by increasing rural poverty and population pressure, land degradation as a result of agricultural expansion and deforestation to meet rising demands for energy, food and construction. Malawi had elaborated a programme of action to promote activities for adapting to climate change. She urged the Secretariat to provide support to Member States in dealing with the health effects of climate change and in mobilizing resources and technical support for implementation of their action plans. She supported the draft resolution contained in resolution EB122.R4.

Dr NAEEM (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the report addressed the main health and environmental concerns in relation to climate change. He expressed satisfaction about the links to the Millennium Development Goals, water stress, and healthy development choices. However, regarding the responses expected from the health sector, the Secretariat should devise a global action plan and communication strategy in order to further work on climate change and health. The Organization should also continue to highlight health concerns within the global response to climate change. Financial resources and a

qualified workforce with effective international solidarity should be made available for developing countries that needed to cope with the impact of climate change on health.

Mr MABUZA (Swaziland) said that climate change was jeopardizing efforts to achieve the Millennium Development Goals. Swaziland was already experiencing the negative impacts of climate change: a four-year drought had resulted in a noticeable rise in chronic malnutrition and micronutrient deficiencies, and thus in the rates of communicable and noncommunicable diseases. In response, a food and nutrition policy had been elaborated which included educating people to cultivate drought-resistant crops. Swaziland needed more resources in order to eliminate hunger. He requested support from WHO in assessing the negative effects of climate change on health, in formulating strategies and in strengthening environmental health capacity. Swaziland planned to involve the private sector and communities in actions to mitigate climate change. He supported the draft resolution.

Dr LEE Seon-kui (Republic of Korea) supported the draft resolution. The health sector response to climate change must be based on scientific evidence, and a surveillance system for illnesses related to climate should be set up. Her Government had assessed the health impacts of climate change and was finalizing the response plan, which would emphasize mitigation and adaptation measures. She urged other Member States to undertake their own assessments and to continue monitoring diseases and health effects of climate change. She called on the Secretariat to support and encourage Member States in order to sustain response to climate change.

Dr PHUSIT PRAKONGSAI (Thailand) said that vulnerable populations in developing countries were especially affected by climate change. He supported the proposal by Maldives to add a new paragraph to the draft resolution, calling for action by Member States. He proposed further the insertion of an additional paragraph to read: “to express, as a priority, national commitment to address the challenges posed to human health by climate change, and to provide clear directions to plan actions and investments at the national level to mitigate health effects of climate change”. He asked for clarification of the definition and scope of the term “global health security”, used in subparagraph 1(1) of the draft resolution. He was concerned that inclusion of the word “security” might have implications for countries’ sovereignty and suggested its deletion.

Dr NDIAYE (Senegal) said that people in Africa appeared to be insufficiently aware of the phenomenon of climate change and its impacts; selection of “Protecting health from climate change” as the theme for World Health Day 2008 had been therefore welcome. Climate change increased morbidity and mortality, especially in countries where health systems remained weak and suffered from shortages of resources. Governments must be prepared to deal with floods, droughts and other manifestations of climate change, particularly in the early stages. Senegal encouraged all measures to mitigate and manage the effects of climate change.

Dr OTTO (Palau) said that developing countries required input, support and collaboration from partners in developed nations if they were to deal with the health effects of climate change. Palau aligned itself with the statements made by other small island States. A concern that was not clearly covered in the report was the effect of climate change on tourism. In 1998, Palau had experienced the El Niño phenomenon, which had killed about 80% of its reef corals, a major tourist attraction. The impact on its tourism industry had been devastating, and the long-term effects on marine biodiversity and on food security were still being assessed.

He supported the draft resolution with the amendments proposed by Maldives and South Africa. He suggested inserting the words “marine life,” before “water resources” in subparagraph 1(3)(c).

Dr MINNIS (Bahamas) said that the low-lying coastal features of many of the islands of the Bahamas made them particularly vulnerable to the effects of climate change, including rising sea levels, more intense storms, increased flooding, air pollution and droughts. Migration of populations

from neighbouring small island States to the Bahamas would impair the health-care system. If small island developing States were to elaborate and implement strategies for climate change, they would require technical expertise in environmental sciences, population migration and emerging diseases. Health personnel would need to recognize, manage and prevent illnesses related to climate change.

Mr ZIBE (Papua New Guinea) said that the selected theme of World Health Day 2008 had been fitting and he welcomed the efforts of WHO and development partners to sustain response to climate change. In his country it could result in population relocation, increasing prevalence of malaria at higher altitudes and an increase in natural disasters. The country was committed to the socioeconomic and environmental development of peoples living in the rainforests and to protecting rainforests, which provided basic sustenance for almost 50% of the population. However, the Kyoto Protocol to the United Nations Framework Convention on Climate Change did not recognize the participation of people living in the rainforests in mitigation and adaptation. He urged WHO to provide support to the developing countries in the four regions where old-growth forest was to be found.

Ms GUY (New Zealand) said that climate change had an increasingly adverse impact on the fundamental determinants of health, and thus serious implications for achievement of the health-related Millennium Development Goals and health equity. The earliest and most severe health effects would be experienced by developing countries and small island States. The Director-General should be given the mandate to consult broadly with Member States on how best to provide practical guidance and support in order to raise awareness of the health implications of climate change, and to promote practical action at all levels. She supported the draft resolution.

Mr MARIN (Belize), referring to recent natural disasters, expressed his country's sympathy and support to the people of China and Myanmar.

Belize understood only too well the health-related challenges of climate change. He acknowledged the support that partners had provided to his country's health system after Hurricane Dean, a category 5 storm, had devastated the country the previous year. As a result of the assistance received, no lives had been lost, and the country had largely recovered. Belize recognized the health risks and challenges from climate change facing the people of island nations. He supported the draft resolution.

Mr LOBATO (Brazil) said that climate change and its potential effects on public health were undoubtedly a major concern for WHO. Preparation of the workplan to which the draft resolution referred was part of broader efforts to strengthen the role of WHO in addressing entities that had the potential to damage the lives and health of a vast majority of mankind. The draft resolution, which he supported, could be improved by replacing the words "... serious risk of climate change to global health security" in subparagraph 1(1) with "serious risks of climate change to global health".

Ms CHASOKELA (Zimbabwe) said that the impacts of climate change in Zimbabwe, including floods and droughts, had been detrimental to food security. WHO should mobilize resources in order to build capacity, to assess the risks of climate change and implement effective responses, particularly in developing countries, which would suffer the most adverse effects. He supported the draft resolution as amended by South Africa.

Mrs LASPINA (Ecuador) said that climate change transcended borders and disrupted the balance between human beings and nature. Poor and less developed countries would suffer disrupted supplies of water and food and a worsening health situation. Natural disasters would result in the mass displacement of populations. She noted that, in the Region of the Americas, PAHO offered support for contingency plans. However, international strategies should address the determinants of health, and increase the responsibility of developed countries, as those had contributed most to the causes of climate change.

Ms VALDEZ (United States of America) said that climate change required a global response. Her country was working nationally and internationally in order to strengthen energy security, maintain and encourage economic growth and address climate change. Its policy on climate change was science-based and encouraged research and global participation. The US Government had invested significantly in climate science, technology, incentives and international assistance. Policies on climate change should complement strategies to promote economic growth and meet the health, educational and other needs of citizens. The United States participated in partnerships that fostered economic growth in the developing world by modernizing energy services. The world community must lower greenhouse emissions, but in such a way as to promote economic growth and greater prosperity. United States' support for programmes to protect human health from risk factors related to climate included strengthening global surveillance systems and incorporating climate considerations into sustainable development projects.

Referring to the report, she said that it was important to use scientific language and not to draw conclusions that went beyond accepted science. She therefore asked why paragraph 7 stated that production and transport of food were major emitters of greenhouse gases, when the report of the Fourth Session of the Intergovernmental Panel on Climate Change had not singled out the transport of food in that way. She supported the draft resolution.

Ms HENDRY (United Kingdom of Great Britain and Northern Ireland) said that climate change was the world's greatest environmental challenge, and would exacerbate other threats to global health. WHO's World Health Day 2008 had been a rallying call for action to protect health from climate change. The United Kingdom had used it to publish new guidance on the health impact of climate change. Further effort was needed on mitigation of, and adaptation to, the effects of climate change.

The draft resolution provided the practical foundations for dealing with climate change from a health perspective. It sought to strengthen WHO's role in advocacy, in collaboration with other organizations within the United Nations system and other research funding bodies, to provide the evidence base for action. She urged all Member States to consult on the draft workplan to be presented to the Executive Board at its 124th session. She supported the suggestion made by Brazil and Thailand to delete the reference to "security" in subparagraph 1(1). With regard to one of the amendments put forward by Ghana, the reference to "stratospheric ozone depletion" in the first preambular paragraph should be retained; it was scientifically correct and had been taken directly from the title of resolution WHA51.29.

Dr KOLLI (WMO) said that WMO's valuable partnership with WHO had supported workshops on climate change and health. WHO's health experts worked with the WMO Commission for Climatology as part of the Expert Team on Climate and Health. The Secretariat's report, in the section on health issues, should have referred to current climate variability, which affected human health, the infrastructure and human resources underpinning health services and field operations. Adaptation to current climate variability, on the basis of credible information, early warnings and advice, would help to build essential capacity. WHO should strengthen its efforts to prepare for climate change, enhance its partnership with WMO at global and regional levels, and facilitate linkages between the national meteorological and hydrological services and national health services of its Member States. He drew attention to the World Climate Conference-3 being organized for 2009 by WMO in partnership with several organizations, and welcomed the involvement of WHO in planning the activities relating to climate and health.

Ms MHLANGA (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that the focus of public health should shift from surveillance and response to a greater emphasis on prediction and prevention. Public health considerations must be revised with respect to disaster management strategies and long-term planning. Although emergency response usually generated much attention, the problem of epidemic diseases could only be alleviated through long-term, sustainable measures in prevention, response and surveillance. The aim was to

complement existing emergency response structures and train national societies in epidemic disease response and best practice, rather than to act as a front-line response unit for outbreaks. Steps would be taken to ensure that planning for the transition from emergency to recovery phases, an essential aspect of response programmes, was funded. Early warning systems for potential outbreaks of diseases were being created in partnership with the scientific community. Climate change would also be integrated into first-aid training at community level.

Climate change was the responsibility of all, and governments and national organizations should consult on the best ways of tackling the humanitarian consequences of climate change in their own countries, while supporting the work on prediction and prevention in others

Ms MERET (International Council of Nurses), speaking at the invitation of the CHAIRMAN and also on behalf of the FDI World Dental Federation, the International Pharmaceutical Federation and the World Medical Association, expressed concern that disruptions in food and water supplies, and in health-care and other services, due to extreme weather events, were threatening the health security of vulnerable populations. Understaffed health systems were already struggling to cope. The health professions were ready to work with WHO and governments to mitigate the health impacts of climate change.

Ms KUONEN-GOETZ (La Leche League International), speaking at the invitation of the CHAIRMAN and also on behalf of the International Lactation Consultant Association and the International Baby Food Action Network, underscored the importance of breastfeeding in limiting the negative impacts of food insecurity on the health of infants and young children in the wake of natural disasters. Operational guidelines and training materials for infant feeding in emergencies (available on the web site of the Emergency Nutrition Network) should be implemented as part of emergency preparedness efforts and to ensure that relief workers were trained in promoting breastfeeding in emergency situations.

Dr HEYMANN (Assistant Director-General) said that WHO would continue to raise awareness of the health impacts of climate change and to make available the necessary evidence. The importance of the subject to WHO could be seen, as noted by delegates, in the Director-General's decision to make it the theme of World Health Day. WHO would also continue to strengthen the capacity of public health systems to deal with public health emergencies resulting from climate change, to encourage research and evidence gathering, and to collaborate with other bodies in the United Nations system and other international organizations. It would scale up its regional activities, as requested in the draft resolution. Climate change and health was already on the agenda for that year's regional committee meetings. Environmental issues would be dovetailed with the Organization's infectious disease alert-and-response activities through the new Health, Security and Environment cluster. He thanked the many Member States, including France, Germany, Italy, Spain and the United Kingdom, that had supported WHO's endeavours on climate change and health.

The CHAIRMAN said that a revised version of the draft resolution, incorporating the various proposed amendments, would be circulated to the Committee for consideration at a later stage in its proceedings.

It was so agreed.

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

Prevention and control of noncommunicable diseases: implementation of the global strategy:
Item 11.5 of the Agenda (Document A61/8)

The CHAIRMAN drew attention to a draft resolution proposed by Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, India, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, New Zealand, Norway, Oman, Palau, Poland, Portugal, Romania, Samoa, Singapore, Slovakia, Slovenia, Spain, Sweden, Tunisia and the United Kingdom of Great Britain and Northern Ireland, to which Canada, China, Mauritius and the United States of America wished to be added as sponsors, which read as follows:

The Sixty-first World Health Assembly,

Recalling resolutions WHA53.17 on the prevention and control of noncommunicable diseases and WHA60.23 on the prevention and control of noncommunicable diseases: implementation of the global strategy;

Reaffirming its commitment to the aim of the global strategy for the prevention and control of noncommunicable diseases¹ to reduce premature mortality and improve quality of life;

Reaffirming also its commitment to addressing key risk factors for noncommunicable diseases through the implementation of the WHO Framework Convention on Tobacco Control, adopted by the Health Assembly in 2003 (resolution WHA56.1) and the global strategy on diet, physical activity and health, endorsed by the Health Assembly in 2004 (resolution WHA57.17);

Deeply concerned that the global burden of noncommunicable diseases continues to grow, in particular in low-income and middle-income countries, and convinced that global action is necessary, including by effectively addressing the key risk factors for noncommunicable diseases;

Reaffirming the leadership role of WHO in promoting global action against noncommunicable diseases, and the need for WHO to continue to cooperate with regional and international organizations in order to reduce effectively the impact of noncommunicable diseases,

1. ENDORSES the action plan for the global strategy for the prevention and control of noncommunicable diseases;
2. URGES Member States:
 - (1) to strengthen national efforts to address the burden of noncommunicable diseases;
 - (2) to consider the proposed actions in the action plan for the prevention and control of noncommunicable diseases and implement relevant actions, in accordance with national priorities;
 - (3) to increase provision of support to the work of the Secretariat to prevent and control noncommunicable diseases, including the implementation of the action plan;
3. REQUESTS the Director-General:
 - (1) to continue to give suitably high priority to the prevention and control of noncommunicable diseases;
 - (2) to continue to implement the actions agreed by the Health Assembly in resolution WHA60.23 on the prevention and control of noncommunicable diseases: implementation of the global strategy;

¹ Document A53/14.

- (3) to report to the Sixty-third World Health Assembly, and subsequently every two years to the Health Assembly, through the Executive Board, on progress in implementing the global strategy on prevention and control of noncommunicable diseases and the action plan.

Dr BLOOMFIELD (New Zealand), introducing the draft resolution, congratulated the Secretariat on the draft action plan for the global strategy for the prevention and control of noncommunicable diseases. The action plan was the crucial next step eight years after the formulation of the global strategy. The draft resolution was confined to most relevant points of the plan, its implementation, and the actions to be undertaken by Member States and the Director-General.

Dr VOLJČ (Slovenia), speaking on behalf of the Member States of the European Union, the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro, Serbia, as well as Ukraine, Moldova and Armenia, described the catastrophic human toll of noncommunicable diseases, and stressed that in many countries those diseases accounted for up to 80% of health-care expenditure. The draft action plan would guide effective implementation of the global strategy, which called for the concerted support of all Member States. He thanked the Secretariat for having invited Member States and other stakeholders to the consultations. Health systems must be strengthened in order to tackle the behavioural risk factors and promote healthy lifestyles, especially among poor and disadvantaged populations, and to meet the challenges in the areas of mental health, the environment and avoidable blindness. Those matters would be explored at the WHO European Ministerial Conference on Health Systems (to be held in Tallin in June 2008) and lessons would be drawn from the European experience. The European Union's Member States expected appropriate budget allocations for the implementation of the global strategy.

Mr LOBATO (Brazil) supported the global strategy and draft plan of action. Progress in the prevention and control of both noncommunicable and communicable diseases necessitated the involvement of the entire international community.

Dr KING (Saint Lucia) stressed that food security must be a mainstay of the global strategy for the prevention and control of noncommunicable diseases and referred to the Declaration of Port-of-Spain at the CARICOM Summit on Chronic Non-Communicable Diseases (Port-of-Spain, 15 September 2007). Farming policies, food production and the trade environment currently left the poor with a choice between starving or eating unhealthy food conducive to noncommunicable diseases, which were the main causes of mortality in Saint Lucia. His Government had introduced dietary guidelines and set targets to reduce food imports by 25% within three years. There had been a rapid improvement in local food production thanks to heavy investment in aquaculture and agriculture with support from partners. Saint Lucia was committed to implementing the global strategy and the action plan. WHO should take the lead in establishing food security as a public health priority, working with partners on matters such as tariffs, trade policies and food production standards. WHO should join with FAO to advocate land-use practices conducive to the sustainable production of healthy food and to adequate supplies of clean water. Healthy food should be considered a public good, with incentives to increase access to such food and disincentives to reduce access to unhealthy food. The action plan should make specific reference to food security in its objectives, activities and indicators.

Mrs BAQUERIZO GUZMÁN (Ecuador), speaking on behalf of the Group of the Americas, welcomed the draft action plan. Implementation of the six objectives would reduce the level of exposure of populations to the common modifiable risk factors for noncommunicable diseases, namely: obesity, tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol.

She highlighted mapping of emerging epidemics of noncommunicable diseases and analysing their social, economic, behavioural and political determinants in order to guide the legislative and

financial measures needed. Implementation would require support for WHO's work in the area of noncommunicable diseases by building national and regional capacity with the help of regional organizations, as well as technical assistance. The action plan was closely connected to existing strategies, the WHO Framework Convention on Tobacco Control and the Global Strategy on Diet, Physical Activity and Health, mentioned under objective 3. At regional level it would strengthen existing strategies such as the Regional Strategy on an Integrated Approach to the Prevention and Control of Chronic Diseases Including Diet, Physical Activity and Health in the Region of the Americas.

Mr HERBERT (Saint Kitts and Nevis) said that implementation of the global strategy for the prevention and control of noncommunicable diseases should be accelerated. In his country, diseases of the circulatory system were the leading cause of morbidity and mortality, and 30% of adults were morbidly obese. The national strategic health plan was closely aligned with the outcome of the CARICOM Summit on Chronic Non-Communicable Diseases (Port-of-Spain, 15 September 2007) and with WHO's global strategy. His country had participated in the Caribbean Cooperation in Health Initiative with technical support from PAHO to prepare a framework for a national intersectoral response. However, further funding was needed. He acknowledged the support of partners in strengthening his country's health system and improving agricultural production.

The global strategy should give due regard to food security and increased availability of high-quality food. His Government was endeavouring to improve local and regional food production, but distortions in international markets continued to make it difficult for local producers to compete against high subsidies and fuel prices. The situation was exacerbated by damage from hurricanes. In his country, price rather than health education was the principal determinant of food choice. WHO needed to focus attention on the vulnerability of economies open to cheap, obesogenic foods.

Prince BIN AHMED BIN ABDELAZIZ (Saudi Arabia) commended the draft action plan for the global strategy for the prevention and control of noncommunicable diseases and supported the draft resolution. He also supported the statement made by the delegate of Slovenia. However, a plan of action for the prevention of avoidable blindness was urgently required, following the adoption of resolutions WHA56.26 on the elimination of avoidable blindness and WHA59.25 on the prevention of avoidable blindness and visual impairment, and the inclusion of visual impairment, including blindness, under strategic objective 3 of the Medium-term strategic plan 2008–2013. The omission of blindness prevention from the draft action plan must be corrected if those earlier commitments were to be realized. He therefore sought the support of Member States in requesting the Secretariat to prepare a separate, but related, plan of action for the prevention of avoidable blindness for submission to the Executive Board at its 124th session and, thereafter, to the Sixty-second World Health Assembly.

Ms HENDRY (United Kingdom of Great Britain and Northern Ireland) commended the action plan and the commitments shown therein. Multisectoral action by all government sectors, civil society and business should be prioritized. She welcomed the emphasis on tackling health inequalities, making strong links between noncommunicable diseases and the work of the WHO Commission on Social Determinants of Health, and healthy lifestyles and the recognition of the responsibility of governments to provide environments that were conducive to making healthy choices, in particular promoting responsible marketing of foods to children. The success of the action plan would depend on the resources available for its implementation, which her Government would continue to support at regional and global levels. She supported the draft resolution.

Ms NICOLAI (Netherlands) commended the priority given to the prevention and control of noncommunicable diseases, and making Member States co-owners of the action plan through consultations. The draft action plan was comprehensive and transparent, a practical instrument for implementation of the global strategy. A range of measures would be required, from health promotion through disease prevention and early intervention to care, supported by research and evaluation. Disease

management should be further investigated and implemented. Member States needed to engage with new national and international partners, including representatives of the private sector and industry.

Dr ESTEGHAMATI (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the epidemic of chronic noncommunicable diseases represented major health challenges in his Region. He stressed rapidly changing lifestyle patterns associated with globalization, inappropriate dietary habits, the change from a physically active life to a sedentary one, an increase in life expectancy of 20 years since the 1960s, and destabilization arising from occupation and conflicts.

Response to noncommunicable diseases had been launched with the support of partners and endorsed by health ministers at the fifty-third session of the Regional Committee for the Eastern Mediterranean, with the global goal of a 2% annual reduction in noncommunicable diseases above the projected trend to 2015. Most countries in the Region had been implementing national strategies, with surveillance as an essential element. Measures had included integration into primary health care, programmes based in the community, strategies and guidelines for specific diseases, strengthened intersectoral approaches, and the involvement of the nongovernmental sector. A regional alliance of nongovernmental organizations against cancer had been established in 2007, and countries were drawing up national plans in line with the Global Strategy on Diet, Physical Activity and Health.

He welcomed the comprehensive draft action plan, which built on related WHO strategies and would guide effective response. Resource mobilization and reorientation of national health systems posed a challenge, but stability and security were pressing issues in his Region. He supported the draft action plan.

Dr MORI (Japan) welcomed the draft action plan. In 2000, his Government had launched a health promotion policy, which included a novel approach based on the “metabolic syndrome”. People between the ages of 40 and 74 were screened for risk factors, such as obesity. Those identified as having metabolic syndrome were offered follow-up health counselling in order to help them change their behaviour.

Japan supported the setting of international standards that were appropriate to individual countries and had contributed to support WHO’s activities in that respect. He drew attention to the link between the draft action plan and the WHO Framework Convention on Tobacco Control and the Global Strategy on Diet, Physical Activity and Health, as well as strategies to reduce the harmful use of alcohol. Japan asked to be added to the list of sponsors of the draft resolution.

Dr HOMASI (Tuvalu) said that Tuvalu had one of the highest rates of noncommunicable diseases in the Western Pacific Region. Its national strategy would include physical health, tobacco control and nutrition. Tuvalu was a low-lying coral island with very poor soil and salty ground water, which made it difficult to grow vegetables and root crops. He acknowledged the support of partners in establishing a nutritional programme that focused on sustainable gardening, education and vegetable cultivation, adapted to the needs of low-lying coral islands. However, he was concerned about the quality of imported food products, particularly meat, which should be regulated to ensure that small island countries did not import poor-quality items that could exacerbate noncommunicable diseases. He supported the draft action plan, particularly objective 3 and the emphasis placed on promoting healthy diets.

Dr KARAMAN (Turkey) expressed pleasure that the draft action plan that had been discussed by the Executive Board at its 122nd session had been amended on the basis of consultations with Member States. As Turkey’s development had progressed, disease patterns had changed. Increased life expectancy was also causing a surge in noncommunicable diseases, which currently caused 78.7% of all deaths. The Ministry of Health’s strategic plan for 2009–2013 aimed to reduce the prevalence of noncommunicable diseases and to lower the associated mortality rate by 25% by 2013 by reducing risk factors and enhancing health promotion. In January 2008, the Government had established a department to deal with noncommunicable diseases and increased the budget for primary health care. The Ministry of Health had carried out studies in health promotion related to the prevention and control of cardiovascular diseases, chronic respiratory tract diseases, tobacco control, obesity and cancer.

Education curricula at primary and secondary schools were being reviewed in order to raise awareness of health issues. The European Network of Health Promoting Schools project would be extended throughout Turkey. The Secretariat should support Member States in the elaboration, implementation and monitoring of their national plans.

Mrs LANGIDRIK (Marshall Islands) said that it would be difficult to design a global strategy for the prevention and control of noncommunicable diseases that could be adopted by every country. Diabetes was the leading cause of morbidity in the Marshall Islands, affecting almost one third of the population over the age of 30; cancer was the second leading cause of mortality. She thanked partners for the financial support given to her country and for support in tackling type 2 diabetes. She supported the statements made by the delegates of New Zealand and Tuvalu, and fully supported the proposed initiative.

Mr MANIMU (Solomon Islands) asked that support be provided for the implementation of strategies outlined in the report. The Solomon Islands was a least-developed country with a fast-growing population, and a rapidly emerging problem of noncommunicable diseases. The world community, neighbouring countries in particular, could assist the Solomon Islands by not exporting cheaply processed, unregulated, poor-quality food to them. Noncommunicable diseases had increased in urban areas among people whose diet consisted predominantly of rice and noodles. The Ministry of Health faced an enormous task, both in terms of increasing health education and managing the care of patients already suffering from noncommunicable diseases, particularly diabetes. He thanked partners for the support they had provided over the past five years and WHO for its technical support in the area of diabetes.

