

COMMITTEE B

FIRST MEETING

Wednesday, 21 May 2008, at 14:40

Chairman: Dr A.R. SICATO (Angola)

1. OPENING OF THE COMMITTEE: Item 12 of the Agenda (Document A61/38)

The CHAIRMAN welcomed participants and introduced Dr Sadasivan, Dr Gwenigale and Dr Jaksons, who would attend the Committee's meetings in their capacity as members of the Executive Board. Any views expressed would therefore be those of the Board, not of their national governments.

He drew attention to the third report of the Committee on Nominations,¹ which contained proposals for the posts of Vice-Chairmen and Rapporteur.

Decision: Committee B elected Dr N. El-Sayed (Egypt) and Dr R. Daniel (Cook Islands) as Vice-Chairmen and Dr W. Jayantha (Sri Lanka) as Rapporteur.²

2. ORGANIZATION OF WORK

The CHAIRMAN drew attention to document EB122/2008/REC/1, which contained the resolutions and decisions adopted by the Board in January 2008 and to which frequent reference would be made. He suggested that the Committee should meet from 09:00 to 12:30, and from 14:30 to 17:30, and urged speakers to restrict the length of their interventions to no more than three minutes.

It was so agreed.

He also drew attention to a supplementary subitem under agenda item 14.2, entitled "Miscellaneous income 2006–2007 and financing gap for strategic objectives 12 and 13".

¹ See page 255.

² Decision WHA61(4).

3. HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN: Item 13 of the Agenda (Documents A61/18 Rev.1, A61/INF.DOC./2, A61/INF.DOC./3 and A61/INF.DOC./4)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Algeria, Bahrain, Bangladesh, Bosnia and Herzegovina, Chad, Egypt, Indonesia, Iraq, Jordan, Kuwait, Lebanon, Malaysia, Pakistan, Palestine, Qatar, Saudi Arabia, Senegal, Syrian Arab Republic, Sudan and United Arab Emirates and its financial and administrative implications, which read:

The Sixty-first World Health Assembly,

Mindful of the basic principle established in the Constitution of WHO, which affirms that the health of all peoples is fundamental to the attainment of peace and security;

Recalling all its previous resolutions on health conditions in the occupied Arab territories;

Taking note of the report of the Director-General on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;¹

Stressing the essential role of UNRWA in providing crucial health and education services in the occupied Palestinian territory particularly in addressing the emergency needs in the Gaza Strip;

Expressing its concern at the deterioration of economic and health conditions as well as the humanitarian crisis resulting from the continued occupation and the severe restrictions imposed by Israel, the occupying power;

Expressing its concern also at the health crisis and rising levels of food insecurity in the occupied Palestinian territory, particularly in the Gaza Strip;

Affirming the need for guaranteeing universal coverage of health services and for preserving the functions of the public health services in the occupied Palestinian territory;

Recognizing that the acute shortage of financial and medical resources in the Palestinian Ministry of Health, which is responsible for running and financing public health services, jeopardizes the access of the Palestinian population to curative and preventive services;

Affirming the right of Palestinian patients and medical staff to have access to the Palestinian health institutions in occupied east Jerusalem;

Deploring the incidents involving lack of respect and protection for Palestinian ambulances and medical personnel by the Israeli army, which led to casualties among Palestinian medical personnel, as well as the restrictions on movement imposed on them by Israel, the occupying power, in violation of international humanitarian law;

Expressing deep concern at the grave implication of the wall on the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;

Expressing deep concern also at the serious implications for pregnant women and patients of Israeli restriction of movement imposed on Palestinian ambulances and medical personnel;

1. DEMANDS that Israel, the occupying power:

- (1) lift immediately the closure in the occupied Palestinian territory, particularly the closure of the crossing points of the occupied Gaza Strip that are causing the serious shortage of medicines and medical supplies therein, and comply in this regard with the provisions of the Israeli-Palestinian Agreement on Movement and Access of November 2005;

¹ Document A61/18 Rev.1.

- (2) reverse its policies and measures that have led to the prevailing dire health conditions and severe food and fuel shortages in the Gaza Strip;
 - (3) comply with the advisory opinion rendered on 9 July 2004 by the International Court of Justice on the wall which, inter alia, has grave implications on the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;
 - (4) facilitate the access of Palestinian patients and medical staff to the Palestinian health institutions in occupied east Jerusalem and abroad;
 - (5) pay the Palestinian Authority all its remaining customs and health insurance revenues, regularly and without delay, in order to enable it to fulfil its responsibilities with respect to basic human needs, including health services;
 - (6) ensure unhindered and safe passage for Palestinian ambulances as well as respect and protection of medical personnel, in compliance with international humanitarian law;
 - (7) improve the living and medical conditions of Palestinian detainees, particularly children, women and patients;
 - (8) facilitate the transit and entry of medicine and medical equipment to the occupied Palestinian territory;
 - (9) shoulder its responsibility towards the humanitarian needs of the Palestinian people and their daily access to humanitarian aid, including food and medicine, in compliance with international humanitarian law;
 - (10) halt immediately all its practices, policies and plans, including its policy of closure, that seriously affect the health conditions of civilians under occupation;
 - (11) facilitate the work of UNRWA and other international organizations and ensure the free movement of their staff and aid provisions;
2. URGES Member States and intergovernmental and nongovernmental organizations:
 - (1) to help to overcome the health crisis in the occupied Palestinian territory by providing assistance to the Palestinian people;
 - (2) to help to lift the restrictions and obstacles imposed on the Palestinian people in the occupied Palestinian territory;
 - (3) to remind Israel, the occupying power, to abide by the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War of 1949; to support and assist
 - (4) the Palestinian Ministry of Health in carrying out its duties including running and financing public health services;
 - (5) to provide financial and technical support to the Palestinian public health and veterinary services;
3. EXPRESSES its deep appreciation to the Director-General for:
 - (1) the efforts to provide necessary assistance to the Palestinian people in the occupied Palestinian territory, including east Jerusalem, and to the Syrian population in the occupied Syrian Golan;
4. REQUESTS the Director-General:
 - (1) to provide support to the Palestinian health and veterinary services including capacity building;
 - (2) to submit a fact-finding report on the health and economic situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;
 - (3) to support the establishment of medical facilities and provide health-related technical assistance for the Syrian population in the occupied Syrian Golan;
 - (4) to continue providing necessary technical assistance in order to meet the health needs of the Palestinian people, including the handicapped and injured;

- (5) to support the development of the health system in Palestine, including development of human resources;
- (6) to report on implementation of this resolution to the Sixty-second World Health Assembly.

1. Resolution Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan.

2. Linkage to programme budget

Strategic Objective 5

Organization-wide expected result 5.3

To reduce the health consequences of emergencies, disasters, crises and conflicts and minimize their social and economic impact.

Norms and standards developed, capacity built and technical support provided to Member States for assessing needs and for planning and implementing interventions during the transition and recovery phases of conflicts and disasters.

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

If fully funded and implemented, the resolution is expected to have an impact on the targets for the second and third indicators for the expected result.

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\$ 5 270 000 over the one-year period of the resolution, including staff, travel, training activities, technical assistance, health supplies, security and operational equipment.

A substantial proportion of these resources have been raised as humanitarian voluntary contributions for re-establishing the functionality of the disrupted health services, complementarily to the funds already available.

The breakdown of the estimated cost of operative paragraph 4 is as follows:

Subparagraph (1)	US\$ 100 000
Subparagraph (2)	US\$ 70 000
Subparagraph (3)	US\$ 50 000
Subparagraph (4)	US\$ 2 million
Subparagraph (5)	US\$ 3 million
Subparagraph (6)	US\$ 50 000
Total	US\$ 5 270 000

(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 10 540 000.

(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009? US\$ 4 500 000 at headquarters, Regional and Jerusalem Office levels.

4. Administrative implications

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

The activities will be primarily implemented through the WHO Office in Jerusalem responsible for WHO's cooperation programme with Palestine. WHO's country-level efforts will be supplemented by support from the Regional Office for the Eastern Mediterranean, and by the headquarters clusters working in the areas of health action in crises, health security and environment.

(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)

It will be necessary to sustain beyond May 2008 the presence at country level of the national and international staff recruited to provide essential health supplies for the health services in the occupied Palestinian territory.

(c) Time frames (indicate broad time frames for implementation and evaluation)

One year.

Mr SHOUKRY (Egypt), speaking on behalf of the sponsors, introduced the draft resolution. The deterioration in the health conditions of the population in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan was a result of the continued Israeli occupation, which ran counter to international conventions and resolutions and violated humanitarian law. The international community must: react to restrictions on the movement of the Palestinian people; provide food and humanitarian aid; and ensure access to health care and medical treatment. The sponsors of the resolution called on WHO to redouble its efforts to ensure that the Palestinian people were provided with essential health care. They demanded the lifting of closure measures against the occupied Palestinian territory, and an end to the building of the wall dividing Israel from the territory because that prevented provision of medical care and ran counter to the advisory opinion of the International Court of Justice. They urged all countries to assist in overcoming the humanitarian crisis, and to provide financial support for the Palestinian Strategic Health Plan.

The draft resolution reflected the determination of Arab countries to support the rights of the Palestinian people and aimed to make it clear to Israel that the international community rejected its practices. The draft resolution dealt with the health situation resulting from the Israeli occupation and fell within the competence of WHO.

Ms FURMAN (Israel) said that the debate was politically motivated and was taking place at the expense of the many crises in the world that required WHO's attention. Israel acknowledged the health concerns in the Palestinian territory and the recent deterioration in health conditions in the Gaza Strip, which she attributed to the policy of the terrorist organization Hamas. Since the takeover of Gaza by Hamas in June 2007, civilians in Gaza and southern Israel had known nothing but fear. Palestinian terror groups had claimed responsibility for a recent attack against the Israeli city of Ashkelon in which a medical clinic was hit, with many seriously injured. Missiles had also fallen near the neonatal intensive care unit of a hospital in Ashkelon. Attacks on medical centres in Ashkelon reduced treatment options for Palestinian patients from Gaza. Attacks on innocent civilians continued, with damage and destruction to homes, schools and medical clinics.

Israel facilitated the delivery of humanitarian aid through crossing points despite coming under Palestinian mortar fire. Since 2008, Israel had been working with international aid agencies, including WHO and the International Committee of the Red Cross, to facilitate the passage of medical supplies

to the territories, including Gaza. Israel worked with the Palestinian Government in the West Bank to provide medical care. In 2007, more than 15 000 permits had been granted to Palestinians from the Gaza Strip to receive treatment in Israel and more than 66 000 to patients from the West Bank, including 10 200 children with birth defects.

Israel was committed to working with the Ministry of Health of the legitimate Palestinian Government, but could not ignore the terrorist attacks emanating from the Gaza Strip. By voting in favour of a resolution that ignored the suffering of Israelis and the existence of the Hamas terrorist organization, Member States would legitimize the policies of that regime. The text contained fabrications. Since June 2007, Israel had been transferring tax revenues to the legitimate Palestinian Government. It delivered fuel to Gaza, but could not compel Hamas to distribute that to the civilian population. She also clarified that residents of the Golan Heights had access to medical treatment under Israel's health-care system.

Israel was committed to improving the health situation of both Palestinians and Israelis, but politicized, repetitious and inaccurate resolutions did not benefit any of the parties involved.

Dr ABU-MUGHLI (Palestine) said that ending the Israeli occupation of the Palestinian territories was essential to improving the health situation of the Palestinian people. The humanitarian crisis in the Gaza Strip was worsening daily as a result of action by Israeli troops. A health sector suffering from a lack of personnel, medical equipment and medicines was facing total paralysis: deprivation of food and fuel; obstacles to the movement of goods and people; absenteeism; reduced ambulance services; increased wounded through Israeli attacks on the Gaza Strip; and imminent breakdown of the water processing plant and drainage system. Even with WHO's support, Palestine was unable to monitor the indicators for the Millennium Development Goals, let alone achieve the targets. The separation wall split communities, affected the environment, and had been condemned by the International Court of Justice, yet its construction continued. Leishmaniasis had spread owing to the impossibility of moving patients.

He appealed to the Health Assembly to support the rights of the Palestinian people. That was not possible while the occupation continued; the international community must remove the obstacles to implementation of those rights. He paid tribute to international efforts to help the Palestinian people construct an independent State and establish a sustainable peace in the Middle East.

The Palestinian Ministry of Health was working with its Israeli counterparts to ensure that health became a bridge to peace. The joint technical groups had been reformed but cooperation and development were being undermined by military activities, especially in the Gaza Strip. WHO should send a mission to determine the true, factual situation in the occupied territories, including the occupied Syrian Golan. He hoped that WHO would raise Palestine's status to that of a full member of the international community.

He thanked all the countries that had supported Palestine's efforts to attain self-determination and access to health services, and he urged the Health Assembly to support the draft resolution.

Mr ANDERSON (United States of America) said that his country strongly regretted the draft resolution, which interjected biased and political considerations into the debate of a global health body. It undermined the progress made towards increased cooperation between Israel and the Palestinians, ignored Hamas's role in perpetuating the crisis in the Gaza Strip, and would not improve the health of Palestinians living in the West Bank and Gaza.

His country had contributed substantially to the humanitarian needs of the Palestinian people and was encouraging the creation of an independent, viable Palestine that would live with Israel in peace and security. That would allow the health needs and other aspirations of the Palestinian people to be realized. He opposed adoption of the draft resolution and requested that it be put to a roll-call vote.

Dr AL-RAIBI (Yemen), endorsing the statements by the delegates of Egypt and Palestine, said that it was incumbent upon the Health Assembly to alleviate the sufferings of the people living in the

occupied Palestinian territory. The embargo by Israel must be lifted. It was unfortunate that the sixtieth anniversary of WHO coincided with the date of the creation of the State of Israel.

Mr GILLANI (Pakistan) expressed concern at the health situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, aggravated by poverty, unemployment, the permit and closure system, and the lack of control over water resources. Deaths and injuries resulting from occupation and conflict had been increasing. Malnutrition and micronutrient deficiencies persisted. Access to health care was affected by sanctions, internal closure, the separation wall and the permit system. The economic siege, degraded health infrastructure and shifts in funding had brought further deterioration.

He commended WHO's health-related support, information, and coordination of basic services. A health emergency was developing and WHO technical support to UNRWA should be enhanced. WHO should influence donors to increase funding. A strong message must also be sent by the Health Assembly calling for an end to economic practices that jeopardized access to and provision of health services in the occupied territories. He supported the draft resolution. He also called for support for the Palestinian people and efforts for peace.

Mr AHMADI (Islamic Republic of Iran) shared the view expressed by the delegates of Egypt and Palestine that the policies of the Israeli regime had created the tragic situation in the occupied territories. Those policies contravened principles enshrined in WHO's Constitution and the Fourth Geneva Convention (relative to the protection of civilian persons in time of war). The international community should take all measures to alleviate the sufferings of the Palestinian people.

Dr AL-MANEA (Saudi Arabia), endorsing the comments of the delegates of Egypt and Palestine, noted that the blockade had also affected emergency services. That deliberate policy exacerbated the situation of the most vulnerable, women and children. If the people of any Member State were in a similar situation, they would appeal to the international community for assistance. In that case the debate would not be about politics, but the right to human dignity and basic services.

Dr AL-HOUSAMI (Syrian Arab Republic) said that, while WHO had been celebrating its sixtieth anniversary, the Palestinians had marked the sixtieth anniversary of the loss of their homeland. WHO was a humanitarian organization and the latest reports illustrated the disaster affecting all members of the Palestinian community. The Gaza Strip had become a prison, stripped of basic necessities and subject to attacks. Syrians were also suffering in the Golan deprived of basic health services, available only to those carrying an identification card issued by Israel. Syrian Arab villages had no access to specialist services such as gynaecology. The occupying forces prevented medical staff from practising in the occupied Syrian Golan and medical students were unable to complete their training. His country was setting up centres with the Syrian Arab Red Crescent. It had written repeatedly to the United Nations, the International Committee of the Red Cross and the European Union to urge them to press Israel on those points. He urged Israel to apply all resolutions relevant to health in the occupied Palestinian territory, including east Jerusalem and the occupied Syrian Golan. He urged Member States to vote in favour of the draft resolution.

Dr TSHABALALA MSIMANG (South Africa) said that the right to health was a fundamental human right. The conditions endured by Palestinians were unacceptable. She called on all countries, especially the Government of Israel and the Palestinian Authority, to find ways under the auspices of WHO for Palestinians to enjoy the right to health care. The Health Assembly must urge all parties to take urgent action for peace and security, conditions that were fundamental to good health. She supported the draft resolution.

Dr BUDIHARDJA (Indonesia) commended WHO's actions. WHO had provided essential medical provisions to the West Bank and the Gaza Strip, established a noncommunicable disease

control and prevention programme, and offered technical support to 13 coordination bodies in the occupied territory. However, the political ramifications of the conflict in that region had had an impact on Palestinian capacity to manage health care.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the situation of the Palestinians was serious. WHO's Constitution stated that health was a state of physical, mental and social well-being and Palestinians lacked that well-being. In addition, economic and health conditions were deteriorating, and food security and medical care were inadequate. He supported the draft resolution.

Mr MBAYE (Senegal), recalling that his country was a sponsor of the draft resolution, expressed sympathy with the Palestinian people and understanding of their predicament. Member States should do their best to improve the health conditions in the occupied territory.

Dr SABATINELLI (Director of Health, UNRWA) recalled that UNRWA was a humanitarian agency providing education, social services, emergency assistance, microfinance, infrastructure and health care to more than four million refugees in five fields of operation: Lebanon, the Syrian Arab Republic, Jordan, the West Bank and the Gaza Strip. Comprehensive health care was delivered by 129 health clinics in the five fields of operation serviced by more than 440 doctors and 3000 health-care workers. UNRWA ran a hospital in the West Bank and had established 11 mobile clinics. Preventive health care placed emphasis on maternal and child health, sanitation services and tertiary health care through contracted hospitals, resulting in a positive impact on the health of refugees. The mortality rate had decreased to 22 per 1000 live births, maternal mortality was around 20 per 100 000, and no major epidemics had been reported in the preceding two decades.

In the Gaza Strip, deteriorating living conditions had led to increasing levels of anaemia, nutritional deficiencies in children and pregnant women, increased diabetes and heart disease, post-traumatic stress disorder due to conflict, and an explosive sanitation situation.

UNRWA was being hampered by movement restrictions on staff and supplies which affected the most vulnerable refugees. Its Health Programme achieved well-managed health care with modest means. However, without additional funds, that quality would be affected. UNRWA must be provided with resources for essential health services, and it needed freedom of movement to deliver those.

Mr SOBIH (League of Arab States) identified the occupation as the root cause of problems faced by the Palestinian people. Road blocks in the West Bank prevented the movement of ambulances, doctors and nurses, with resultant suffering. The Gaza Strip was a humanitarian tragedy: sewage poured into rivers and children suffered psychological disorders. Prisoners in Israel lacked health services. Palestine had been demanding justice for 60 years and it needed the support of countries to end the occupation. The Arab Peace Initiative was a good opportunity. WHO's role was extremely important, and he asked the Organization to send a commission of enquiry to look into health conditions in the occupied Palestinian territories and occupied Golan. The Palestinian delegation should become a full member of WHO. He congratulated UNRWA on its work in a difficult situation.

The CHAIRMAN said that Tunisia had asked to be included in the list of sponsors of the draft resolution. He recalled the proposal to proceed to a roll-call vote.

At the invitation of the CHAIRMAN, Mr BURCI (Legal Counsel) explained the modalities of the roll-call vote. The Member States whose right to vote had been suspended under Article 7 of the Constitution, or which were absent because they had not submitted credentials, were: Argentina, Cape Verde, Comoros, Dominica, Grenada, Guinea-Bissau, Kyrgyzstan, Niue, Central African Republic, Somalia, Turkmenistan. Those countries would not be called out during the roll-call vote.

A vote was taken by roll-call, the names of the Member States being called in the French alphabetical order, starting with Lesotho, the letter L having been determined by lot.

The result of the vote was as follows:

In favour: Afghanistan, Albania, Algeria, Andorra, Angola, Armenia, Austria, Azerbaijan, Bahrain, Bangladesh, Belgium, Bhutan, Bosnia and Herzegovina, Bolivarian Republic of Venezuela, Botswana, Brazil, Brunei Darussalam, Bulgaria, Chile, China, Congo, Costa Rica, Croatia, Cuba, Cyprus, Czech Republic, Democratic People's Republic of Korea, Denmark, Djibouti, Ecuador, Egypt, Estonia, Finland, France, Germany, Greece, Guyana, Hungary, Indonesia, Iceland, Ireland, Islamic Republic of Iran, Italy, Jamaica, Japan, Jordan, Kuwait, Latvia, Lebanon, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Malaysia, Maldives, Mali, Mauritius, Mexico, Monaco, Morocco, Netherlands, Nicaragua, Niger, New Zealand, Norway, Oman, Uganda, Pakistan, Panama, Paraguay, Philippines, Poland, Portugal, Qatar, Republic of Korea, Romania, Russian Federation, San Marino, Saudi Arabia, Senegal, Serbia, Slovakia, Slovenia, South Africa, Spain, Sudan, Sweden, Switzerland, Syrian Arab Republic, The former Yugoslav Republic of Macedonia, Tunisia, Turkey, Ukraine, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Yemen, Zambia, Zimbabwe.

Against: Australia, Canada, Federated States of Micronesia, Fiji, Israel, Marshall Islands, Nauru, Palau, United States of America.

Abstaining: Barbados, Burkina Faso, Cameroon, Cook Islands, El Salvador, Guatemala, Kiribati, Malawi, Singapore, Thailand, Tonga.

Absent: Antigua and Barbuda, Bahamas, Belarus, Belize, Benin, Bolivia, Burundi, Cambodia, Chad, Colombia, Côte d'Ivoire, Democratic Republic of the Congo, Dominican Republic, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Georgia, Ghana, Guinea, Haiti, Honduras, India, Iraq, Kazakhstan, Kenya, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malta, Mauritania, Moldova, Mongolia, Montenegro, Mozambique, Myanmar, Namibia, Nepal, Nigeria, Papua New Guinea, Peru, Rwanda, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Samoa, Sao Tome and Principe, Seychelles, Sierra Leone, Solomon Islands, Sri Lanka, Suriname, Swaziland, Tajikistan, Timor-Leste, Togo, Trinidad and Tobago, Tuvalu, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Viet Nam.

The draft resolution was therefore approved by 97 votes to 9, with 11 abstentions.¹

Mr LOGAR (Slovenia), speaking in explanation of vote on behalf of the European Union, welcomed the resolution in view of the deteriorating health situation in the occupied Palestinian territory, including east Jerusalem. Nevertheless, political and other changes that had occurred since the Sixtieth World Health Assembly should have been reflected. The resolution lacked balance. It singled out Israel as responsible for the current health situation. It should have emphasized the responsibilities of the Palestinian authorities and cooperation and negotiations under way between Israel and the Palestinian Authority.

The European Union would assist a Palestinian Government whose policy and actions reflected the Quartet principles. It had pledged some €1000 million to the Palestinian people in 2007 and welcomed the results of the International Donors' Conference for the Palestinian State (Paris, 17 December 2007). The European Union remained concerned about the impact of the conflict on the

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA61.3.

health situation of both Palestinians and Israelis, and would contribute to improving health conditions in the occupied Palestinian territory.

Mr OLDHAM (Canada), speaking in explanation of vote, said that Canada remained concerned at the humanitarian situation facing Palestinians, in particular in the Gaza Strip. Aid to the Palestinian people would continue through nongovernmental and multilateral organizations. His Government was committed to supporting the Palestinian Authority in its reform and development efforts. Regrettably, the resolution presented a one-sided approach to addressing the health care and humanitarian needs of the Palestinians and focused only on the actions of one country.

Mr YAMANAKA (Japan), speaking in explanation of vote, expressed concern over the health situation in the occupied Palestinian territory, notably with regard to maternal and child health. In addition to the significant announcement that it would provide US\$ 150 million in the coming year at the International Donors' Conference for the Palestinian State, Japan would shortly pledge a further US\$ 11 million in humanitarian aid, for the provision of medicines and food in the Gaza Strip. WHO should confine itself to health issues and not engage in political debates. However, his country appreciated the efforts made by the various delegations to produce a more balanced text, and had therefore voted in favour of the resolution.

Ms ANGELL-HANSEN (Norway), speaking in explanation of vote, endorsed the explanation of vote provided by the delegate of Slovenia on behalf of the European Union. Norway remained committed to furthering the peace process in the Middle East and to providing financial support to the Palestinian people, in the area of health as in others.

Mrs KALMETA (Bosnia and Herzegovina) and Mr McKERNAN (New Zealand), speaking in explanation of vote, associated themselves with the statement made by the delegate of Slovenia.

Ms TAN (Singapore), speaking in explanation of vote, said that Singapore supported all peace efforts for the Middle East and had consistently taken a stand on the right of Palestinians to a homeland and on the two-State solution. However, it was inappropriate to introduce political considerations into Health Assembly resolutions. For that reason, Singapore had abstained.

Mr THOM (Australia), speaking in explanation of vote, expressed concern about the health situation in the Palestinian territories, but considered that this stand-alone agenda item unnecessarily introduced political issues. Australia had voted against the resolution because it did not recognize the responsibilities also of the Palestinian authorities to take determined and sustained action to improve conditions on the ground. He supported the call by the Quartet on the Middle East for the provision of essential services to the Gaza Strip without obstruction and shared the Quartet's concern at the impact that the closure of major Gaza crossing points had on the health of the Palestinian people. Australia was committed to providing practical support to the Palestinians, and had doubled its financial support to the Palestinian people in 2008 to US\$ 45 million.

Mr GUNNARSSON (Iceland), speaking in explanation of vote, supported the statements made by the delegates of Slovenia and Norway.

4. PROGRAMME BUDGET AND FINANCIAL MATTERS: Item 14 of the Agenda

Programme budget 2006–2007: performance assessment: Item 14.1 of the Agenda (Documents A61/19 and A61/21)

Professor PEREIRA MIGUEL (Portugal), speaking as Chairman of the Programme, Budget and Administration Committee, reported that at its eighth meeting the Committee had noted that overall expenditure in the biennium 2006–2007 was marginally below the programme budget originally approved. Implementation rates varied. Underfunding in some areas and carry-overs in others were due to unpredictable timing of receipt of funds, specific earmarking of voluntary contributions, voluntary contributions for partnerships, and changes in policy for recording income and expenditure. The scarcity of flexible resources and the shrinking proportion of assessed contributions posed significant challenges to full implementation of the programme budget. The Committee had underlined performance assessment for reprogramming and preparation of the Proposed programme budget 2010–2011. It had stressed the timely receipt of both the summary assessment and the full performance reports. It had suggested that the Secretariat submit remedial proposals to the Committee.

The Committee recommended, on behalf of the Executive Board, that the Health Assembly note the report contained in document A61/19.

Mr KANG'OMBE (Malawi), speaking on behalf of the Member States of the African Region, acknowledged the improved management of human resources and faster selection processes. The policy of sharing experiences through staff rotation and mobility, within the Organization and between regions, should be implemented. On financial matters, the Secretariat was to be commended for its revised accounting policy as part of the global management system; complying with internal and external audit recommendations; and maintaining internal controls.

He applauded programme expenditure at 94% of the original budget and 85% of the revised budget, given that contributions arrived late in the biennium, much of the funding was earmarked, and a new accounting policy had been introduced. The Secretariat should encourage its partners to transfer funds on time and subject to minimum constraints.

Assessed contributions had declined in proportion to the total budget, from 46% in 1998–1999 to 21% in 2006–2007. That decline was likely to continue unless Member States increased their contributions. Member States' voluntary contributions were also declining as a proportion of total voluntary contributions, from 63% in 2004–2005 to 52% in 2006–2007. In all, Member States had provided 54% of the Organization's total funding in 2006–2007, as compared with 71% in 2004–2005. The financial resource base of WHO had shifted. Its capacity to decide how to use resources had weakened.

Mr FISHER (Denmark) welcomed the report, which was important for evaluating past performance and directing the future activities of WHO. He regretted that the full report had not been available for discussion before debating the Proposed programme budget 2010–2011. The timeline should be adjusted in future. The full report should also evaluate the Organization's overall results.

Results showed that US\$ 1600 million would be carried over from the biennium 2006–2007 to the biennium 2008–2009, more than 40% of the budget for the biennium. Further information should be provided on how those resources would be spent. He expressed concern that carry-overs were occurring in a situation where the implementation rate had fallen. Although an increase in the Organization's income was positive, he questioned whether the budget should continue to increase at the same rate in the future. Voluntary contributions alone had tripled over the preceding 10 years. Existing activities might be consolidated rather than accepting more donations for future activities. The Organization should prioritize, making efficient use of existing resources. His country would support WHO in making those difficult choices.

Mr MANINRAKA (Kiribati) commended results-based management for its transparency and performance, an approach that should be used for future bienniums.

He expressed concern that the report did not detail the situation at the country level, where WHO still applied a top-down approach to budgetary management. His country's biennium budget was guided not by WHO's strategic plans but by the WHO country office, which also dictated the number and type of health programmes to be followed. Regular monitoring of the WHO country programme budget and WHO national programmes funded through the Ministry of Health was not possible. Obtaining information on his country's programme budget was difficult as the budget format was too complicated. Delays in the provision of such information forced the Ministry to reprogramme budget allocations or to rush completion of existing programmes, since otherwise the funds would be lost.

He had raised those issues at the meeting of the Regional Committee for the Western Pacific in Auckland, New Zealand, in 2006. Until they were resolved, his country would continue to underspend its WHO programme budgets, thereby jeopardizing the health goals of those national programmes.

The Secretariat should streamline its budget and financial management policies at the country level. It should provide a more autonomous system that was simple to administer and allowed Member States access to budget information at any time.

Mr MACPHEE (Canada) said that annual financial reports provided Member States and the Director-General with an important financial overview and a means to verify expenditure in relation to the programme budget.

He expressed disappointment that the full assessment report was not available. The Secretariat should find an opportunity before the Executive Board session in January 2009 that would enable Member States to discuss together the report's analysis, and provide the Executive Board with a broad perspective in budget and funding priorities for the following biennium.

Mr ANDERSON (United States of America) welcomed the report. Performance assessment of previous bienniums was an important tool for setting objectives. The Organization was improving its monitoring and evaluation and had managed some of the challenges related to increasing voluntary contributions. The creation of the advisory group and the use of corporate accounts improved the framework for the allocation of resources; however, as effective mechanisms to mitigate the imbalance in the implementation of activities, for both the bienniums 2006–2007 and 2008–2009, more information was required, as it was regarding the allocation of the large amount of carry-over funds.

Mrs PRADHAN (Assistant Director-General) said that constant efforts were being undertaken to improve performance assessment through a results-based framework. She thanked donors and Member States for increasing their financial commitment to the Organization's programme of work. The Organization faced financial challenges such as the large number of partnerships, bulk purchase requirements, and the unpredictable timing of receipt of resources throughout the biennium, making implementation difficult. Detailed discussions had been held on how those resources could be better managed. The Organization depended heavily on voluntary contributions, almost 80% of its income in the biennium 2006–2007. Under results-based management, the Secretariat was working to improve that balance, make the best use of resources, and exercise budgetary discipline within the Organization.

The Committee noted the report.

The meeting rose at 17:30.

SECOND MEETING

Thursday, 22 May 2008, at 09:20

Chairman: Dr A.R. SICATO (Angola)

1. FIRST REPORT OF COMMITTEE B (Document A61/43)

Dr JAYANTHA (Sri Lanka), Rapporteur, read out the draft first report of Committee B.

The report was adopted.¹

2. PROGRAMME BUDGET AND FINANCIAL MATTERS: Item 14 of the Agenda (continued)

Financial report and audited financial statements for the period 1 January 2006–31 December 2007: Item 14.2 of the Agenda (Documents A61/20, A61/20 Add.1 and A61/22)

Professor PEREIRA MIGUEL (Portugal), speaking as Chairman of the Programme, Budget and Administration Committee, outlined the contents of the report contained in document A61/22.

The CHAIRMAN invited the Committee to consider the draft resolution recommended by the Programme, Budget and Administration Committee in paragraph 7 of document A61/22.

The draft resolution was approved.²

- **Miscellaneous Income 2006–2007 and financing gap for strategic objectives 12 and 13** (Document A61/41)

Mr JEFFREYS (Comptroller) gave a brief outline of the report.

Mr MACPHEE (Canada) requested additional information on the shortfall of US\$ 82 million in the financing of strategic objectives 12 and 13. There was little option but to use US\$ 15 million from the surplus in the Miscellaneous Income account. He sought information on the new funding sources referred to in paragraph 5 of the report, since the remaining shortfall of US\$ 67 million was considerable. He asked to what degree the shortfall was a result of the disparity between the income received as the cost of overheads from voluntary funding and the agreed cost of handling programmes. Since more than 80% of the Organization's income came from voluntary funds, and since those higher delivery and management costs had to be borne by the regular budget, would efforts be made to deal with that gap? He asked what action would be taken if the suggested cost reductions and new funding sources failed to eliminate the shortfall by the end of the current biennium.

¹ See page 258.

² Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA61.5.

Ms SPRATT (United States of America) shared the concerns expressed by the previous speaker; those issues should be further considered as part of planning for the forthcoming biennium. The External Auditor's report noted some encouraging proactive measures, such as the use of programme support cost income to cover only fixed indirect costs of management, and a more accurate assessment of the cost of hosting partnerships. The measures proposed for tackling that issue required further reporting.

Mr DAVIES (New Zealand) supported the two previous statements. Member States must be clear about how contributions were made from external sources and internal sources, and how that represented the expenditure on strategic objectives 12 and 13. He was concerned that the Organization's base programmes might be compromised if funds were reallocated to support items which had lower priority.

Mrs PRADHAN (Assistant Director-General) emphasized that strategic objectives 12 and 13 were core to the Organization: they established parameters for its overall direction, management and functioning. They provided for support functions to implement strategic objectives 1 to 11. The financing of strategic objectives 12 and 13 was crucial.

The Health Assembly had mandated the Organization to charge 13% of programme support costs to voluntary resources. However, programmatic needs caused some voluntary contributions to be realized at a lower rate. The average level of programme support costs from voluntary resources was therefore less than 7%. That had resulted in the critical financing gap.

The Organization must secure the financing of its core technical work, which was delivering good health results. However, services must also be delivered efficiently and cost-effectively. The financial shortfall would be met in the current biennium by using some of the savings from the Miscellaneous Income account, and through efficiency savings. That would mean examining financing requirements and priorities, under strategic objectives 12 and 13, in the six regional offices and at headquarters. Some items, particularly under strategic objective 12, were essential for the support and improved functioning of country offices. Some voluntary contributions might be raised directly for that purpose, thus reducing the funding gap. The Secretariat would report back to Member States at the end of the biennium 2008–2009 on the innovative financing measures and improved discipline.