Dr RAMATLAPENG (Lesotho) said that changes in lifestyle had increased incidence of noncommunicable diseases in her country. More than 30% of the adult population was obese, both men and women and in both urban and rural areas. Diabetes was estimated to account for up to 40% of adult outpatient visits and admissions, while cervical cancer accounted for half the referrals to South Africa for treatment. National efforts to prevent and control noncommunicable diseases included: integration of prevention and control into health and social welfare policy; draft legislation for tobacco control; a ban on tobacco use in public places; a draft alcohol policy; education of young people about healthy lifestyles and not initiating tobacco use; and strengthening surveillance, research and screening programmes. Lesotho was party to the Ouagadougou Declaration of April 2008. Control of noncommunicable diseases was achievable only with action by individuals, households and communities. Lesotho was therefore paying a monthly monetary incentive to community health workers; had instituted free primary health care services; and planned to renovate, expand or build health centres with improved working conditions in order to attract and retain skilled staff. There had been inadequate consultation on the WHO MPOWER package of tobacco control measures, and she proposed deletion of paragraph 24 of the draft action plan, as it was similar to sections of the WHO Framework Convention on Tobacco Control, which should remain the cornerstone of the global strategy.

Dr PONGPISUT JONGUDOMSUK (Thailand) supported the amendments to the draft resolution that would be proposed later by the delegate of Bhutan on behalf of the South-East Asia Region.

Ms SELAO (South Africa) said that South Africa had intensified efforts to preventing and controlling noncommunicable diseases; those diseases were largely preventable through effective interventions. Her country had implemented stringent tobacco control legislation and focused on good nutrition and healthy lifestyles. African health ministers had decided to mark an annual "Healthy Lifestyles Day". She agreed that the priority accorded to noncommunicable diseases should be raised internationally and supported the proposal to include noncommunicable diseases in the Millennium Development Goals. Her country had already established national targets for reducing mortality caused by some noncommunicable diseases, for example through increased screening. International targets should be set.

She welcomed the draft action plan but expressed concern about the WHO's MPOWER package, as it was based on only six policies out of a broad range of equally cost-effective options. The Parties to the Framework Convention on Tobacco Control were preparing guidelines, which would be considered and adopted during the third session of the Conference of the Parties in South Africa later that year. That Convention should be the cornerstone of the draft action plan for the global strategy.

Ms NYANDORO (Zimbabwe) said that her country had recognized the epidemic of noncommunicable diseases, had undertaken a STEPwise survey of risk factors, and had formulated a strategy with objectives in line with WHO guidelines. She asked WHO to continue to provide technical support, particularly in drawing up simplified generic guidelines for health workers to record accurate prevalence data. The report and draft action plan were balanced and addressed the major risk factors. Specific references to the MPOWER package in paragraphs 24 and 25(d) of the draft action plan would appear to restrict the measures that could be used to reduce modifiable risk factors in relation to tobacco control.

Dr CUMBERBATCH (Trinidad and Tobago), speaking on behalf of the 15 member countries of the Caribbean Community, recalled the Health Assembly in 1978, presided by his country, at which the strategy of health for all by the year 2000 was adopted. That strategy had included reducing the prevalence of noncommunicable diseases. They had caused an estimated 35 million deaths in 2005, and the number was predicted to increase. At the CARICOM Summit on Chronic Non-Communicable Diseases, the member countries of the Caribbean Community had formulated a subregional strategy, outlined in the Declaration of Port-of-Spain, to address the "silent tsunami" of chronic noncommunicable diseases, with objectives similar to those of the global plan of action. They endorsed the implementation of those further strategies, and would promote increased physical activity and mount public education programmes, using the media as partners. Health ministries would plan the screening and managing of chronic diseases, with consideration of the gender dimension. WHO's Member States should learn from the implementation of the "Health for All" strategy, in order to ensure the success of the present initiative.

Dr DEHANEY (Jamaica) said that in Jamaica four of the five leading causes of death were chronic noncommunicable diseases. Research had shown a worryingly high prevalence of risk factors in the adolescent population. The Ministry of Health's strategic plan for the promotion of healthy lifestyles in Jamaica was focused on behavioural elements and targeted communities, schools and workplaces through a national healthy lifestyle project. A national health fund, derived from taxation on tobacco, provided a range of affordable medicines and diagnostic tests in order to prevent and control noncommunicable diseases. The Declaration of Port-of-Spain, underscored the link between health and development that had been articulated in the 2001 Nassau Declaration: the health of the region was the wealth of the region. Jamaica endorsed the draft action plan which should galvanize Member States. All its objectives were pertinent. The establishment of an adequately staffed and funded unit for noncommunicable disease and health promotion, human resource training and dietary guidelines were crucial to its success.

She proposed several amendments to the draft action plan: in paragraph 2, second bullet point, a phrase should be added so that the point ended "strengthening the capacity of individuals and populations, and creating a supportive environment to empower them to make healthier choices and follow lifestyle patterns that foster good health"; in subparagraph 15(d), the words "health in early childhood" should be replaced by "health throughout childhood and adolescence"; in paragraph 19, *Reorientation and strengthening of health systems*, (a), "standards for primary care" should be replaced by "standards and protocols for all levels of care"; and in paragraph 29, Action for the Secretariat, a new bullet point should be added to read "to determine the impact of environmental and emotional factors on the development of chronic diseases".

The meeting rose at 16:55.

EIGHTH MEETING

Thursday, 22 May 2008, at 18:25

Chairman: Dr F. CICOGLA (Italy)

TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

Prevention and control of noncommunicable diseases: implementation of the global strategy:
Item 11.5 of the Agenda (Document A61/8) (continued)

Dr FORRESTER (Jamaica) said that in a spirit of collaboration she wished to withdraw the amendment she had proposed and looked forward to inclusion of the points made in the implementation plans.

Mr FISKE (Denmark) said that Denmark found the health determinants and risk factors outlined in the draft action plan to be appropriate but emphasized social determinants and the challenge of social inequity in health, the significance of the primary health care sector in disease management programmes, and the role of general practitioners, with involvement of other health professionals when appropriate. The relation between the patient and the health system must be moved further away from the traditionally paternalistic scenario. He concurred with the emphasis placed on helping people to manage their own conditions, through the provision of education, psychosocial support and financial assistance. He expressed appreciation for the work carried out so far and confidence in the ambitious draft action plan.

Mrs LLOYD (Seychelles), speaking on behalf of the Member States of the African Region, said that, although she appreciated the fact that the wide group of diseases classified as noncommunicable was receiving deserved attention, resources for their prevention and control were inadequate in her Region. The costs of managing them were extremely high. Weak health systems and competing health priorities meant that the overriding burden of communicable disease siphoned away available resources. More support was needed from WHO, countries rich in resources and other partners.

She endorsed the principles and most details of the draft action plan, stressing that Member States and development partners should take all necessary steps, such as improving nutrition, promoting exercise and reducing substance abuse, in dealing with the social determinants of health. The plan called for noncommunicable diseases to be seen in their wider development context and for resources to be devoted to reducing the risk factors for those diseases. That was commendable, but the theoretical strategies must be followed by concrete actions by all parties. Risk factor reduction would entail improving the fundamental aspects of human existence: housing, nutrition, education, employment and security. Thus intersectoral collaboration, public and private sector partnerships and capacity building would be crucial.

She approved the time frame, objectives, stakeholder roles and success indicators of the action plan. However, drawing attention to paragraph 21, under objective 3, she urged that the plan should prioritize the elements of the WHO Framework Convention on Tobacco Control, rather than just the WHO's MPOWER interventions. Consequently, she proposed that a new subparagraph 2(4) should be added to the draft resolution, reading as follows: "to give high priority to the implementation of all the elements of the WHO Framework Convention on Tobacco Control". Further, the African Region supported Saudi Arabia's request for a parallel but related plan of action for the prevention of avoidable blindness, to be presented to the Executive Board at its 124th session in January 2009 and subsequently to the Sixty-second World Health Assembly.

Mr FAUGOO (Mauritius) welcomed the draft action plan and supported the draft resolution. Mauritius concurred with the view of the President of the Health Assembly that it had been a gross omission that none of the Millennium Development Goals addressed noncommunicable diseases. He suggested the corrected formulation of a “Millennium Development Goal Plus”.

Mauritius had been referred to as a microcosm of the world, because its population was representative of two thirds of the world in terms of ethnicity. Thus, the explosion of diabetes worldwide had been partly predicted from the results of successive surveys on noncommunicable diseases in Mauritius; the same approach could be used for other noncommunicable diseases. Conscious of its alarming situation with regard to such diseases, with 20% of the over-30 population and 50% of the over-50s suffering from diabetes alone, Mauritius had elaborated a national strategy line, with the proposed global action plan, including a service framework for diabetes and an action plan for cancer control and prevention. A committee had been set up for the prevention and management of cardiovascular diseases. National action plans were dealing with risk factors such as use of tobacco, lack of physical activity, poor nutrition and alcohol misuse.

Numerous challenges remained: secondary and tertiary prevention of noncommunicable diseases was tremendously costly, and economic resources and technical expertise were needed. Additionally, many of the underlying risk factors had to be dealt with globally and in a concerted manner. Commending the work on the WHO Framework Convention on Tobacco Control, he called for similar strategies to be prepared in order to deal with other risk factors, such as unhealthy diet, misuse of alcohol and sedentary lifestyle.

Mr LARSEN (Norway) commented on the major inequalities in noncommunicable diseases within and between countries. Both the diseases themselves and their risk factors followed distinct socioeconomic gradients. Policies must include action on the underlying social determinants such as poverty, economic inequality, education, early childhood development, the work environment, behavioural factors and equitable health systems. The work of the Commission on Social Determinants of Health needed follow-up in order to ensure policy coherence.

Marketing could contribute to an unhealthy food environment and obesity. Children needed, and had the right to, protection, and the cross-border nature of marketing techniques made global collaboration important. Norway was leading a European network on reducing marketing pressure on children and welcomed the Secretariat's elaboration of recommendations on the marketing of food and non-alcoholic beverages to children, as called for in resolution WHA60.23. Legal and financial instruments, often used effectively in prevention of tobacco and alcohol use, were needed to counteract the growing threat of an epidemic of overweight. The draft action plan could have been strengthened in that respect. He supported the draft resolution.

Dr ZERARRI (Morocco) said that, in line with the draft plan of action, his Government had assigned priority status to five noncommunicable diseases, and had established centres nationwide for the treatment of diabetes and kidney disease among children and for treatment of cancer.

Dr MALEFHO (Botswana) commended the global strategy. His country had established a programme for the surveillance, prevention and control of noncommunicable diseases, and a national cancer registry. The Ministry of Health was also conducting a survey, based on the WHO STEPwise approach, of common risk factors, and would use its results in the preparation of a strategic plan.

Dr ROSELL-UBIAL (Philippines) stated that national policies in sectors other than health had a bearing on noncommunicable diseases and that multisectoral frameworks were needed. Protocols should be designed to guide Member States in analysing social determinants in order to formulate relevant health-care measures.

She agreed with previous speakers that a Millennium Development Goal Plus should be introduced. That would provide a framework for countries to set priorities for noncommunicable diseases and provide resources.

Her country wished to sponsor the draft action plan as many of its strategies had already been implemented in health-care sectors in the Philippines.

Mr ASLANYAN (Canada) said that his country was pleased to be a sponsor of the draft resolution and agreed with the suggestion of the delegate of Seychelles to include a reference to implementation of the WHO Framework Convention on Tobacco Control. The draft action plan should be linked to existing global strategies for greater efficiency and to avoid duplication at national level. The priorities of the draft plan should be focused during the first two years and then modified appropriately for the remaining three years. He supported the suggestion made by the delegate of Saudi Arabia to formulate an action plan for the prevention of avoidable blindness, to be presented to the Executive Board at its 124th session.

Ms ROYALL (United States of America) said that the double disease burden in developing countries made implementation of the strategy for the prevention and control of noncommunicable diseases crucial to global public health. She remained concerned, however, about some aspects of the draft action plan. Objective 1 placed emphasis on social determinants, whereas economic and environmental factors should also be tackled, after consultation with other competent United Nations organizations. Furthermore, the plan placed insufficient emphasis on obesity as a risk factor for noncommunicable diseases.

WHO should draw upon the full range of scientific evidence and make use of data and expertise available in Member States and the private sector before undertaking further research, and exercise caution in extrapolating results from one context to another. She suggested that guidelines drawn up in her country would be useful to WHO for formulating policies. WHO could enhance the draft action plan by strengthening the capacity of Member States to measure their growing disease burden.

Dr BAI Huqun (China) said that WHO should help low-income countries to prevent and control noncommunicable diseases and slow the rising rate of mortality attributable to those. Hypertension, diabetes and cancer were an increasing burden for China, accounting for more than 80% of all deaths. Globalization and rapid economic growth had led to changes in lifestyle, and increased risk factors such as alcohol, tobacco and stress. Timely measures were needed. He agreed with other speakers that reducing noncommunicable diseases should be one of the Millennium Development Goals.

Mr MENESES (Mexico) supported the draft resolution, which represented a positive first step towards containing future epidemics of noncommunicable diseases.

Dr MOHAMMED (Oman) stressed the importance of fighting against noncommunicable diseases at government level, in accordance with objective 1 of the draft action plan. Countries should receive support from WHO, United Nations and other relevant organizations.

Further measures were needed to address the issue of cancer. Medication to fight cancer more effectively must be made available at reasonable prices. Furthermore, priorities should be reviewed periodically, in order to ensure that the correct indicators were being used and that programmes were cost-effective.

He agreed with the delegate of Saudi Arabia with regard to controlling avoidable blindness, particularly so as to improve the quality of life of the elderly.

Dr KIMANI (Kenya) said that the first part of paragraph 24 of the draft action plan, which referred to the WHO's MPOWER package for tobacco control, was causing confusion regarding the status of the WHO Framework Convention for Tobacco Control. He therefore supported the amendment to the draft resolution proposed by the delegate of Seychelles, in order to adopt a broader approach to tobacco control.

Dr LOPES DO NASCIMENTO (Sao Tome and Principe), recording his country's approval for the draft action plan, said that it would aid Member States in establishing their national plans. WHO's

STEPwise approach on surveillance had been implemented in his country by health-sector workers and the National Institute for Statistics. A national plan on tobacco consumption and its secondary effects and protocols on hypertension and diabetes treatment had been drawn up.

He supported the draft resolution but proposed the addition at the end of the third preambular paragraph of the words “and the evidence-based strategies and interventions to reduce alcohol-related harm”.

Dr OTTO (Palau) said that his country was embarrassed to be among the 10 countries in the world with the highest obesity rates. The many reasons for that status were those covered by the draft action plan. The cost and burden of such diseases were breaking the health system in Palau. He supported the draft action plan and draft resolution and thanked partners for their support in that area.

It was good that breastfeeding was the first recommendation under “promoting healthy diet” and he commended the prominence given to tobacco control. He supported the amendment proposed by the delegate of Seychelles. He proposed that the Global Strategy for Infant and Young Child Feeding be mentioned when strategies and instruments relevant to the draft action plan were listed, as in paragraphs 5, 8, 23 and 25(a) of the draft action plan.

Dr TSHERING (Bhutan), speaking on behalf of the Member States of the South-East Asian Region, said that the draft action plan was timely, as noncommunicable diseases and their risk factors were increasing worldwide, especially among poor, less educated and marginalized populations. He welcomed the focus on low-income and middle-income countries, where the potential for cost-effective interventions was highest.

Implementation would require adequate human resources, multisectoral collaboration and strengthening of health systems and primary health care. Communities and partners outside the health sector should be involved in tackling risk factors. A macro-level system should be established through legislation in order to prevent exposure of individuals and groups to risk factors and to create environments for healthy lifestyles. The indicators needed further clarification: they should be realistic and measurable. Country-level indicators could be used to monitor the progress and reflect the specific circumstances of each country.

The Secretariat should consider allocating a proportionately larger share of resources to the prevention and control of noncommunicable diseases, focusing on developing the core capacity of Member States and the technical capacity of the Secretariat. The Member States of his Region would formulate and implement national action plans that were feasible, specific and sensitive to resources.

Endorsing the draft action plan, he considered that the Secretariat of the WHO Framework Convention on Tobacco Control should be given a greater role in implementing the tobacco control objectives. In the draft resolution, he suggested the following two subparagraphs for inclusion in paragraph 2:

“to enact appropriate legislations to prevent and protect individuals and populations from inappropriate exposure to modifiable risk factors and to strengthen institutional capacity for law enforcement;”

“to establish/strengthen infrastructures for noncommunicable diseases and health promotion, which is adequately and sustainably financed with an effective management structure and a mechanism to ensure accountability;”.

He further suggested the insertion of the following text into subparagraph 1(3): “to consider allocating higher proportion of budget to the prevention and control of noncommunicable diseases focusing on the core-capacity development of the member countries and technical capacity of the WHO Secretariat;”.

Mr MABUZA (Swaziland) said that the long-term health care required for noncommunicable diseases was demanding and expensive for households, workplaces and the country as a whole, and he urged WHO to take a leading role in controlling the escalating costs of treatment. Following a survey on the burden of noncommunicable diseases in Swaziland, the Ministry of Health and Social Welfare

was educating the public on proper diet, physical activity and regular screening for early detection. He thanked partners for their support in those areas and fully supported the draft resolution.

Professor PUSKA (Finland) highlighted the heavy mortality worldwide from noncommunicable diseases and the major burden they placed on health services and socioeconomic development. The global strategy, whose objectives were reaffirmed in resolution WHA53.17 in 2000, had correctly noted the major role of a few global risk factors. WHO had prepared two instruments to tackle some of those factors globally: the WHO Framework Convention on Tobacco Control and the Global Strategy on Diet, Physical Activity and Health. The latest instrument would be a global strategy on the harmful use of alcohol, to be elaborated in line with the draft resolution approved at the Committee's sixth meeting. He stressed effective implementation of those instruments, global leadership, collaboration with other United Nations agencies and nongovernmental organizations, and support for national programmes. He emphasized the links between noncommunicable diseases and issues such as social determinants of health, health promotion, mental health, and public health infrastructures, including institutional bases.

Given the global burden and the potential for prevention of noncommunicable diseases, and the importance that many States evidently placed upon tackling the problem, a greater share of resources should be allocated by WHO. His country had been successful in preventing noncommunicable diseases and would support WHO's work in that area.

Dr ST JOHN (Barbados), expressing support for the draft resolution, said that, in view of the Caribbean Community countries' Declaration of Port-of-Spain in 2007, she welcomed the Director-General's emphasis on the issue of noncommunicable diseases. For more than 20 years, Barbados had provided essential medicines free at the point of delivery in the public and private sectors. Its Ministry of Health had established a chronic disease and health promotion unit in December 2006, and a multisectoral commission on chronic noncommunicable diseases in 2007.

Implementation of the global strategy had included the establishment of a national registry for stroke, cardiovascular disease and cancer, in collaboration with the University of the West Indies; a behavioural risk factor survey based on WHO's STEPwise approach, supported by PAHO; and guidelines for healthy and nutritious foods in primary and secondary schools. Continued support had been received from international partners, including PAHO, and the Government had doubled its budgetary allocation to chronic noncommunicable disease programmes for the current financial year. It would also formulate a surveillance protocol for the region.

Mr SAMIEI (IAEA) recalled that nuclear medicine and radiotherapy were often the sole means of diagnosis and treatment for noncommunicable diseases. Quality assurance for accurate dosimetry, dose delivery and patient protection was crucial. Many countries still lacked the adequate infrastructure of radiation medicine and radiopharmaceuticals. His Agency, through its Technical Cooperation Programme and Division of Human Health, had been collaborating with WHO in capacity building for more than two decades. In its Programme of Action for Cancer Therapy it was working with WHO on six cancer prevention, control and treatment projects, one in each WHO Region, to be formalized as a joint WHO-IAEA cancer control programme. IAEA endorsed the global strategy and offered its full collaboration and support.

Dr RAHIMY (International Pediatric Association), speaking at the invitation of the CHAIRMAN, said that paediatricians must familiarize themselves with advances in knowledge and technology for the diagnosis and treatment of noncommunicable diseases. His Association ran programmes on the management of those diseases in the framework of national and international workshops and seminars. Child health problems varied, depending on socioeconomic, cultural and educational circumstances, and required coordinated cooperation at all levels. His Association represented more than one million paediatricians in every sector, from clinics through universities to intergovernmental agencies. It stood ready to extend expertise to any country in the world,

implementing global prevention and control initiatives to achieve the goal of “healthy children for a healthy world”.

Mrs MORTARA (International Union against Cancer), speaking at the invitation of the CHAIRMAN, said that the draft action plan tied in with her organization’s work in outlining actions to be taken to fight cancer (as presented in its World Cancer Declaration in 2006), in carrying out a survey of risk factor awareness in 40 countries, and in promoting implementation of the WHO Framework Convention on Tobacco Control through its GLOBALink tobacco control network. The draft action plan rightly considered the four types of noncommunicable diseases together, and the clear potential for synergies in prevention and control. However, she emphasized the risk factors specific to each, and that many cancers did not share common risk factors with other noncommunicable diseases. She highlighted the crucial role of national nongovernmental organizations. The Secretariat and Member States should prioritize cancer control in public health policy; national cancer plans and programmes were key elements in strategies for the prevention and control of noncommunicable diseases.

Ms LINNECAR (Consumers International), speaking at the invitation of the CHAIRMAN, recognized that the draft action plan contained a range of policies to tackle obesity, a major risk factor for diabetes, cancer and cardiovascular diseases. However, she urged the Secretariat to timetable the preparation of recommendations on the marketing of unhealthy food and non-alcoholic beverages to children, in pursuance of resolution WHA60.23. Irresponsible marketing could undermine many of the positive proposals on healthy diets made elsewhere in the draft action plan. Furthermore, efforts at national or regional level must complement international action, in order to avoid the targeting of the most vulnerable consumers in areas where there were the fewest controls. Recommendations should be made in consultation with all relevant stakeholders, avoiding any potential conflicts of interest, and leading to global policies to protect all children from the marketing of unhealthy food and beverages. Her organization had drafted an international code on the subject, in collaboration with the International Obesity Taskforce, which could be a model for a future international framework.

Mr FAIRCLOTH (Corporate Accountability International), speaking at the invitation of the CHAIRMAN, welcomed the emphasis in the draft action plan on ratifying and implementing the WHO Framework Convention on Tobacco Control and the Global Strategy on Diet, Physical Activity and Health. Objective 6 of the draft action plan should include indicators for monitoring activities aimed at thwarting the adoption, implementation and enforcement of tobacco control measures by tactics such as threatening governments with legal action, promoting self-regulation, demanding a seat at the policy-making table and promoting so-called “corporate social responsibility” initiatives.

He expressed concern over potential conflicts of interest in implementing the Global Strategy on Diet, Physical Activity and Health. The consultations with Member States and nongovernmental organizations on the draft action plan had been made public, whereas the food industry’s input had not. Resolution WHA60.23 requested the Director-General to make recommendations on the marketing of food and non-alcoholic beverages to children; however, the draft action plan included only actions by Member States at national and regional levels. That would allow the transnational food industry to target countries and regions with the least regulation. WHO must develop policies that could be applied coherently across borders. He supported the call for binding international regulations to protect children from the marketing of unhealthy foods.

Dr BENZIAN (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, welcomed and supported the draft action plan. Oral disease was linked to diabetes and cardiovascular diseases and he urged the Health Assembly to consider oral health as integral to prevention and control of noncommunicable diseases.

Dental decay was the most common noncommunicable disease in the world and completely preventable, through oral hygiene, exposure to fluoride and by limiting sugar consumption. Annual

sugar consumption should be included among the action plan's indicators for monitoring the global strategy. He emphasized the oral health implications of that strategy, the need to follow up on resolution WHA60.17 on oral health, the need for a global oral health unit, both at WHO headquarters and in the regions, and strengthening the Organization's capacity to provide technical advice in that field.

Mr RIGBY (International Association for the Study of Obesity), speaking at the invitation of the CHAIRMAN, thanked Member States, especially those that had adopted the Declaration of Port-of-Spain in 2007, for having drawn attention to obesity as a major risk factor for noncommunicable diseases. Ensuring a healthier diet would require the involvement of all sectors of government and society. The Sixtieth World Health Assembly had recognized the need to address the marketing of unhealthy foods and beverages to children. As many countries were unable to act alone in a globalized world, WHO must ensure that recommendations for responsible marketing were made according to a clear time frame, implemented, monitored and sustained. He recommended to Member States the draft international code on the subject drawn up by his Association in conjunction with Consumers International. Some transnationals were willing to stop targeting children under the age of 12 within the year, and would review their marketing techniques by 2010. But more than limited, voluntary actions were needed in order to protect children. Effective global standards must be set, in line with resolution WHA60.23. The Global Prevention Alliance of leading organizations concerned with the prevention of obesity and related chronic diseases supported WHO in vigorously pursuing the implementation of such global strategies.

Dr ALWAN (Assistant Director-General), thanked the Member States for the rich contributions that had helped to produce the draft action plan.

The subject of the prevention of avoidable blindness and visual impairment had been incorporated into the updated Medium-term strategic plan 2008–2013 and, as mentioned by the delegate of Saudi Arabia, formed the basis of two resolutions that were being implemented. The Secretariat would follow up on the request for a specific plan, to be discussed by the Executive Board. The Mental Health Global Action Programme, a WHO priority, would be launched in October 2008. He stressed that the WHO Framework Convention on Tobacco Control was the cornerstone of action against tobacco use. The six MPOWER interventions listed in paragraph 24 of document A61/8 could represent an entry point to full implementation of the Framework Convention. Regarding the Secretariat's mandate to provide a set of recommendations on marketing of foods and non-alcoholic beverages to children, pursuant to resolution WHA60.23, that issue had not been included in the draft action plan because steps had already been taken to implement it, while the focus of the plan was on new priorities. He reassured delegates and partner organizations that a transparent, evidence-based process had been planned, with a specific time frame, to produce the recommendations in question by 2010.