Mr JEFFREYS (Comptroller) added that it might be necessary to defer some expenditures, particularly on real estate. A further source of funding currently under consideration was the interest earned on voluntary programmes, provided that donor agreements allowed that.

The CHAIRMAN invited the Committee to consider the draft resolution in paragraph 7 of document A61/41.

The draft resolution was approved.¹

Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution: Item 14.3 of the Agenda (Documents A61/35 and A61/INF.DOC./1)

Special arrangements for settlement of arrears: Item 14.4 of the Agenda (Document A61/35)

Professor PEREIRA MIGUEL (Portugal), speaking as Chairman of the Programme, Budget and Administration Committee, outlined the contents of that Committee's third report.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA61.6.

The CHAIRMAN noted that, since the meeting of the Programme, Budget and Administration Committee the previous week, Azerbaijan had paid its arrears. Given that Azerbaijan was no longer concerned by Article 7 of the Constitution, reference to that Member State would be deleted from the second preambular paragraph of the resolution contained in paragraph 7(I) of document A61/35.

He invited the Committee to consider the draft resolution recommended by the Programme, Budget and Administration Committee, contained in paragraph 7(II) of document A61/35.

The draft resolution was approved.¹

The CHAIRMAN invited the Committee to consider the draft resolution recommended by the Programme, Budget and Administration Committee, contained in paragraph 7(I) of document A61/35. Given that the Committee had approved the resolution concerning Kyrgyzstan, reference to that Member State should be deleted from the second preambular paragraph of the draft resolution.

The draft resolution was approved.²

3. AUDIT AND OVERSIGHT MATTERS: Item 15 of the Agenda

Report of the External Auditor to the Health Assembly: Item 15.1 of the Agenda
(Documents A61/23 and A61/24)

Professor PEREIRA MIGUEL (Portugal), speaking as Chairman of the Programme, Budget and Administration Committee, outlined the contents of that Committee's fourth report (document A61/24).

The CHAIRMAN invited Mr Rai (External Auditor) to present the External Auditor's report.

Mr RAI (External Auditor) summarized the report, confirming that the financial statements of WHO had been found to be a fair representation of the Organization's financial position at 31 December 2007.

He confirmed that the Secretariat had accepted the results of the follow-up review of the internal Contract and procurement services unit. Greater control would be taken over insurance management, and the procurement of vaccines and supplier performance, using the global management system. A review of that system's future implementation had highlighted risk, including system security and organizational readiness and training. The Secretariat had accepted the relevant recommendations. He also highlighted the Secretariat's efforts to bridge the financing gap for management and administrative functions, the implementation of the environmental policy, and the increased delegation of authority to WHO Representatives in cases of emergency. A formalization of the Organization's ethics policy was still needed. Comprehensive plans for human resources should be put on record. The procedures for appointments and extensions in the offices concerned should be streamlined. It was also necessary to monitor and verify reports relating to direct financial cooperation.

The observations and recommendations contained in the report had been accepted by the Director-General, and the Secretariat was already taking actions thereon. Monitoring implementation of those recommendations was vital.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA61.8.

² Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA61.7.

Mr MACPHEE (Canada) said that the External Auditor's report was fundamental in determining the financial well-being of the Organization. He commended the detail provided on the implementation status of recommendations. Action remained to be taken on technical service agreements.

The offices of the Internal and External Auditors should collaborate, as Member States relied largely on the latter to highlight issues raised by the former.

A concern was the mismatch between areas of shortfall and excessive spending in the Programme budget. The auditors played a vital role in identifying trends and cost-saving measures.

Mrs PRADHAN (Assistant Director-General) said that the Secretariat accepted and would implement all the recommendations of the External Auditor, with a view to ensuring greater effectiveness, efficiency, security and transparency.

The CHAIRMAN invited the Committee to approve the draft resolution.

The draft resolution was approved.¹

Report of the Internal Auditor: Item 15.2 of the Agenda (Documents A61/25 Rev.1 and A61/26)

Professor PEREIRA MIGUEL (Portugal), speaking as Chairman of the Programme, Budget and Administration Committee of the Executive Board, outlined the contents of that Committee's fifth report (document A61/26).

Ms KRARUP (Denmark) commended the report by the Office of Internal Oversight Services. She welcomed the follow-up to criticisms of weaknesses in the financial administration of the Regional Office for Africa. The strengthening of oversight was vital given the proportion of the Organization's budget that was devoted to the African Region. Donors must be certain that funds were used for their intended purpose.

Ms SPRATT (United States of America) said that the Office of Internal Oversight Services enhanced accountability, improved strategic management and strengthened internal controls. The Office's recommendations, particularly those related to internal procurement controls in the field, should be implemented and monitored in a sustainable manner.

She recommended the inclusion in the report of an annex detailing each recommendation for the reporting period, its implementation status and whether or not it was considered critical.

Ms KITSELL (United Kingdom of Great Britain and Northern Ireland) outlined a proposal for the establishment of an independent expert oversight advisory committee or audit committee within the Organization. For example, in 2007 the United Nations in New York had established an Independent Audit Advisory Committee comprising five independent members. It provided advice to Member States in order to increase accountability.

She was not seeking re-establishment of the former Audit Committee, whose members had in many cases been experts in health rather than finance; the committee would complement the work of the Internal and External Auditors. Her delegation was ready to work with the Secretariat and any interested Member States in drawing up terms of reference for such a committee.

Ms FINSTAD (Norway) said that she shared the concerns expressed by the delegate of Denmark.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA61.9.

Mr MACPHEE (Canada) commended the Internal Auditor's report, particularly the table detailing action taken, which would help Member States to identify issues of concern. He welcomed the positive findings with regard to the assistance being provided to country offices in Africa.

However, he expressed concern at the number of audit reports still awaiting initial response. The reference to a high risk of fraud suggested that more effective controls were needed.

With regard to the committee proposed by the delegate of the United Kingdom of Great Britain and Northern Ireland, he would be interested in discussing its nature and potential to facilitate the work of the committees of the Health Assembly and to better inform Member States.

Ms HALÉN (Sweden) endorsed the Danish intervention. The Internal Auditor's recommendations should be implemented at all levels, especially those regarding bottlenecks in recruitment and inadequate risk management and procurement procedures.

Mr DAVIES (New Zealand) supported the comments by other Member States including the proposal to set up an independent audit committee, which with careful framing should ensure performance gains. It should be concerned with probity and fraud, but also analysis of the effectiveness of the Organization in terms of its performance objectives.

Ms SPRATT (United States of America) supported discussion of an independent audit committee that would ensure consistency between internal and external audit functions. Giving such a committee a composition of independent external experts should ensure objectivity and technical competence.

Ms SAMMALKIVI (Finland) strongly supported the Danish intervention.

Ms BENNETT (Australia) said that Australia would be interested in discussing the establishment of an independent audit oversight committee. The role of such a committee should be examined carefully in the context of the Programme, Budget and Administration Committee and the internal and external audit processes already in place.

Mr LANGFORD (Director, Office of Internal Oversight Services) said that, following the Sixtieth World Health Assembly, the Regional Director had increased his personal involvement in the elimination of the weaknesses identified in the African Region. Increased funding for staff and consultants, support and training had been provided by WHO headquarters. A compliance officer had been trained by the Office of Internal Oversight Services to deal exclusively with audit issues. The new Director of Administration and Finance had taken up his post in August 2007 and had provided the required leadership. An audit team had visited the Regional Office in November 2007. The report had noted improvements and identified areas for strengthening. In March 2008, he had himself visited the Regional Office. The Office had recently received an encouraging response to the latest audit from the African Region: specific weak areas were being strengthened; backlogs were being reduced; account balances were more current; and weaknesses identified in audits were being dealt with more promptly. The Regional Office was scheduled for an audit visit in late 2008, with an update provided in January 2009.

Implementation of audit recommendations was improving: older items were being dealt with; and the current level of implementation was acceptable.

Replying to the delegate of Canada, he said that many audit reports were issued only weeks before publication of the Internal Auditor's report to the Health Assembly. The response to complex issues could not be implemented within weeks. Follow-up normally took place after about six months. A comparison between the 2007 and 2008 reports suggested a considerable increase in the number of cases in which a response had been received within the year in which the audit report had been issued. The report to the Sixty-second World Health Assembly would, in response to the suggestion of the delegate of the United States of America, endeavour to flag critical recommendations.

Realistically, fraud could not be eliminated entirely, but the risk of fraud was decreasing, in particular in the African Region. He noted the considerable support expressed for the idea of re-establishing an audit committee that would strengthen all oversight. It could be implemented without repeating the mistakes of the past.

Mrs PRADHAN (Assistant Director-General) said that the Secretariat took the work of the Internal Auditor as seriously as it took the work of the External Auditor. All recommendations were monitored closely and followed up. Risks were continually being identified and mitigated. There was absolutely zero tolerance for fraud in the Organization, and prompt action had been initiated in any case that had been uncovered. The Member States that had raised concerns could rest assured that rigorous checks and balances and a system of monitoring were in place to ensure that the funds from both assessed and voluntary contributions were utilized in the manner and for the purpose intended.

The Committee noted the report.

4. STAFFING MATTERS: Item 16 of the Agenda

Human resources: annual report: Item 16.1 of the Agenda (Document A61/27)

Dr JAKSONS (representative of the Executive Board) noted that the ninth annual report provided complete data on WHO's staffing profile as at 31 December 2007, including data on overall gender distribution and geographical representation; age, grade, length of service and turnover of staff; distribution of the workforce by occupational group; internal and external recruitment; and national professional officers. The new contractual arrangements introduced by WHO were reflected in the report. Tendencies towards an increase in the number of staff on long-term appointments and a decrease in temporary appointments had been observed.

Mr KIFLEYESUS (Eritrea), speaking on behalf of the Member States of the African Region, noted the encouraging increase in the representation of the African Region. The conversion of certain eligible appointments to continuing appointments under the new contractual arrangements should be maintained. WHO should ensure that women were well represented in the Organization. In terms of geographical representation, Africa should be better represented, in keeping with its size and disease burden. Dental, nutrition, medical, nursing and veterinary specialists accounted for more than 50% of occupational groups whereas specialists in reproductive health and pharmacy were absent. The Secretariat should rectify that situation.

Mr MANINRAKA (Kiribati), welcoming equitable representation in staffing, said that more opportunities should be given to candidates from unrepresented Pacific island countries. More exposure to the workings of WHO at all levels would tackle the persisting skills gaps in the countries concerned. Potential adverse effects could be avoided through fixed-term duration of employment with WHO, after which candidates would return to work in their home countries.

Mrs RENOUL (France) welcomed the reform of contractual arrangements and improved information on staffing and human resource management. She enquired about the likely impact of the new arrangements on geographical and post mobility. Management plans should take account of the large number of staff expected to retire before 2017.

Ms SPRATT (United States of America) welcomed the report and noted the increased percentages of women appointed. The issue of overrepresentation and underrepresentation of Member States should continue to be addressed. Nine countries that had in the past been adequately represented

were currently overrepresented. She asked what was being done to avoid such cases, and whether the new contractual arrangements had affected geographical representation by region within the Organization.

Dr ALLEN-YOUNG (Jamaica) called for greater consideration to be given to employing health professionals from the Caribbean at higher levels of the Organization and supported the suggestion that certain professions, notably pharmacists, be represented in greater numbers on the staff.

Mr HENNING (Director, Human Resources) said that improving the gender balance in the Organization would continue, with the ultimate goal of 50:50 representation. Concerning the geographical representation of regions such as the Western Pacific Region, the Secretariat was continuing to identify possible candidates. Various mechanisms were being considered so that qualified professionals would return to their countries after a given number of years at WHO, notably under the Associate Professional Officer programme. Geographical mobility did exist, with flows of staff between the regional offices and headquarters in both directions. In that context, preference was normally given to internal over external candidates. A pilot project on international mobility was to be implemented in 2010.

With the introduction of the global management system in 2008, longer-term plans for human resources reflected the Medium-term strategic plan 2008–2013 and took account of likely staffing changes resulting from retirement and geographical mobility. The different professions were represented according to programmatic needs, and improved geographical representation was part of the Organization's recruitment strategy.

The Committee noted the report.

Amendments to the Staff Regulations and Staff Rules: Item 16.2 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R11, and A61/28)

The CHAIRMAN invited the Committee to consider the draft resolution contained in resolution EB122.R11.

The draft resolution was approved.¹

5. MANAGEMENT MATTERS: Item 17 of the Agenda

Method of work of the Health Assembly: Item 17.1 of the Agenda (Documents EB122/2008/REC/1, resolution EB122.R8, and A61/30)

Dr JAKSONS (representative of the Executive Board) introduced the report, noting the Board's concern that Health Assembly procedures should be brought more into line with those of other United Nations organizations.

Dr ZHAO Zilin (China) agreed with the proposed resolution, including the recommendation concerning the Committee on Nominations. He repeated the suggestion made by the member for China on the Executive Board that the Programme, Budget and Administrative Committee should discuss the method of work of the Health Assembly's General Committee with the aim of enhancing its efficiency.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA61.10.

Mr FAÏHUN (Benin), speaking on behalf of the Member States of the African Region, commended the improved organization of the Health Assembly, to which the Executive Board's recommendations would contribute. He agreed that the abolition of the Committee on Nominations could be considered, if recommendations from the regions and the regional distribution of posts continued to form the basis of candidatures.

With regard to the method of voting on two or more proposals, the Health Assembly's procedures should be aligned more closely with those of other United Nations bodies. He supported the draft resolution and proposals therein to amend rules concerning adoption of the Health Assembly's agenda.

Ms SPRATT (United States of America) supported the draft resolution and the changes it proposed. Candidatures should continue to be recommended by the regions, and proposals for the provisional agenda of the Executive Board should be accompanied by an explanatory memorandum to assist the officers of the meeting, the full Executive Board and the Secretariat.

Mr SOLOMON (Office of the Legal Counsel) thanked the delegates for their comments and support. He suggested a consequential amendment to paragraph 3 of the proposed resolution concerning the amendment of certain Rules of Procedure that referred to the Committee on Nominations. Since the text had been drafted, it had been found that Rule 92 also made reference to the Committee and therefore should also be amended accordingly.

The draft resolution, as amended, was approved.¹

Multilingualism: implementation of action plan: Item 17.2 (Documents EB122/2008/REC/1, resolution EB122.R9, and A61/31)

Dr JAKSONS (representative of the Executive Board) introduced the report, recalling the Executive Board's discussions on multilingualism, and noting the contribution of linguistic diversity to the Organization's mandate. Predominant use of English had led some Executive Board members to show their commitment to multilingualism by making presentations in other languages. The Organization's principle of geographical representation would safeguard linguistic diversity. The global management system would establish a database of staff linguistic competences.

Dr ZHAO Zilin (China) welcomed the action being taken to promote multilingualism but noted differences in the treatment accorded to the different languages. He asked why the summary records of neither the Health Assembly nor the Executive Board existed in Chinese. He looked forward to improvements in that area, and the timely translation of key publications into the official languages, including Chinese. Such work should be included in the ordinary budget. The regional offices should also accord importance to the use of Chinese, providing translations of decisions and meeting documents of the Regional Office for the Western Pacific. He endorsed the draft resolution.

Mr MACPHEE (Canada) welcomed the progress achieved but noted that the cost implications should be published. Information would also be welcome concerning the proposed body that would determine priorities on translation of information products. Referring to the remarks made by the delegate of China, he noted that translation into the official languages often delayed the delivery of documents for meetings. Moreover, increased meetings of bodies such as the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property were straining translation resources. Priorities needed to be established so that the Secretariat could draw up procedures.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA61.11.

Dr TSESHKOVSKIY (Russian Federation) said that multilingualism helped to give equal access to information about WHO throughout the world. WHO's Russian translations were used widely by medical experts within the Russian Federation and other members of the Commonwealth of Independent States. Improved quality of translation would increase readership of WHO's texts. Standards, rules and technical regulations should all be translated. Since the plan of action had been presented at the 121st session of the Executive Board, more material had been published in Russian by the Regional Office for Europe and the WHO web site offered Russian content. A dialogue had been instituted between the Russian health ministry, WHO's Secretariat and the Regional Office for Europe on those issues. In 2007, the information needs of Russian health specialists had been surveyed in order to determine translation priorities. He supported the proposal for a body to that end. His country was also willing to assist with the compiling of technical glossaries. He supported the draft resolution.

Mr FAÏHUN (Benin), speaking on behalf of the African Region, said that multilingualism had a political and management dimension and should be part of the reform process. A multilingual WHO was better placed to achieve the attainment by all peoples of the highest possible level of health. He welcomed the proposal for the Medium-term strategic plan 2008–2013 to implement resolutions WHA50.32, WHA51.30 and WHA60.11. He commended WHO's efforts in the African Region to promote multilingualism, but noted that the availability of information in Portuguese lagged behind the other two official languages of the Region. The financial burden of multilingualism notwithstanding, WHO should continue its efforts, especially with regard to funding. He supported the draft resolution.

Mr SHIRALIYEV (Azerbaijan) supported the proposed plan of action but expressed misgivings about the prospects for its implementation in the light of the inaccurate rendering in Russian of the title of the draft resolution considered by the Committee under agenda item 13.

Mr EVANS (Assistant Director-General) said that the Secretariat had taken note of all the points raised. It would endeavour to determine the exact nature of the problem raised by the delegate of China regarding the summary records of the Health Assembly. Replying to the comment of the delegate of Azerbaijan, he pointed out that paragraph 2(3) of the draft resolution contained in resolution EB122.R9 indicated that health-care background would be taken into account when recruiting WHO's language services staff. That should help improve the quality of translation.

The CHAIRMAN invited the Committee to consider the draft resolution.

The draft resolution was approved.¹

The meeting rose at 11:35.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA61.12.

THIRD MEETING

Thursday, 22 May 2008, at 14:20

Chairman: Dr A.R. SICATO (Angola)

later: Dr R. DANIEL (Cook Islands)

1. ORGANIZATION OF WORK

The CHAIRMAN recalled the decision of the General Committee to revise the programme of work, if necessary. It had been decided to transfer agenda items 11.2 (Monitoring achievement of the health-related Millennium Development Goals), 11.14 (Progress reports on technical and health matters) and possibly, depending on progress, 11.13 (counterfeit medical products) from Committee A to Committee B.¹

Dr Daniel took the chair.

2. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 18 of the Agenda

- **United Nations reform process and WHO's role in harmonization of operational development activities at country level** (Document A61/32)

Dr JAKSONS (representative of the Executive Board) recalled that the report on collaboration within the United Nations system and WHO's role in the harmonization of operational development activities at country level had been discussed by the Executive Board at its 122nd session. Discussions had focused on the need to continue to participate actively in United Nations reform, including the eight "Delivering as One" pilot initiatives. At country level, all United Nations agencies should support one national health plan through a joint United Nations cooperation strategy on health. Centralized fund-raising was needed to facilitate core voluntary contributions and to encourage donors to provide predictable amounts for defined periods. WHO would remain committed to United Nations reform and would properly reflect health matters in the international development agenda. Reform would lead to changes in line with the principles set out in the Paris Declaration on Aid Effectiveness: ownership, harmonization, alignment and mutual accountability (2005) and the Rome Declaration on Harmonization (2003).

Mr MACPHEE (Canada) supported the United Nations reform agenda and welcomed WHO's contribution. WHO's regional and country office staffing had been strengthened in line with harmonization objectives through transfers of resources and managerial responsibility. He welcomed rationalized procedures and reduced transaction costs. WHO's participation in the United Nations "Delivering as One" pilot initiatives was a benchmark. A WHO staff member had been selected as a resident coordinator and further appointments should follow.

¹ See summary record of the second meeting of the General Committee, section 2.

The sharing of offices within the United Nations family should bring efficiency and cost savings. With reference to paragraph 11 of the Secretariat's report, he was concerned that the proposed split in the structure of CEB might adversely affect efforts at harmonization.

Dr MUKONKA (Zambia), speaking on behalf of the Member States of the African Region, thanked WHO for organizing the first interregional meeting on the International Health Partnership and Harmonization for Health in Africa in Lusaka in February 2008. He commended WHO's efforts to align its country cooperation strategies with national strategic health plans. However, the priorities of the development assistance framework might not adequately reflect the individual needs and priorities of different countries. He called for accelerated implementation of capacity building for harmonization and alignment.

He welcomed the Secretariat's request to Member States to formulate national strategies for taking gender issues into account. However, the limited capacity to translate global strategies on gender mainstreaming into national plans required further technical support. Member States in the African Region were implementing strategies to reduce transaction costs through joint planning, procurement, accounting, monitoring and evaluation. WHO needed to further rationalize procedures at country level. Duplication by various United Nations agencies could still lead to administrative burdens for country staff. WHO, UNICEF and UNFPA had separate but similar programmes on reproductive health, HIV/AIDS and child health, which led national programme officers to devote more time to the demands of the United Nations agencies and less to programme implementation. He therefore commended WHO's harmonization with other agencies.

Mrs ADAM (Switzerland) welcomed WHO's efforts in the United Nations reform process. United Nations General Assembly resolution 62/208 was essential to that process. She supported the European Union's position, to be stated later.

The United Nations development system should follow the guidance of the General Assembly on national ownership and common programming and use opportunities for joint initiatives. Although responsibilities for development strategies lay with recipient governments, joint programming with the United Nations Country Team was usually based on the United Nations Development Assistance Framework. WHO country cooperation should harmonize with national strategies and the Assistance Framework, as part of a programme, and avoid a project approach. WHO should enable field representatives to participate in national planning processes through delegation of power, adequate programming and budgeting, and hosting arrangements with resident organizations.

Leadership was fundamental in guidance and accountability. United Nations country teams and all agencies should fully support the Regional Coordinator, who should be delegated adequate authority. WHO should strengthen the position of the senior resident official.

Simplified business practices for funds, programmes and specialized agencies were needed at all levels. The United Nations should apply standardized accounting, audit, cash transfers and human resources management. The High-Level Committee on Management of CEB was pursuing those matters, and WHO should implement CEB's decisions. Member States needed regular progress updates on both the "Delivering as One" approach and implementation of the recommendations of the United Nations General Assembly as outlined in the triennial comprehensive policy review.

Dr FORSTER (Namibia) said that global health initiatives had brought resources and opportunities but also leadership and coordination challenges. Improved harmonization by the United Nations organizations added value and efficiency to collaboration. Two principal goals of the United Nations Development Assistance Framework in Namibia involved the health sector. National strategic plans on HIV/AIDS, tuberculosis and malaria and the roadmap for reduction of maternal mortality provided a common framework for development partners. Namibia's partner organizations – WHO, UNICEF and UNFPA – had improved coordination through joint progress meetings.

Mr KOVAC (Slovenia), speaking on behalf of the European Union 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, Serbia and the European Free Trade Association country Norway, member of the European Economic Area, as well as Ukraine, Moldova and Armenia, welcomed WHO's collaboration and commitment to United Nations reform. WHO should provide regular updates on the "Delivering as One" pilot initiatives. WHO should support its country offices, especially those that followed the United Nations "Delivering as One" approach. WHO's training and guidance were essential and interagency contributions should be evaluated in the annual performance assessment. Effective Resident Coordinators were needed for United Nations reform, and he urged WHO to define, with key partners, their leadership functions. WHO should continue its work on gender mainstreaming and the promotion of gender equality, both within its own activities and as part of United Nations interagency cooperation. The Secretariat's report highlighted collective action in order to rationalize procedures and reduce transaction costs. Clear targets should be demonstrated.

At the High Level Forum on Aid Effectiveness to be held in Accra in September 2008, WHO and other United Nations agencies should demonstrate their commitment to the harmonization agenda. WHO country cooperation strategies should be fully aligned with national health and development plans in a unified system at country level.

He welcomed the review of pilot project sessions for heads of WHO country offices, referred to in paragraph 22 of the report, and requested that feedback be provided.

Mr ANDERSON (United States of America) said that the United States prioritized United Nations reform and advocated the need to streamline United Nations agencies, focus on results, and coordinate activities in the field. The reform efforts of WHO and its partners must lead to improved service delivery, credible reporting of programmes and financial accountability. WHO's shared work on results-based management, financial accountability and performance systems with other agencies could contribute to harmonizing business practices and management methods in the United Nations system. He noted implementation of the global management system and the low-cost location for the processing of financial and human resources transactions, and asked whether the Secretariat envisaged wider use of the location for the United Nations system. He commended the Secretariat's implementation of the International Public Sector Accounting Standards and encouraged shared experience with the rest of the system. The "Delivering as One" pilot initiatives should undergo rigorous independent evaluation. He noted that the implementation of resolution 62/208 of the United Nations General Assembly – adopted in the context of the triennial comprehensive policy review of operational activities for development of the United Nations system – required the involvement of all partners, including private sector and civil society stakeholders.

Dr ALLEN-YOUNG (Jamaica), speaking on behalf of the countries in the region of the Caribbean Community, said that the recent hurricane relief for Caribbean countries had been coordinated between WHO and PAHO and confirmed the benefits of the harmonized operations at country level. Funding had led to stricter building codes for hospitals in Jamaica so that they might withstand hurricanes of a higher category. Harmonization had also integrated HIV/AIDS strategies across the United Nations system, with more efficient use of fiscal and human resources. The countries in the the Caribbean Community supported the draft resolution.

Mr KANG'OMBE (Malawi), speaking on behalf of Malawi, Mozambique, the Netherlands, Norway, the United Republic of Tanzania and the United Kingdom of Great Britain and Northern Ireland, said that the United Nations should focus on priority areas on the basis of the "Delivering as One" principle.

Administrative cost savings should be transferred to programme activities in the countries where the savings were achieved. While recognizing the efforts of CEB, the United Nations headquarters should resolve the problems hampering progress of the "Delivering as One" initiative. He requested

UNDP and other United Nations agencies to resolve rapidly the “firewall” issue and strengthen the role of the Resident Coordinators. The United Nations headquarters should innovate by decentralizing decision-making to the country level, and accept pooled funding and harmonized reporting to headquarters. Moreover, the headquarters of specialized agencies should encourage the use of national budgetary systems for resource reporting and procurement. Lastly, alignment with national priorities must be complemented by united and predictable funding from donors.

Ms GONZÁLEZ NAVARRO (Cuba) pointed out that resolution 62/208 of the United Nations General Assembly did not provide a single model applicable to all countries. Instead, it reaffirmed that the operational activities for the development of the United Nations system must be universal, voluntary, neutral and multilateral, and required flexible approaches to individual developing countries. She would welcome further information from the Secretariat on the recruitment of WHO staff under the UNDP scheme referred to in paragraph 10 of the report, and on how it was contributing to increased savings and efficiency.

Ms MOLIN VALDES (United Nations International Strategy for Disaster Reduction) said that her organization was collaborating with WHO on a joint strategy for disaster reduction, in the context of the One United Nations programme and based on the Hyogo Framework for Action that required the collaboration of all sectors. The aim was to support countries in setting up national monitoring mechanisms and to make hospitals and health facilities and personnel safe from disasters. Cooperation would take place with the WHO regional offices through the Safe Hospitals campaign. Experience had shown that the health sector had a leadership role in the area of disaster reduction.

Mr SAMIEI (IAEA) recalled that IAEA’s Programme of Action for Cancer Therapy integrated radiation medicine into cancer control programmes. In developed countries, more than 45% of all cancers were now cured, and patients’ quality of life had improved. In developing countries, however, the vast majority of cancer patients arrived too late for curative treatment. Prevention programmes were lacking. Cooperation between IAEA, WHO and other stakeholders had led to six pilot projects for cancer control – one in each WHO region – with a view to the eventual implementation of cancer control programmes in those countries. The Programme was mobilizing funds, including grants, loans and equipment. Eventually, those projects could be replicated by other countries and provide regional cancer training.

Mr AITKEN (Representative of the Director-General for Partnerships and United Nations Reform) said that in the area of the global harmonization and alignment agenda, the Paris Declaration on Aid Effectiveness was being followed up. Country cooperation strategies were now better harmonized and the United Nations Development Assistance Framework would serve as a model in overcoming duplication of programmes at the country level. In reference to the comments regarding alignment and improvement of business practices at country level, the United Nations Secretary-General would write shortly to all Member States, informing them of key projects to improve alignment. Responding to comments made by the delegate of the United States, he said that efforts were being made to ensure that global management systems were able to interact with each other. Referring to the issue raised by the delegate of Canada, he said that the fact that the United Nations Development Group was now part of the three main pillars of CEB had revealed harmonization of aspects that had thus far stood outside the scope of the CEB. The first meeting of the eight WHO country representatives covering the pilot projects in the context of the “Delivering as One” initiative, held in Rwanda in April 2008, had emphasized the need for alignment of the United Nations system with country priorities and for country ownership of the work carried out across the United Nations system. A presentation would be made regarding the WHO Office in Kuala Lumpur to United Nations colleagues in the finance network of the High-Level Committee on Management.

Evaluation of the pilot initiatives would begin with stocktaking. Effective policy evaluation on the impact of the initiatives would be conducted between 2009 and 2011. As pointed out by the delegate of Cuba and demonstrated by the pilot projects, no single model could be applied in the

context of United Nations reform, and country leadership in that connection was critical to the process. The Secretariat would report regularly to the Executive Board and Health Assembly on progress in that area.

The Committee noted the report.

3. INTERNATIONAL AGENCY FOR RESEARCH ON CANCER: AMENDMENTS TO STATUTE: Item 19 of the Agenda (Document A61/33)

Ms MCKEOUGH (Office of the Legal Counsel), introducing the item, said that IARC, which was part of WHO, had amended its Statute as set out in Annex 1 to document A61/33. The amendments, which had been approved by the required two-thirds majority of the Agency's Governing Council, abolished the ceiling of 20 members of the Agency's Scientific Council and made it possible for each Participating State to nominate experts for membership in the Scientific Council. The amendments would enter into force once they had been accepted by the Health Assembly.

There were two small errors in the draft resolution contained in document A61/33. The operative paragraph Article VI(2) of the Agency's Statute should read "Each participating State may nominate up to two experts for membership in the Scientific Council and, if a Participating State makes such a nomination, the Governing Council shall appoint one of them"; and in the second line of Article VI(5) the word "shall" should be replaced by "may".

The draft resolution, as amended, was approved.¹

4. OUTCOME OF THE SECOND SESSION OF THE CONFERENCE OF THE PARTIES TO THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL: Item 20 of the Agenda (Document A61/34)

Ms JAQUEZ (Mexico) expressed satisfaction at the results of the work carried out under the WHO Framework Convention on Tobacco Control, which had been ratified by 140 States thus far. The Framework Convention exemplified an international instrument enabling the international community to protect universal goods. WHO itself was using it as a model in other public health fields. She emphasized guidelines for the implementation of articles of the Framework Convention.

Mexico had complied with the Framework Convention, by creating smoke-free zones, by regulating the content, promotion and ownership of tobacco products, their packaging and labelling, and by educating the public. Mexico had drafted a new law covering all aspects of tobacco control. It had established a national tobacco control office, in cooperation with WHO and partners.

Mr LAFEBER (Netherlands) endorsed the outcome of the second session of the Conference of the Parties, which had set an ambitious agenda for the third session. He complimented the Convention Secretariat on its work.

Ms ROBINSON (European Commission), supporting the remarks of the previous speaker, noted that the decision to negotiate a protocol on illicit trade in tobacco products had been facilitated by financial support provided by the European Anti-Fraud Office. The European Commission was

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA61.13.

strongly committed to concluding the negotiations by 2010. Progress was being made on tobacco advertising, packaging and labelling. Implementation of the Framework Convention in European Union Member States and worldwide was actively promoted.

Dr SARKER (Bangladesh) reported that Bangladesh had enacted a comprehensive tobacco control law in 2005 and formulated regulations in 2006. It had participated actively in the second session of the Conference of the Parties. The Bangladesh Ministry of Health and Family Welfare, working with WHO, had developed a national strategic plan of action for tobacco control in 2009 and 2010, which laid the foundation for tobacco control action.

Mr MACPHEE (Canada), noting that the Convention Secretariat had a tight budget, expressed satisfaction that some work could be undertaken by WHO's Tobacco Free Initiative, thereby freeing the Convention Secretariat's resources for its specific tasks. He welcomed the successful outcome of the first meeting of the Intergovernmental Negotiating Body on a Protocol on Illicit Trade in Tobacco Products, and urged the Body to make a draft of the protocol available in the coming months for the negotiations that were to take place in October 2008.

Ms MULVEY (Corporate Accountability International), speaking at the invitation of the CHAIRMAN, said that, in the coming months, her organization and its allies in the Network for Accountability of Tobacco Transnationals would be advocating the adoption of strong guidelines on Articles 13, 11 and 5.3 of the Framework Convention. Guidelines on Article 13, which covered tobacco advertising, promotion and sponsorship, would help the Parties put in place comprehensive bans to protect current and future generations from addiction to tobacco products. Guidelines were urgently needed on Article 11, so that tobacco packages and labels conveyed accurate information about the dangers of tobacco. The guidelines on Article 5.3, on protection of public health policies, would help Parties to limit interaction with the tobacco industry, reject partnerships or non-enforceable agreements with tobacco corporations and ensure transparency of tobacco industry activities.

Negotiations on the protocol on illicit trade in tobacco products also had to be insulated from tobacco industry interference. The protocol must require tobacco corporations to take responsibility for their supply chains, provide financial disincentives to the illicit tobacco trade, and prevent government collaboration with the tobacco industry. Social responsibility schemes that polished the image of tobacco corporations could undermine the Framework Convention. The Parties to the Convention and the United Nations system must reject such tactics.

Dr NIKOGOSIAN (Head, Convention Secretariat) agreed that the second session of the Conference of the Parties had set an ambitious agenda. The Parties had decided to open negotiations and develop instruments on 10 of 17 substantive articles, including a protocol on illicit trade in tobacco products. They had taken decisions on financial resources and mechanisms of assistance for Parties in need, which outlined new ways to support implementation of the Convention.

He announced that the second session of the Intergovernmental Negotiating Body would be held in Geneva from 20 to 25 October 2008, and the third session of the Conference of the Parties would take place in Durban, South Africa, from 17 to 22 November 2008.

The Committee noted the report.

5. TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (transferred from Committee A)¹

Monitoring achievement of the health-related Millennium Development Goals: Item 11.12 of the Agenda (Document A61/15)

The CHAIRMAN invited the Committee to consider the following draft resolution proposed by Albania, Andorra, Argentina, Armenia, Australia, Austria, Azerbaijan, Belgium, Bosnia and Herzegovina, Brazil, Bulgaria, Canada, Croatia, Cyprus, Czech Republic, Democratic Republic of the Congo, Denmark, Ecuador, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Kenya, Latvia, Liberia, Lithuania, Luxembourg, Malta, Mexico, Monaco, Netherlands, New Zealand, Norway, Poland, Portugal, Romania, Serbia, Slovakia, Slovenia, Spain, Sweden, The former Yugoslav Republic of Macedonia, Turkey, Ukraine, and the United Kingdom of Great Britain and Northern Ireland.