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

Global immunization strategy: Item 11.7 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R7, and A61/10) (continued from the fourth meeting)

The CHAIRMAN invited consideration of a revised version of the draft resolution contained in resolution EB122.R7, which incorporated amendments proposed by the delegations of Greece, Japan, Lesotho, Mozambique, Palau, Sao Tome and Principe, Thailand and Tuvalu, and read as follows:

The Sixty-first World Health Assembly,

Having considered the report on the global immunization strategy;

Applauding the remarkable investments in human and financial resources made by Member States and partner agencies in support of vaccines and immunization as well as the launch of innovative financing mechanisms such as the International Finance Facility for

Immunisation, and the advance market commitment for a pneumococcal conjugate vaccine through the GAVI Alliance;

Recognizing the immense contribution that immunization has made to the control of the common communicable diseases in the countries where it has been effectively applied; [Greece]

Recognizing that continued efforts are also required to strengthen surveillance of communicable diseases and ensure the quality of the production, management and administration of vaccines; [Greece]

Recalling resolution WHA56.20 on reducing global measles mortality, and commending Member States' and their partners' success in exceeding the goal of reducing deaths worldwide due to measles by 50% by the end of 2005 compared with the 1999 level;

Commending also Member States' and their partners' progress in increasing the availability, affordability and uptake of hepatitis B vaccine worldwide;

Recognizing the availability of underutilized and new vaccines that could have significant impact on the health of the peoples of the world, including the achievement of Millennium Development Goal 4; [Mozambique]

Encouraged by the progress in molecular biology and genetics that is accelerating the discovery and development of new vaccines and by the increasing number of developing-country manufacturers producing vaccines that meet WHO requirements for vaccines of assured quality;

Alarmed that many developing countries are not on track to meet the internationally agreed target in Millennium Development Goal 4 for reducing the under-five mortality rate;

Concerned by the insufficient level of resources available for the introduction of new vaccines, especially in low-income and middle-income countries, which will prevent these countries to achieve Millennium Development Goal 4; [Mozambique]

~~Concerned that there are insufficient resources available for introduction of new vaccines, especially in low-income and middle-income countries;~~ [Mozambique]

Concerned that there are insufficient resources available for introduction of new vaccines, especially in low-income and middle-income countries, **given the high cost of these vaccines, and that there are inadequate numbers of manufacturers in developing countries of products that are prequalified by WHO;** [Thailand]

Stressing the vital role that vaccine and immunization programmes can play in reducing ~~infant~~ **under-five** [Mozambique] mortality and in facilitating the delivery of a package of life-saving interventions,

1. URGES Member States:

- (1) **to review the national strategy and programme performance, to identify areas for improvement and** [Thailand] to implement fully the strategy for reducing measles mortality in order to achieve the goal set in the Global Immunization Vision and Strategy 2006–2015 of a 90% reduction in the global measles mortality rate between 2000 and 2010;
- (2) to enhance efforts to improve delivery of high-quality immunization services in order to achieve the target of equitable coverage of at least 80% in all districts by 2010 set in the Global Immunization Vision and Strategy 2006–2015;
- (3) **to adopt policies for ensuring that new life-saving vaccines are introduced into national immunization schedules no later than five years after their market availability and to expand coverage with these new vaccines in order to accelerate the achievement of Millennium Development Goal 4;** [Mozambique]
- ~~(3) —to further expand access to, and coverage of, available and cost-effective new life-saving vaccines of assured quality, in accordance with national priorities, for all target populations in order to accelerate the achievement of Millennium Development Goal 4;~~ [Mozambique]
- (4) to further expand access to, and coverage of, available, **affordable** [Thailand] and cost-effective new life-saving vaccines of assured quality **and desired efficacy,**

[Thailand] **while maintaining efforts to ensure regular vaccination programmes** [Japan] in accordance with **the burden of disease and** [Thailand] national priorities, for all target populations in order to accelerate the achievement of Millennium Development Goal 4, **and to ensure long-term financial and programmatic sustainability;** [Thailand]

OR

(4) to develop, strengthen and/or maintain surveillance systems for vaccine-related adverse events, **linked with systems for monitoring compliance with safe injection practices;** [Lesotho]

(5) **to strengthen efforts to protect, promote and support breastfeeding;** [Tuvalu]

(6) **to strengthen surveillance systems for vaccine-preventable diseases and monitoring of vaccination programmes;** [Sao Tome]

2. REQUESTS the Director-General:

(1) to work **and increase collaboration** [Greece] with Member States **in order** to sustain political commitment at all levels for achieving high immunization coverage rates with all available cost-effective vaccines;

(2) to collaborate with international partners **and intergovernmental partners** [Palau], including UNICEF and the GAVI Alliance, in order to continue to mobilize the financial resources required to achieve the objective, **and to increase the number of manufacturers of WHO-prequalified vaccines;** [Thailand]

(3) to collaborate with international partners, **intergovernmental partners** [Palau] and donors as well as vaccine producers to mobilize necessary resources to support low-income and middle-income countries with the aim of increasing the supply of affordable **new** [Thailand] vaccines of assured quality;

(4) **to work with UNICEF to build on existing international efforts and partnerships and facilitate the development of a consensus among developing and developed countries for meeting the financial gaps and other requirements for the attainment of the Millennium Development Goal 4 through immunization;** [Mozambique]

~~(4)~~ (5) to take measures, as appropriate, to assist developing countries to establish and strengthen their capacity for vaccine research, development and regulation, for the purpose of improving the output of vaccine production with the aim of increasing the supply of affordable vaccines of assured quality;

~~(5)~~ (6) to provide guidelines and technical support to Member States in order to **establish integrated surveillance of adverse events following immunization and to minimize unnecessary** vaccine-related adverse events; [Thailand]

~~(6)~~ (7) to facilitate scientific, technical and financial investments in the research and development of safe and effective vaccines against poverty-related and neglected diseases;

~~(7)~~ (8) to monitor progress towards achievement of global immunization goals and report on such progress to the Sixty-fourth World Health Assembly.

(9) **to accelerate the implementation of the global framework for vaccine-preventable disease surveillance and immunization programme monitoring, especially through prospective, time-limited projects to generate the comprehensive epidemiological data required to guide immunization programmes, and strengthen national capacity for making evidence-based policy decisions to adopt new vaccines;**[Thailand]

Dr VOLJČ (Slovenia) said that the countries of the European Union, on whose behalf he was speaking, could accept most of the amendments proposed to the draft resolution. The text might be improved if the penultimate preambular paragraph were further amended to read: "Concerned that there are insufficient resources available for introduction of new vaccines, especially in low-income

and middle-income countries, taking into account the need for expanded global vaccination production capacity". The European Union had some difficulties with the new subparagraph 1(3) proposed by Mozambique, as it was difficult to define "life-saving vaccines" and many countries in the European Union had their own mechanisms for evaluating new vaccines for safety, quality, efficacy and cost-effectiveness. The paragraph should be deleted, particularly as its sense was already captured in subparagraph 2(1). With regard to subparagraph 1(4), the European Union preferred the first of the two alternatives. In the last amendment to that subparagraph, "ensure" should be replaced by "strengthen". In subparagraph 2(2), the text proposed by the delegate of Thailand "and to increase the number of manufacturers of WHO prequalified vaccines" should be replaced by "to increase the amount of WHO prequalified vaccines".

Mr LARSEN (Norway) said that in his country comprehensive epidemiological data were generated continuously and were not time-limited. He therefore suggested that in subparagraph 2(9), the words " , especially through prospective, time-limited projects to generate" be replaced by " , through gathering of".

Dr SOPON IAMSIRITHAWORN (Thailand) said that he could agree to the European Union's suggestion to replace "ensure" with "strengthen" in subparagraph 1(4). He would prefer, however, that the text proposed by the delegate of Thailand in subparagraph 2(2) remain unchanged. The phrase "time-limited projects to generate the comprehensive epidemiological data" in subparagraph 2(9) had been taken from the Secretariat's report; however, he could accept the new wording suggested by the delegate of Norway.

Dr VOLJČ (Slovenia) requested more time to consider the comments made by other delegations.

Mr ABDOO (United States of America) proposed some further amendments. In the seventh preambular paragraph, "the achievement of Millennium Development Goal 4" should read "the achievement of the health-related Millennium Development Goals". The words "... internationally agreed target in Millennium Development Goal 4 for reducing ..." in the ninth preambular paragraph should be amended to read "... internationally agreed Millennium Development Goals, including that of reducing ...". The end of the tenth preambular paragraph should be amended to read " , which will hamper the ability of these countries to achieve the health-related Millennium Development Goals". The penultimate preambular paragraph should be reworded as follows: "Concerned that there are insufficient resources available for introduction of new vaccines, especially in low-income and middle-income countries, given the costs related to introduction of these vaccines, and taking into account the need for expanded global production capacity for WHO prequalified vaccines". Subparagraph 1(3) should be amended to read: "to stimulate rapid introduction and uptake of life-saving vaccines into national immunization schedules and to expand coverage of these vaccines to accelerate the achievement of the health-related Millennium Development Goals". Referring to the first option for subparagraph 1(4), the text suggested by the delegate of Japan, "ensure regular vaccination programmes", should be replaced by "strengthen regular vaccination programmes". The end of that paragraph should be amended to read: "... in order to accelerate the achievement of the health-related Millennium Development Goals, and to promote long-term financial and programmatic sustainability". Subparagraph 1(5) should be deleted since the resolution related to global immunization, not breastfeeding. The words "increase the number of manufacturers of WHO prequalified vaccines" in subparagraph 2(2) should be replaced by "increase the global production capacity for WHO prequalified vaccines", and the word "new" should be deleted from subparagraph 2(3). Lastly, he expressed support for the amendment to subparagraph 2(9) proposed by the delegate of Norway.

Dr RAMATLAPENG (Lesotho) said that the two versions of subparagraph 1(4) were not intended to be alternatives. Both should be retained in the draft resolution, and the subsequent paragraphs renumbered accordingly.

Mr ASLANYAN (Canada) requested a revised version of the draft resolution and supported the amendments to subparagraph 1(3) suggested by the delegate of the United States.

The CHAIRMAN said that, in view of the numerous amendments suggested, the Secretariat would prepare a revised version of the text for subsequent consideration by the Committee.

It was so agreed.

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

The meeting rose at 20:20.

NINTH MEETING

Friday, 23 May 2008, at 09:45

Chairman: Dr F. CICOGNA (Italy)

1. SECOND REPORT OF COMMITTEE A (Document A61/44)

Dr PARIRENYATWA (Zimbabwe), Rapporteur, read out the draft second report of Committee A (contained in document A61/44).

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

Prevention and control of noncommunicable diseases: implementation of the global strategy:
Item 11.5 of the Agenda (Document A61/8) (continued from the eighth meeting)

The CHAIRMAN drew the Committee's attention to a revised version of the draft resolution proposed at the seventh meeting, which read:

The Sixty-first World Health Assembly,

Recalling resolutions WHA53.17 on the prevention and control of noncommunicable diseases and WHA60.23 on the prevention and control of noncommunicable diseases: implementation of the global strategy;

Reaffirming its commitment to the aim of the global strategy for the prevention and control of noncommunicable diseases² to reduce premature mortality and improve quality of life;

Reaffirming also its commitment to addressing key risk factors for noncommunicable diseases through the implementation of the WHO Framework Convention on Tobacco Control, adopted by the Health Assembly in 2003 (resolution WHA56.1) and the global strategy on diet, physical activity and health, endorsed by the Health Assembly in 2004 (resolution WHA57.17) **and the evidence-based strategies and interventions to reduce alcohol-related harm;** [Sao Tome and Principe]

Deeply concerned that the global burden of noncommunicable diseases continues to grow, in particular in low-income and middle-income countries, and convinced that global action is necessary, including by effectively addressing the key risk factors for noncommunicable diseases;

Reaffirming the leadership role of WHO in promoting global action against noncommunicable diseases, and the need for WHO to continue to cooperate with regional and international organizations in order to reduce effectively the impact of noncommunicable diseases;

¹ See page 256.

² Document A53/14.

1. ENDORSES the action plan for the global strategy for the prevention and control of noncommunicable diseases;
2. URGES Member States:
 - (1) to strengthen national efforts to address the burden of noncommunicable diseases;
 - (2) to consider the proposed actions in the action plan for the prevention and control of noncommunicable diseases and implement relevant actions, in accordance with national priorities;
 - (3) to increase provision of support to the work of the Secretariat to prevent and control noncommunicable diseases, including the implementation of the action plan;
 - (4) **to give high priority to the implementation of the elements of the WHO Framework Convention on Tobacco Control;** [Seychelles]
 - (5) **to enact appropriate legislation to protect individuals and populations by preventing their inappropriate exposure to modifiable risk factors, and to strengthen institutional capacity for law enforcement;** [Bhutan]
 - (6) **to establish or strengthen infrastructures for prevention and control of noncommunicable diseases and for health promotion, with adequate and sustainable financing of an effective management structure and a mechanism to ensure accountability;** [Bhutan]
3. REQUESTS the Director-General:
 - (1) to continue to give suitably high priority to the prevention and control of noncommunicable diseases **and to consider allocating a higher proportion of budget to their prevention and control, with a focus on the development of core capacity of the Member States and increased technical capacity of the WHO Secretariat;** [Bhutan]
 - (2) to continue to implement the actions agreed by the Health Assembly in resolution WHA60.23 on the prevention and control of noncommunicable diseases: implementation of the global strategy;
 - (3) to report to the Sixty-third World Health Assembly, and subsequently every two years to the Health Assembly, through the Executive Board, on progress in implementing the global strategy on prevention and control of noncommunicable diseases and the action plan.

Dr BLOOMFIELD (New Zealand) expressed his appreciation for the wide support for the draft resolution and the constructive suggestions made by many delegations. He proposed, in the interests of consistency, to replace the phrase “to reduce alcohol-related harm” at the end of the third preambular paragraph by “to reduce public health problems caused by the harmful use of alcohol (resolution WHA58.26)”. In subparagraph 2(4), he suggested inserting the words “of the elements” after “implementation”.

The content of the proposed new subparagraphs 2(5) and 2(6) appeared to be covered by the draft action plan for the global strategy for the prevention and control of noncommunicable diseases, and by resolution WHA60.23. He suggested deleting both paragraphs and inserting a new paragraph between subparagraphs 2(2) and 2(3), to read: “to continue to implement the actions agreed by the Health Assembly in resolution WHA60.23 on the prevention and control of noncommunicable diseases: implementation of the global strategy”.

Dr VOLJČ (Slovenia), speaking on behalf of the European Union, suggested including the words “within the framework of the Medium-term strategic plan” in subparagraph 3(1) after “to consider,” to reflect the fact that the Medium-term strategic plan, including budgetary allocations, had been adopted in 2007 and could not be significantly modified.

The draft resolution, as amended, was approved.¹

Global immunization strategy: Item 11.7 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R7, and A61/10) (continued from the eighth meeting)

The CHAIRMAN drew attention to a revised version of the draft resolution contained in resolution EB122.R7, which read as follows:

The Sixty-first World Health Assembly,
Having considered the report on the global immunization strategy;²

Applauding the remarkable investments in human and financial resources made by Member States and partner agencies in support of vaccines and immunization as well as the launch of innovative financing mechanisms such as the International Finance Facility for Immunisation, and the advance market commitment for a pneumococcal conjugate vaccine through the GAVI Alliance;

Recognizing the immense contribution that immunization has made to the control of the common communicable diseases in the countries where it has been effectively applied; [Greece]

Recognizing that continued efforts are also required to strengthen surveillance of communicable diseases and ensure the quality of the production, management and administration of vaccines; [Greece]

Recalling resolution WHA56.20 on reducing global measles mortality, and commending Member States' and their partners' success in exceeding the goal of reducing deaths worldwide due to measles by 50% by the end of 2005 compared with the 1999 level;

Commending also Member States' and their partners' progress in increasing the availability, affordability and uptake of hepatitis B vaccine worldwide;

Recognizing the availability of underutilized and new vaccines that could have significant impact on the health of the peoples of the world, including the achievement of the health-related [USA] Millennium Development Goals 4 [USA]; [Mozambique]

Encouraged by the progress in molecular biology and genetics that is accelerating the discovery and development of new vaccines and by the increasing number of developing-country manufacturers producing vaccines that meet WHO requirements for vaccines of assured quality;

Concerned that many developing countries are not on track to meet the internationally agreed target in the health-related Millennium Development Goals **including that of for** [USA] reducing the under-five mortality rate;

Concerned by the insufficient level of resources available for the introduction of new vaccines, especially in low-income and middle-income countries, which will prevent hamper the ability of [USA] these countries to achieve Millennium Development Goal 4; [Mozambique]

~~Concerned that there are insufficient resources available for introduction of new vaccines, especially in low income and middle income countries;~~ [Mozambique]

Concerned that there are insufficient resources available for introduction of new vaccines, especially in low-income and middle-income countries, **given the high costs (related to introduction [USA]) of these vaccines, and that there are inadequate numbers of manufacturers in developing countries of products that are taking into account the need**

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA61.14.

² Document A61/10.

for expanded global production capacity for these vaccines [USA] [Slovenia] **prequalified by WHO**; [Thailand]

Stressing the vital role that vaccine and immunization programmes can play in reducing **infant under-five** [Mozambique] mortality and in facilitating the delivery of a package of life-saving interventions,

1. URGES Member States:

(1) **to review national strategy and programme performance, to identify areas for improvement and** [Thailand] to implement fully the strategy for reducing measles mortality in order to achieve the goal set in the Global Immunization Vision and Strategy 2006–2015 of a 90% reduction in the global measles mortality rate between 2000 and 2010;

(2) to enhance efforts to improve delivery of high-quality immunization services in order to achieve the target of equitable coverage of at least 80% in all districts by 2010 set in the Global Immunization Vision and Strategy 2006–2015;

~~(3) to adopt policies for ensuring that new~~ **stimulate rapid introduction and uptake of** [USA] [Canada] **life-saving vaccines are introduced** [USA] [Canada] **into national immunization schedules no later than five years after their market availability** [USA, Canada] **and to expand coverage with of these new** [USA, Canada] **vaccines in order to accelerate the achievement of the health-related** [USA, Canada] **Millennium Development Goals 4** [USA] [Canada]; [Mozambique]

~~(3) to adopt policies for ensuring that new life-saving vaccines are introduced into national immunization schedules no later than five years after their market availability and to expand coverage with these new vaccines in order to accelerate the achievement of Millennium Development Goal 4~~ [Slovenia]; [Mozambique]

~~(3) to further expand access to, and coverage of, available and cost effective new life-saving vaccines of assured quality, in accordance with national priorities, for all target populations in order to accelerate the achievement of Millennium Development Goal 4;~~ [Mozambique]

(4) to further expand access to, and coverage of, available, **affordable** [Thailand] and cost-effective new life-saving vaccines of assured quality **and desired efficacy**, [Thailand] **while maintaining efforts to ensure strengthen** [USA] **regular vaccination programmes** [Japan] in accordance with **the burden of disease and** [Thailand] national priorities, for all target populations in order to accelerate the achievement of **the health-related** [USA] Millennium Development Goals 4, **and to ensure strengthen** [Slovenia] **promote** [USA] **long-term financial and programmatic sustainability**; [Thailand]

~~(5) to strengthen efforts to protect, promote and support breastfeeding~~ [USA]; [Tuvalu]

(6) **to strengthen surveillance systems for vaccine-preventable diseases and monitoring of vaccination programmes**; [Sao Tome and Principe]

2. REQUESTS the Director-General:

(1) to work **and increase collaboration** [Greece] with Member States **in order** to sustain political commitment at all levels for achieving high immunization coverage rates with all available cost-effective vaccines;

(2) to collaborate with international partners **and intergovernmental partners** [Palau], including UNICEF and the GAVI Alliance, in order to continue to mobilize the financial resources required to achieve the objective, **and to increase the number of**

~~manufacturers of global production capacity of [USA] WHO-prequalified vaccines;~~
[Thailand]

(3) to collaborate with international partners, **intergovernmental partners** [Palau] and donors as well as vaccine producers to mobilize necessary resources to support low-income and middle-income countries with the aim of increasing the supply of affordable ~~new~~ [USA] [Thailand] vaccines of assured quality;

(4) **to work with UNICEF to build on existing international efforts and partnerships and facilitate the development of a consensus among developing and developed countries for meeting the financial gaps and other requirements for the attainment of the Millennium Development Goal 4 through immunization;**
[Mozambique]

(4) (5) to take measures, as appropriate, to assist developing countries to establish and strengthen their capacity for vaccine research, development and regulation, for the purpose of improving the output of vaccine production with the aim of increasing the supply of affordable vaccines of assured quality;

(5) (6) to provide guidelines and technical support to Member States in order to **establish integrated surveillance of adverse events following immunization and to minimize unnecessary** vaccine-related adverse events; [Thailand]

(6) (7) to facilitate scientific, technical and financial investments in the research and development of safe and effective vaccines against poverty-related and neglected diseases;

(7) (8) to monitor progress towards achievement of global immunization goals and report on such progress to the Sixty-fourth World Health Assembly;

(9) **to accelerate the implementation of the global framework for vaccine-preventable disease surveillance and immunization programme monitoring, especially through prospective, time-limited projects to generate the** through the gathering of [USA] [Norway] **the comprehensive epidemiological data required to guide immunization programmes, and to strengthen national capacity for making evidence-based policy decisions to adopt new vaccines.** [Thailand]

Mr ASLANYAN (Canada) requested that, in the interests of consistency, the term “new and underused vaccines” be used throughout the draft resolution.

Dr CHITUWO (Zambia), supported by Dr TSHABALALA MSIMANG (South Africa), said that the ninth preambular paragraph should begin “concerned that” rather than “alarmed that”.

Dr SUWIT WIBULPOLPRASERT (Thailand) suggested replacing “including” by “particularly” in the same paragraph, to place emphasis on the target of reducing under-five mortality by two thirds.

Dr STEIGER (United States of America) proposed a different formulation for that paragraph: “Concerned that many developing countries are not on track to meet the internationally agreed targets in the health-related Millennium Development Goals, particularly that of reducing the under-five mortality rate”. The wording “the health-related Millennium Development Goals” should also appear in the following preambular paragraph.

Dr SUWIT WIBULPOLPRASERT (Thailand) asked whether the intention in proposing that formulation was to omit the specific reference to Millennium Development Goal 4.

Dr STEIGER (United States of America) confirmed that. Progress on immunization brought benefits in terms of achieving all the Millennium Development Goals so the focus of the resolution should not be exclusively on Goal 4.

Dr LEVENTHAL (Israel) suggested reversing the order of the seventh and eighth preambular paragraphs. That would bring together the seventh, ninth and tenth preambular paragraphs, all of which dealt with the Millennium Development Goals.

It was so agreed.

Mr ASLANYAN (Canada) suggested deleting the tenth preambular paragraph. The issues it concerned were covered by other parts of the preamble.

It was so agreed.

Dr SUWIT WIBULPOLPRASERT (Thailand) argued for retaining the original amended version of the twelfth preambular paragraph, incorporating the first of the amendments proposed by the delegate of the United States of America. The paragraph would then read: “Concerned that there are insufficient resources available for introduction of new vaccines, especially in low-income and middle-income countries, given the high costs related to introduction of these vaccines, prequalified by WHO, and that there are inadequate numbers of manufacturers in developing countries, taking into account the need for expanded global production capacity for these vaccines”.

It was important to mention both the high cost of the new vaccines and the lack of manufacturing capacity for them, given that the new vaccines contributed so significantly to reducing child mortality.

Dr STEIGER (United States of America) did not agree. The cost of the vaccines was not always a barrier to delivery; it was the cost of introducing and distributing them that often proved difficult for countries to overcome. As for the production of vaccines, it was not the absolute number of manufacturers that caused the problem, but a lack of global production capacity.

Dr SOPON IAMSIRITHAWORN (Thailand) said that new vaccines were always expensive. When new vaccines were introduced in countries where national immunization programmes already existed, personnel and other associated costs were much the same. The variable was the cost of the vaccines themselves.

Dr LEVENTHAL (Israel) suggested finalizing the text of the resolution in a drafting group, rather than the full Committee.

The CHAIRMAN said that, in view of the time constraints, it would be best for the Committee to continue its discussion and aim for a consensus.

Mr ASLANYAN (Canada) suggested adding the words “introduction of new and underutilized vaccines” as a way of reconciling the proposed amendments.

Dr RAMATLAPENG (Lesotho) suggested an alternative version of the twelfth preambular paragraph: “Concerned that there are insufficient resources available for the introduction of new vaccines, especially in low-income and middle-income countries, given the high cost of these vaccines and that there are inadequate numbers of manufacturers in developing countries of products that are prequalified, and also taking into account the need for expanded global production capacity for WHO-prequalified vaccines”. The text should mention the need to produce more of the WHO-prequalified vaccines.

Dr TSHABALALA MSIMANG (South Africa) supported the amendment proposed by the delegate of Thailand. There were indeed too few manufacturers. That point should feature both in the preamble and in subparagraph 2(2). More manufacturers would mean more competition, which would reduce the cost of the vaccines.

Dr BAI Huqun (China) also preferred the version proposed by the delegate of Thailand, which would encourage increased production capacity in developing countries.

Ms NYANDORO (Zimbabwe) supported the version proposed by the delegate of Thailand together with the amendment proposed by the delegate of South Africa.

Dr STEIGER (United States of America) suggested a compromise version, reading: “Concerned that there are insufficient resources available for new and underutilized vaccines, especially in low- and middle-income countries, given the costs related to the introduction of these vaccines, and taking into account the need for expanded global production capacity for WHO-prequalified vaccines, including in developing countries”.

Dr PHUSIT PRAKONGSAI (Thailand) could not accept that version. It was important, for the sake of children’s health, to make the right decision. Vaccines prevented diseases, and if there were more manufacturers the price of the vaccines would come down. The cost of the hepatitis B vaccine had fallen dramatically with the increased number of manufacturers in the developing countries.

The CHAIRMAN proposed suspending the discussion and invited the delegations of Thailand, the United States of America and other interested delegations to meet and produce an agreed text. The Committee was invited, meanwhile, to approve the thirteenth preambular paragraph.

It was so agreed.

The CHAIRMAN invited the Committee to approve the amended subparagraph 1(1).

It was so agreed.

Mrs MACHATINE (Mozambique) did not accept the revisions to the amended subparagraph 1(3), preferring to retain the version originally proposed by her delegation.

Dr STEIGER (United States of America) said that he preferred not to set a time frame for the introduction of vaccines into national immunization schedules. Even in his own country, the one now proposed would be difficult to achieve. He suggested “to urge the rapid introduction and uptake of vaccines”.

Mrs MACHATINE (Mozambique) proposed a new version of the paragraph, already agreed with the delegation of Thailand: “to adopt policies ensuring that new life-saving vaccines are introduced into national immunization schedules in accordance with national priorities, no later than five years after their market availability, and to expand coverage with these new vaccines while maintaining efforts to ensure regular vaccination programmes to accelerate the achievement of Millennium Development Goal 4”.

Dr STEIGER (United States of America) said that he could accept that version, except for the five-year time frame.

Mrs MACHATINE (Mozambique) said that the text would have to be rephrased for her delegation to agree.

Mr ASLANYAN (Canada) said that he could accept the amended version proposed by the delegate of Mozambique, except for the five-year time limit, which would be difficult to achieve in health systems of countries such as his own with a number of different jurisdictions.

Dr TSHABALALA MSIMANG (South Africa) said that she did not understand the objection to the five-year time frame. WHO sometimes used ambitious targets to inspire Member States and motivate progress. The amendment proposed by the delegates of Mozambique and Thailand provided for some flexibility in meeting the five-year target.

Professor HORVATH (Australia), while acknowledging that targets were important, agreed with the delegate of Canada that a fixed time frame would not be practical.

Dr STEIGER (United States of America) agreed. He could, however, accept some such phrase as “as soon as possible”, “as soon as practicable”, or “with all deliberate speed”. There were 50 separate jurisdictions in his country making decisions on immunization: while national recommendations were issued, local government decision-making processes meant that many would not be able to comply within a five-year time frame.

Dr LEVENTHAL (Israel) said that it was also important to consider the supply side when stipulating any time frame for the introduction of vaccines. Manufacturers would not necessarily be able to meet the demand for large quantities of a new vaccine to be used in mass immunization programmes. In that sense, he agreed with the delegates of Canada, Australia and the United States of America.

Dr TSHABALALA MSIMANG (South Africa) wondered what kind of flexibility was implied by a phrase such as “as soon as possible”. The point made by the delegate of Israel again raised the question of the inadequate numbers of manufacturers. However, the proposed new amendment provided some flexibility around the five-year time frame, and that would enable other manufacturers, in the interim, to come on board.

Mr MCKERNAN (New Zealand) agreed with the delegates of Canada and the United States of America. His country did not want a time frame included in subparagraph 1(3). Even though many vaccines brought into his country would be put into use well within a five-year period, it would be unwise to stipulate that time frame. In any case, it would be unnecessary if the text included the phrases “rapid introduction and uptake” and “in accordance” with national priorities.

Dr SOPON IAMSIRITHAWORN (Thailand) said that the key points at issue were how countries determined their national priorities, and the timing for introducing new vaccines; 100% coverage would not be expected in the first year.

Dr VOLJČ (Slovenia), speaking on behalf of the European Union, suggested the phrase “possibly within five years”.

Dr FORRESTER (Jamaica) suggested that, as there was to be an informal drafting meeting on part of the text, discussion should cover subparagraph 1(3) as well.

Dr TSHABALALA MSIMANG (South Africa) expressed surprise that the time frame was causing such concern. The “3 by 5 Initiative” had been unrealistic but had not been rejected even though health systems, particularly those in the developing countries, were not capable of meeting the target set.

Dr CHITUWO (Zambia) did not see how the time frame would be a constraint if subparagraph 1(3) was taken as a whole. It was intended to motivate, not to compel anyone.

Dr STEIGER (United States of America) agreed with the delegate of Jamaica that the paragraph should be further discussed in informal consultations. He pointed out that the term “ensure” would actually mean introducing the vaccines within a fixed time.

The CHAIRMAN suggested postponing further discussion of subparagraph 1(3), so that the delegations of Mozambique, the United States of America and other interested countries could prepare a text for later consideration.

It was so agreed.

The CHAIRMAN, seeing no objection from Mozambique or other countries, took it that the Committee agreed to the deletion of the former versions of subparagraph 1(3).

Dr EZOE (Japan), in regard to subparagraph 1(4), asked why the United States had proposed the word “strengthen” rather than “ensure”.

Dr STEIGER (United States of America) replied that his country, in common with Slovenia, opposed the use of binding language. The word “ensure” implied a guarantee when no such guarantee could be given in regard to all countries at all times. He therefore preferred “strengthen” in both instances.

Dr EZOE (Japan) said that the explanation satisfied him.

Dr VOLJČ (Slovenia) said that the European Union had been uneasy with the term “life-saving vaccines” and would have preferred “vaccines of public health importance”. To save time, however, he would not propose an amendment.

The CHAIRMAN, seeing no further objection to the text, took it that the Committee approved subparagraph 1(4), as amended.

It was so agreed.

The CHAIRMAN also took it that the Committee wished to approve subparagraph 1(5), as amended.

Dr STEIGER (United States of America) withdrew his proposal to delete subparagraph 1(5) and proposed adding at the end, after “breastfeeding”, the phrase “to boost the development of infants’ overall immune systems”.

Dr OTTO (Palau) expressed support of the United States’ position, nevertheless commenting that breastfeeding favoured other health-related Millennium Development Goals.

Dr AL-HAMAD (Kuwait) proposed that the words “early and effective” be inserted before the word “breastfeeding” so that subparagraph, becoming subparagraph 6 rather than 5, would read “to strengthen efforts to protect, promote and support early and effective breastfeeding to boost the development of infants’ overall immune systems”.

Seeing no objection, the CHAIRMAN took it that the Committee wished to approve that subparagraph as amended.

It was so agreed.

The CHAIRMAN took it that the Committee wished to approve subparagraph 1(7), as amended.

It was so agreed.

The CHAIRMAN took it that the Committee wished to approve subparagraph 2(1), as amended.

It was so agreed.

The CHAIRMAN took it that the Committee wished to approve subparagraph 2(2), as amended.

Dr SOPON IAMSIRITHAWORN (Thailand) said that subparagraph 2(2) was related to the twelfth preambular paragraph, already discussed. Thailand considered it important to have more manufacturers of WHO-prequalified vaccines and therefore wished to retain the words “number of manufacturers of”.

The CHAIRMAN suggested that discussion of subparagraph 2(2) be suspended pending the informal consultations already decided upon.

It was so agreed.

The CHAIRMAN took it that the Committee wished to approve subparagraph 2(3), as amended.

It was so agreed.

The CHAIRMAN asked whether there was agreement on the amended version of subparagraph 2(4).

Dr LEVENTHAL (Israel) said that subparagraphs 2(4) and 2(2) appeared to overlap but, to save time, he would not insist on merging them although, clearly, the text could be improved.

Subparagraph 2(4), as amended, was approved.

The CHAIRMAN took it that the Committee wished to approve subparagraph 2(6), as amended.

It was so agreed.

The CHAIRMAN took it that the Committee wished to approve subparagraph 2(9), as amended.

It was so agreed.

The CHAIRMAN said that the item would be left open with the aim of seeking consensus on the outstanding points.

(For approval of the draft resolution, see summary record of the tenth meeting.)

Health of migrants: Item 11.9 of the Agenda (Documents EB122/28/REC/1, resolution EB122.R5 and A61/12) (continued from the fifth meeting)

The CHAIRMAN drew attention to the revised version of the draft resolution contained in resolution EB122.R5, incorporating amendments proposed by the delegations of Greece, Senegal, Suriname and Thailand, which read:

The Sixty-first World Health Assembly,
Having considered the report on health of migrants;

Recalling the United Nations General Assembly resolution 58/208 underlining the need for a high-level dialogue on the multidimensional aspects of international migration and development (New York, 23 December 2003);

Recalling the first plenary session of the United Nations General Assembly on migration issues and the conclusions of the High-level Dialogue on Migration and Development (New York, 14–15 September 2006) with their focus on ways to maximize the development benefits of migration and to minimize its negative impacts;

Recognizing that the revised International Health Regulations (2005) include provisions relating to international passenger transport;

Recalling resolutions WHA57.19 and WHA58.17 on international migration of health personnel: a challenge for health systems in developing countries, calling for support to the strengthening of health systems, in particular human resources for health;

Recognizing the need for WHO to consider the health needs of migrants in the framework of the broader agenda on migration and development;

Recognizing that health outcomes can be influenced by the multiple dimensions of migration;

Noting that some groups of migrants ~~experience increased health risks~~ **are vulnerable to occupational health risks**; [Thailand]

Recognizing the need for additional data on migrants' health and their access to health care in order to substantiate evidence-based policies;

Taking into account the determinants of migrants' health in developing intersectoral policies to protect their health;

Mindful of the role of health in promoting social inclusion;

Acknowledging that the health of migrants is an important public health matter for both Member States and the work of the Secretariat;

Noting that Member States have a need to formulate and implement strategies for improving the health of migrants;

Noting that policies addressing migrants' health should be sensitive to the specific health needs of women, men and children;

Recognizing that health policies can contribute to development and to achievement of the Millennium Development Goals;

Noting that migration requires humanitarian responses, [Greece]

1. CALLS UPON Member States:

- (1) to promote migrant-sensitive health policies;
- (2) to **promote** [Greece] equitable access to health promotion, **disease prevention** [Thailand] and care for migrants, subject to national laws and practice, and devise mechanisms for enhancing the health of migrants without discrimination on the basis of gender, age, religion, nationality or race;
- (3) **to establish health information systems in order** [Thailand] to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;
- (4) ~~to identify better the gaps in service delivery in order to improve the health of all populations, including migrants;~~ **to devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery**; [Senegal]
- (5) to gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination;
- (6) to raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues;
- (7) to train health professionals to deal with the health issues associated with population movements;

(8) to promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process;

~~(9) to promote strengthening of health systems in developing countries; [Thailand]~~

~~(10)~~(9) to contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium Development Goals;

(10) to provide basic occupational health services and rehabilitation schemes for migrants who suffer occupational diseases or injuries; [Greece]

2. REQUESTS the Director-General:

(1) to promote migrants' health on the international health agenda in collaboration with other relevant international organizations;

(2) to explore policy options and approaches for improving the health of migrants;

(3) to analyse the major challenges to health associated with migration;

(4) to support the development of regional and national assessments of migrants' health status and access to health care;

(5) to promote the inclusion of migrants' health in the development of regional and national health strategies where appropriate;

(6) to help to collect and disseminate data **and information** [Thailand] on migrants' health;

(7) to promote dialogue and cooperation on migrants' health among all Member States involved in the migratory process, within the framework of the implementation of their health strategies;

(8) to promote interagency, interregional and international cooperation on migrants' health with an emphasis on developing partnerships with other organizations and considering the impact of other policies;

(9) to encourage the exchange of information through a technical network of collaborating centres, academic institutions, **civil society** [Thailand] and other key partners in order to further research into migrants' health and to enhance capacity for technical cooperation;

(10) to submit to the Sixty-third World Health Assembly, through the Executive Board, a report on the implementation of this resolution;

(11) to promote exchange of information on migrants' health, nationally, regionally, and internationally, making use of modern information technology. [Suriname]

The CHAIRMAN, introducing the draft resolution, invited the delegate of Portugal to present the outcome of informal consultations on the subject.

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the European Union Member States, expressed his gratitude for constructive proposals that had enhanced the draft resolution. For the sake of consensus, some proposed amendments had been dropped and others slightly modified. He suggested that, with the Chairman's agreement, the proposed amendments to operative paragraphs be discussed one by one. In regard to the preamble, the proposed amendment by the delegate of Thailand in the eighth paragraph had been dropped, as had the new final paragraph proposed by the delegate of Greece.

The CHAIRMAN, noting the agreement signified by the delegates of both countries, took it that the Committee accepted those suggestions.

It was so agreed.

Professor PEREIRA MIGUEL (Portugal), with reference to subparagraph 1(2), said that the words “and secure” proposed by the delegate of Greece had been dropped with its agreement and that those proposed by the delegate of Thailand, namely “disease prevention”, had been retained, as had been additional wording proposed by the delegates of the Democratic Republic of the Congo, Senegal and the United Kingdom of Great Britain and Northern Ireland, to be inserted after the word “practice”, as follows: “without discrimination on the basis of gender, age, religion, nationality or race”.

The CHAIRMAN took it that the Committee wished to approve that paragraph as amended and, as a result, reject the alternative version of subparagraph 1(2).

It was so agreed.

Professor PEREIRA MIGUEL (Portugal) said that the amendment proposed by the delegate of Thailand to subparagraph 1(3) had been accepted, as had the proposed amendment by the delegate of Senegal to subparagraph 1(4). In regard to subparagraph 1(9), it had been agreed that the proposed amendment by the delegate of Thailand be deleted and, in consequence, subparagraph 1(10) should be renumbered 1(9). It had also been agreed that the additional paragraph proposed by the delegate of Greece be dropped.

It was so agreed.

Professor PEREIRA MIGUEL (Portugal) said that in subparagraph 2(6) the words “and information” proposed by the delegate of Thailand had been retained; in subparagraph 2(7) some additional wording proposed by the delegates of Mexico and Thailand, “with particular attention to the strengthening of health systems in developing countries” and placed after “health strategies”, had been retained; in subparagraph 2(9) insertion of the words “civil society” after “academic institutions,” as proposed by the delegate of Thailand had been accepted, as had the new subparagraph 2(11) proposed by the delegate of Suriname.

Mr WATERBERG (Suriname) proposed that subparagraph 2(11) should be renumbered 2(9), so that subparagraphs 2(9) and 2(10) became 2(10) and 2(11).

The CHAIRMAN took it that the Committee agreed to all those proposed amendments and that it wished to approve the draft resolution as amended.

The draft resolution, as amended, was approved.¹

The CHAIRMAN expressed the Committee’s gratitude to the delegate of Portugal for steering the discussions to consensus.

Professor PEREIRA MIGUEL (Portugal) said that his country was extremely pleased that, after a process lasting almost two years, the resolution had been adopted. Portugal considered the health of migrants to be a global issue that needed addressing by WHO and all its Member States, taking a public health perspective. He wished in particular to thank the Director-General for her support, including her presence in Portugal for the Conference on Health and Migration in the European Union organized within the context of the country’s tenure of the Union Presidency.

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA61.17.

During the discussions at the Health Assembly, Portugal had suggested that the Secretariat should conduct a wide global consultation with the collaboration of Member States on how best to implement the resolution. Portugal held to that idea, and undertook to provide active support should that path be pursued.

The meeting rose at 11:35.

TENTH MEETING

Friday, 23 May 2008, at 14:30

Chairman: Dr F. CICOGNA (Italy)

TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

Global immunization strategy: Item 11.7 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R7, and A61/10) (continued from the ninth meeting, section 2)

Mr ASLANYAN (Canada) said that the informal working group had finalized several amendments to the draft resolution on the global immunization strategy that had been discussed at the previous meeting. The penultimate preambular paragraph should read: “Concerned that there are insufficient resources available for introduction of new and underutilized vaccines, especially in low-income and middle-income countries, and given the costs related to procurement and introduction of these vaccines, and taking into account the need to expand the number of manufacturers, particularly in developing countries, that can produce to the standards required to attain and maintain WHO prequalification and to create a competitive marketplace for these vaccines”. Subparagraph 1(3) should be amended to read: “to stimulate rapid introduction and uptake of life-saving vaccines into national immunization schedules in accordance with national priorities, and to expand coverage of these vaccines in order to accelerate the achievement of the health-related Millennium Development Goals”. Subparagraph 2(2) should read: “to collaborate with international partners and intergovernmental partners to provide technical support to expand the number of manufacturers, particularly in developing countries, that can produce to the standards required to attain and maintain WHO prequalification”. As the references to UNICEF and the GAVI Alliance had been deleted from subparagraph 2(2), the words “and the GAVI Alliance” should be inserted after “UNICEF” in subparagraph 2(4).

The CHAIRMAN took it that those amendments were acceptable to the Committee.

The draft resolution, as amended, was approved.¹

Counterfeit medical products: Item 11.13 of the Agenda (Document A61/16)

The CHAIRMAN drew attention to a draft resolution on counterfeit medical products proposed by Gambia, Ghana, Nigeria, Tunisia and the United Arab Emirates, which read:

The Sixty-first World Health Assembly,

Recalling resolutions WHA41.16, WHA47.12, and WHA52.19;

Having considered the report on counterfeit medical products;²

Concerned about the situation in which counterfeit medical products continue to move in international commerce representing a major threat to public health, especially in the poorer areas of developing countries, and a challenge to the credibility and effectiveness of health systems;

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA61.15.

² Document A61/16.

Aware of the importance of ensuring effective collaboration among patients, health professionals, commercial private sector and government institutions to effectively combat counterfeit medical products;

Cognizant of the importance of ensuring effective international collaboration and exchange of information to effectively combat counterfeit medical products;

Noting with satisfaction that, in spite of severe financial constraints, the Secretariat has intensified activities aimed at strengthening international collaboration to combat counterfeit medical products;

Congratulating all parties concerned that have fulfilled their responsibilities in compliance with the components of the above-mentioned resolutions that specifically focus on combating counterfeit medical products, and encouraging them to continue to do so;

Congratulating also all parties that have contributed to the establishment of the International Medical Products Anti-Counterfeiting Taskforce, based on the Declaration of Rome of 16 February 2006, and encouraging them to continue to support its activities;

Commending the leadership shown by WHO in promoting the establishment of the International Medical Products Anti-Counterfeiting Taskforce which is contributing to strengthening international collaboration and national efforts aimed at combating counterfeit medical products;

Inviting bilateral agencies, multilateral agencies inside and outside the United Nations system, and voluntary organizations, to support the International Medical Products Anti-Counterfeiting Taskforce, and to support developing countries in setting up and carrying out programmes aimed at combating counterfeit medical products, and thanking those that are already doing so;

Requesting governments, pharmaceutical manufacturers and other concerned parties to cooperate in the detection, investigation and prevention of the increasing incidence of falsely labelled, spurious or counterfeited medical products moving in international commerce,

1. URGES Member States:

- (1) to reaffirm their commitment to develop, implement and monitor national policies and to take all necessary measures in order to ensure access to high quality medical products;
- (2) to establish and enforce legislation and regulations that prevent counterfeit medical products to be manufactured, exported, imported or traded in international transactions and the regulated distribution system, taking into account the principles and recommendations developed by the International Medical Products Anti-Counterfeiting Taskforce;
- (3) to establish effective mechanisms of coordination and collaboration among health, enforcement and other relevant authorities in order to improve detection, investigation and prosecution of cases of counterfeit medical products;
- (4) to establish appropriate mechanisms enabling international cooperation and exchange of information among relevant authorities involved in detecting and combating counterfeit medical products;
- (5) to promote awareness among health professionals and consumers of the risks posed by counterfeit medical products, especially when acquired through unregulated outlets or unauthorized internet sites;

2. REQUESTS the Director-General:

- (1) to support Member States in their efforts to develop and implement policies and programmes aimed at combating counterfeit medical products, including facilitating the exchange of information at the international level and the development of tools, guidelines, training and awareness initiatives, and methodology for evaluation and monitoring;

- (2) to strengthen the Secretariat of the International Medical Products Anti-Counterfeiting Taskforce, in order to improve WHO's capacity to support the work of Member States and to intensify collaboration with international organizations and other relevant parties at the international level, seeking extrabudgetary resources in addition to those in the regular budget to this end;
- (3) to continue the development and dissemination of independent information on instances of counterfeit medical products;
- (4) to cooperate with Member States, at their request, with international organizations and other relevant parties in detecting, monitoring and analysing cases of counterfeit medical products and their impact on public health;
- (5) to report to the Sixty-third World Health Assembly on progress achieved and problems encountered in the implementation of the work of the International Medical Products Anti-Counterfeiting Taskforce, with recommendations for action.

The financial and administrative implications were as follows:

1. Resolution Counterfeit medical products	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
11. To ensure improved access, quality and use of medical products and health technologies.	11.2 International norms, standards and guidelines for the quality, safety, efficacy and cost-effective use of medical products and technologies developed and their national and/or regional implementation advocated and supported.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution is consistent with the expected result. Indicators specific to counterfeit medical products will be designed as needed.	
3. Financial implications	
(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)	
US\$ 30 million is needed for the next five years. Of this amount, one third (US\$ 10 million) is needed at headquarters for global planning and coordination between stakeholders, for global policy guidance, and for the running costs of the secretariat of the International Medical Products Anti-Counterfeiting Taskforce (IMPACT); two thirds (US\$ 20 million) are needed for support activities at regional and country levels.	
(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)	
Total costs are estimated at US\$ 5.2 million.	
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?	
US\$ 2 million is already available for the biennium. This implies the need for an additional provision of US\$ 3.2 million (US\$ 1.2 million at headquarters and US\$ 2 million at the regional and country levels).	

(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)

Additional funding from voluntary contributions is expected through active resource mobilization.

4. Administrative implications

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

Currently, most activities are performed at headquarters (involving the IMPACT secretariat, global advocacy and stakeholder coordination, and fund-raising) and in two WHO regions (involving the regional offices for South-East Asia and the Western Pacific).

(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)

At headquarters, three additional full-time equivalents will be required in the professional category, together with one staff member in the general service category. During the biennium 2008–2009, one additional full-time equivalent will be needed in the professional category in each of three regional offices (plus administrative support); during the biennium 2010–2011, three more full-time equivalents (plus administrative support) will be needed for the other regional offices (namely, those for the Americas, Europe and the Eastern Mediterranean). A total of nine full-time equivalents will be therefore required in the professional category, together with three or four full-time equivalents in the general service category. In at least 10 countries, a dedicated national programme officer will be needed.

(c) Time frames (indicate broad time frames for implementation)

The global programme will be expanded into the African, South-East Asia and Western Pacific regions (involving at least five countries) in 2009; and into all regions (involving 10 countries) during the biennium 2010–2011.

Professor AKUNYILI (Nigeria), introducing the draft resolution on behalf of the Member States of the African Region, said that counterfeit medical products were prevalent in her Region. Such products was detrimental to health, wasted resources and could, in the case of antibiotics, result in antimicrobial resistance. Production or circulation of those could be facilitated by a lack of appropriate legislation, inadequate enforcement of existing legislation, shortages of regular medical products, and weak penal sanctions. It was estimated that 30% of Member States had either malfunctioning or no regulatory systems for medical products, environments in which counterfeits could thrive. The rural and poorer populations of Africa were disadvantaged by illicit trade activities, and unregulated pharmaceutical markets and distribution. A study involving laboratory testing of medicines carried out by the National Agency for Food and Drug Administration and Control in Nigeria, and supported by WHO and the Department for International Development of the United Kingdom of Great Britain and Northern Ireland, had revealed that 16.7% of medicines circulating in Nigeria were counterfeit. The counterfeiting of medical products was a vile and serious crime that put human lives at risk and undermined the credibility of health systems.

The Health Assembly, in resolutions WHA41.16, WHA47.13 and WHA52.19, had recognized the threat posed by counterfeit medical products and requested the Director-General to support Member States in their efforts to combat the manufacture, distribution, trade and use of such products. WHO had launched the International Medical Products Anti-Counterfeiting Taskforce, which sought to strengthen international collaboration among stakeholders with a view to halting the production, movement and commerce of counterfeit medical products.

All 46 Member States of the African Region supported the draft resolution. The text was not intended to address intellectual property issues but to focus on the public health consequences of counterfeit medical products. In order to emphasize that generic medicines should not be confused with counterfeit drugs, the words “access to high quality medical products” at the end of subparagraph 1(1) should be amended to read “access to medicines that have been appropriately evaluated for efficacy, safety and quality”.

Dr VOLJČ (Slovenia), speaking on behalf of the European Union, said that the fight against counterfeit medical products was a priority: they endangered human health and undermined health-care systems. The Internet and globalization had made the issue relevant from a public and individual health perspective. A study conducted by WHO and the International Criminal Police Organization had found that in 2007 about half the antimalarial medicines in some South-East Asian countries were counterfeit. In May 2008, the European Commission had shown a 51% increase in counterfeit medicines seized by customs authorities in 2007.

The global nature of the problem required international action and cooperation on the part of diverse institutions, such as health and customs authorities, the pharmaceutical industry, law enforcement bodies and financial institutions. Credible reports that the marketing of counterfeit medicines had taken the form of organized crime were alarming. The European Union welcomed WHO's engagement and supported the work of the International Medical Products Anti-Counterfeiting Taskforce and called on all WHO's Member States to do likewise. The European Union was investigating the distribution of pharmaceuticals, including counterfeit products, and would draft legislation that took account of the national legislation developed by the Anti-Counterfeiting Taskforce.

The European Union wished to be included among the sponsors of the draft resolution. He proposed some amendments. In the fourth preambular paragraph, the words “and other relevant international organizations” should be added after “government institutions”. In the tenth preambular paragraph, the words “the pharmaceutical industry” should be added after “voluntary organizations”. In subparagraph 1(1), the words “high quality medical products” should be replaced by “medical products of verified quality, safety and efficacy”. The words “and national” should be inserted between “international” and “transactions” in subparagraph 1(2). In subparagraph 1(3), “, custom” should be added after “enforcement”; and “unregulated outlets or unauthorized internet sites” in subparagraph 1(5) should be amended to read “unregulated internet sites or outlets”.

Mr CHAUDHRY (India), speaking on behalf of the Member States of the South-East Asia Region, welcomed the progress made by the International Medical Products Anti-Counterfeiting Taskforce since its launch in 2006 and commended WHO's recommendation of coordinated action. He asked for updated WHO guidelines for elaborating measures, the major contributing factors and steps to be followed in developing national strategies in order to combat counterfeit medicines.

The countries of the Region, recognizing the magnitude of public health risks, were committed to combating medicines that did not meet standards of quality, safety and efficacy. In all those countries, the counterfeiting of medicines was considered a criminal offence. Those countries applied the definition of “counterfeit medicines” as given on the WHO web site. He noted that an alternative definition had been elaborated during a conference organized by the International Medical Products Anti-Counterfeiting Taskforce in December 2007.