The Sixty-first World Health Assembly,

Recalling the 2005 World Summit Outcome and the commitments taken by the international community to fully implement the Millennium Development Goals;

Concerned by the lack of progress made, especially in the sub-Saharan African countries, in achieving the Millennium Development Goals, and in particular the health-related Goals;

Recalling the General Assembly resolution 60/265 dated 12 July 2006 on follow-up to the development outcome of the 2005 World Summit, including the Millennium Development Goals and the other internationally agreed development goals, and the WHO Medium-term strategic plan 2008–2013, particularly the objectives 2, 4, 7 and 12;

Welcoming the Secretariat's report on Monitoring of the achievement of the health-related Millennium Development Goals;

Underlining in particular the need to build sustainable national health systems; strengthen national capacities; fully honour financing commitments made by national governments and their development partners in order to better fill many of the resource gaps in the health sector; put the Paris Declaration on Aid Effectiveness into practice; increase predictability of aid,

1. DECIDES:

(1) to include the monitoring of the achievement of the health-related Millennium Development Goals as a regular item on the agenda of the Health Assembly;

(2) to support the United Nations Secretary-General's call to action, including the United Nations High-Level Event on the Millennium Development Goals (New York, 25 September 2008);

2. REQUESTS the Director-General:

(1) to submit annually a report on the status of progress made, including on main obstacles and ways to overcome them, according to the new monitoring framework, in achievement of the health-related Millennium Development Goals, through the Executive Board to the Health Assembly;

(2) to that effect, to continue to cooperate closely with all other United Nations and international organizations involved in the process of achieving the Millennium Development Goals in the framework of WHO's Medium-term strategic plan 2008–2013;

¹ See summary record of the second meeting of the General Committee, section 2.

- (3) to work with all relevant partners to help to ensure that action on the health-related Millennium Development Goals is one of the main themes of the United Nations High-Level Event on the Millennium Development Goals (New York, 25 September 2008).

Dr CIPIL (Turkey) noted that, halfway to 2015, progress had been made in achieving the Millennium Development Goals, but many low-income countries might fail to meet those targets. It was therefore crucial to calculate and monitor indicators and establish safe databases. WHO should spearhead efforts to establish information networks and guidelines in cooperation with institutions, and should ensure that health staff had access to those resources. In order to make efficient use of human resources, preventive and primary health care services should be given priority access to medical education. In that respect, political determination, intersectoral cooperation and adequate budget allocations were vital.

Dr AHMED (Pakistan), speaking on behalf of the countries of the Eastern Mediterranean Region, said that achieving the Millennium Development Goals remained a challenge for the Region's 10 countries, which had high under-five child mortality and maternal mortality rates and suffered from political instability, lack of effective national policies, difficult economic circumstances, weak health systems and low literacy rates. The Region needed cost-effective action to achieve universal coverage, address equity issues and provide a strongly supportive policy environment.

HIV prevalence had been stable in the Region, although some countries had reported a rise among people with high-risk behaviours. Access to antiretroviral therapy remained low, with only 6% of those in need being covered. The malaria burden had gradually decreased, with the number of reported cases falling from 6.1 million in 2000 to 3.6 million in 2006. Access to artemisinin-based combination therapy and insecticide-treated bednets was gradually increasing.

The Millennium Development Goals provided a strategic opportunity to strengthen primary health care. Functioning health systems (including information systems), surveys and health system research were important. WHO had introduced additional indicators such as the cause of death, coverage of interventions, risk factors and the health system. The establishment of a global observatory to monitor progress towards health-related Millennium Development Goals would also further strengthen monitoring, particularly in low-income countries.

Climate change could jeopardize achievement of the Millennium Development Goals. The Secretariat must pay attention to Goal 7 and scale up technical support for assessing and addressing the implications of climate change.

Mr LARSEN (Norway) welcomed the report, which highlighted progress and weaknesses in achieving the Millennium Development Goals. Nutrition, the environment and partnerships were common linkages across health-related Millennium Development Goals 4, 5 and 6. He expressed concern that progress towards the attainment of universal access to reproductive health had not been mentioned in the report. Greater progress was still needed with regard to Goal 6. Closer coherence within the Secretariat could improve guidance to Member States and partners. A platform for multi-stakeholder accountability was required. Improving maternal and newborn health was an opportunity to strengthen health service delivery which would, in turn, benefit other health-care programmes. Norway was encouraged by the global and national response to Goals 4 and 5, in which it had taken particular responsibility by mobilizing advocacy and action.

He supported the draft resolution.

Mr JERMAN (Slovenia), speaking on behalf of the European Union, the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, as well as Albania, Bosnia and Herzegovina, Montenegro, Serbia, Ukraine, Moldova and Armenia, proposed that the item under consideration should be regularly included in the Health Assembly's agenda. The Millennium Development Goals were at the core of international development strategy. Many low-income countries, especially in Africa, were struggling to meet the targets of the three health-related Millennium

Development Goals. He recommended a focus on the main issues highlighted in the report, namely: building sustainable national health systems; strengthening national capacities; honouring financial commitment; putting into practice the Paris Declaration on Aid Effectiveness; and increasing predictability of aid.

The countries of the European Union were among the sponsors of the draft resolution.

Mrs ALABI (Ghana) supported the draft resolution but proposed the insertion of an additional preambular paragraph, which would read “Concerned that the high rates of morbidity and mortality are underpinned by high levels of malnutrition and noting that the problem of climate change and increasing global food crisis may further undermine achievement of Millennium Development Goals 4 and 5, but encouraged by the positive trends for early and exclusive breastfeeding as an effective, low-cost and environmentally friendly measure to reduce under-five mortality”. She further proposed the insertion of an additional paragraph, requesting the Director-General “to assist low-income countries, particularly sub-Saharan countries, to strengthen breastfeeding and other effective and sustainable feeding practices, which would reduce malnutrition among children under five and to provide support for advocacy at non-health forums to increase food security”.

Ms ROCHE (New Zealand), welcoming the report, noted progress in combating HIV/AIDS and reducing infant mortality, but expressed concern at the slow progress in improving maternal health and child nutrition. She supported the renewed focus on primary health, building capability at the national level, strengthening health systems and developing public policies. Overall attainment of the Millennium Development Goals must not take place at the expense of the poorest and most vulnerable countries.

She agreed with the recommendation contained in the draft resolution that a progress report on the Millennium Development Goals be presented annually to the Health Assembly.

Ms TOR-DE TARLÉ (France), speaking on behalf of Germany, Denmark, Finland, Luxembourg, the Netherlands and Sweden, said that universal access to sexual and reproductive health had been introduced as new Millennium Development Goal 5B at the United Nations General Assembly in 2007. That area had not been reflected strongly enough in the report. WHO should include Goal 5B in future reports on the progress of the Millennium Development Goals. She also emphasized strengthened health systems.

Lack of protection against socioeconomic risks of illness prevented people from accessing health care. France prioritized that issue. On 7 May 2008, as part of the G8 initiative, it had held a joint conference with Germany entitled, “Providing for Health” in order to make health insurance coverage an essential element in achieving the health-related Millennium Development Goals.

Professor MWAKYUSA (United Republic of Tanzania), speaking on behalf of the Member States of the African Region, strongly supported the report. The WHO Regional Committee for Africa, at its fifty-fifth session, had adopted resolution AFR/RC55/R2 entitled “Achieving health Millennium Development Goals: situation analysis and perspectives in the African Region”.

Fully functioning and equitable health systems remained a priority and, to that end, 37 countries had been supported to develop or review their health policies and strategic plans over the preceding four years. Reductions in childhood morbidity and mortality had been experienced in seven countries, but maternal mortality ratios remained unacceptably high. Ministers of health of the African Union had adopted the Maputo Plan of Action for achieving universal access to comprehensive reproductive health. Thirty-seven countries had developed national road maps for accelerating the achievement of Millennium Development Goals 4 and 5. Availability of skilled personnel had increased in 25 countries. In 21 countries, interventions had been scaled up for the prevention of mother-to-child transmission of HIV by HIV testing, counselling, adapting national curricula and development plans, and training. The percentage of districts with at least one HIV testing and counselling facility had increased from 5% in 2004–2005 to 60% in 2006–2007. The total number of pregnant mothers

accessing services for prevention of mother-to-child transmission of HIV had increased from 190 000 in 2004–2005 to over 300 000 in 2006–2007. At the end of December 2007, about 1.9 million people living with HIV/AIDS had been receiving antiretroviral therapy, representing 42% of those in need, compared with 17% in 2005, but the coverage for children was still too low at 30%. It should be noted that the incidence of HIV infection had declined in some countries.

The spread of HIV infection had exacerbated the increased incidence of tuberculosis. The countries in the Region were implementing collaborative tuberculosis/HIV interventions, improved diagnostic facilities, and expanded provision of directly observed treatment centres in order to increase access to tuberculosis care and ensure management of multidrug-resistant tuberculosis. Tuberculosis case detection had increased. The number of high-burden countries that were implementing WHO tuberculosis control strategy in at least 50% of districts had increased from 6% to 44%.

Some countries had experienced a reduction in the incidence of malaria, due to use of insecticide-treated bednets, the introduction of artemisinin-based combination therapy, and the application of indoor residual spraying.

He highlighted several challenges: improved health information systems were needed; countries needed to honour their financial commitment of allocating at least 15% of their national budget to the health sector; and malnutrition, which was associated with more than 50% of child mortality, had to be addressed. He appealed to donors to increase their aid for development to 0.75% of gross domestic product.

Dr PILLAY (South Africa) thanked the Secretariat for the report. Achieving health-related Millennium Development Goals 4, 5 and 6 was linked to progress on the other Goals. He proposed that in the second preambular paragraph of the draft resolution the words “lack of” should be replaced by “relatively slow”, and that the fifth preambular paragraph be amended to read: “Underlining in particular the need to build sustainable health systems and health systems strengthening, in particular national health capacity, honour financial commitments made by national governments and the development partners in order to better fill many of the resource gaps in the health sector, put the Paris Declaration on Aid Effectiveness into practice, and increase predictability of aid”.

Dr FORSTER (Namibia) commended the timely report. Namibia’s internal and external resources had increased over the preceding three years, as a consequence of the Millennium Declaration and initiatives such as the Abuja Declaration. As a result, programmes related to the Millennium Development Goals were rapidly expanding.

He proposed that WHO and other development partners should increase their technical support to Member States in strengthening monitoring and information systems. Namibia supported the draft resolution.

The CHAIRMAN requested submission of proposed amendments in writing.

Dr SANTÍN PEÑA (Cuba) said that, as indicated in the report, and despite some examples of success, current trends showed that low-income countries would not reach the health-related Millennium Development Goals. With regard to Cuba’s progress in achieving the targets, a recent UNDP report had noted its success in reducing the proportion of underweight children under five to below 5%. Cuba’s infant mortality rate was 5.3 per 1000 live births, on a par with that of developed countries, the under-five mortality rate 7 per 1000 live births, and the maternal mortality ratio 21 per 100 000 live births; these were among the lowest figures in the region. The low incidence of HIV infection, at 0.09%, was attributable to Cuba’s multisectoral programme, which had contained, but not reduced, the epidemic. Access to information, prevention practices and antiretroviral treatment was free. The rate of transmission of HIV from mother to child was only 2.6%. Malaria had been eradicated in 1967 and the incidence of tuberculosis was 6.6% per 100 000 population, one of the lowest on the continent. Cuba was implementing a strategy for environmental sustainability.

With regard to development aid, Cuba supported some 36 000 health workers in 70 countries and, over 10 years, had provided free training for 100 000 doctors in low-income countries, a significant contribution for a small, developing country. Some 86% of its medicines were produced locally, and access to essential medicines was universal.

Investment in health systems in developing countries was insufficient; unless developed countries fulfilled their aid commitments, most of the targets would not be reached.

Dr FORRESTER (Jamaica), speaking on behalf of the member countries of the Caribbean Community, said that the wide disparities between the developed and developing countries, particularly low-income countries, seemed to have motivated the setting of high targets. A tiered system of goals for the various regions of the world would have been better, as the goals set seemed to relate primarily to sub-Saharan Africa and South Asia. Military expenditure and global increases in oil and food prices affected the levels of aid provided and undermined the achievement of the health-related Goals. The current global food shortage could place an additional 100 million people below the poverty line and erode the gains made in reducing poverty and malnutrition. The countries of the Caribbean Community had agreed to the Goals without realizing that severe constraints on funding, health personnel and equipment would make their attainment difficult.

Those countries had been praised for their efficient health systems, despite a relatively low per capita investment in health. Indicators compared relatively well with those of other middle-income countries. The region had made significant gains towards Goals 1, 2, 3 and 4. Its infant mortality rate stood at 19.9 per 1000 live births and the maternal mortality ratio was below 95 per 100 000 live births; most births were attended by skilled attendants. Poverty had been measurably reduced – in Jamaica, for instance, from 18% in 2000 to 14% in 2006. Progress had been slow, however, and there was a lack of timely, accurate statistics and health information. For Goal 6, the Caribbean had the second highest HIV/AIDS prevalence rates. Gains had been recorded in halting the epidemic but more work was needed in order to reduce the prevalence of HIV, contain co-infection with tuberculosis, and monitor drug-resistant tuberculosis. Over the previous two years, both the Bahamas and Jamaica had experienced outbreaks of malaria. For Goal 7, the Caribbean had good access to safe water and good sanitation, but climate change could threaten water quality.

Much had been gained through global partnerships, especially in the area of HIV, but small island States faced increases in tuberculosis and other conditions. The achievement of the Goals would require efforts to retain and train health workers, to improve employment rates, to reduce crime, and to improve health, education, agriculture and the environment. For the Caribbean, it was more realistic to expect achievement of the health-related Goals by 2025, and therefore the region should consider setting up a framework involving UNDP, UNICEF, the World Bank and PAHO similar to that established for the African Union. Aid should not be restricted to specific programmes, so that funding could be used to strengthen health systems as a whole and primary health care, critical to the attainment of the Goals.

She commended the report, and supported its conclusion that more development aid was needed on the basis of a global partnership for development. However, the report lacked information on the interdependence of the health-related Goals and responsibilities of other sectors. She asked WHO to collaborate more closely with other United Nations agencies in order to discuss increased aid in attaining the Millennium Development Goals as a whole. She supported the draft resolution.

Dr GUZMAN-ALA (Philippines) said that her country would increase efforts to achieve the health-related Goals. It had mobilized resources using a sector-wide approach, in line with the Paris Declaration on Aid Effectiveness. Investment priorities included health infrastructure, human resources and health systems. Data would be disaggregated by quintiles and resources targeted on the poorest quintiles. In achieving the health-related Goals, her country had adopted a strategy of setting higher targets as the levels were attained, and of establishing timelines for action. Her country was committed to concentrating efforts and resources towards the most needy sectors. She supported the draft resolution.

Mrs GOY (Luxembourg) said that her country prioritized the attainment of the health-related Goals. That depended on increased political will and pooled efforts. The obstacles to progress in achieving those Goals, especially in the sub-Saharan African countries, must be examined systematically, and solutions found, within the framework of the global partnership. The draft resolution, which had been endorsed in its original version by 51 countries, aimed to include the regular monitoring of the achievement of the health-related Goals. For that reason, she looked forward to its adoption by consensus.

Mrs LIMARQUEZ CANO (Spain) said that Spain supported the draft resolution. It had devoted considerable financial resources and political commitment to achieving the health-related Goals. Under its cooperation programme for 2005–2008, it had increased its financial contributions, particularly for health funds aimed at vulnerable populations. The health-related Goals promoted a global vision of progress based on equality, tolerance, the capacity to innovate and respect for the environment. Spain participated in cooperation programmes that prevented discrimination based on gender, age or social condition so that all citizens in developing countries could enjoy the right of access to quality medical systems.

Dr TAKAOKA (Japan) said that strengthening health systems – through training for doctors and nurses, effective monitoring, reliable information and evaluation – was vital to the achievement of the health-related Goals. To mark the midpoint of the process of achieving the Goals, her country would host the Fourth Tokyo International Conference on African Development (Yokohama, 28–30 May 2008) and the G8 Summit (Toyako, Hokkaido, 7–9 July 2008). Japan called upon the international community to strengthen commitment to global health.

Dr SARKER (Bangladesh), speaking on behalf of the Member States of the South-East Asia Region, said that progress made towards the achievement of the health-related Goals in the Region varied from country to country and from goal to goal. For most of the indicators at country level, estimated values were being used in the absence of accurate data. Available data showed that countries with strong public health systems were making good progress. However, strengthening health systems and research in the Region remained a major challenge in achieving the health-related Goals.

To reflect those concerns, he proposed several amendments to the draft resolution. After the second preambular paragraph a new paragraph should be inserted, which would read: “Concerned by the inadequate financial investments by the Official Development Assistance on MDG, the imbalance of investment across health-related MDGs in favour of diseases specific than health systems capacity strengthening, mother and child health and malnutrition”; and a further paragraph should be inserted after the third preambular paragraph, which would read: “Concerned by the fact that achievement of the MDGs varies from country to country and from goal to goal”. In paragraph 2(3) two new subparagraphs should be inserted, to read: “to support countries in the area of poor performance of specific MDGs”, and “to support countries for strengthening their health systems”. A new operative paragraph should be inserted, with the following wording:

2. URGES Member States:

- (1) to continue sustaining high-level political commitments and work with development partners towards strengthening the national health systems, including health system information for monitoring MDG progress, while ensuring for the poor access to essential health services;
- (2) to accelerate the level of investment on Official Development Assistance to reach the goal of 0.7% of OECD/DAC donors' gross national income with a special focus on health-related MDGs.”