Referring to subparagraph 1(2) of the draft resolution, he said that the principles and recommendations developed by the Taskforce were unclear. Any such principles should seek to protect public health interests rather than trade interests. Moreover, generic or branded medical products that were available but not registered in a particular country should not be considered as counterfeit, but simply as unregistered products. Any changes in the definition of counterfeit medicines should state explicitly that generics did not in any way entail patent infringement.

It was premature to consider the Secretariat's report, as Member States had not had an opportunity to discuss thoroughly the implications, scope, issues and challenges of the recommended

strategies, currently being discussed by the Anti-Counterfeiting Taskforce. Therefore, the countries of his Region did not support the draft resolution. Further consideration of the agenda item on counterfeit medical products should be deferred until all aspects of the work of the Taskforce had been considered and until due process had been followed with regard to those recommendations.

Dr KUSTANTINAH (Indonesia) said that Indonesia remained committed to combating counterfeit drugs in cooperation with WHO, had participated in the work of the Anti-Counterfeiting Taskforce and had hosted the ASEAN-China Conference on Combating Counterfeit Medical Products in 2007. As the draft resolution had implications for sectors other than the health sector, Member States would require more time to consider the text, particularly the principles and recommendations elaborated by the Taskforce.

Dr CIPIL (Turkey) said that her country considered that the counterfeiting of medical products was a serious crime. It threatened human life, undermined the credibility of health systems and affected all medical products: medicines, pharmaceutical ingredients, medical devices and diagnostics. The Anti-Counterfeiting Taskforce was important in the fight against counterfeit medical products and in fostering collaboration and coordination between Member States and stakeholders globally.

Turkey was experiencing problems associated with counterfeit medicine packages, rather than counterfeit medical products. A Turkish pharmaceuticals' "track and trace system" had been established, and a data matrix identifier was included on packages. Her country supported the efforts to combat counterfeit medical products and agreed that the guidance of the Secretariat was vital for Member States.

Dr KAMOTO (Malawi) said that her country's drug regulatory body had the legal mandate to ensure that only those medicines certified as safe and effective were available. Her Government had strengthened legislation and penalties in regard to counterfeiting drugs, and regulations controlling the entry and exit of pharmaceutical products. Malawi had also intensified its public awareness programme on counterfeit characteristics. National and regional committees should be formed in order to investigate counterfeit products. She urged the Director-General to support Member States in strengthening their regulatory authorities and enforcing legislation with stronger penal sanctions.

In countries with a burden of communicable diseases such as tuberculosis and HIV/AIDS, counterfeit medical products would reverse any gains that might have been achieved. Proliferation of such products could lead, for diseases such as tuberculosis, to the development of multidrug-resistant and extensively drug-resistant forms, thus making control even more difficult and expensive.

Mr TOBAR (Argentina) pointed out that WHO, in seeking the attainment of health for all peoples, had a duty to keep people safe from the harmful impact of counterfeiting. However, the proposed measures to combat counterfeiting involved various authorities, and the report appeared to have focused on combating counterfeiting as an end in itself rather than on its effect on people's health. The wording of the first bullet point of paragraph 10 underestimated the role of governments; Argentina had a national medicines policy that complied with the requirements of safety, quality and traceability.

The International Medical Products Anti-Counterfeiting Taskforce was composed of bodies covering a broad spectrum of interests that might not prioritize public health. The Taskforce did not have a mandate from the Health Assembly, a fact that might preclude the latter from considering its findings. It was inappropriate for WHO to deal with questions related to intellectual property rights, neither could his Government support the elaboration of guidelines or standards for the international harmonization of mechanisms to control counterfeiting and piracy. Article 1.1 of the Agreement on Trade-Related Aspects of Intellectual Property Rights stated that Members shall be free to determine the appropriate methods of implementing the provisions of the Agreement within their own legal system and practice. For all those reasons, he was unable to support the report.

Dr TSHABALALA MSIMANG (South Africa) thanked the Director-General for support to Member States in the complicated area of counterfeit medical products, in strengthening and harmonizing regulatory capacities. Access to medicines that had been evaluated for safety, quality and efficacy should be promoted. Therefore, notwithstanding the requests made by delegations for reconsideration, she sought speedy action at global level. She supported the draft resolution as amended by Nigeria.

Dr ZHOU Jun (China) said that his Government had implemented effective measures, in cooperation with competent international authorities and other governments, to combat counterfeit medical products. It had also decided to participate in the International Medical Products Anti-Counterfeiting Taskforce. With strong guidance from international organizations such as WHO and with close cooperation between intergovernmental organizations, it should be possible to prevent the proliferation of counterfeit medical products.

Dr ZERARRI (Morocco) said that medical products in his country were strictly regulated. New pharmaceutical products, and manufacture or import of high-quality medical products, had to be licensed. Morocco produced more than 70% of all medical products consumed nationally, thus minimizing the risk of counterfeit medical products. The Ministry of Health had its own internationally recognized laboratory for ensuring the quality, efficacy and safety of medical products. Inspectors were trained and aware of counterfeiting at the international level. Regular controls covered production, storage, distribution and dispensing of products destined for health sectors. A national pharmacovigilance system had been established to increase detection and contain counterfeiting.

Although control and licensing of medical products had led to improved quality of medicines and medical devices sold in Morocco, fraud had not been eliminated in connection with products sold through “free zones”. WHO should establish on its web site a database containing the names and details of approved companies, and list those products that had been authorized by the Member States. An international early warning system could also be established that would raise the alarm when a counterfeit product was discovered.

Dr ALKUWARIE (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, emphasized the danger posed to public health by counterfeit medical products, which could lead to drug resistance and even death. The Center for Medicines in the Public Interest in the United States of America predicted that counterfeit drug sales could reach US\$ 75 000 million globally in 2010. In 2006, WHO had launched the International Medical Products Anti-Counterfeiting Taskforce, with principles based on the Declaration of Rome. The Taskforce aimed to bring together all the major anti-counterfeiting bodies, but some had not been able to fund their participation. In her Region, some countries had begun to legislate and raise awareness in order to combat counterfeit drugs, others were establishing interministerial bodies. She commended WHO, welcomed the proposed measures, and called for support from the major anti-counterfeiting bodies, the sharing of information and the provision of adequate funding.

Dr MOHAMMED (Oman) said that the number of medical products was constantly increasing, as were prices. He supported the comments made by the delegates of Morocco and the United Arab Emirates. The draft resolution did not appear to contain an accepted definition of counterfeit drugs; therefore, he proposed that the words “as per the definition developed by the WHO Secretariat” be inserted after “counterfeit medical products” in the fourth preambular paragraph. The views expressed by the delegate of India led him to consider that a definition might prove helpful to many countries and lead to consensus on the draft resolution.

Dr ZARAMBA (Uganda), recognizing the dangers posed by counterfeit medicines, commended WHO’s initiative in relation to the International Medical Products Anti-Counterfeiting Taskforce. Uganda’s drug regulatory authority was active within the Taskforce, which other Member States

should continue to support. He requested the Secretariat to report on the progress of the Taskforce and to conduct a survey on the extent of counterfeit medical products in Member States.

Dr FORRESTER (Jamaica) commended WHO's leadership in promoting regulatory safeguards to medical and pharmaceutical products, including the formation of the Anti-Counterfeiting Taskforce. Medicines that were mislabelled in order to deceive consumers were counterfeit, whereas medicines without regulatory approval were not necessarily so. Expansion of the nomenclature to embrace other products, such as raw materials, should not be allowed to divert attention from the major problem, namely, counterfeit drugs or medicines. According to WHO, a counterfeit medicine was one that was fraudulently mislabelled with respect to identity or source and might contain wrong ingredients, wrong amounts or no active ingredient. She stressed the distinction between counterfeit and substandard medicines. Generic medicines that did not bear another firm's brand name or trademark were not counterfeits. Nor were products made under legitimate limitations and exceptions to patents, or generic medicines that were off-patent, or legitimately licensed under voluntary or non-voluntary licences. Not all products that infringed patents or other intellectual property rights could be described as counterfeits. She differentiated between counterfeiting and the importing of legitimate stock at a lower price which was resold legally under the exhaustion-of-rights doctrine. She therefore called on WHO to respect its definition of counterfeit medicines.

WHO's programme for prequalification of medical products to treat malaria, HIV/AIDS and tuberculosis should be expanded. The dissemination of good manufacturing practices in producing countries should be continued and ongoing support provided to countries for capacity building and improving their communications networks.

With regard to the draft resolution, and in order to maintain consistency, the first line of the eleventh preambular paragraph should read either "manufacturers of medical products" or "pharmaceutical manufacturers" and continue "manufacturers of other medical products and concerned parties ...".

Dr SHIMIZU (Japan) said that prompt action was needed to combat the production and sale of counterfeit medicines. Specific targets and concrete countermeasures should be indicated, as well as explicit timelines at both international and national levels. His Government had adopted measures to that effect, which should be taken in all countries. He supported the draft resolution.

Mr WATERBERG (Suriname) said that the serious threat posed by counterfeit medicines was emphasized by the report's examples of fatalities caused by counterfeit ingredients. He supported the draft resolution.

Dr DAHN (Liberia) supported the draft resolution, but proposed amending subparagraph 1(2) so that it began "to consider establishing enforcing legislation and regulations that render the act of falsely labelling, manufacturing or selling counterfeit drugs as criminal and not civil offences...".

Dr TIPICHA POSAYANONDA (Thailand) noted that the agenda item had not been considered by the Executive Board at its 122nd meeting in January and asked whether the Executive Board or the Secretariat had discussed or endorsed documents from the International Medical Products Anti-Counterfeiting Taskforce. She further asked how the recommendations of the Taskforce differed from the WHO guidelines for the development of measures to combat counterfeit medicines. The agenda item was closely related to the discussions of the working group on the report of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, which was meeting at the same time, making it difficult for her delegation to participate. She requested the Committee to defer consideration of the agenda item and the draft resolution.

Ms NYANDORO (Zimbabwe) said that, although there had been few documented cases of counterfeit medical products in Zimbabwe, the issue posed a serious threat. The Anti-Counterfeiting

Taskforce should be supported with resources for the strengthening of regulatory bodies. Zimbabwe wished to participate in both regional and international initiatives to address the scourge of counterfeit medical products. She supported the draft resolution.

Mr DELGADO (Bolivarian Republic of Venezuela) said that further study was needed on the counterfeiting of medical products and the consequences. Therefore, he supported the position of the delegates of India, Argentina and Thailand.

Mr ABDOO (United States of America) said that a coordinated international approach to the counterfeiting of medical products was essential, and the Anti-Counterfeiting Taskforce had filled that role well. He congratulated Member States and the Taskforce for preparing strategies, guidance and training materials and urged continued support for the Taskforce. He supported the draft resolution, but proposed the following amendments. The fourth preambular paragraph should be modified to add “consumers, including” before “patients and health professionals,”. In subparagraph 1(1), the word “ensure” should be replaced by “promote”. In subparagraph 1(5), the word “unauthorized” should be replaced by “illicit”. A new subparagraph 1(6) would read “to control the transshipment of pharmaceutical ingredients (APIs and excipients) that are used in the production of counterfeit medicines”.

Dr VEGA (Chile) commented that the report appeared to emphasize combating counterfeiting as an end in itself, a legal matter, rather than the public health implications of counterfeit medicines. Chile’s control and surveillance mechanisms ensured the quality, effectiveness and safety of medicines, thus combating the circulation of counterfeit medicines in the country. She agreed with the delegates of Argentina, India, Thailand and Venezuela that the document prepared by the Anti-Counterfeiting Taskforce had not been mandated by the Health Assembly, and she could not approve the draft resolution.

Mr GAUDÊNCIO (Brazil) expressed concern with the suggestion in the report that national drug policies could prioritize medicine manufacturing for export over public health aspects of good manufacturing practice. That interpretation might affect the legitimate production of generics, which was driven by national policies that prioritized health over trade. He was also alarmed about the role of WHO in the Anti-Counterfeiting Taskforce, in which the interests of WIPO, WTO, the European Commission, the Council of Europe, the International Federation of Pharmaceutical Manufacturers and Associations and the International Criminal Police Organization overrode the legitimate concerns of WHO for public health. WHO had a crucial role in promoting health issues, and that should not be mixed with law enforcement measures, which might be interpreted as a means to drive out producers of legitimate generics. He did not recognize the legitimacy of the International Medical Products Anti-Counterfeiting Taskforce, and therefore its report, and so he saw no reason to discuss the draft resolution. He too requested that the agenda item be deferred.

Dr PALAU (Honduras) said that counterfeit medical products were clearly a public health risk. She agreed with the delegate of Jamaica that those should be clearly distinguished from good-quality generic products, which could be certified by WHO and be useful in poor countries. If that distinction was made, she would be prepared to support WHO measures to combat counterfeit medicines.

Dr MALEFHO (Botswana) said that the global problem of counterfeit medicines and medical supplies particularly affected developing countries. He supported the draft resolution, as amended by Nigeria.

Dr MUKONKA (Zambia) said that counterfeit medical products were major obstacles to meeting the health goals set by any country. A recent study carried out in six sub-Saharan countries had tested samples of antimalarial medicines procured from private pharmacies in urban areas; more

than one third were found to be substandard. He recognized the importance of preventing the trade of counterfeit medical products and therefore supported the draft resolution.

Dr KIMANI (Kenya) asked Member States to respect the WHO definition of “counterfeit”. He supported the delegate of Jamaica with regard to the definition of “generics”, as they were not counterfeits. Weak regulatory authorities encouraged counterfeiting, and WHO should support countries with that problem in combating counterfeit products.

Dr ABEYKOON (Sri Lanka) supported those delegates who had proposed deferment of consideration of the draft resolution.

Dr YOOSUF (Maldives) welcomed the efforts to improve access to high-quality affordable medicines in developing countries. In the absence of an agreed definition of “counterfeit”, however, he supported the proposal to defer consideration of the draft resolution. If the item was to be considered at the forthcoming meeting of the Executive Board, he proposed an addition to the end of the fourth preambular paragraph, reading “Aware of the fact that generic medicines are not necessarily counterfeit medicines and that counterfeiting brands is a trademark or IPR issue, any measures to combat counterfeit medicines should not negatively affect access to quality generic medicines in developing countries”.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the issue of counterfeit medical products was of concern to all, but more precise definitions were needed and the draft resolution could not be adopted hastily, before agreement had been reached. A definition of pharmaceutical products should make clear whether it included products other than medicines, and whether “medicines” also included generic medicines. In Cuba, the State regulatory authority monitored the quality of medicines in accordance with WHO’s recommendations, and included a testing centre for medical equipment. It coordinated with other State bodies, as well as manufacturers, distributors, importers, exporters and regulatory authorities in other countries in order to combat the counterfeiting of medical products.

Dr SARKER (Bangladesh) said that the issue of counterfeit medical products had to be examined carefully before a resolution was adopted. He favoured deferring consideration of the matter until the Sixty-second World Health Assembly and supported the position taken by India and other countries.

Mr AGYARKO (Ghana) said that Africa was probably the Region most severely affected by the scourge of counterfeit drugs. The issue was a public health emergency, and he urged the Committee to take action on the draft resolution, perhaps with some redrafting and clarification of definitions.

Dr BALE (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the Pharmaceutical Security Institute, of which he was President, was working with the International Medical Products Anti-Counterfeiting Taskforce to combat the rising phenomenon of counterfeit medicines. Patents had nothing to do with counterfeiting; both originator and generic drugs were counterfeited. Moreover, the term “counterfeiting” encompassed more than deliberate manufacture of fake drugs; it also included practices such as altering the expiry date on a product. He applauded the work of the Taskforce in closing the gaps that facilitated counterfeiting. He called for further involvement and support from all stakeholders in the supply chain. Only concerted action and strong support from WHO could stem counterfeiting of medical products.

Mr CHAN Xuanhao (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that the health professions were extremely concerned about the sale of counterfeit medicines and their life-threatening potential. Health professionals had a crucial role in reporting anomalies in their patients’ response to treatment which might be due to counterfeit products. Global

associations of health professionals had elaborated a model for raising awareness, among health professionals and patients, of the dangers of such products. His organization had taken a lead role in drawing up the communication strategy of the Anti-Counterfeiting Taskforce.

A comprehensive definition of the term “counterfeit medical products” was needed, which should cover the product, its container, packaging and information inserts. Member States should adopt and enforce legislation and regulations to prevent the manufacture, sale and distribution of counterfeit products, taking into account the principles and recommendations of the Taskforce. The secretariat of the Taskforce should be strengthened in order to improve WHO’s capacity to support the work of Member States, and to intensify collaboration with all relevant parties.

The CHAIRMAN said that it appeared that some Member States needed more information on the issue before adopting a resolution. Given the gravity of the issue and the need to reach global consensus thereon, he suggested that the Committee agree to defer action on the resolution until the following year and to refer the matter to the Executive Board for further discussion, including the draft resolution with all the amendments proposed during the debate. He emphasized that deferral did not reduce the importance of the issue.

It was so agreed.

The meeting was suspended at 16:35 and resumed at 16:50.

Female genital mutilation: Item 11.8 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R13, and A61/11) (continued from the fifth meeting)

Mr BERLING-RASMUSSEN (Denmark) said that consensus had been reached on the bracketed text in the draft resolution contained in resolution EB122.R13. In the preambular paragraph that referred to the Beijing Declaration and Platform for Action, it had been agreed that the first word of the paragraph should be “Recalling” and that the words “and related reports” should be deleted. Immediately below that paragraph, the following new preambular paragraph would be inserted: “Affirming that all these outcomes constitute an essential framework for advancing the rights of women and girls and eliminating female genital mutilation;”. It had also been agreed that subparagraph 1(6) would read: “to develop or reinforce social and psychological support services and care and to take measures to improve health, including sexual and reproductive health, in order to assist women and girls who are subjected to this violence”.

Noting that the preambular paragraph that mentioned the United Nations Commission on the Status of Women made reference to a resolution adopted by that Commission in 2007, he said that the reference should be changed to reflect the most recent resolution adopted by the Commission on the subject of female genital mutilation (resolution E/CN.6/2008/L.2/Rev.1).

The draft resolution, as amended, was approved.¹

Dr STEIGER (United States of America), speaking in explanation of position, said that his Government understood that the references to the Beijing Declaration and Platform for Action, the International Conference on Population and Development and their five- and ten-year reviews did not create or recognize any rights, in particular a right to abortion, nor could they be interpreted as constituting support, endorsement or promotion of abortion. The United States also understood that there was international consensus that the term “sexual and reproductive health” did not include abortion or constitute support, endorsement or promotion of abortion or the use of abortifacients.

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA61.16.

Mr MERCIECA (Malta), speaking in explanation of position, said that Malta unreservedly condemned female genital mutilation and urged all Member States to enact legislation to protect girls and women from all forms of violence, including genital mutilation. However, the resolution, particularly its recognition of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, appeared to authorize and condone abortion, thereby condemning one form of violence while condoning another.

The meeting rose at 17:35.

ELEVENTH MEETING

Saturday, 24 May 2008, at 09:20

Chairman: Dr F. CICOGNA (Italy)

1. THIRD REPORT OF COMMITTEE A (Document A61/46)

The SECRETARY read out the draft third report of Committee A and drew attention to the fact that one element was missing: it had been decided to recommend to the Executive Board that, at its 124th session in January 2009, it consider the draft resolution on item 11.13, Counterfeit medical products.

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

Climate change and health: Item 11.11 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R4 and A61/14) (continued from the seventh meeting, section 2)

The CHAIRMAN drew attention to the revised version of the draft resolution contained in resolution EB122.R4, which read:

The Sixty-first World Health Assembly,

Having considered the report on climate change and health;

Recalling resolution WHA51.29 on the protection of human health from risks related to climate change and stratospheric ozone depletion and acknowledging and welcoming the work carried out so far by WHO in pursuit of it;

Recognizing that, in the interim, the scientific evidence of the effect of the increase in atmospheric greenhouse gases, and of the potential consequences for human health, has considerably ~~strengthened~~ **improved [Ghana]**;

Noting with concern the recent findings of the Intergovernmental Panel on Climate Change that the effects of temperature increases on some aspects of human health are already being observed; that the net global effect of projected climate change on human health is expected to be negative, especially in developing countries, small island developing States and vulnerable local communities which have the least capacity to prepare for and adapt to such change, and that exposure to projected climate change could affect the health status of millions of people, through increases in malnutrition, in death, disease and injury due to extreme weather events, in the burden of diarrhoeal disease, in the frequency of cardiorespiratory diseases, and through altered distribution of some infectious disease vectors;

Noting further that climate change could jeopardize achievement of the Millennium Development Goals, including the health-related Goals, and undermine the efforts of the Secretariat and Member States to improve public health and reduce health inequalities globally;

Recognizing the importance of addressing in a timely fashion the health impacts resulting

¹ See page 257.

from climate change due to the cumulative effects of emissions of greenhouse gases, and further recognizing that solutions to the health impacts of climate change should be seen as a joint responsibility of all States **but that industrialized states must take greater responsibility in this regard**; [South Africa]

Recognizing the need to assist Member States in assessing the implications of climate change for health and health systems in their country, in identifying appropriate and comprehensive strategies and measures for addressing these implications, in building capacity in the health sector to do so and in working with government and nongovernmental partners to raise awareness of the health impacts of climate change in their country and take action to address them;

Further recognizing that strengthening health systems to enable them to deal with both gradual changes and sudden shocks is a fundamental priority in terms of addressing the direct and indirect effects of climate change for health,

1. REQUESTS the Director-General:

- (1) to continue to draw to the attention of the public and policy-makers the serious risk of climate change to global health ~~security~~ [Brazil] [Thailand] [United Kingdom] and to the achievement of the health-related Millennium Development Goals, and to work with FAO, WMO, UNDP, UNEP, the United Nations Framework Convention on Climate Change secretariat, and other appropriate organizations of the United Nations, in the context of United Nations reform initiatives, and with national and international agencies, to ensure that these health impacts and their resource implications are understood and can be taken into account in further developing national and international responses to climate change;
- (2) to engage actively in the UNFCCC Nairobi Work Programme on Impacts, Vulnerability and Adaptation to Climate Change, in order to ensure its relevance to the health sector, and to keep Member States informed about the work programme in order to facilitate their participation in it as appropriate and access to the benefits of its outputs;
- (3) to continue close cooperation with Member States and appropriate United Nations organizations, other agencies and funding bodies in order to develop capacity to assess the risks from climate change for human health **and security** [Jamaica] and to implement effective response measures, by promoting further research and pilot projects in this area, including work on:
 - (a) health vulnerability to climate change and the scale and nature thereof;
 - (b) health protection strategies and measures relating to climate change and their effectiveness, including cost-effectiveness;
 - (c) the health impacts of potential adaptation and mitigation measures in other sectors such as **marine life**, [Palau] water resources, land use, and transport, in particular where these could have positive benefits for health protection;
 - (d) decision-support and other tools, such as surveillance and monitoring, for assessing vulnerability and health impacts and targeting measures appropriately;
 - (e) assessment of the likely financial costs and other resources necessary for health protection from climate change;
- (4) to consult Member States on the preparation of a workplan for scaling up WHO's technical support to Member States for assessing and addressing the implications of climate change for health and health systems, including practical tools and methodologies and mechanisms for facilitating exchange of information and best practice and coordination between Member States, and to present a draft workplan to the Executive Board at its 124th session;

2. URGES Member States:

- (1) to develop health measures and integrate them into national plans for adaptation to climate change; [Maldives]**
- (2) to build the capacity of public health leaders to be proactive in providing technical guidance on health issues, be competent in developing and implementing strategies for mitigating the effects of, and adapting to, climate change, and show leadership in supporting the necessary rapid and comprehensive action; [Jamaica]**
- (3) to strengthen the capacity of health systems for monitoring and minimizing the public health impacts of climate change through adequate preventive measures, preparedness, timely response and effective management of natural disasters; [Maldives]**
- (4) to promote effective engagement of the health sector and its collaboration with all related sectors, agencies and key partners at national and global levels in order to reduce the current and projected health risks from climate change; [Maldives]**
- (5) to express, as a priority, national commitment to meeting the challenges posed to human health by climate change, and to provide clear directions for planning actions and investments at the national level in order to mitigate the health effects of climate changes; [Thailand]**
- (6) in collaboration with organizations of the United Nations system and other parties, to examine the feasibility of establishing an international financing instrument to provide support to developing countries in order to mitigate the impact of climate change. [South Africa]**

Ms HENDRY (United Kingdom of Great Britain and Northern Ireland) said that, after informal consultations with a number of Member States, some further amendments to the draft resolution had been proposed. In the sixth preambular paragraph beginning “Recognizing the importance”, it was proposed that the final phrase “but that industrialized states must take greater responsibility in this regard” be replaced by the words “and that developed countries should assist developing countries in this regard;”, in paragraph 1, it was proposed to insert a new subparagraph 2bis, reading: “to work to promote the consideration of the health impacts of climate change by the relevant United Nations bodies and international financial institutions in any relevant future international financing instruments to address the impacts of climate change in developing countries”, in subparagraph 1(3), the words “and security” should be deleted. In subparagraph 2(1), the words “as appropriate” should be added after “climate change”. In subparagraph 2(2), “mitigating” should be replaced by “addressing”. In subparagraph 2(5), “as a priority” should be deleted and the word “mitigate” replaced by “address”. Lastly, subparagraph 2(6) should be deleted.

Mr KOLI (Solomon Islands) expressed support for the draft resolution and thanked the global community, and specific partner countries, for all their support since the tsunami in 2006.

Mr ABDOO (United States of America) said that concerns remained, especially in some of the proposed amendments to the draft resolution. In subparagraph 1(2)bis, he was proposing that the text end at “relevant United Nations bodies”, the remainder of the sentence being deleted. The United States could not accept the specific reference to financial institutions. Creating an international financing instrument in order to address climate change in developing countries was being discussed in negotiations within the United Nations Framework Convention on Climate Change. As it stood, the language used could prejudice those negotiations. Moreover, the relevant international institutions should consider the health impacts of climate change in all aspects of their work, not simply in connection with financing instruments. The word “national” in subparagraph 2(1) should be deleted, because his country had no specific national plan for adaptation to climate change. The term “national” was also inappropriate in subparagraph 2(5).

Dr TSHABALALA MSIMANG (South Africa) expressed support for the amendments proposed. On the subject of financial instruments, the impact of climate change on health should not be forgotten during the negotiations. As for the further amendment proposed by the previous speaker, it was difficult to understand the reluctance to mention assistance to developing countries in addressing the impact of climate change.

In response to a request from the CHAIRMAN for an alternative wording, Mr ABDOO (United States of America) proposed that the subparagraph read “to work to promote the consideration of the health impacts of climate change by the relevant United Nations bodies to help developing countries to address the health impacts of climate change”.

The CHAIRMAN, noting that the delegate of South Africa was willing to accept that wording, invited the Committee to approve the draft resolution, as amended.

The draft resolution, as amended, was approved.¹

3. FOURTH REPORT OF COMMITTEE A

Mr PARIRENYATWA (Zimbabwe), Rapporteur, read out the draft fourth report of Committee A.

The report was adopted.²

The meeting was suspended at 09:45 and resumed at 12:35.

4. TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (resumed)

Public health, innovation and intellectual property: draft global strategy and plan of action:
Item 11.6 of the Agenda (Document A61/9) (continued from the second meeting)

Dr VIROJ TANGCHAROENSATHIEN (Thailand), speaking as chairman of the informal drafting group, thanked all participants for their spirit of compromise in moving forward the work on the global strategy and plan of action.

He drew the Committee’s attention to the revised version of the draft resolution, which read:

The Sixty-first World Health Assembly,

Having considered the report of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property;

Recalling the establishment pursuant to resolution WHA59.24 of an intergovernmental working group to draw up a global strategy and plan of action in order to provide a medium-term framework based on the recommendations of the Commission on Intellectual Property, Innovation and Public Health, and to secure, inter alia, an enhanced and sustainable basis for needs-driven, essential health research and development relevant to diseases that

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA61.19.

² See page 257.

disproportionately affect developing countries, proposing clear objectives and priorities for research and development, and estimating funding needs in this area;

Recalling resolutions WHA49.14 and WHA52.19 on revised drug strategy, WHA53.14 and WHA54.10 and WHA57.14 on HIV/AIDS, WHA56.27 on intellectual property rights, innovation and public health, WHA58.34 on the Ministerial Summit on Health Research, WHA59.26 on international trade and health; and WHA60.30 on Public Health, Innovation and Intellectual Property;

Welcoming the progress made by the Intergovernmental Working Group in elaborating the global strategy and the identification of the stakeholders in the plan of action,

1. ADOPTS the global strategy and the agreed parts of the plan of action¹ on public health, innovation and intellectual property, attached to this resolution;
2. URGES Member States:²
 - (1) to implement the specific actions recommended in the global strategy and plan of action on public health, innovation and intellectual property;
 - (2) to support actively the wide implementation of the global strategy and plan of action on public health, innovation and intellectual property, and to consider providing adequate resources for its implementation;
3. CALLS UPON relevant international organizations and other relevant stakeholders to give priority within their respective mandates and programmes to implementing the global strategy and plan of action on public health, innovation and intellectual property;
4. REQUESTS the Director-General in implementing the global strategy and agreed parts of the plan of action without prejudice to the existing mandates:
 - (1) to provide support for Member States, upon request, in implementing the global strategy and plan of action on public health, innovation and intellectual property and in monitoring and evaluating its implementation;
 - (2) to support effective promotion and implementation of the global strategy on public health, innovation and intellectual property and the plan of action;
 - (2)*bis* to continue to implement the mandates contained in WHA resolutions WHA49.14, WHA52.19, WHA53.14, WHA54.10, WHA57.14, WHA56.27, WHA59.26, and WHA60.30, as well as WHA60.18, WHA56.30, WHA 55.14 and WHA 55.11;
 - (3) to finalize urgently the outstanding components of the plan of action, concerning time frames, progress indicators and estimated funding needs, and to submit the final plan of action including the open paragraphs on stakeholders for consideration by the Sixty-second World Health Assembly through the Executive Board;
 - (3)*bis* to coordinate with other relevant international intergovernmental organizations, including WIPO, WTO and UNCTAD, to effectively implement the global strategy and plan of action;
 - (4) notwithstanding the request in subparagraph (3) above, to prepare a Quick Start Programme with adequate budget provision and begin immediately to implement the elements of the global strategy and plan of action on public health, innovation and intellectual property that fall under the responsibility of WHO;
 - (5) to establish urgently a results-oriented and time-limited expert working group to examine current financing and coordination of research and development, as well as

¹ On the specific actions and stakeholders components.

² Where applicable, also regional economic integration organizations.

proposals for new and innovative sources of funding to stimulate research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases, and open to consider proposals from Member States, and submit progress report to the Sixty-second World Health Assembly and the final report to the Sixty-third World Health Assembly through the Executive Board;

(5)*bis* to reflect, as appropriate, the global strategy and plan of action on public health, innovation and intellectual property in the further development of WHO's research strategy;

(6) to include adequate resources in the forthcoming proposed programme budgets for effective implementation of the global strategy and plan of action on public health, innovation and intellectual property;

(7) to monitor performance and progress in implementing the global strategy and plan of action on public health, innovation and intellectual property, and to report progress to the Sixty-third World Health Assembly through the Executive Board, and subsequently every two years, until the fulfilment of the time frame, to the Health Assembly, through the Executive Board.

ANNEX 1

Draft global strategy on public health, innovation and intellectual property

The context

1. In resolution WHA59.24 the Health Assembly recognized the growing burden of diseases and conditions that disproportionately affect developing countries, and particularly women and children. Reducing the very high incidence of communicable diseases in those countries is an overriding priority. At the same time, it is important for WHO Member States and the WHO Secretariat to recognize and better address the increasing prevalence of noncommunicable diseases in those countries. (*consensus*)

2. Currently, 4.8 billion people live in developing countries, representing 80% of the world population. Of this number, 2.7 billion, representing 43% of the world population, live on less than US\$ 2 a day. Communicable diseases account for 50% of the developing countries' burden of disease. Furthermore, poverty, among other factors, directly affects the acquisition of health products¹ and medical devices, especially in developing countries. (*consensus*)

3. Member States,² the pharmaceutical industry, charitable foundations and nongovernmental organizations have taken initiatives in recent years to develop new products against diseases affecting developing countries and to increase access to existing health products and medical devices. However, these initiatives are not sufficient to surmount the challenges of meeting the goal of ensuring access and innovation for needed health products and medical devices. More efforts should be made to avoid

¹ The term "health products" hereafter should be understood to include vaccines, diagnostics and medicines in accordance with resolution WHA59.24.

² Where applicable, also regional economic integration organizations.

suffering and reduce preventable mortality and to meet the health-related Millennium Development Goals and to implement States' obligations and commitments arising under applicable international human rights instruments with provisions relevant to health. (*consensus*)

4. Proposals should be developed for health-needs driven research and development that include exploring a range of incentive mechanisms, including where appropriate, addressing the de-linkage of the costs of research and development and the price of health products and methods for tailoring the optimal mix of incentives to a particular condition or product with the objective of addressing diseases that disproportionately affect developing countries. (*consensus*)

5. Advances in biomedical science have provided opportunities to develop new, affordable, safe and effective health products and medical devices, particularly those that meet public health needs. Urgent efforts should be made to make these advances more affordable, accessible and widely available in developing countries. (*consensus*)

6. The Report of the Commission on Intellectual Property Rights, Innovation and Public Health provides an analysis of the problems and makes recommendations that form a basis of future actions. (*consensus*)

7. Intellectual property rights are an important incentive for the development of new health-care products. This incentive alone does not meet the need for the development of new products to fight diseases where the potential paying market is small or uncertain. (*consensus*)

8. The Doha Ministerial Declaration on the TRIPS Agreement and Public Health confirms that the agreement does not and should not prevent Members from taking measures to protect public health. The declaration, while reiterating commitment to the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), affirms that the Agreement can and should be interpreted and implemented in a manner supportive of the rights of WTO Members to protect public health and, in particular, to promote access to medicines for all. (*consensus*)

9. Article 7 of the TRIPS agreement states that "the protection and enforcement of intellectual property rights should contribute to the promotion of technological innovation into the transfer and dissemination of technology, to the mutual advantage of producers and users of technological knowledge and in a manner conducive to social and economic welfare, and to a balance of rights and obligations". (*consensus*)

10. The Universal Declaration of Human Rights provides that "everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits" and that "everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author". (*consensus*)

11. The price of medicines is one of the factors that can impede access to treatment. (*consensus*)

12. International intellectual property agreements contain flexibilities that could facilitate increased access to pharmaceutical products by developing countries. However, developing countries may face obstacles in the use of these flexibilities. These countries may benefit, inter alia, from technical assistance. (*consensus*)

The aim

13. The global strategy on public health, innovation and intellectual property aims to promote new thinking on innovation and access to medicines, as well as, based on the recommendations of the CIPIH report, provide a medium-term framework for securing an enhanced and sustainable basis for needs driven essential health research and development relevant to diseases which disproportionately affect developing countries, proposing clear objectives and priorities for R&D, and estimating funding needs in this area. (consensus)

14. The elements of the global strategy, which are designed to promote innovation, build capacity, improve access and mobilize resources, will: (consensus)

- a) provide an assessment of the public health needs of developing countries with respect to diseases that disproportionately affect developing countries and identify their R&D priorities at the national, regional and international levels (consensus)
- b) promote R&D focusing on Type II and Type III diseases and the specific R&D needs of developing countries in relation to Type I diseases¹ (consensus)
- c) build and improve innovative capacity for research and development, particularly in developing countries (consensus)
- d) improve, promote and accelerate transfer of technology between developed and developing countries as well as among developing countries (consensus)
- e) encourage and support the application and management of intellectual property in a manner that maximizes health-related innovation, especially to meet the R&D needs of developing countries, protects public health and promotes access to medicines for all, as well as explore and implement, where appropriate, possible incentive schemes for R&D (consensus)
- f) improve delivery of and access to all health products and medical devices by effectively overcoming barriers to access (consensus)
- g) secure and enhance sustainable financing mechanisms for R&D and to develop and deliver health products and medical devices to address the health needs of developing countries (consensus)
- h) develop mechanisms to monitor and evaluate the implementation of the strategy and plan of action, including reporting systems. (consensus)

The principles

15. The WHO Constitution states that “the objective of WHO shall be the attainment by all peoples of the highest possible level of health”. Accordingly, WHO shall play a strategic and central role in the

¹ For the purposes of this strategy, the definitions of Type I, II and III diseases are as referred to by the Commission on Macroeconomics and Health and as further elaborated in the CIPIH report: *Type I diseases* are incident in both rich and poor countries, with large numbers of vulnerable populations in each. *Type II diseases* are incident in both rich and poor countries, but with a substantial proportion of the cases in poor countries. *Type III diseases* are those that are overwhelmingly or exclusively incident in developing countries. The prevalence of diseases and thereby their categorization in the typology can evolve over time. (consensus)

relationship between public health and innovation and intellectual property within its mandates (including those contained in relevant WHA resolutions), capacities and constitutional objectives, bearing in mind those of other relevant intergovernmental organizations. In this context, WHO, including the regional and, when appropriate, country offices, needs to strengthen its institutional competencies and relevant programs in order to play its role in implementing this global strategy with its plan of action. *(consensus)*

16. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. *(consensus)*

17. *(deleted on consensus)*

18. [The right to health takes precedence over commercial interests]

or

[the interests of health and trade should be appropriately balanced and coordinated.]

or

[delete]

19. The promotion of technological innovation and the transfer of technology should be pursued by all states and supported by intellectual property rights. *(consensus)*

20. Intellectual property rights do not and should not prevent Member States from taking measures to protect public health. *(consensus)*

21. International negotiations on issues related to intellectual property rights and health should be coherent in their approaches to the promotion of public health. *(consensus)*

22. The strengthening of the innovative capacity of developing countries is essential to respond to the needs of public health. *(consensus)*

23. Research and development of developed countries should better reflect the health needs of developing countries. *(consensus)*

24. The Global Strategy and the Plan of Action should promote the development of health products and medical devices needed by Member States, especially developing countries, that are:

- (i) developed in an ethical manner;
- (ii) available in sufficient quantities;
- (iii) effective, safe and of good quality;
- (iv) affordable and accessible;
- (iii) used in a rational way.

(consensus)

25. Intellectual property rights are an important incentive in the development of new health care products. However, this incentive alone does not meet the need for the development of new products to fight diseases where the potential paying market is small or uncertain. (*consensus*)

26. Several factors contribute to the price of health products and medical devices, and public policies should address these factors to increase their affordability and accessibility. Among others, competition and reduction or elimination of import tariffs on these products and devices can contribute to the reduction of prices. Countries should monitor carefully supply and distribution chains and procurement practices to minimize costs that could adversely influence the price of these products and devices. (*consensus*)

The elements

Element 1. Prioritizing research and development needs

27. Health research and development policies of developed countries need to reflect adequately the health needs of developing countries. Gaps in research on Type II and Type III diseases and on the specific R&D needs of developing countries in relation to Type I diseases need to be identified urgently. A better understanding of the developing countries' health needs, and their determinants is essential to drive sustainable research and development on new and existing products. (*consensus*)

28. The actions to be taken to prioritize research and development needs are as follows:

(1.1) mapping global research and development with a view to identifying gaps in research and development on diseases that disproportionately affect developing countries (*consensus*)

(a) *develop methodologies and mechanisms to identify gaps in research on Type II and Type III diseases and on developing countries' specific R&D needs in relation to Type I diseases* (*consensus*)

(b) *disseminate information on identified gaps, and evaluate their consequences on public health* (*consensus*)

(c) *provide an assessment of identified gaps at different levels – national, regional and international – to guide research aimed at developing affordable and therapeutically sound products to meet public health needs.* (*consensus*)

(1.2) formulating explicit prioritized strategies for research and development at country and regional and interregional levels (*consensus*)

(a) *set research priorities so as to address public health needs and implement public health policy based on appropriate and regular needs assessments* (*consensus*)

(b) *conduct research appropriate for resource-poor settings and research on technologically appropriate products for addressing public health needs to combat diseases in developing countries* (*consensus*)

(c) *include research and development needs on health systems in a prioritized strategy* (*consensus*)

(d) urge the leadership and commitment of governments, regional and international organizations and the private sector in determining priorities for R&D to address public health needs (consensus)

(e) increase overall R&D efforts on diseases that disproportionately affect developing countries, leading to the development of quality products to address public health needs, user friendly (in terms of use, prescription and management) and accessible (in terms of availability and affordability). (consensus)

(1.3) encouraging research and development in traditional medicine in accordance with national priorities and legislation, and taking into account the relevant international instruments, including, as appropriate, those concerning traditional knowledge and the rights of indigenous peoples *(consensus)*

(a) set research priorities in traditional medicine (consensus)

(b) support developing countries to build their capacity in research and development in traditional medicine (consensus)

(c) promote international cooperation and the ethical conduct of research (consensus)

(d) support South–South cooperation in information exchange and research activities (consensus)

(e) support early-stage drug research and development in traditional medicine systems in developing countries. (consensus)

Element 2. Promoting research and development

29. There are many determinants of innovation capacity. Political, economic and social institutions in each country should participate in the development of health research policy, taking into consideration their own realities and needs. The range of measures to promote, coordinate and finance public and private research in both developed and developing countries into Type II and Type III diseases and into the needs of developing countries in relation to Type I diseases needs to be substantially enhanced. Greater investment, in both developed and developing countries, is essential. *(consensus)*

30. The actions to be taken to promote research and development are as follows:

(2.1) supporting governments to develop or improve national health research programmes and establish, where appropriate, strategic research networks to facilitate better coordination of stakeholders in this area *(consensus)*

(a) promote cooperation between private and public sectors on research and development (consensus)

(b) provide support for national health research programmes in developing countries through political action and, where feasible and appropriate, long-term funding (consensus)

(c) support governments in establishing health-related innovation in developing countries. (consensus)

(2.2) promoting upstream research and product development in developing countries (consensus)

(a) support discovery science, including, where feasible and appropriate, voluntary open-source methods, in order to develop a sustainable portfolio of new products (consensus)

(b) promote and improve accessibility to compound libraries through voluntary means, provide technical support to developing countries and promote access to drug leads identified through the screening of compound libraries (consensus)

(c) identify incentives and barriers, including IP-related provisions, at different levels – national, regional and international – that might affect increased research on public health, and suggest ways to facilitate access to research results and research tools (consensus)

(d) support basic and applied scientific research on Type II and Type III diseases and on the specific R&D needs of developing countries in relation to Type I diseases (consensus)

(e) support early-stage drug research and development in developing countries (consensus)

(f) build capacity to conduct clinical trials and promote public and other sources of funding for clinical trials and other mechanisms for stimulating local innovation, taking into account international ethical standards and the needs of developing countries (consensus)

(g) promote the generation, transfer, acquisition upon agreed terms, and voluntary sharing of new knowledge and technologies, consistent with national law and international agreements, to facilitate the development of new health products and medical devices to tackle the health problems of developing countries. (consensus)

(2.3) improving cooperation, participation and coordination of health and biomedical research and development (consensus)

(a) stimulate and improve global cooperation and coordination in research and development, in order to optimize resources (consensus)

(b) enhance existing fora and examine the need for new mechanisms, in order to improve the coordination and sharing of information on research and development activities (consensus)

(c) encourage further exploratory discussions on the utility of possible instruments or mechanisms for essential health and biomedical R&D, including, inter alia, an essential health and biomedical R&D treaty (consensus)

(d) support active participation of developing countries in building technological capacity (consensus)

(e) promote the active participation of developing countries in the innovation process. (consensus)

(2.4) Promoting greater access to knowledge and technology relevant to meet public health needs of developing countries *(consensus)*

(a) promote the creation and development of accessible public health libraries in order to enhance availability and use of relevant publications by universities, institutes and technical centres, especially in developing countries (consensus)

(b) promote public access to the results of government funded research, by strongly encouraging that all investigators funded by governments submit to an open access database an electronic version of their final, peer-reviewed manuscript (consensus)

(c) support the creation of voluntary open databases and compound libraries, including voluntary provision of access to drug leads identified through the screening of such compound libraries (consensus)

(d) encourage the further development and dissemination of publicly or donor-funded medical inventions and know-how through appropriate licensing policies, including but not limited to open licensing, that enhance access to innovations for development of products of relevance to the public health needs of developing countries on reasonable, affordable and non-discriminatory terms (consensus)

(e) consider, where appropriate, use of a “research exception” to address public health needs in developing countries consistent with the Agreement on Trade-Related Aspects of Intellectual Property Rights. (consensus)

(2.5) Establishing and strengthening national and regional coordinating bodies on research and development *(consensus)*

(a) develop and coordinate a research and development agenda (consensus)

(b) facilitate the dissemination and use of research and development outcomes. (consensus)

Element 3. Building and improving innovative capacity

31. There is a need to frame and develop and support effective policies that promote the development of capacities in developing countries related to health innovation. Key areas for investment are capacities relating to science and technology, local production of pharmaceuticals, clinical trials, regulation, intellectual property and traditional medicine. *(consensus)*

32. The actions to be taken to build and improve innovative capacity are as follows:

(3.1) building capacity of developing countries to meet research and development needs for health products *(consensus)*

(a) support investment by developing countries in human resources and knowledge bases, especially in education and training including in public health (consensus)

(b) support existing and new research and development groups and institutions, including regional centres of excellence, in developing countries (consensus)

(c) strengthen health surveillance and information systems. (consensus)

(3.2) Framing, developing and supporting effective policies that promote the development of capacities for health innovation *(consensus)*

(a) establish and strengthen regulatory capacity in developing countries (consensus)

(b) strengthen human resources in research and development in developing countries through long-term national capacity building plans (consensus)

(c) encourage international cooperation to develop effective policies for retention of health professionals, including researchers in developing countries (consensus)

(d) urge Member States to establish mechanisms to mitigate the adverse impact of the loss of health personnel in developing countries, particularly researchers, through migration, including by ways for both receiving and originating countries to support the strengthening of national health and research systems, in particular human resource development in the countries of origin, taking into account the work of WHO and other relevant organizations. (consensus)

(3.3) providing support for improving innovative capacity in accordance with the needs of developing countries *(consensus)*

(a) develop successful health innovation models in developing innovative capacity (consensus)

(b) intensify North–South and South–South partnerships and networks to support capacity building (consensus)

(c) establish and strengthen mechanisms for ethical review in the research and development process, including clinical trials, especially in developing countries. (consensus)

(3.4) supporting policies that will promote innovation based on traditional medicine within an evidence-based framework in accordance with national priorities and taking into account the relevant provisions of relevant international instruments *(consensus)*

(a) establish and strengthen national and regional policies to develop, support, promote traditional medicine (consensus)

(b) encourage and promote policies on innovation in the field of traditional medicine (consensus)

(c) promote standard setting to ensure the quality, safety and efficacy of traditional medicine, including by funding the research necessary to establish such standards (consensus)

(d) encourage research on mechanisms for action and pharmacokinetics of traditional medicine (consensus)

(e) *promote South–South collaboration in traditional medicine* (consensus)

(f) *formulate and disseminate guidelines on good manufacturing practices for traditional medicines and laying down evidence-based standards for quality and safety evaluation.* (consensus)

(3.5) developing and implementing, where appropriate, possible incentive schemes for health-related innovation (consensus)

(a) *encourage the establishment of award schemes for health-related innovation* (consensus)

(b) *encourage recognition of innovation for purposes of career advancement for health researchers.* (consensus)

Element 4. Transfer of technology

33. North–South and South–South development cooperation, partnerships and networks need to be supported in order to build and improve transfer of technology related to health innovation. Article 7 of the TRIPS Agreement states that the protection and the enforcement of intellectual property rights should contribute to the promotion of technological innovation and the transfer and dissemination of technology, to the mutual advantage of producers and users of technological knowledge and in a manner conducive to social and economic welfare, and to the balance of rights and obligations. (consensus)

34. The actions to be taken in relation to this element are as follows:

(4.1) promoting transfer of technology and the production of health products in developing countries (consensus)

(a) *explore possible new mechanisms and make better use of existing mechanisms to facilitate transfer of technology and technical support to build and improve innovative capacity for health-related research and development, particularly in developing countries* (consensus)

(b) *promote transfer of technology and production of health products in developing countries through investment and capacity building.*(consensus)

(c) *promote transfer of technology and production of health products in developing countries through identification of best practices, and investment and capacity building provided by developed and developing countries where appropriate.* (consensus)

(4.2) supporting improved collaboration and coordination of technology transfer for health products, bearing in mind different levels of development (consensus)

(a) *encourage North–South and South–South cooperation for technology transfers, and collaboration between institutions in developing countries and the pharmaceutical industry* (consensus)

(b) facilitate local and regional networks for collaboration on research and development and transfer of technology (consensus)

(c) continue to promote and encourage technology transfer to least-developed country members of the WTO, consistent with Article 66.2 of the Agreement on Trade-Related Aspects of Intellectual Property Rights (consensus)

(d) promote the necessary training to increase absorptive capacity for technology transfer. (consensus)

(4.3) developing possible new mechanisms to promote transfer of and access to key health-related technologies (consensus)

(a) examine the feasibility of voluntary patent pools of upstream and downstream technologies to promote innovation of and access to health products and medical devices (consensus)

(b) explore and, if feasible, develop possible new mechanisms to promote transfer of and access to key health-related technologies of relevance to public health needs of developing countries especially on Type II and III diseases and the specific R&D needs of developing countries in respect of Type I diseases, which are consistent with the provisions of the TRIPS agreement and instruments related to that agreement, which provide flexibilities to take measures to protect public health. (consensus)

Element 5. Application and management of intellectual property to contribute to innovation and promote public health

35. The international regimes on intellectual property aim, inter alia, to provide incentives for the development of new health products. However, incentive schemes for research and development, especially on Type II and Type III diseases and the specific R&D needs of developing countries in respect of Type I diseases, need to be explored and implemented, where appropriate. There is a crucial need to strengthen innovation capacity as well as capacity to manage and apply intellectual property in developing countries, including, in particular, the use to the full of the provisions in the TRIPS Agreement and instruments related to that agreement, which provide flexibilities to take measures to protect public health. (consensus)

36. The actions to be taken in relation to this element are as follows:

(5.1) supporting information sharing and capacity building in the application and management of intellectual property with respect to health-related innovation and the promotion of public health in developing countries (consensus)

(a) encourage and support the application and management of intellectual property in a manner that maximizes health-related innovation and promotes access to health products and that is consistent with the provisions in the TRIPS Agreement and other WTO instruments related to that agreement and meets the specific R&D needs of developing countries (consensus)

(b) promote and support, including through international cooperation, national and regional institutions in their efforts to build and strengthen capacity to manage and apply

intellectual property in a manner oriented to public health needs and priorities of developing countries (consensus)

(c) facilitate widespread access to, and promote further development of, including, if necessary, compiling, maintaining and updating, user-friendly global databases which contain public information on the administrative status of health-related patents, including supporting the existing efforts for determining the patent status of health products, in order to strengthen national capacities for analysis of the information contained in those databases, and improve the quality of patents (consensus)

(d) stimulate collaboration among pertinent national institutions and relevant government departments, as well as between national, regional and international institutions, in order to promote information sharing relevant to public health needs (consensus)

(e) strengthen education and training in the application and management of intellectual property, from a public health perspective taking into account the provisions contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights, including the flexibilities recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health and other WTO instruments related to the TRIPS Agreement (consensus)

(f) facilitate, where feasible and appropriate, possible access to traditional medicinal knowledge information for use as prior art in examination of patents, including, where appropriate, the inclusion of traditional medicinal knowledge information in digital libraries (consensus)

(g) promote active and effective participation of health representatives in intellectual-property-related negotiations, where appropriate, in order that such negotiations also reflect public health needs (consensus)