The CHAIRMAN asked the delegate of Bangladesh to submit his proposed amendments to the Secretariat in writing.

Dr PHUSIT PRAKONGSAI (Thailand) said that equitable access to health care by all citizens was essential to achieving the health-related Goals. Thailand had achieved universal access to maternal and child health services since the early 1990s, prevention of vertical HIV transmission in 2000; a comprehensive health service package for all citizens in 2002; universal access to antiretroviral treatment in 2003, universal access to renal replacement therapy in 2007, and a functioning primary health care system at the district level.

However, the poorest regions of the world were far from achieving those Goals because of weak health systems and scarce financial resources. Worldwide, there was a severe imbalance in levels of investment across the health-related Goals. For example, high levels of resources had been devoted to HIV/AIDS, tuberculosis and malaria, as compared to reducing child mortality (Goal 4) or to reducing maternal mortality (Goal 5). Extending access to well-known, low-cost interventions in the area of public health to the poor could be decisive in improving child survival.

It was time to renew global commitment to achieving the health-related Goals. He supported the amendments to the draft resolution proposed by the delegate of Bangladesh.

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

The meeting rose at 17:00.

FOURTH MEETING

Friday, 23 May 2008, at 09:50

Chairman: Dr A.R. SICATO (Angola)

later: Dr R. DANIEL (Cook Islands)

1. SECOND REPORT OF COMMITTEE B: (Document A61/45)

Dr JAYANTHA (Sri Lanka), Rapporteur, read out the second report of Committee B.

Dr DAYRIT (Secretary) drew attention to a technical correction under Agenda Item 17.1 on page 11 of the report. The amended version of Rule 92 was to be inserted following Rule 68 and would read: “Verbatim records of all plenary meetings and summary records of the meetings of the General Committee and of committees and subcommittees shall be made by the Secretariat. Unless otherwise expressly decided by the committee concerned, no record shall be made of the proceedings of the Committee on Credentials other than the report presented by the committee to the Health Assembly”.

The report was adopted.¹

2. STAFFING MATTERS: Item 16 of the Agenda (continued)

Appointment of representatives to the WHO Staff Pension Committee: Item 16.3 of the Agenda (Document A61/29)

The CHAIRMAN proposed the nomination of Dr Ebenezer Appiah-Denkyira of the delegation of Ghana as a member, and Dr Palanitina Tupuimatagi Toelupe of the delegation of Samoa as an alternate member to the WHO Staff Pension Committee for a three-year term until May 2011.

It was so decided.²

Dr Daniel took the Chair.

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

Monitoring achievement of the health-related Millennium Development Goals: Item 11.12 of the Agenda (Document A61/15) (continued from the third meeting, section 5)

Mrs BAQUERIZO GUZMÁN (Ecuador), speaking on behalf of the Member States of the Region of the Americas, accorded great importance to the achievement of the Millennium

¹ See page 258.

² Transmitted to the Health Assembly in the Committee's third report, and adopted as decision WHA61(9).

Development Goals and expressed particular concern about the number of people dying from preventable conditions because of a lack of basic health care. The current generation was the first to have the power to eradicate poverty within its own lifetime, and it must rise to the challenge of providing the highest attainable standard of health care for all, especially the poorest and most vulnerable. She appealed for the resources and political will needed to build effective health systems.

Mr GREEN (United Kingdom of Great Britain and Northern Ireland) said that new approaches were needed to accelerate progress towards attainment of the Millennium Development Goals, particularly in combating noncommunicable diseases and malnutrition.

As the briefing on the International Health Partnership and the United Nations Secretary General's call to action had highlighted, improved coordination, mutual accountability and predictable financing were essential for the establishment of functioning health systems. The G8 Summit and the Accra High-Level Forum on Aid Effectiveness provided opportunities to reaffirm the Organization's commitment to the Millennium Development Goals. Moreover, a resolution should be adopted by the current Health Assembly to ensure that monitoring of the Goals was included in the agenda of subsequent Health Assemblies.

Dr GHOLBZOURI (Morocco) said that the achievement of the Millennium Development Goals was conditional on the mobilization of human, technical and financial resources. In Morocco rates of child and maternal mortality remained high. Consequently, the Government's health strategy for 2008–2012 was focusing on Millennium Development Goals 4, 5 and 6 through improved neonatal and obstetric care, an expanded programme of immunization, improved care in maternity departments and birth clinics, and improved core training for medical staff. The incidence of tuberculosis had been reduced and there had been no recent case of malaria. A small increase in the prevalence of HIV infection had focused attention on prevention, the free provision of triple therapy, and the introduction of psychological support facilities and measures to promote tolerance within society. Accelerated achievement of the Millennium Development Goals would require an overhaul of primary health-care provision, and improved information, education and communication. Morocco's National Human Development Initiative promoted development and well-being and sought to strengthen partnerships with nongovernmental and international organizations.

Dr ZHAO Zilin (China) supported the findings of the report. Greater investment, technical support and government commitment were required if the health-related Millennium Development Goals were to be achieved. Matters of health needed to be integrated into broader economic and social development. Improved coordination, policy development and data collection procedures were needed for the practical achievement of the Goals.

He had three proposals for WHO: it should be more active in coordinating projects run by international organizations; it should improve collection of data on HIV/AIDS; and it should give artemisinin a greater role in the prevention and control of malaria in African countries.

His Government's commitment to health matters had slowed the spread of both HIV infection and malaria. The introduction of the directly observed treatment, short course strategy across the country had increased rates of diagnosis of tuberculosis. Current priorities included increased investment in rural areas and access to drinking water.

Dr MHLANGA (Zimbabwe) supported the amendments to the draft resolution proposed by Ghana. He welcomed the Secretariat's plans to establish a global health observatory to monitor progress towards the Millennium Development Goals.

Zimbabwe had witnessed a decline in the prevalence of HIV infection and maternal mortality, and remained committed to the achievement of the Millennium Development Goals. He highlighted the need to tackle the challenges of food security caused by climate change and the global food crisis.

Dr SOMBIE (Burkina Faso) said that, with regard to its health-related Millennium Development Goals, his country had seen a significant decrease in HIV prevalence, but progress had been slow in reducing child and maternal mortality. He supported the draft resolution.

Dr MAFE (Nigeria) supported the draft resolution. Her country's achievement of the Millennium Development Goals would require political will and a strengthened health system. Her Government had demonstrated its commitment through an increased awareness of maternal, newborn and child health and a new National Strategic Health Investment Plan.

She also highlighted the greater availability of emergency obstetric care, improved training in obstetrics and neonatal care for medical staff, including the Midwifery Corps Scheme for the staffing of primary health centres, more family planning information, an expanded child immunization programme, new treatment methods such as anti-shock garments to protect against obstetric haemorrhages and magnesium sulphate against eclampsia, and the Safe Motherhood Project, which aimed to increase food availability and delivery.

Mr LOBATO (Brazil) supported the suggestion that the Organization should play a greater role in monitoring progress on the Millennium Development Goals. Monitoring must be based on Member States' own national statistics, where available, and not solely on projections. The goal of reducing maternal mortality must be considered in relation to women's reproductive and sexual rights and policies that aimed to combat violence against women.

Mr ANDERSON (United States of America) said that 2008 provided opportunities for the international community to discuss accelerated achievement of the Millennium Development Goals. He emphasized the importance, in addition to official development assistance, of good economic policy and private capital flows in financing development.

Dr PÉREZ SIERRA (Bolivarian Republic of Venezuela) agreed that, as stated in the report, some success had already been achieved in Venezuela in meeting the targets set by the United Nations Millennium Declaration. Living standards had been transformed and the country's Human Development Index ranking had risen. Provision of clean drinking water had improved and sewerage systems had been upgraded. Health coverage had also been significantly extended. People with HIV/AIDS received free treatment and 95% of Venezuelans had access to free primary health care. Infant mortality rates had been considerably reduced, and life expectancy had increased from 70 to 74 years. Maternal mortality had decreased but remained an important challenge. Vaccine coverage had been a success, with vaccines reaching more than 10 million Venezuelans in 2007. Full coverage against measles and rubella had been achieved with certification by PAHO.

Regarding the proposal for the establishment of a global health observatory, she emphasized strengthened coordination with government health agencies and with other United Nations bodies.

Ms TELLIER (UNFPA), welcoming the report, pointed out that Millennium Development Goal 5 was the least likely to be met. Efforts to improve the health of women and children, and women's access to reproductive health services had to be strengthened. Under Goal 5, the monitoring indicators were contraceptive prevalence rate, adolescent birth rate, antenatal care coverage and unmet needs for family planning. Many countries were making progress. It was necessary to sustain the momentum created by the Women Deliver Conference (London, 18–20 October 2007) and the Countdown to 2015 Conference: maternal, newborn and child survival (Cape Town, South Africa, 17–19 April 2008). Investing in women's health and education paid dividends in the education and health of their children, as well as the improved well-being of families and nations.

Ms ARENDT LEHNERS (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN and with the support of the International Baby Food Action Network, pointed out that a further global increase in early and exclusive breastfeeding would be an important

contribution to achieving Millennium Development Goal 4. Timely initiation and exclusive breastfeeding were crucial. Breastfeeding interventions were complex but highly cost-effective. United Nations agencies and donor countries should increase their financial and technical support in that area. She noted, however, that channelling such funding through public-private partnerships raised the threat of interventions becoming centred on profit rather than public health.

Dr EVANS (Assistant Director-General) confirmed that the Secretariat intended to set up a task force, at the request of the WHO Global Policy Group, on the issues of accountability and coordination under the Millennium Development Goal agenda. International Health Partnership Plus, in collaboration with the World Bank, was considering country compacts, frameworks for mutual accountability and the development of a common monitoring and evaluation framework. The Organization would also be involved in the work of the United Nations General Assembly session in September 2008 that was to discuss the Millennium Development Goals. There was long-standing collaboration with the United Nations Statistics Division in compiling information on progress related to the Millennium Development Goals. In response to the issue raised by the delegation of France, he confirmed that the new target 5B on reproductive health, under Millennium Development Goal 5, would be included in the reports submitted to WHO's governing bodies.

The CHAIRMAN invited the Committee to consider the revised text of the draft resolution introduced the previous day, which incorporated amendments proposed at the Committee's third meeting. Moldova wished to be included in the list of sponsors. The text read:

The Sixty-first World Health Assembly,

Recalling the 2005 World Summit Outcome and the commitments taken by the international community to fully implement the Millennium Development Goals;

Concerned by the relatively slow (South Africa) progress made, especially in the sub-Saharan African countries, in achieving the Millennium Development Goals, and in particular the health-related Goals;

Concerned by the inadequate financial investments by the Official Development Assistance on MDG, the imbalance of investments across health-related MDG in favour of diseases specific than health systems capacity strengthening, mother and child health and malnutrition; (Bangladesh)

Concerned that the high rates of morbidity and mortality are underpinned by high levels of malnutrition and noting that the problem of climate change and increasing of global food crisis may further undermine achievement of MDG-4 and 5, but encouraged by the positive trends for early and exclusive breastfeeding as an effective, low cost and environmentally friendly measure to reduce under-five mortality; (Ghana)

Recalling the General Assembly resolution 60/265 dated 12 July 2006 on follow-up to the development outcome of the 2005 World Summit, including the Millennium Development Goals and the other internationally agreed development goals, and the WHO Medium-term strategic plan 2008–2013; (USA)

And concerned by the fact that achievement of MDGs varies from country to country and from goal to goal; (Bangladesh)

Welcoming the Secretariat's report on Monitoring of the achievement of the health-related Millennium Development Goals;

Underlining in particular the need to build sustainable national health systems; strengthen national capacities; fully honour financing commitments made by national governments and their development partners in order to better fill many of the resource gaps in the health sector; (China) increase predictability of aid.

Sustainable health systems and health systems strengthening; in particular strengthened national health capacity; the honouring of financial commitments made by National Governments, and their development partners in order to better fill many of the resource gaps in the health sector; put the Paris Declaration on Aid Effectiveness into practice; increase predictability of Aid, (South Africa)

1. DECIDES:
 - (1) to include the monitoring of the achievement of the health-related Millennium Development Goals as a regular item on the agenda of the Health Assembly;
 - (2) to support the United Nations Secretary-General's call to action, including the United Nations High-Level Event on the Millennium Development Goals (New York, 25 September 2008);
2. URGES Member States: (Bangladesh)
 - (1) to continue sustaining high-level political commitments and work with development partners towards strengthening the national health systems including health information system for monitoring MDG progress, while ensuring for the poor access to essential health services; (Bangladesh)
 - (2) to accelerate the level of investment on Official Development Assistance to reach the goal of 0.7% of OECD/DAC donors' Gross National Income with a special focus on health-related MDGs. (Bangladesh)
3. REQUESTS the Director-General:
 - (1) to submit annually a report on the status of progress made, including on main obstacles and ways to overcome them, according to the new monitoring framework, in achievement of the health-related Millennium Development Goals, and in particular Goals 4, 5 and 6, through the Executive Board to the Health Assembly;
 - (2) to that effect, to continue to cooperate closely with all other United Nations and international organizations involved in the process of achieving the Millennium Development Goals in the framework of WHO's Medium-term strategic plan 2008–2013;
 - (3) to work with all relevant partners to help to ensure that action on the health-related Millennium Development Goals is a central theme one of the main themes of the United Nations High-Level Event on the Millennium Development Goals (New York, 25 September 2008);
 - (4) to assist low-income countries, sub-Saharan countries to strengthen breastfeeding and other effective and sustainable feeding practices, which would reduce malnutrition among children under five and to provide support for advocacy at non-health to increase food security; (Ghana)
 - (5) to support countries, in the area of poor performance of specific MDGs; (Bangladesh)
 - (6) to support countries for strengthening their health systems. (Bangladesh)

Mr JERMAN (Slovenia), speaking on behalf of the European Union and its Member States, welcomed the broad consensus among speakers on the need for better monitoring of the achievement of the health-related Millennium Development Goals. The revised draft resolution was a compromise text produced following bilateral discussions with delegations that had tabled amendments the previous day. New preambular paragraphs should be added with the following wording:

“Concerned by the fact that achievement of MDGs varies from country to country and from goal to goal;

Concerned that the high rate of morbidity and mortality are underpinned by social determinants of health and noting that these social determinants of health may further undermine achievements of the health-related MDGs;”.

In the seventh (previously fifth) preambular paragraph, the phrase beginning “put to the Paris Declaration” should be replaced by “to take concrete, effective and timely action in implementing all agreed commitments on aid effectiveness”. A new eighth preambular paragraph should be added, with wording taken from resolution WHA58.30:

“Acknowledging that rapid progress will require political commitment and a scaling-up of more efficient and effective strategies and actions, greater investment of financial resources, adequately staffed and effective health systems, capacity-building in the public and private sectors, a clear focus on equity in access and outcomes, and collective action within and between countries;”

A new ninth preambular paragraph should be added, with wording taken from the Ministerial declaration of the 2007 high-level segment of the United Nations Economic and Social Council:

“Reaffirming the commitments by many developed countries to achieve the target of 0.7% of GNI for official development assistance by 2015 and to reach at least 0.5 % of GNI for ODA by 2010, as well as the target of 0.15 % to 0.20 % for least developed countries, and urge those developed countries that have not yet done so to make concrete efforts in this regard in accordance with their commitments.”

The aim of the draft resolution was to ensure that achievement of the health-related Millennium Development Goals was placed high on the agenda of the Sixty-second World Health Assembly, to which end consensus at the current meeting was required.

Dr PHUSIT PRAKONGSAI (Thailand) considered that high-level political commitment was needed to achieve the Goals, notably in developing countries in the South-East Asia Region. He approved the new ninth preambular paragraph, but wished to retain paragraph 2(1), as contained in the revised draft before the Committee.

Mr ANDERSON (United States of America), Ms FINSTAD (Norway) and Mr KANG’OMBE (Malawi) supported the text presented by the delegate of Slovenia.

Dr PÉREZ SIERRA (Bolivarian Republic of Venezuela) asked to be included in the list of sponsors and agreed with the comments of the delegates of Slovenia and Thailand.

Mrs ALABI (Ghana) noted that achievement of the health-related Millennium Development Goals varied between countries and was particularly slow in low-income countries, notably those in sub-Saharan Africa. The draft resolution should therefore highlight the levels reached by the different countries as an incentive to further commitment. Environmental factors were as important as social determinants; that should be reflected in the text, as should malnutrition, a critical factor related to Goals 4 and 5, which were of special importance to the developing countries, notably those in sub-Saharan Africa.

The CHAIRMAN suggested that an informal group meet to finalize the text of the draft resolution. The Committee would continue its work while the group met.

It was so agreed.

(For resumption of the discussion and approval of the draft resolution, see page 225 below.)