(h) strengthen efforts to effectively coordinate work relating to intellectual property and public health among the Secretariats and governing bodies of relevant regional and international organizations to facilitate dialogue and dissemination of information to countries. (consensus)

(5.2) providing as appropriate, upon request, in collaboration with other competent international organizations technical support, including, where appropriate, to policy processes, to countries that intend to make use of the provisions contained in the agreement on Trade-Related Aspects of Intellectual Property Rights, including the flexibilities recognized by the Doha Ministerial Declaration on the TRIPS agreement and Public Health and other WTO instruments related to the TRIPS agreement, in order to promote access to pharmaceutical products (consensus)

(a) consider, whenever necessary, adapting national legislation in order to use to the full the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS agreement), including those recognized by the Doha Declaration on TRIPS agreement and Public Health and the WTO decision of 30 August 2003 (consensus)

(b) take into account, where appropriate, the impact on public health when considering adopting or implementing more extensive intellectual property protection

than is required by the Agreement on TRIPS, without prejudice to the sovereign rights of Member States (consensus)

(c) take into account in trade agreements the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights and including those recognized by the Declaration on the TRIPS Agreement and Public Health adopted by the WTO Ministerial Conference (Doha, 2001) and the WTO decision of 30 August 2003 (consensus)

(d) consider, where appropriate, taking necessary measures in countries with manufacturing capacity to facilitate, through export, access to pharmaceutical products in countries with insufficient or no manufacturing capacity in the pharmaceutical sector in a manner consistent with the Agreement on Trade-Related Aspects of Intellectual Property Rights, the Doha Declaration on the TRIPS Agreement and Public Health and the WTO decision of 30 August 2003 (consensus)

(e) encourage finding ways, in ongoing discussions, to prevent misappropriation of health-related traditional knowledge, and consider, where appropriate, legislative and other measures to help prevent misappropriation of such traditional knowledge. (consensus)

(5.3) exploring and, where appropriate, promoting possible incentive schemes for research and development on Type II and Type III diseases and on developing countries' specific research and development needs in relation to Type I diseases (consensus)

(a) explore and, where appropriate, promote a range of incentive schemes for research and development including addressing, where appropriate, the de-linkage of the costs of research and development and the price of health products, for example through the award of prizes, with the objective of addressing diseases which disproportionately affect developing countries. (consensus)

(b) (deleted by consensus)

(c) (deleted by consensus)

(d) (deleted by consensus)

(e) (deleted by consensus)

Element 6. Improving delivery and access

37. Support for and strengthening of health systems is vital for the success of the strategy, as are the stimulation of competition and the adoption of appropriate pricing and taxation policies for health products. Mechanisms to regulate the safety, quality and efficacy of medicines and other health products, coupled with adherence to good manufacturing practices and effective supply chain management, are critical components of a well-functioning health system. (consensus)

38. International agreements that may have an impact on access to health products in developing countries need to be regularly monitored with respect to their development and application. Any flexibilities in such agreements, including those contained in the TRIPS agreement and recognized by

the Doha Declaration on the TRIPS Agreement and Public Health that would permit improved access need to be considered for action by national authorities in the light of the circumstances in their countries. The impact of such actions on innovation needs to be monitored. (consensus)

39. The actions to be taken to improve delivery and access are as follows:

(6.1) encouraging increased investment in the health-delivery infrastructure and financing of health products in order to strengthen the health system (consensus)

(a) *invest in developing health-delivery infrastructure and encourage financing of health products* (consensus)

(b) *develop effective and sustainable mechanisms in least-developed countries in order to improve access to existing medicines, acknowledging the transitional period until 2016¹* (consensus)

(c) *prioritize health care in national agendas* (consensus)

(d) *encourage health authorities to improve domestic management capacities in order to improve delivery and access to medicines and other health products with quality, efficacy, safety and affordability and, where appropriate, to develop strategies to promote rational use of medicines* (consensus)

(e) *increase investment in human resource development in the health sector* (consensus)

(f) *develop effective country poverty reduction strategies that contain clear health objectives* (consensus)

(g) *encourage pooled procurement mechanisms for health products and medical devices, where appropriate.* (consensus)

(6.2) establishing and strengthening mechanisms to improve ethical review and regulate the quality, safety and efficacy of health products and medical devices (consensus)

(a) *develop and/or strengthen the capacity of national regulatory authorities to monitor the quality, safety and efficacy of health products while sustaining ethical review standards* (consensus)

(b) *promote operational research to maximize the appropriate use of new and existing products, including cost-effective and affordable products in high disease-burden settings* (consensus)

(c) *comply with good manufacturing practices for safety standards, efficacy and quality of health products* (consensus)

(d) *strengthen the WHO prequalification programme* (consensus)

¹ In line with the extension, provided to least-developed countries, in Article 7 of the Doha Declaration on the TRIPS Agreement and Public Health.

(e) *(deleted by consensus)*

(f) *where appropriate, initiate programmed actions on regional and subregional levels with the ultimate goal of harmonization of processes employed by the regulatory authorities for drug marketing approvals (consensus)*

(g) *promote ethical principles for clinical trials involving human beings as a requirement of registration of medicines and health-related technologies, with reference to the Declaration of Helsinki, and other appropriate texts, on ethical principles for medical research involving human subjects, including good clinical practice guidelines (consensus)*

(h) *support regional networks and collaborative efforts to strengthen the regulation and implementation of clinical trials using appropriate standards for medicines evaluation and approval. (consensus)*

(6.3) *promoting competition to improve availability and affordability of health products consistent with public health policies and needs (consensus)*

(a) *support the production and introduction of generic versions, in particular of essential medicines, in developing countries, through the development of national legislation and/or policies that encourage generic production and entry, including a “regulatory exception” or “Bolar”-type provision, and which are consistent with the TRIPS Agreement and instruments related to that agreement (consensus)*

(b) *frame and implement policies to improve access to safe and effective health products, especially essential medicines, at affordable prices, consistent with international agreements (consensus)*

(c) *consider where appropriate, inter alia, the reduction or elimination of import tariffs on health products and medical devices and the monitoring of supply and distribution chains and procurement practices to minimize cost and increase access (consensus)*

(d) *encourage pharmaceutical companies and other health-related industries to consider policies, including differential pricing policies, that are conducive to promoting access to quality, safe, efficacious and affordable health products in developing countries, consistent with national law (consensus)*

(e) *consider, where appropriate, the development of policies to monitor pricing and to improve affordability of health products; further support WHO’s ongoing work on pharmaceutical pricing. (consensus)*

[(f) adopt or effectively implement competition policies in order to prevent or remedy anti-competitive practices related to the use of medicinal patents, including the use of measures that favour competition available under intellectual property law] (cross ref to potential duplication with paragraph 5.3(c))

text proposed by informal group to replace 6.3(f):

Consider, where necessary, and provided that they are consistent with the provisions of the Agreement on TRIPS [and Development Agenda adopted by WIPO], taking appropriate measures to prevent the abuse of intellectual property rights by rights

holders or the resort to practices which unreasonably restrain trade or adversely affect the international transfer of technology, in the field of health products

(g) increase information among policy makers, users, doctors and pharmacists regarding generic products. (consensus)

Element 7. Promoting sustainable financing mechanisms

40. In recent years donors have provided substantial additional financing to make health products available in developing countries through new mechanisms. Additional financing has also been secured for research and development activities relevant for the control and treatment of the diseases covered by this strategy. Nonetheless, further funding on a sustainable basis is essential to support a long-term research and development effort for products to meet the health needs of developing countries. The most serious gaps in financing for health products and research and development covered by this strategy need to be identified and analysed. (consensus)

41. It is important to make maximum use of, and complement as appropriate and feasible, current initiatives, thereby contributing to a flow of resources into innovation and implementation. (consensus)

42. The actions to be taken to promote sustainable financing mechanisms are as follows:

(7.1) endeavouring to secure adequate and sustainable financing for research and development, and improve coordination of its use, where feasible and appropriate, in order to address the health needs of developing countries (consensus)

(a) establish a results-oriented and time-limited expert working group under the auspices of WHO and linking up with other relevant groups to examine current financing and coordination of research and development, as well as proposals for new and innovative sources of financing to stimulate R&D related to Type II and Type III diseases and the specific R&D needs of developing countries in relation to Type I diseases (consensus)

(b) consider channelling additional funds to health-oriented research organizations as appropriate in both the private and public sector of developing countries and promote good financial management to maximize its effectiveness as recommended by resolution WHA58.34 (consensus)

(c) create a database of possible sources of financing for R&D. (consensus)

(7.2) facilitating the maximum use of, and complementing as appropriate, existing financing, including that through public–private and product development partnerships, in order to develop and deliver safe, effective and affordable health products and medical devices (consensus)

(a) document and disseminate best practices in public–private and product development partnerships (consensus)

(b) develop tools to periodically assess performance of public–private and product development partnerships (consensus)

(c) support public–private and product development partnerships and other appropriate research and development initiatives in developing countries. (consensus)

Element 8. Establishing monitoring and reporting systems

43. Systems should be established to monitor performance and progress of this strategy. A progress report will be submitted to the Health Assembly through the Executive Board every two years. A comprehensive evaluation of the strategy will be undertaken after four years. (consensus)

44. Steps to be taken will include:

(8.1) measuring performance and progress towards objectives contained in the strategy and plan of action (consensus)

(a) establish systems to monitor performance and progress of the implementation of each element of the Global Strategy and Plan of Action (consensus)

(b) monitor and report periodically to WHO's governing bodies on the gaps and needs related to health products and medical devices in developed and developing countries (consensus)

(c) continue to monitor, from a public health perspective, in consultation as appropriate with other international organizations, the impact of intellectual property rights and other issues addressed in the report of the Commission on Intellectual Property Rights, Innovation and Public Health, on the development of, and access to, health care products, and to report thereon to the Health Assembly (consensus)

(d) monitor and report on the impact of incentive mechanisms on innovation of and access to health products and medical devices (consensus)

(e) monitor and report on investment in research and development to address the health needs of developing countries. (consensus)

* **Stakeholder(s)**

Lead stakeholders are indicated by bold typeface.

Reference to **Governments** means WHO Member States¹ are urged to take action.

WHO means the Director-General is requested to take action.

Other International Intergovernmental Organizations, both global and regional, means WHO Member States, or WHO as mandated by its Member States through this Plan of Action, invite these Organizations to take action. The Director-General is requested to bring this Global Strategy and Plan of Action to the attention of all relevant international organizations and invite them to consider the relevant provisions of this Global Strategy and Plan of Action.

Member States are urged to raise appropriate issues in the governing bodies of the organizations.

Other relevant stakeholders means WHO Member States, or WHO as mandated by its Member States through this Plan of Action, invite these relevant actors to take action. These include inter alia, as appropriate, international and national research institutions; academia; national and regional regulatory agencies; relevant health-related industries, including both public and private; public-private partnerships; public-private and product development partnerships; nongovernmental organizations; concerned communities; development partners; charitable foundations; publishers; research and development groups; regional bodies; regional organizations. (consensus)

¹ Where applicable, also regional economic integration organizations.

Elements and sub-elements	Specific actions	Stakeholder(s)*	Time frame
Element 1. Prioritizing research and development needs			
(1.1) mapping global research and development with a view to identifying gaps in research and development on diseases that disproportionately affect developing countries (consensus)	(a) develop methodologies and mechanisms to identify gaps in research on Type II and Type III diseases and on developing countries' specific R&D needs in relation to Type I diseases (consensus)	WHO; Governments; other relevant stakeholders	2008–2015
	(b) disseminate information on identified gaps, and evaluate their consequences on public health (consensus)	WHO; Governments; other relevant stakeholders	2008–2015
	(c) provide an assessment of identified gaps at different levels – national, regional and international – to guide research aimed at developing affordable and therapeutically sound products to meet public health needs (consensus)	WHO; Governments; other relevant stakeholders	2008–2015
(1.2) formulating explicit prioritized strategies for research and development at country and regional and interregional levels (consensus)	(a) set research priorities so as to address public health needs and implement public health policy based on appropriate and regular needs assessments (consensus)	Governments; regional organizations	2008–2015
	(b) conduct research appropriate for resource-poor settings and research on technologically appropriate products for addressing public health needs to combat diseases in developing countries (consensus)	Governments; WHO; other relevant stakeholders (including academia, relevant health-related industries, national research institutions, public–private partnerships)	2008–2015

	(c) include research and development needs on health systems in a prioritized strategy (consensus)	Governments; WHO; other relevant stakeholders (including academia, national research institutions, public–private partnerships)	2008–2015
	(d) urge the leadership and commitment of governments, regional and international organizations and the private sector in determining priorities for R&D to address public health needs (consensus)	WHO ; Governments; other International Intergovernmental Organizations; other relevant stakeholders (including private sector)	2008–2015
	(e) increase overall R&D efforts on diseases that disproportionately affect developing countries, leading to the development of quality products to address public health needs, user friendly (in terms of use, prescription and management) and accessible (in terms of availability and affordability (consensus)	Governments ; WHO; other relevant stakeholders (including academia, relevant health related industries, national research institutions, public–private partnerships)	2008–2015
(1.3) encouraging research and development in traditional medicine in accordance with national priorities and legislation, and taking into account the relevant international instruments, including, as appropriate, those concerning traditional knowledge and the rights of indigenous peoples (consensus)	(a) set research priorities in traditional medicine (consensus)	Governments ; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including academia, national research institutions, public–private partnerships, concerned communities)	2008–2015

	(b) support developing countries to build their capacity in research and development in traditional medicine (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including academia, relevant health-related industries, national research institutions, public–private partnerships)	2008–2015	
	(c) promote international cooperation and the ethical conduct of research (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders	2008–2015	
	(d) support South–South cooperation in information exchange and research activities (consensus)	Governments; WHO; other International Intergovernmental Organizations; regional organizations; other relevant stakeholders	2008–2015	
	(e) support early-stage drug research and development in traditional medicine systems in developing countries (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders	2008–2015	
Elements and sub-elements		Specific actions	Stakeholder(s)*	Time frame
Element 2. Promoting research and development				
(2.1) supporting governments to develop or improve national health research programmes and establish, where appropriate, strategic research networks to facilitate better coordination of stakeholders in this area (consensus)	(a) promote cooperation between private and public sectors on research and development (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders	2008–2015	
	(b) provide support for national health research programmes in developing countries through political action and, where feasible and appropriate, long-term funding (consensus)	Governments; regional organizations; WHO (technical assistance); other relevant stakeholders	2008–2015	

	(c) support governments in establishing health-related innovation in developing countries (consensus)	Governments; regional organizations; WHO (technical assistance); other relevant stakeholders	2008–2015
(2.2) promoting upstream research and product development in developing countries (consensus)	(a) support discovery science, including, where feasible and appropriate, voluntary open-source methods, in order to develop a sustainable portfolio of new products (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders	2008–2015
	(b) promote and improve accessibility to compound libraries through voluntary means, provide technical support to developing countries and promote access to drug leads identified through the screening of compound libraries (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders	2008–2015
	(c) identify incentives and barriers, including IP-related provisions, at different levels – national, regional and international – that might affect increased research on public health, and suggest ways to facilitate access to research results and research tools (consensus)	Governments; WHO; other International Intergovernmental Organizations (including WIPO and WTO); other relevant stakeholders	2008–2015
	(d) support basic and applied scientific research on Type II and Type III diseases and on the specific R&D needs of developing countries in relation to Type I diseases (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders	2008–2015

	(e) support early-stage drug research and development in developing countries (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including relevant health-related industries, academia, international and national research institutions, donor agencies, development partners, non-governmental organizations)	2008–2015
	(f) build capacity to conduct clinical trials and promote public and other sources of funding for clinical trials and other mechanisms for stimulating local innovation, taking into account international ethical standards and the needs of developing countries (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including relevant health-related industries, academia, development partners, charitable foundations, public–private partnerships, non-governmental organizations)	2008–2015
	(g) promote the generation, transfer, acquisition upon agreed terms, and voluntary sharing of new knowledge and technologies, consistent with national law and international agreements, to facilitate the development of new health products and medical devices to tackle the health problems of developing countries (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including academia, international and national research institutions; relevant health-related industries, development partners)	

(2.3) improving cooperation, participation and coordination of health and biomedical research and development (consensus)	(a) stimulate and improve global cooperation and coordination in research and development, in order to optimize resources (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders	2008–2015
	(b) enhance existing fora and examine the need for new mechanisms, in order to improve the coordination and sharing of information on research and development activities (consensus)	Governments; WHO; other relevant stakeholders	2008–2015
	(c) encourage further exploratory discussions on the utility of possible instruments or mechanisms for essential health and biomedical R&D, including, inter alia, an essential health and biomedical R&D treaty (consensus)	Interested Governments; [WHO]; other relevant stakeholders (including nongovernmental organizations)	[2008–2010]
	(d) support active participation of developing countries in building technological capacity (consensus)	Governments; WHO; other relevant stakeholders	2008–2015
	(e) promote the active participation of developing countries in the innovation process (consensus)	Governments; WHO; other relevant stakeholders	2008–2015
(2.4) promoting greater access to knowledge and technology relevant to meet public health needs of developing countries (consensus)	(a) promote the creation and development of accessible public health libraries in order to enhance availability and use of relevant publications by universities, institutes and technical centres, especially in developing countries (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including academia, research institutions, relevant health-related industries, nongovernmental organizations, publishers)	2008–2015

	(b) promote public access to the results of government funded research, by strongly encouraging that all investigators funded by governments submit to an open access database an electronic version of their final, peer-reviewed manuscripts (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including academia, research institutions)	2008–2015
	(c) support the creation of voluntary open databases and compound libraries, including voluntary provision of access to drug leads identified through the screening of such compound libraries (consensus)	Governments; WHO; other International Intergovernmental Organizations (including WIPO); other relevant stakeholders (including relevant health-related industries)	2008–2015
	(d) encourage the further development and dissemination of publicly or donor-funded medical inventions and know-how through appropriate licensing policies, including but not limited to open licensing, that enhance access to innovations for development of products of relevance to the public health needs of developing countries on reasonable, affordable and non-discriminatory terms (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including academia, national research institutions)	2008–2015
	(e) consider, where appropriate, use of a “research exception” to address public health needs in developing countries consistent with the Agreement on Trade-Related Aspects of Intellectual Property Rights (consensus)	Governments	

(2.5) establishing and strengthening national and regional coordinating bodies on research and development (consensus)	(a) develop and coordinate a research and development agenda (consensus)	Governments; regional organizations; WHO; other relevant stakeholders	2008–2015
	(b) facilitate the dissemination and use of research and development outcomes (consensus)	Governments; regional organizations; WHO; other relevant stakeholders	2008–2015
Elements and sub-elements	Specific actions	Stakeholder(s)*	Time frame
Element 3. Building and improving innovative capacity			
(3.1) building capacity of developing countries to meet research and development needs for health products (consensus)	(a) support investment by developing countries in human resources and knowledge bases, especially in education and training including in public health (consensus)	Governments; other International Intergovernmental Organizations; other relevant stakeholders (including development partners)	2008–2015
	(b) support existing and new research and development groups and institutions, including regional centres of excellence, in developing countries (consensus)	Governments; other International Intergovernmental Organizations; other relevant stakeholders (including research and development groups, relevant health-related industries, development partners)	2008–2015
	(c) strengthen health surveillance and information systems (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including nongovernmental organizations, research institutions, academia)	2008–2015
(3.2) framing, developing and supporting effective policies that promote the development of capacities for health innovation (consensus)	(a) establish and strengthen regulatory capacity in developing countries (consensus)	Governments; WHO; other relevant stakeholders (including national and regional regulatory agencies)	2008–2015

	(b) strengthen human resources in research and development in developing countries through long-term national capacity building plans (consensus)	Governments ; other International Intergovernmental Organizations; other relevant stakeholders (including development partners, international and national research institutions)	2008–2015
	(c) encourage international cooperation to develop effective policies for retention of health professionals, including researchers in developing countries (consensus)	Governments; WHO ; other International Intergovernmental Organizations (including IOM and ILO); other relevant stakeholders	2008–2015
	(d) urge Member States to establish mechanisms to mitigate the adverse impact of the loss of health personnel in developing countries, particularly researchers, through migration, including by ways for both receiving and originating countries to support the strengthening of national health and research systems, in particular human resource development in the countries of origin, taking into account the work of WHO and other relevant organizations (consensus)	[Governments]	2008–2015

(3.3) providing support for improving innovative capacity in accordance with the needs of developing countries (consensus)	(a) develop successful health innovation models in developing innovative capacity (consensus)	Governments; WHO; other International Intergovernmental Organizations (including WIPO, OECD and UNCTAD); other relevant stakeholders (including academia, research institutions, health-related industries, developmental partners)	2008–2015
	(b) intensify North–South and South–South partnerships and networks to support capacity building (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including academia, research institutions, relevant health-related industries)	2008–2015
	(c) establish and strengthen mechanisms for ethical review in the research and development process, including clinical trials, especially in developing countries (consensus)	Governments; WHO; other relevant stakeholders (including academia, research institutions)	2008–2015
(3.4) supporting policies that will promote innovation based on traditional medicine within an evidence-based framework in accordance with national priorities and taking into account the relevant provisions of relevant international instruments (consensus)	(a) establish and strengthen national and regional policies to develop, support, promote traditional medicine (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including concerned communities)	2008–2015
	(b) encourage and promote policies on innovation in the field of traditional medicine (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including international and national research institutions, concerned communities)	

	(c) promote standard setting to ensure the quality, safety and efficacy of traditional medicine, including by funding the research necessary to establish such standards (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including national and regional regulatory agencies, international and national research institutions, development partners, concerned communities)	
	(d) encourage research on mechanisms for action and pharmacokinetics of traditional medicine (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including academia, international and national research institution, relevant health-related industries, concerned communities)	
	(e) promote South–South collaboration in traditional medicine (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including research institutions, regional bodies, academia)	2008–2015
	(f) formulate and disseminate guidelines on good manufacturing practices for traditional medicines and laying down evidence-based standards for quality and safety evaluation (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including national and regional regulatory agencies, relevant health-related industries)	2008–2015

(3.5) developing and implementing, where appropriate, possible incentive schemes for health-related innovation (consensus)	(a) encourage the establishment of award schemes for health-related innovation (consensus)	Governments; [WHO]/[WHO]/[WHO]; other International Intergovernmental Organizations [(including WIPO)]; other relevant stakeholders (including academia, international and national research institutions, development partners, charitable foundations)	
	(b) encourage recognition of innovation for purposes of career advancement for health researchers (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including academia, international and national research institutions, development partners, charitable foundations)	
Elements and sub-elements	Specific actions	Stakeholder(s)*	Time frame
Element 4. Transfer of technology			
(4.1) promoting transfer of technology and the production of health products in developing countries (consensus)	(a) explore possible new mechanisms and make better use of existing mechanisms to facilitate transfer of technology and technical support to build and improve innovative capacity for health-related research and development, particularly in developing countries (consensus)	Governments; WHO; other International Intergovernmental Organizations (including WTO, UNCTAD, UNIDO, WIPO); other relevant stakeholders (including international and national research institutions, relevant health-related industries)	
	(b) promote transfer of technology and production of health products in developing countries through investment and capacity building (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including health-related industries)	

	(c) promote transfer of technology and production of health products in developing countries through identification of best practices, and investment and capacity building provided by developed and developing countries where appropriate (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including relevant health-related industries, academia, nongovernmental organizations, development partners, charitable foundations)	2008–2015
(4.2) supporting improved collaboration and coordination of technology transfer for health products, bearing in mind different levels of development (consensus)	(a) encourage North–South and South–South cooperation for technology transfers, and collaboration between institutions in developing countries and the pharmaceutical industry (consensus)	Governments; WHO; other International Intergovernmental Organizations (including WIPO); other relevant stakeholders (including relevant health-related industries, international and national research institutions, academia, nongovernmental organizations, development partners)	2008–2015
	(b) facilitate local and regional networks for collaboration on research and development and transfer of technology (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including relevant health-related industries, national research institutions, academia, nongovernmental organizations)	2008–2015
	(c) continue to promote and encourage technology transfer to least-developed country members of the WTO, consistent with Article 66.2 of the Agreement on Trade-Related Aspects of Intellectual Property Rights (consensus)	Governments	2008–2015

	(d) promote the necessary training to increase absorptive capacity for technology transfer (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including research institutions)	2008–2015
(4.3) developing possible new mechanisms to promote transfer of and access to key health-related technologies (consensus)	(a) examine the feasibility of voluntary patent pools of upstream and downstream technologies to promote innovation of and access to health products and medical devices (consensus)	Governments; WHO/[WHO]; other International Intergovernmental Organizations (including WIPO); other relevant stakeholders (including international and national research institutions, relevant health-related industries, nongovernmental organizations, academia)	
	(b) explore and, if feasible, develop possible new mechanisms to promote transfer of and access to key health-related technologies of relevance to public health needs of developing countries especially on Type II and III diseases and the specific R&D needs of developing countries in respect of Type I diseases, which are consistent with the provisions of the TRIPS agreement and instruments related to that agreement, which provide flexibilities to take measures to protect public health (consensus)	Governments; WHO; other International Intergovernmental Organizations (including WIPO, WTO); other relevant stakeholders (including health-related industries)	

Elements and sub-elements	Specific actions	Stakeholder(s)*	Time frame
Element 5. Application and Management of intellectual property to contribute to innovation and promote public health (consensus)			
(5.1) support information sharing and capacity building in the application and management of intellectual property with respect to health-related innovation and the promotion of public health in developing countries (consensus)	(a) encourage and support the application and management of intellectual property in a manner that maximizes health-related innovation and promotes access to health products and that is consistent with the provisions in the TRIPS Agreement and other WTO instruments related to that agreement and meets the specific R&D needs of developing countries (consensus)	<p>[Governments; WHO; other International Intergovernmental Organizations (including WIPO, WTO, UNCTAD); other relevant stakeholders (including international and national research institutions development partners)]</p> <p>[Governments; WHO; other International Intergovernmental Organizations (including WIPO, WTO, UNCTAD); other relevant stakeholders (including international and national research institutions, development partners)]</p>	

	(b) promote and support, including through international cooperation, national and regional institutions in their efforts to build and strengthen capacity to manage and apply intellectual property in a manner oriented to public health needs and priorities of developing countries (consensus)	Governments; WHO/[WHO]; other International Intergovernmental Organizations (including [WIPO]/[WIPO] , [WTO]/[WTO] , UNCTAD; other relevant stakeholders (including international and national research institutions, development partners)	
	(c) Facilitate widespread access to, and promote further development of, including, if necessary, compiling, maintaining and updating, user-friendly global databases which contain public information on the administrative status of health-related patents, including supporting the existing efforts for determining the patent status of health products, in order to strengthen national capacities for analysis of the information contained in those databases, and improve the quality of patents (consensus)	[Governments]/[Governments]; [WHO]/[WHO]; other International Intergovernmental Organizations (including [WIPO]/[WIPO] , [WTO]/[WTO] , [UNCTAD] ; other relevant stakeholders (including international and national research institutions, development partners)]	
	(d) stimulate collaboration among pertinent national institutions and relevant government departments, as well as between national, regional and international institutions, in order to promote information sharing relevant to public health needs (consensus)	Governments; WHO; Other International Intergovernmental Organizations [(including WIPO and WTO)]; other relevant stakeholders (including academia, international and national research institutions, development agencies, nongovernmental organizations, relevant health-related industries)	

	(e) strengthen education and training in the application and management of intellectual property, from a public health perspective taking into account the provisions contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights, including the flexibilities recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health and other WTO instruments related to the TRIPS Agreement (consensus)	Governments; [WHO]/[WHO] ; other International Intergovernmental Organizations (including [WIPO]/[WIPO] , [WTO]/[WTO] , [UNCTAD]/[UNCTAD]); other relevant stakeholders (including international and national research institutions, development partners)	
	(f) facilitate, where feasible and appropriate, possible access to traditional medicinal knowledge information for use as prior art in examination of patents, including, where appropriate, the inclusion of traditional medicinal knowledge information in digital libraries. (consensus)	Governments; WHO ; other International Intergovernmental Organizations [(including WIPO, WTO)]; other relevant stakeholders (including concerned communities)	
	(g) promote active and effective participation of health representatives in intellectual-property-related negotiations, where appropriate, in order that such negotiations also reflect public health needs (consensus)	Governments	

	(h) strengthen efforts to effectively coordinate work relating to intellectual property and public health among the Secretariats and governing bodies of relevant regional and international organizations to facilitate dialogue and dissemination of information to countries (consensus)	Governments; WHO; other International Intergovernmental Organizations (including WIPO, WTO and UNCTAD)	
(5.2) providing as appropriate, upon request, in collaboration with other competent international organizations technical support, including, where appropriate, to policy processes, to countries that intend to make use of the provisions contained in the agreement on Trade-Related Aspects of Intellectual Property Rights, including the flexibilities recognized by the Doha Ministerial Declaration on the TRIPS agreement and Public Health and other WTO instruments related to the TRIPS agreement, in order to promote access to pharmaceutical products (consensus)	(a) consider, whenever necessary, adapting national legislation in order to use to the full the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS agreement), including those recognized by the Doha Declaration on TRIPS agreement and Public Health and the WTO decision of 30 August 2003 (consensus)	Governments; WHO; Other International Intergovernmental Organizations (including WIPO, WTO and UNCTAD)	
	(b) Take into account, where appropriate, the impact on public health when considering adopting or implementing more extensive intellectual property protection than is required by the Agreement on TRIPS, without prejudice to the sovereign rights Member States (consensus)	Governments; [WHO; Other International Intergovernmental Organizations (including WIPO, WTO and UNCTAD)]	
	(c) take into account in trade agreements the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights and including those recognized by the	Governments	

	Declaration on the TRIPS Agreement and Public Health adopted by the WTO Ministerial Conference (Doha, 2001) and the WTO decision of 30 August 2003 (consensus)		
	(d) consider, where appropriate, taking necessary measures in countries with manufacturing capacity to facilitate, through export, access to pharmaceutical products in countries with insufficient or no manufacturing capacity in the pharmaceutical sector in a manner consistent with the Agreement on Trade-Related Aspects of Intellectual Property Rights, the Doha Declaration on the TRIPS Agreement and Public Health and the WTO decision of 30 August 2003 (consensus)	Governments	
	(e) encourage finding ways, in ongoing discussions, to prevent misappropriation of health-related traditional knowledge, and consider, where appropriate, legislative and other measures to help prevent misappropriation of such traditional knowledge (consensus)	Governments; WHO; other International Intergovernmental Organizations (including WIPO, WTO, UNEP); other relevant stakeholders (including concerned communities)	
(5.3) exploring and, where appropriate, promoting possible incentive schemes for research and development on Type II and Type III diseases and on developing countries' specific research and development needs in relation to Type I diseases (consensus)	(a) explore and, where appropriate, promote a range of incentive schemes for research and development including addressing,	[Governments; [WHO]/[WHO]; other International Intergovernmental Organizations; other relevant	

	where appropriate, the de-linkage of the costs of research and development and the price of health products, for example through the award of prizes, with the objective of addressing diseases which disproportionately affect developing countries (consensus)	stakeholders (including international and national research institutions, development partners, charitable foundations, relevant health-related industries, nongovernmental organizations)]	
Elements and sub-elements	Specific actions	Stakeholder(s)*	Time frame
Element 6. Improving delivery and access (consensus)			
(6.1) encouraging increased investment in the health-delivery infrastructure and financing of health products in order to strengthen the health system (consensus)	(a) invest in developing health-delivery infrastructure and encourage financing of health products (consensus)	Governments; WHO; other International Intergovernmental organizations; other relevant stakeholders (including development partners, charitable foundations, private sector, relevant health-related industries)	
	(b) develop effective and sustainable mechanisms in least-developed countries in order to improve access to existing medicines, acknowledging the transitional period until 2016 ¹ (consensus)	Governments; WHO; other international intergovernmental organizations (including WTO); other relevant stakeholders	
	(c) prioritize health care in national agendas (consensus)	Governments	2008–2015

¹ In line with the extension, provided to least-developed countries, in Article 7 of the Doha Declaration on the TRIPS Agreement and Public Health.

	(d) encourage health authorities to improve domestic management capacities in order to improve delivery and access to medicines and other health products with quality, efficacy, safety and affordability and, where appropriate, to develop strategies to promote rational use of medicines. (consensus)	Governments; WHO	
	(e) increase investment in human resource development in the health sector (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including development partners, nongovernmental organizations, charitable foundations)	2008–2015
	(f) develop effective country poverty reduction strategies that contain clear health objectives (consensus)	Governments; other relevant stakeholders (including development partners)	2008–2015
	(g) encourage pooled procurement mechanisms for health products and medical devices, where appropriate (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders	
(6.2) establishing and strengthening mechanisms to improve ethical review and regulate the quality, safety and efficacy of health products and medical devices (consensus)	(a) develop and/or strengthen the capacity of national regulatory authorities to monitor the quality, safety and efficacy of health products while sustaining ethical review standards (consensus)	Governments; WHO; other relevant stakeholders (including national and regional regulatory agencies, development partners)	

	(b) promote operational research to maximize the appropriate use of new and existing products, including cost-effective and affordable products in high disease-burden settings (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including international and national research institutions, nongovernmental organizations, development partners, charitable foundations)	
	(c) comply with good manufacturing practices for safety standards, efficacy and quality of health products (consensus)	Governments; WHO; other relevant stakeholders (including national regulatory bodies, relevant health-related industries, development partners)	2008–2015
	(d) strengthen the WHO prequalification programme (consensus)	Governments; WHO , other International Intergovernmental Organizations; other relevant stakeholders (including development partners)	
	(f) where appropriate, initiate programmed actions on regional and subregional levels with the ultimate goal of harmonization of processes employed by the regulatory authorities for drug marketing approvals (consensus)	Governments; [WHO]/[WHO]; other relevant stakeholders (including national and regional regulatory agencies, regional bodies, development partners)	

	(g) promote ethical principles for clinical trials involving human beings as a requirement of registration of medicines and health-related technologies, with reference to the Declaration of Helsinki, and other appropriate texts, on ethical principles for medical research involving human subjects, including good clinical practice guidelines (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including national and regional regulatory agencies)	
	(h) support regional networks and collaborative efforts to strengthen the regulation and implementation of clinical trials using appropriate standards for medicines evaluation and approval (consensus)	Governments; WHO; other relevant stakeholders (including national and regional regulatory agencies, international and national research institutions, regional bodies, development partners)	
(6.3) promoting competition to improve availability and affordability of health products consistent with public health policies and needs (consensus)	(a) support the production and introduction of generic versions, in particular of essential medicines, in developing countries, through the development of national legislation and/or policies that encourage generic production and entry, including a “regulatory exception” or “Bolar”-type provision, and which are consistent with the TRIPS Agreement and instruments related to that agreement (consensus)	Governments	
	(b) frame and implement policies to improve access to safe and effective health products, especially essential medicines, at affordable prices, consistent with international agreements (consensus)	Governments; [WHO]/[WHO]; [other international intergovernmental organizations (including WTO and WIPO)]; other relevant stakeholders	

	(c) consider where appropriate, inter alia, the reduction or elimination of import tariffs on health products and medical devices and the monitoring of supply and distribution chains and procurement practices to minimize cost and increase access (consensus)	Governments	
	(d) encourage pharmaceutical companies and other health-related industries to consider policies, including differential pricing policies, that are conducive to promoting access to quality, safe, efficacious and affordable health products in developing countries, consistent with national law (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including relevant health-related industries)	
	(e) consider, where appropriate, the development of policies to monitor pricing and to improve affordability of health products; further support WHO's ongoing work on pharmaceutical pricing (consensus)	Governments	
	(g) increase information among policy makers, users, doctors and pharmacists regarding generic products (consensus)	Governments; WHO other relevant stakeholders (including nongovernmental organizations, relevant health related industry)	

Elements and sub-elements	Specific actions	Stakeholder(s)*	Time frame
Element 7. Promoting sustainable financing mechanisms (consensus)			
(7.1) endeavouring to secure adequate and sustainable financing for research and development, and improve coordination of its use, where feasible and appropriate, in order to address the health needs of developing countries (consensus)	(a) establish a results-oriented and time-limited expert working group under the auspices of WHO and linking up with other relevant groups to examine current financing and coordination of research and development, as well as proposals for new and innovative sources of financing to stimulate R&D related to Type II and Type III diseases and the specific R&D needs of developing countries in relation to Type I diseases (consensus)	Governments; WHO ; other International Intergovernmental Organizations; other relevant stakeholders	
	(b) consider channelling additional funds to health-oriented research organizations as appropriate in both the private and public sector of developing countries and promote good financial management to maximize its effectiveness as recommended by the resolution WHA 58.34 (consensus)	Governments ; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including development partners, charitable foundations, international and national research institutions, academia, private sector, relevant health-related industries)	
	(c) create a database of possible sources of financing for R&D (consensus)	Governments ; WHO ; other relevant stakeholders	
(7.2) facilitating the maximum use of, and complementing as appropriate, existing financing, including that through public-private and product development partnerships, in order to develop and deliver safe, effective and affordable health products and medical devices (consensus)	(a) document and disseminate best practices in public-private and product development partnerships (consensus)	Governments; WHO ; other relevant stakeholders (including research institutions, public-private and product development partnerships)	2008–2015

	(b) develop tools to periodically assess performance of public–private and product development partnerships (consensus)	Governments; WHO ; other relevant stakeholders (including research institutions, public–private and product development partnerships, charitable foundations)	2008–2009
	(c) support public–private and product development partnerships and other appropriate research and development initiatives in developing countries (consensus)	Governments; WHO; other International Intergovernmental Organizations; other relevant stakeholders (including relevant health-related industries, charitable foundations, development partners, nongovernmental organizations, academia, research institutions)	2008–2015
Elements and sub-elements	Specific actions	Stakeholder(s)*	Time frame
Element 8. Establishing monitoring and reporting systems			
(8.1) measuring performance and progress towards objectives contained in the strategy and plan of action (consensus)	(a) establish systems to monitor performance and progress of the implementation of each element of the Global Strategy and Plan of Action (consensus)	Governments; WHO	From 2009
	(b) monitor and report periodically to WHO's governing bodies on the gaps and needs related to health products and medical devices in developed and developing countries (consensus)	Governments; WHO	[From 2009]
	(c) to continue to monitor, from a public health perspective, in consultation as appropriate with other international organizations, the impact of intellectual property	Governments; WHO ; other International Intergovernmental Organizations (including WIPO and WTO); other relevant stakeholders	

	rights and other issues addressed in the report of the Commission on Intellectual Property Rights, Innovation and Public Health, on the development of, and access to, health care products, and to report thereon to the Health Assembly (consensus)		
	(d) monitor and report on the impact of incentive mechanisms on innovation of and access to health products and medical devices (consensus)	Governments; WHO; other International Intergovernmental Organizations (including WIPO and WTO); other relevant stakeholders	
	(e) monitor and report on investment in research and development to address the health needs of developing countries (consensus)	Governments; WHO; other relevant stakeholders	

A global responsibility for action: (deleted by consensus)

Dr VIROJ TANGCHAROENSATHIEN (Thailand) continued by explaining the changes made by the drafting group. In the draft global strategy outstanding issues remained in paragraphs 18 and 39 (6.3)(f).

In the draft plan of action (Annex 1) paragraph 3.2(d), the square brackets had been removed around the word “Governments” in the “Stakeholder” column. In paragraph 4.3(a), it had been agreed to delete the bracketed reference to “WHO” in bold type, and to retain the mention of WHO in the Stakeholder column. In paragraph 5.1(d), the drafting group had agreed to delete the phrase “[including WIPO and WTO]” in the Stakeholder column. In paragraph 5.1(f), the text in the Stakeholder column, “WHO; other International Intergovernmental Organizations [(including WIPO, WTO)]; other relevant stakeholders, including” had been placed in square brackets, pending a decision whether to delete it. In paragraph 6.3(b), it had been agreed to retain WHO as a stakeholder. The bold-type reference to WHO had therefore been deleted, and the square brackets around the text “other international intergovernmental organizations (including WTO and WIPO)” had also been removed. Paragraph 6.3(f) was missing because no consensus had yet been reached on the text. If the Committee decided to retain that paragraph, the drafting group was proposing that Governments should be the only stakeholders.

The text of the draft resolution itself would have to be considered once consensus had been reached on the draft global strategy and plan of action.

The CHAIRMAN invited members of the Committee to comment first on the draft global strategy and plan of action.

Dr SILBERSCHMIDT (Switzerland) asked if the Legal Counsel could explain the implications of approving text in which some portions remained in square brackets.

Mr BURCI (Legal Counsel) said that, if the Committee could not reach consensus on the entire text, it would be clear that the bracketed text had not been agreed upon. That would leave two options: either to continue working on the document, defer its approval until the following year and devise a process for solving the outstanding problems; or for the Health Assembly to adopt those parts of the global strategy and plan of action on which agreement had been reached. That would imply either referring the parts still in brackets to the governing bodies in 2009, or resolving the outstanding issues in time for the remaining part of the text to be approved by the governing bodies in 2009.

Mrs VELÁSQUEZ DE VISUAL (Bolivarian Republic of Venezuela) said that discussion of the topic covered in paragraph 18 was far from over. However, the drafting group’s important work and a spirit of compromise had brought her delegation to join the agreements reached in the negotiations. Given that the right to health took precedence over commercial interests, the issue should remain on the Organization’s agenda. Speaking also on behalf of Argentina, Bolivia, Cuba, Dominican Republic, Ecuador, Honduras and Nicaragua, she asked for it to be placed on record that the draft global strategy and plan of action contained innovative elements, including texts of great significance to human rights in the context of poverty and social exclusion for millions of people, as paragraph 2 of the document made clear. The delegations she had named had participated actively in the negotiations on the text, and emphasized health as part of the right to life, and its precedence over commercial interests. WHO was the natural forum in which to acknowledge that. No consensus had been reached on the version of paragraph 18 proposed in that light, although the proposal reflected the principles of the Organization as enshrined in its Constitution. She supported the draft global strategy and plan of action, and encouraged the Committee to approve it. The Organization’s future work on public health should focus on the issues arising in connection with intellectual property.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) asked how the delegate of Venezuela would suggest proceeding with paragraph 18 of the draft global strategy.

Mrs VELÁSQUEZ DE VISUAL (Bolivarian Republic of Venezuela) said that her delegation and the other delegations she had mentioned agreed to withdraw their proposal for paragraph 18 and to allow the draft strategy to be approved without it, on the understanding that the question remained open.

Mrs BAQUERIZO GUZMÁN (Ecuador) supported the deletion of paragraph 18. Turning to paragraph 39 (6.3)(f) of the draft global strategy, she intended, for the sake of compromise, to withdraw the phrase “[*and Development Agenda adopted by WIPO*]”, proposed by her delegation in the text drafted by the informal group.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) said that the text drafted by the informal drafting group would therefore be retained, without the text added by the delegation of Ecuador, and the original version of the paragraph would be deleted.

Mrs VELÁSQUEZ DE VISUAL (Bolivarian Republic of Venezuela) enquired what decision the Committee would make on paragraph 18.

The CHAIRMAN said that he took it that there were no objections to deleting paragraph 18.

It was so agreed.

Dr LEVENTHAL (Israel) explained that, as many delegates had not been involved in the drafting groups, discussion might continue for some time yet. The importance of the document being discussed might, he suggested, warrant either referring it to the Executive Board and subsequent discussion at the Sixty-second World Health Assembly or continuing the discussion in the month ahead in order to elucidate all points.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) confirmed that the Committee had reached consensus on the draft global strategy, and he listed the outstanding elements in square brackets in the draft plan of action.

Mrs VELÁSQUEZ DE VISUAL (Bolivarian Republic of Venezuela) asked that her country's reservation on element 5.1(f), expressed during the Intergovernmental Working Group in April, be placed on record. There was a contradiction between the text adopted and Article 124 of her country's Constitution, and the text seemed to imply the promotion of an inappropriate use of traditional medicinal knowledge information. She agreed with the principle of approving the document by consensus.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) explained that the text referred to by Venezuela was still in square brackets and that the Member State had wanted to remove the text in square brackets because it conflicted with its Constitution.

Mrs VELÁSQUEZ DE VISUAL (Bolivarian Republic of Venezuela) stated that the primary stakeholders in traditional medicinal knowledge should be national governments and the communities directly affected by decisions on the issue.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) recommended that consensus be sought to approve the draft plan of action with the outstanding elements in square brackets and asked for suggestions on how to resolve those elements in the future.

Dr SILBERSCHMIDT (Switzerland) proposed amendments to the draft resolution in order to achieve approval by consensus. He would prefer to see all outstanding issues resolved by the Committee at the current meeting. He suggested amendments to be used in the event of failure to agree

on the outstanding elements in square brackets. Paragraph 1 would be amended to read “adopts the global strategy and the agreed parts of the plan of action ...”; the chapeau of paragraph 4 would be amended to read “requests the Director-General, with regard to paragraphs of the plan of action where the role of WHO as stakeholder has been agreed upon ...”; and subparagraph 4(3) would be amended to read “to finalize urgently the outstanding components of the plan of action, concerning time frames, progress indicators and estimated funding needs, and to submit the final plan of action, including the open paragraphs on stakeholders, for consideration by ...”. His proposed amendments would ensure that the standard WHO procedure to conclude work would be used rather than a renewal of intergovernmental discussions.

Dr GASHUT (Libyan Arab Jamahiriya), speaking on behalf of the Member States of the Eastern Mediterranean Region, encouraged the Committee to reach agreement on the outstanding elements in square brackets. If not, her country supported the amendments proposed by the delegate of Switzerland. She supported approval of the draft global strategy and of the parts of the plan of action that had been agreed on.

Mr BENTO ALCÁZAR (Brazil) rejected the amendments proposed by the delegate of Switzerland. The last chance to reach agreement on the outstanding elements in square brackets might be in plenary; meanwhile, he favoured approving the draft resolution without amendments.

Mrs BAQUERIZO GUZMÁN (Ecuador) supported the approval of the global strategy and agreed that consensus should be sought on the plan of action.

The DIRECTOR-GENERAL thanked Member States for their hard work and tenacity. She understood that the Committee had reached consensus on the global strategy, and on the plan of action with the exception of the outstanding elements in square brackets. The delegate of Brazil had suggested that the Committee should approve the draft resolution, without amendments, and that, during the move from the room where Committee A was being held to the room where the plenary was to be held, the outstanding elements in square brackets would be agreed upon and, in plenary, Member States would give final approval to the draft resolution.

Mr BENTO ALCÁZAR (Brazil) asked for clarification that the Committee was considering the draft resolution, without amendments.

Mr HOHMAN (United States of America) sought an assurance that, if the Committee approved the draft resolution without amendments, it could still be amended in plenary.

Dr SILBERSCHMIDT (Switzerland) said that, if the draft resolution was approved without any final agreement on the outstanding elements in square brackets, his country would propose the same amendments to the draft resolution in plenary.

Mrs MUGO (Kenya), speaking on behalf of the Member States of the African Region, supported the amendments proposed by the delegate of Switzerland and commended Member States' flexibility.

Dr GWENIGALE (Liberia) confirmed his support for the amendments proposed by the delegate of Switzerland.

Mr TRAMPOSCH (Slovenia), speaking on behalf of the European Union, endorsed the statement made on behalf of the African Region and supported the amendments to the draft resolution proposed by the delegate of Switzerland.

Mr ROTTINGEN (Norway) expressed support in principle for the amendments to the draft resolution suggested by the delegate of Switzerland, but hoped that agreement could still be reached on the outstanding elements.

Mr BENTO ALCÁZAR (Brazil) suggested that the Committee should approve the draft resolution as proposed by the drafting group and conclude its work. If necessary, the draft resolution could then be amended by the Health Assembly in plenary.

Mr TRAMPOSCH (Slovenia), speaking on behalf of the Member States of the European Union, asked whether the draft resolution could definitely be amended in plenary.

Mr BURCI (Legal Counsel) confirmed that plenary sessions of the Health Assembly had full authority to adopt, reject or amend draft resolutions approved and submitted to them by subsidiary bodies, which included Committee A. In reply to Mr HOHMAN (United States of America), he said that the draft global strategy and plan of action could indeed also be amended in plenary as it would be annexed to, and therefore form an integral part of, the draft resolution.

Dr SILBERSCHMIDT (Switzerland) expressed the view that to follow the suggestion by the delegate of Brazil and approve the draft resolution without agreeing on all aspects of the instruments contained in its annexes would set a worrying precedent. He suggested instead that the draft resolution be approved with the amendments he had proposed, which could then be deleted, if appropriate, during consideration of the draft resolution in plenary.

Mr BENTO ALCÁZAR (Brazil) agreed with the suggestion made by the delegate of Switzerland.

The draft resolution, as amended, was approved.¹

Mrs NAVARRO (Bolivia), speaking also on behalf of Barbados, said that the expert working group should be able to consider proposals for new incentive schemes to stimulate research and development. Barbados and Bolivia reserved the right to present proposals to the expert group and considered that the draft resolution just approved should be read in the light of that understanding.

(For resumption of the discussion, see section 6.)

5. FIFTH REPORT OF COMMITTEE A (Document A61/50)

Dr PARIRENYATWA (Zimbabwe), Rapporteur, read out the draft fifth report of Committee A.

The report was adopted.²

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted, as amended in plenary, in resolution WHA61.21.

² See page 257.

6. TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (resumed)**Public health, innovation and intellectual property: draft global strategy and plan of action:**
Item 11.6 of the Agenda (Document A61/9) (resumed)

Mrs BAQUERIZO GUZMÁN (Ecuador), speaking on behalf of the Member States of the Region of the Americas, expressed satisfaction that the draft resolution on the global strategy and plan of action on public health, innovation and intellectual property had been approved and thanked all those involved. In reaffirming health and human rights, she said that implementation of the strategy and plan would contribute to achieving the aims of the 1978 Declaration of Alma-Ata.

Mr ECHEVERRY VÁSQUEZ (Colombia) commended the progress made by the Intergovernmental Working Group and the consensus reached during the Sixty-first World Health Assembly. The draft global strategy should benefit his country in research and development, health innovation, technology transfer and access to health products. He emphasized quality of and access to medicines, and the possible future production of medicines specific to the needs of developing countries. He therefore expressed support for stimulating competition and policies on anticompetitive practices, market-adjusted prices, and access to products.

The draft global strategy was consistent with the Doha Declaration on the TRIPS Agreement and Public Health with regard to protection for the life and rights of patients, placing public health considerations above commercial and intellectual property rights. States could contribute to building consensus by representing neither other States nor the interests of any particular sector of civil society. They must defend the poorest in society and those not enjoying access to health care. Implementing the global strategy and plan of action would require coordinated efforts between WHO, WIPO and WTO.

Mrs MUGO (Kenya), speaking on behalf of the Member States of the African Region, said that the draft global strategy acknowledged that better understanding of developing countries' health needs and determinants was essential to sustainable research and development on new and existing products. She stressed policies that enhanced health innovation in developing countries, North–South and South–South cooperation, and support for partnerships in order to build and improve technology transfer related to health innovation.

Supporting and strengthening health systems, stimulating competition and adopting appropriate pricing and taxation policies for health products were vital. The application of international agreements that affected access to health products in developing countries should be regularly monitored.

The Commission on Intellectual Property Rights, Innovation and Public Health had strongly endorsed the need for more research resources, for new funds and approaches relevant to developing countries. A sustainable financing mechanism was needed in order to achieve the goals of the draft global strategy and plan of action. Without innovative financing and better coherence, the Intergovernmental Working Group would have failed Africa.

Africa welcomed the recommendation concerning the expert working group that would examine financing and coordination of research and development. The Member States of the African Region supported the draft resolution and would support implementation of the global strategy and plan of action. She called upon WHO and relevant international organizations and bodies to prioritize the global strategy, and launch activities as soon as possible.

7. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of the Committee completed.

The meeting rose at 14:05.