Progress reports on technical and health matters: Item 11.4 of the Agenda (Documents A61/17 and A61/17 Add.1)

A. Control of human African trypanosomiasis (resolution WHA57.2)

Dr MIAKALA MIA NDOLO (Democratic Republic of the Congo), speaking on behalf of the Member States of the African Region, said that resolution WHA57.2 on the control of human African trypanosomiasis was as topical as ever. Affecting humans and livestock alike, the disease remained a serious public health problem and was a factor of underdevelopment in the 36 affected countries of sub-Saharan Africa. Although a regional strategy to combat the disease had been launched by the WHO Regional Committee for Africa at its 55th session in 2005, the resources available for implementation were still inadequate. He appealed to the international community to mobilize the necessary financial and technical resources to improve screening, diagnosis and treatment, with a view to total eradication of the disease. His country's experience of integrating human African trypanosomiasis control into the primary health-care system had been very positive and pointed the way forward. However, that policy was hampered by the non-availability of simplified, reliable and affordable diagnostic tools and easily administered medicines. He called upon the international community and research institutions to support research and development for new diagnostic tools and safer, more effective and affordable medicines. He called upon the States in which the disease was endemic to implement the Plan of Action for the Pan African Tsetse and Trypanosomiasis Eradication Campaign.

He warned that foreseeable ecological changes resulting from global warming could encourage the spread of more resistant insect vectors.

Dr LOKMAN HAKIM SULAIMAN (Malaysia) welcomed the reduction in the number of new cases of human African trypanosomiasis reported in countries in which the disease was endemic. However, the disproportionate reduction of 61% in countries where the aetiological agent was *Trypanosoma brucei gambiense* and 21% in countries where the disease was caused by *T. b. rhodesiense* needed to be explained, especially in the light of the concern felt at the declining priority given to control of the disease. He would welcome a report outlining progress on the specific actions set out in paragraphs 2(1), 2(2) and 2(3) of resolution WHA57.2, in particular to help in gauging the success of the Special Programme for Research and Training in Tropical Diseases.

Although trypanosomiasis was not endemic in Malaysia, his country would continue to support international research and development initiatives aimed at controlling trypanosomiasis and other neglected diseases. Malaysia had established in vitro and in vivo screening facilities for trypanosomiasis, leishmaniasis and lymphatic filariasis in support of the Drugs for Neglected Diseases initiative, of which it was a founding member. Those facilities could be used by any interested parties to screen for potential compounds.

Dr SASIDHORN TANGSAWADEE (Thailand) welcomed progress made towards controlling human African trypanosomiasis, but cautioned against complacency. Immediate and competing demands for limited financial resources could mean failure to contain and eliminate the disease. A strong policy and resolute action were needed. She called for innovative financing of research and development of affordable diagnostic tests and oral medication that would be safe, easy to administer and effective against all forms of the disease. At country level, governments and other development partners must sustain their commitment. Surveillance and control must be integrated into health systems.

Dr NAKATANI (Assistant Director-General), referring to the need to expedite research, said that the Secretariat was creating a resource bank in order to make research more readily available. Better surveillance should be an integral part of strengthening health systems. Cooperation between the Secretariat, governments and other partners should speed up progress towards the eventual elimination of the disease.

B. Strengthening nursing and midwifery (resolution WHA59.27)

Ms SMADU (Canada) commended the collaborative efforts of WHO and its partners towards developing the nursing and midwifery professions, an important part of strengthening health systems. International shortages of nurses and midwives had become one of the main obstacles to meeting global targets such as Millennium Development Goals. Overcoming that crisis would require sustained action at country level. Nurses and midwives were acknowledged leaders in the continuing improvement of health systems but were underrepresented in decision-making forums at national, regional and multilateral levels. Governments needed to involve nurses and midwives in national, regional and international policy. Canada supported the work of many governments in improving health care. Recruitment and retention of nurses and midwives depended on investment in improving the workplace through informed management and accountability.

Dr CIPIL (Turkey) commended the work of WHO's Global Advisory Group on Nursing and Midwifery and stressed that the planning of health workforces was a key factor in strengthening health systems. To that end, Turkey had amended its law on nursing with improved arrangements for training and practice.

Mr AL-SHIABI (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed optimism about the future of nursing and midwifery services in the world. Yemen and other countries in the Region were strengthening the role of nurses and midwives in obstetrics. Morbidity and mortality rates were declining. The Gulf Cooperation Council had stepped up its cooperation with WHO, including the Regional Office. He commended the work of WHO's Global Advisory Group on Nursing and Midwifery, and its important role in reducing communicable diseases and epidemics worldwide.

Dr DARUNEE RUJKORAKAN (Thailand) expressed her appreciation for WHO's work in implementing resolution WHA59.27. In that regard, she emphasized that programmes to strengthen nursing and midwifery capacity should be prioritized and conducted on a sustainable basis. The Secretariat and Member States should encourage the involvement of nurses and midwives in all relevant public health policy. They should also support implementation of the Islamabad Declaration on Strengthening Nursing and Midwifery and the Chiangmai Declaration on Nursing and Midwifery for Primary Health Care. Both provided principles for strengthening the role of nurses and midwives within health systems, ensured an optimal mix of skills and promoted positive working environments.

Mr MABUZA (Swaziland) said that his country, like many others, had a shortage of nurses and a poor nurse-to-patient ratio. The incidence of new and emerging diseases, and the increased disease burden, made further demands on direct patient care. Swaziland had doubled its intake of nursing students. His country appreciated the capacity-building support provided by WHO, the International Council of Nurses and other development partners. He appealed for support for programmes to develop nursing leadership in several countries. Swaziland had initiated a health programme for health workers affected by HIV infection and AIDS. He sought support for such initiatives, which contributed to the retention and productivity of the health workforce.

Dr CHITUWO (Zambia) said that, in the context of the implementation of resolution WHA59.27, his Government had introduced measures designed to improve staff recruitment, training and retention. However, Zambia was still critically short of the nursing skills it needed to support implementation of national and international policies and health-related goals. In December 2007, Zambia had hosted the global consultation on scaling-up the capacity of nursing and midwifery, which had led to the establishment of a global programme of work on strengthening nursing and midwifery 2008–2009. Zambia provided implementation support for that programme of work.

Dr TSHABALALA MSIMANG (South Africa) expressed support for the Kampala Declaration on Fair and Sustainable Health Financing. She urged Member States, including developed countries, to update their human resource plans and ensure that their workers were trained to meet domestic needs. That would alleviate the pull factor of migration for health workers, particularly for nurses and midwives. The Organization should support efforts to train mid-level health workers. She requested clarification from the Director-General on how Member States would participate in the consultations on a global code for ethical recruitment, and when that work would be completed. The task groups that were working in response to the crisis in human resources for health should be truly representative of all regions, particularly those that were seriously affected by migration and the consequent shortage of health workers.

A programme of hospital revitalization had improved infrastructure, management, equipment and quality of care. A core set of standards for health facilities had been introduced and many nurses were working in well-equipped, modern hospitals. Improved remuneration had attracted nurses back to the public health sector, including from the private sector. Nursing schools and colleges were being reopened in order to combat the current shortage in her country. However, some Member States had been negatively affected by limitations dictated by some international organizations on the size of their civil service and on salaries. She proposed that the next Health Assembly should consider a resolution on workforce development, particularly for nurses and midwives.

Mr RAKUOM (Kenya) said that his country's strategic plan for nursing and midwifery aimed to increase recruitment, improve training, supplies and equipment, and realign nursing within health management. Nurses had worked with and supervised community health workers, resulting in a significant increase in immunization coverage, skilled attendance at birth, and access to antiretroviral drugs, which would contribute to achieving Millennium Development Goals 4, 5 and 6. Some 3000 nurses would be recruited to respond to the needs of the community nursing programme.

Despite those needs, his country was currently unable to employ all the nurses trained in Kenya. Bilateral agreements had therefore been concluded in order to manage their recruitment by other countries. He urged the Organization and its partners to complete the international code of practice on ethical recruitment of health workers in time for consideration at the Sixty-second World Health Assembly. They should also increase support for initiatives concerning nurses and midwives, and report to the Health Assembly in 2010.

Dr FORRESTER (Jamaica) said that health workforce issues such as training, recruitment, migration, retention and task shifting were critical to achieving the Millennium Development Goals and domestic health objectives. The current shortage of nurses and midwives in Jamaica could be detrimental to service delivery and health-care providers.

Jamaica supported the Organization's position on strengthening nursing and midwifery services in the Region of the Americas, and the measures it had taken to support those professions. That support should continue. The Regional Office should, however, be more visible in order to provide the guidance and support required by nursing leaders. Her Government supported the Islamabad Declaration on Strengthening Nursing and Midwifery, and looked forward to the elaboration of a global code of practice on ethical recruitment.

Ms VALLIMIES-PATOMÄKI (Finland) commended the progress reported in strengthening nursing and midwifery, although concerns remained. Nurses played an important role in controlling noncommunicable diseases and in changing people's health behaviour. Evidence indicated that expanded roles for nurses and better patient education promoted patients' capacity for self care. Nursing and midwifery services should be at the core of primary health-care systems in order to facilitate the achievement of the Millennium Development Goals.

The Organization should promote the involvement of nurses and midwives in all its priority programmes with greater technical advice for Member States. Results should be measured against

specific indicators, and reports submitted on a regular basis, starting in 2010. Her Government looked forward to a report on ethical recruitment guidelines in 2009.

Mrs DE SOUSA (Portugal) said that nurses and midwives were fundamental to the achievement of the Millennium Development Goals. Research had indicated a clear correlation between the number of nurses and midwives and a decrease in some diseases and improved quality of life. Portugal supported the Organization's efforts to extend the role of nurses and midwives. Action plans were needed for strengthened capacity. Nurses and midwives should be given a more active role in developing national health policies and programmes. They should also be given a greater role in the Organization, which should create more posts for them.

Dr ABOUBACAR (Niger), speaking on behalf of the Member States of the African Region, said that the Region was facing a serious shortage of nurses and midwives and that those available were not adequately trained to ensure the effective and efficient implementation of policies. In most of the countries, that situation had resulted in insufficient numbers of new nurses and midwives, uneven provision of services in rural and urban areas, internal and external migration, increased workload and poor productivity owing to absenteeism, illness and burnout. Those shortages were due to inadequate policies, a lack of planning and poor human resource management, inadequate and irrelevant training, and a decreased workforce resulting from HIV/AIDS and poor work conditions.

The Secretariat had supported the countries in the Region in developing national policies for health workers, and specific plans for strengthening nursing and midwifery. A regional plan for training and recruitment had also been established. Basic training for nurses and midwives had been updated in some countries and was being harmonized in the 15 countries of the Economic Community of West African States.

The countries of the Region aimed to reduce the brain drain by increasing salaries, improving working conditions, and giving incentives for working in difficult areas. The strengthening of health systems would include training for health workers, incentives, and human resource management, including the introduction of information technology systems.

Mrs CHERQAUI (Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that nursing and midwifery services were fundamental to health-care programmes. Investments were being made in training for nurses and midwives, who required benefits to attract them to the professions. Lack of planning had led to poor distribution of those workers and a lack of trainers. That had resulted in a slowdown in training and a lack of places for potential students. Sufficient funds must also be allocated to training if further progress was to be made. She urged the Organization and development partners to support the countries of the Region in that regard.

Ms TOUYAMA (Japan) said that Japan had focused on human resource development as a means of enhancing maternal and child health through bilateral cooperation with countries such as Afghanistan, Cambodia and Madagascar. As the host country for the Fourth Tokyo International Conference on African Development and the G8 Hokkaido Toyako Summit, her Government was currently promoting the health of people worldwide. That included both a disease-specific approach and a comprehensive approach that included strengthening health systems in a balanced manner. The challenges in the field of nursing and midwifery involved promoting primary health care and tackling emerging health issues.

Ms GUY (New Zealand), in her capacity as president of the New Zealand Nurses Organisation, encouraged other countries to include nurses in their delegations. Recalling resolution WHA59.27, she stressed the contents of the progress report. It noted the Declaration on Strengthening Nursing and Midwifery adopted in 2007, which outlined principles on workforce capacity, skills and a positive workplace. It also recommended that Member States establish policies to ensure self-sufficiency in workforce production. She considered that ensuring a supply of trained nurses and midwives to meet

global requirements must be a priority for all Member States. Governments should actively involve nurses and midwives in policy development and implementation at all levels.

New Zealand was training an unprecedented number of nurses and extending their role in the health system. The leadership role of the Chief Nurse in the Ministry of Health had been strengthened accordingly. Through a collaborative relationship, the Government, health system employers and unions shared authority for resolving workforce issues. The New Zealand Nurses Organisation and the District Health Boards were jointly implementing recommendations on workforce management aimed at improving health services and quality of workplace environment for nurses and midwives. Her country supported international and regional work to strengthen nursing and midwifery and welcomed global action in that area.

Mrs CHOTA (Uganda) drew attention to the fact that nursing and midwifery accounted for about 90% of all health service delivery. Nursing and midwifery in the African Region were characterized by inadequate policies, planning and human resources management, attrition due to HIV/AIDS, and poor working conditions.

Uganda's National Health Policy placed emphasis on human resources. There was a database for nurses and midwives, comprehensive and specialized nurses' training, a leadership programme for nurses and midwives with appointments to management positions, the restructuring of the Ministry of Health, and elaboration of nursing and midwifery guidelines. Financial challenges nonetheless remained in the areas of education, management, leadership and research. Member States should increase financial resources for capacity building in those areas. She called on WHO to support strengthening of nursing and midwifery and requested the Director-General to support Member States, in collaboration with local and global partners, in applying ethical recruitment guidelines and to report progress in 2009; and to report to the Sixty-third World Health Assembly on progress made in the implementation of resolution WHA59.27.

Ms AL-QATTAN (Kuwait) said that nursing and midwifery were among her Government's priorities, in view of the shortage of personnel in those sectors. The percentage of Kuwaiti nationals employed in nursing and midwifery did not exceed 9%, out of a total of 12 000 employees. As a result, her Government was developing strategies to attract nationals into those professions. Particular emphasis was also placed on training opportunities, including in the workplace, and strategies were being implemented in accordance with WHO's recommendations.

Mrs MAKHAKHE (Lesotho) said that, recognizing the crucial contribution of the nursing and midwifery professions to health systems and to the achievement of the health-related Millennium Development Goals, Lesotho had made progress in developing human resources in nursing. The number of nurses' training colleges had increased from three to five. There was also the challenge of ensuring equitable geographical distribution and providing a motivated nursing and midwifery workforce. The Government had increased the role of nurses and midwives in the planning and implementation of health policy. It had also introduced incentives to retain nurses who had remained in the country and was encouraging the return of those who had left. Legislation and regulatory processes affecting nurses were being reviewed. She requested the Organization: to continue its support for the Global Advisory Group on Nursing and Midwifery and to recruit nurses and midwives in country offices, in accordance with WHO's policies and programmes; to support capacity building for nursing and midwifery leadership; and to report to the Sixty-third World Health Assembly in 2010 on progress made in the implementation of resolution WHA59.27.

Ms BENNETT (Australia) said that a chief nursing and midwifery officer would soon be appointed to her Government's Department of Health and Ageing to advise on nursing and midwifery workforce planning. Australia was committed to maternity reforms, which included tackling the following: postnatal depression, the high proportion of births by Caesarean section in Australia, the gap in health outcomes and services for indigenous mothers and babies, and the lower than optimal

rate of breastfeeding. Her country was developing a maternity services plan, that would optimize the role of midwives in the provision of maternity care and ensure national coordination of maternity services.

Mr TREVOR CLARKE (Barbados) commended the Secretariat's efforts to develop a global code of practice for the international recruitment of health workers. His country had committed itself to resolution WHA59.27 through the establishment of polyclinics and district hospitals throughout the island, with defined population targets. The provision of adequate staff and training for those institutions were national priorities. His Government had nominated nurses and midwives to policy formulation committees and acknowledged the valuable role of nurses in the National Strategic Plan for Health 2002–2012. In view of the changing circumstances of the nursing and midwifery professions, the Nurses Act 2008 had reduced the age of entry into nursing from 18 to 16 years, which coincided with the school-leaving age. The Nursing Council for Barbados would be given a full-time secretariat. Barbados had recently recruited nurses from Saint Vincent and the Grenadines in the context of an initiative within the Caribbean Community that complied with the principle of ethical recruitment of staff and the code of practice for the international recruitment of health workers. Nurses would be trained in specialist skills that would benefit them and their country of origin. He requested the Secretariat to provide an update on the implementation of the code of practice at the Sixty-second World Health Assembly. The general health of the nation depended on training and retaining competent nurses and midwives, and his country would continue to support their expanding role in the Caribbean Community, with a view to achieving the health-related Millennium Development Goals.

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

Monitoring achievement of the health-related Millennium Development Goals: Item 11.12 of the Agenda (Document A61/15) (resumed)

Mr JERMAN (Slovenia) said that following informal consultations on the draft resolution, a compromise text had been agreed.

Dr DAYRIT (Secretary) read out the proposed amendments to the draft resolution. New third and fourth preambular paragraphs should be inserted, to read:

“Concerned by the fact that the achievement of Millennium Development Goals varies from country to country and from goal to goal;

Concerned that the high rate of morbidity and mortality are underpinned by social determinants of health and high levels of malnutrition, and noting that these social determinants of health may further undermine achievements of the health-related Millennium Development Goals;”.

In the preambular paragraph beginning “Recalling the General Assembly resolution ...”, the phrase “particularly the objectives 2, 4, 7 and 12” should be deleted. In the preambular paragraph beginning “Underlining in particular ...”, the word “to” should be inserted before “strengthen” and should also replace “fully”, the phrase “put the Paris Declaration on Aid Effectiveness into practice” should be replaced by “to take concrete, effective and timely action in implementing all agreed commitments on aid effectiveness”, and the words “and to” should be inserted before “increase predictability of aid”. A new final preambular paragraph should be inserted, to read:

“Reaffirming the commitments by many developed countries to achieve the target of 0.7% of gross national income for official development assistance by 2015, and to reach at least 0.5% of gross national income for official development assistance by 2010, as well as the target of 0.15% to 0.20% for least developed countries, and urge those developed countries that have not yet done so to make concrete efforts in this regard in accordance with their commitments”.

A new paragraph 2 should be inserted to read:

“URGES Member States to continue sustaining high-level political commitments and work with developing partners towards strengthening the national health systems, including health information systems for monitoring Millennium Development Goal progress”.

Paragraph 2 of the original text of the draft resolution would thus become paragraph 3.

The draft resolution, as amended, was approved.¹

The meeting rose at 13:40.

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA61.18.

FIFTH MEETING

Friday, 23 May 2008, at 14:40

Chairman: Dr A.R. SICATO (Angola)

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

Progress reports on technical and health matters: Item 11.14 of the Agenda (Documents A61/17 and A61/17 Add.1) (continued from the fourth meeting, section 3)

B. Strengthening nursing and midwifery (resolution WHA59.27) (continued from the fourth meeting, section 3)

Mrs BANDAIZI (Malawi) said that nursing formed the backbone of Malawi's health delivery system and was crucial to achieving the health-related Millennium Development Goals. Nurses were supported from the highest level (Director of Nursing Services) down. In order to meet shortages of personnel caused by migration, Malawi had intensified the training of nurses; introduced incentive packages to retain them; improved the working environment through "care of the carer" policies; and made provision for post-exposure prophylaxis.

She called on the Secretariat to provide more resources and technical support in order to increase nursing and midwifery programmes; to train more tutors; strengthen curricula; and develop standards. She commended efforts to implement resolution WHA59.27 and looked forward to a progress report at the Sixty-third World Health Assembly in 2010.

Ms CHASOKELA (Zimbabwe) acknowledged the significant role played by nurses and midwives in her country. They provided services to the poor and vulnerable groups, conducted primary health-care activities, and were responsible for training and supervising community health workers. Thanks to them, health-care coverage had improved and HIV/AIDS prevention, treatment and care had been expanded.

However, the emigration of nurses and midwives threatened Zimbabwe's endeavours to achieve the Millennium Development Goals. With support from WHO and partners, post-basic training facilities had been strengthened and the number of training schools and registered nurses had increased. However, the number of educators still fell short of needs. The curriculum for midwives had been revised. Her country planned to train 800 midwives per year as of September 2008. Subject to support from WHO and partners, Zimbabwe would be on course to attain the Goals.

She expressed appreciation of the work of the Global Advisory Group on Nursing and Midwifery and support for the global programme of work for the period 2008–2009 and the updated Strategic Directions for Strengthening Nursing and Midwifery Services 2009–2015. She questioned the decline in the number of posts for nurses and midwives within the Secretariat, especially at country level. The Secretariat should submit a progress report to the Sixty-third World Health Assembly in 2010 through the Executive Board, and report on progress in elaborating the code of practice for the recruitment on health personnel (resolutions WHA57.19 and WHA58.17) in 2009.

Ms WISKOW (ILO) noted that ILO's primary goal was to promote decent work for all, and that that encompassed the following: opportunities for decent and productive employment with fair pay; security in the workplace; social protection for families; freedom for people to express their concerns, and organize and participate in the decisions affecting their lives; and equality of opportunity and treatment for women and men. WHO and ILO had a long tradition of cooperation on nursing and midwifery. She recalled that the International Labour Conference had adopted the Nursing Personnel

Convention (no. 149) in 1977, and like resolution WHA59.27 the Convention recognized the vital role played by nursing personnel. The standards set out in the Convention and its accompanying recommendation provided guidance on adequate conditions of employment and work for nursing personnel that were “likely to attract persons to the profession and to retain them in it”. She emphasized the strong links between working conditions and the retention and performance of nursing personnel. Concerns included poor working conditions, low pay, high workloads, insecure environments, long hours, lack of professional development, insufficient equipment, and weak management support.

The decent work concept provided a framework for such retention; this included recognition, participatory decision-making, adequate remuneration and safe and secure working conditions. The promotion of the ILO Nursing Personnel Convention had been integrated into WHO’s global programme of work for 2008–2009 on scaling up the capacity of nursing and midwifery to contribute to attaining the Millennium Development Goals.

Mr BENTON (International Council of Nurses), speaking at the invitation of the CHAIRMAN, applauded WHO’s initiatives to strengthen nursing and midwifery, particularly the global survey on strategic directions, the work of the Global Advisory Group on Nursing and Midwifery to develop indicators and care models, and work on a code of practice on the recruitment of health personnel. Through its member associations and its International Centre on Human Resources in Nursing, his organization monitored the global nursing situation. It had become common in many countries to see patients sharing beds or packed in narrow hallways on stretchers, with little regard for their privacy, dignity or personal care. Entire health-care systems were heading for disaster because of shortages of nurses and other health personnel. The results were threats to patient safety, an increased risk of error, poor care outcomes, staff turnover and migration. The Council and its global partner associations, together with ILO and the Global Health Workforce Alliance, had launched a positive practice campaign in order to improve working environments, staff recruitment and retention. He asked when WHO would join.

He was heartened to see renewed WHO and government commitment to addressing the nursing and midwifery crisis and applauded PAHO’s goal of increasing the number of nurses. Donors were important at a time when 57 States were in crisis, and primary health-care was back on the agenda. Never had WHO’s leadership – nationally and regionally – been more important, yet the percentage of nursing specialists in the Secretariat had fallen to less than 1%. What plans did the Secretariat have to strengthen nursing and midwifery within its ranks and to increase the number of posts for nurse specialists at country and regional levels?

The Council and its member associations were ready to work with the Secretariat and countries to implement national strategies and mechanisms that made optimum use of nurses’ potential and skills in order to achieve the Millennium Development Goals.

Dr ETIENNE (Assistant Director-General) thanked Member States, professional associations and stakeholders for their collaborative efforts to improve nursing and midwifery. The Secretariat was working actively with the Global Health Workforce Alliance to address the factors contributing to the crisis in human resources for health. It had reintroduced the process for developing the code of practice on the recruitment of health personnel into the cycle of WHO governing body meetings, and would launch a broad consultation of Member States and stakeholders with a view to presenting the draft code to the Executive Board in January 2009 and subsequently to the Sixty-second World Health Assembly.

The Secretariat continued to strengthen its work in nursing and midwifery at all levels. It provided support for the work of the Global Advisory Group on Nursing and Midwifery, the global programme of work, and the Global Standards for Initial Nursing and Midwifery Education. It had instituted changes in recruitment and staffing patterns to support WHO’s changing agenda. Recruitment processes based on competency offered opportunities for nurses and midwives to work in WHO’s technical programmes at all levels. In addition, nurses and midwives were increasingly being

sought for regional and country office positions. WHO would establish a high-level group on primary health-care renewal, in which nurses and midwives would be represented, to guide policy development, resource mobilization, implementation and evaluation.

C. International health and trade (resolution WHA59.26)

Mr LOBATO (Brazil), remarking that resolution WHA59.26 requested the Director-General to “provide support to Member States [...] in their efforts to frame coherent policies to address the relationship between trade and health”, “support [...] their efforts to build the capacity to understand the implications of international trade and trade agreements for health” and “continue collaborating with the competent international organizations in order to support policy coherence between trade and health sectors”, applauded the Secretariat’s initiatives to those ends. He was nevertheless concerned that the Region of the Americas, in particular the Regional Office in Washington, had been left behind. The Organization and all the regional offices must support the efforts of Member States in framing policies that took account of the risks certain policies posed to the achievement of public health objectives.

Mrs LIQUELA (Mozambique), speaking on behalf of the Member States of the African Region, said that trade policies helped to overcome diseases arising from food insecurity, poverty, and lack of access to water, sanitation and shelter. They also had the potential to worsen health problems. Agreements such as those on technical barriers to trade, sanitary and phytosanitary measures, trade-related aspects of intellectual property rights (TRIPS) and trade in services, all presented both risks and opportunities for public health. African governments needed a clear understanding of the complex relationship between trade and health so as to regulate accordingly in their countries. However, because they had limited information on the implications of WTO multilateral trade agreements on health and health services, they were not in a position to negotiate effectively. For instance, some African States had yet to take full advantage of the flexibilities provided for in the TRIPS agreement, despite the massive African demand for inexpensive medicines. Greater coherence between trade and health policies was essential to ensure that international trade and trade rules maximized health benefits and minimized health risks, especially for the poor and vulnerable.

The extent and impact of trade in health services in the Region had yet to be fully documented. The WHO Regional Office for Africa had provided support to 21 African Member States for preliminary studies on trade in health services. The Regional Committee for Africa had adopted resolution AFRO/RC56/R4 on poverty, trade and health, which urged Member States to promote consultation among stakeholders on the relationship between international trade and health, and where necessary, to adopt policies, laws and regulations. Member States had to develop strategies that would ensure that proposed trade measures and agreements did not conflict with public health objectives. That approach required health and trade officials to work together and health officials had to be included in trade negotiations.

Member States were encouraged to negotiate with caution and to provide flexibility in protecting health and access to health care. In the case of agreements already signed, they were obliged by their own constitutions and by treaties on international human rights to protect and safeguard public health.

Ms MOENG (South Africa) said that any initiative in regard to the impact of global trade on human resources for health, in particular the development of the protocol for ethical recruitment, required the full participation of regional and subregional structures such as the African Union. Action was needed to build the capacity of developing countries to analyse the impact of trade on health and to respond to the drawbacks. Indicators should be devised for monitoring and assessing the impact of international trade on health at global and regional level.

Dr PHUSIT PRAKONGSAI (Thailand) said that dissemination of relevant studies, research findings and policy recommendations had helped Member States, especially developing countries, to apply the lessons of the past to their own policies. The training materials, guidelines and tool kits developed on public health and international trade had also been useful.

Cooperation between WHO and other global agencies responsible for trade and development, such as WIPO, WTO, UNCTAD and the World Bank, should be strengthened and expanded.

International trade was impairing populations' health. In Thailand, for example, soaring demand for health care from foreign patients had drawn health personnel, especially doctors, from rural areas to larger public hospitals and from public to private hospitals in Bangkok. The ASEAN Free Trade Area framework, which had lowered prices for alcoholic beverages and increased investment in their production, exemplified how international trade had undermined efforts to control alcohol consumption, with attendant health risks. The attempts to include TRIPS-plus provisions in a bilateral free trade agreement between Thailand and the United States of America had demonstrated that TRIPS-plus prevented entry of generic medicines into the market and therefore limited or even barred the poor from access to essential medicines.

Close cooperation was required between the Thai ministries of public health, commerce, finance and foreign affairs and the private hospital industry in order to prevent current developments in international trade from harming public health. Public policies, particularly on international and regional trade in services, had to protect the health of the population first and take precedence over commercial interests.

Dr EVANS (Assistant Director-General) assured the delegate of Brazil that the Organization would pay closer attention to the Region of the Americas. He assured the delegate of South Africa that WHO was working actively on the protocol for the ethical recruitment of health workers through the Global Health Workforce Alliance and would inform the Alliance of South Africa's request for full regional participation in the process. Regarding the African Region's request for the establishment of global indicators to monitor the impact of international trade on health, the knowledge base analysis that was part of the Secretariat's programme of work would increasingly comprise indicators introduced via instruments such as health impact assessments. As the delegate of Thailand had stated, international trade and health called for increasing interaction. The Secretariat would work in the spirit of the resolution in order to find out how it could best clarify the complexity of those interactions and help Member States to promote and protect health in an era of global trade.

D. Health promotion in a globalized world (resolution WHA60.24)

Mr KÖKÉNY (Hungary) welcomed the report and looked forward to the elaboration of a global framework for the promotion of health, which should meet the individual needs of Member States, as there was no "one size fits all" answer. He encouraged WHO to provide concrete guidance on how to organize health promotion policy, infrastructure and interventions. The involvement of other sectors and policies could be encouraged by examining health promotion as an enterprise. The findings and recommendations of the Commission on Social Determinants of Health, to be published later in the year, would help to evaluate progress in that area, particularly with regard to the impact of health promotion policy on health inequalities.

Dr KARAMAN (Turkey) supported the Secretariat's efforts to highlight progress in global health promotion. Sustainable structures, increased financing and trained staff were crucial to health promotion, and adequate mechanisms should be in place to enable everyone to gain access to social, economic, political and environmental determinants throughout their life. Turkey had incorporated health promotion in the official policy of the Ministry of Health; a "Strategic Plan 2009–2013" had been drafted and a "Department of Health Promotion and Development" established. She welcomed WHO's initiative to increase health capacity at country offices. The draft global framework, in parallel with global policy and the development of health promotion, would be a useful guide for country strategies.

Dr USA RAIKLEDKAEW (Thailand) requested the Secretariat to take into consideration: the evaluation of health promotion infrastructure, including resources; the full and cost-effective integration of health promotion programmes into national health-care systems and society; and coordination at the global level of health promotion and related resolutions. The Secretariat should generate and disseminate knowledge on the health impact of globalization. That would benefit health promotion policy at all levels.

Ms DLADLA (South Africa), commending the report, said that health promotion and healthy lifestyle had been a priority in her country and summarized a range of healthy habits that had been encouraged in South Africa.

The principles of the primary health-care approach, including equity, intersectoral collaboration, community participation and the use of acceptable methods and technology, should also guide health promotion strategies. The Bangkok Charter for Health Promotion in a Globalized World would give strong direction to the Secretariat and Member States in their bid to enhance health promotion. The African Union Ministers of Health Meeting (Geneva, 17 May 2008) had decided to dedicate a special day focused on “Healthy Lifestyles”, in line with the Africa Health strategy.

She called on the Secretariat to assess the harmful effects of trade, products, services and market strategies on health in the different WHO regions.

Dr AMANKWAH (Ghana), speaking on behalf of the 46 Member States of the African Region, said that the global community should jointly focus on the major health implications linked to globalization, such as unhealthy eating and increased tobacco and alcohol consumption. The traditional practices that had hitherto protected the health of his people and the environment were being dismantled, and that contributed to higher levels of communicable diseases. For example, trees were being felled without appropriate environmental safeguards; used vehicles, garments and home appliances unfit for developed countries were being dumped in Africa; and environmentally damaging industries were being dismantled in developed countries and reassembled in Africa. Non-biodegradable plastic bags were clogging up gutters and waterways and creating major sanitation problems. Resolution WHA60.24 had addressed those issues. He thanked the Secretariat for the progress report but noted with concern that further progress could be made in developing and enforcing of appropriate health legislation. Innovative approaches for increasing health literacy and health promotion among children should be pursued.

He commended the progress made in strengthening WHO’s organizational capacity in health promotion and requested the Director-General, together with health ministers, to continue to advocate for health in the global non-health forums, as mentioned in resolution WHA60.24. Progress was uneven in Member States and investment in WHO’s capacity should materialize in tangible national action. WHO should strengthen national capacities, in both analysis and advocacy, in regard to the health implications of development policies. He asked for guidelines and support in redirecting health workers and stakeholders towards promotion of health and well-being.

He asked the Secretariat to analyse the constraints and opportunities related to the intersectoral approach to health delivery and to provide strategies and guidelines.

Mr KOVAČ (Slovenia), speaking on behalf of the European Union, the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, and also Albania, Bosnia and Herzegovina, Montenegro, Serbia, Ukraine, Moldova and Armenia, noted that the Bangkok Charter for Health Promotion in a Globalized World could serve to improve public health and reduce health inequalities if its proposals on an intersectoral approach were fulfilled. That could be achieved through political will, professional skills, partnerships, and financial resources.

Both the intersectoral approach to health promotion in tackling communicable and noncommunicable diseases and its capacity should be recognized in the implementation of full-scale health promotion. WHO should play a leading role in the urgent provision of a global health promotion framework. Health promotion, as outlined in the Bangkok Charter, should be continuously

and carefully reviewed in WHO's major policy documents such as the Eleventh General Programme of Work, the Medium-term strategic plan 2008–2013 and the biennial budgets, but should not duplicate existing mechanisms. The Commission on Social Determinants of Health was expected to present, later in 2008, further concrete measures to reduce health inequalities between and within countries.

The European Union had recognized health promotion both legally, through its inclusion under a special article for public health, and concretely, by making it a priority in its long-term public health programmes, to which substantial funding had been allocated.

Dr MORI (Japan) emphasized that health promotion was an entry point for better public health in the twenty-first century. The national health movement "Japan Health 21", introduced in 2000, had transcended the traditional approach to prevention and control of diseases in Japan. Legislation had supported that movement. The Japanese had become aware of "metabolic syndrome" and the measuring of abdominal circumference had become an integral part of adult health check-ups.

The Commission on Social Determinants of Health, which had met in Japan in January 2008, would provide important guidance in health promotion. He supported WHO's health promotion activities and expected strong leadership in that regard.

Dr BLOOMFIELD (New Zealand) welcomed the progress report. The Secretariat's work on health promotion should link three key areas: the determinants of health; primary health care; and the prevention and control of noncommunicable diseases. That approach was essential in order to tackle health inequalities. He further encouraged the Secretariat to link the global health promotion framework being developed with work under way in those three areas.

Ms LO (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that the Federation was developing a joint framework with WHO for global action entitled "Towards 100 per cent voluntary blood donation". A natural link existed between health promotion, disease prevention and blood donation. Most regular blood donors had a sense of responsibility for the health and well-being of others, and were recognized as an important resource by health-care professionals. Safe and available blood transfusion was also a key to achieving the health-related Millennium Development Goals.

Health promotion was integral to the Federation's programmes. New programmes, such as the "Club 25 Programmes" had demonstrated that health promotion should be accessible to all. Young blood donors were the focus of "Club 25". As well as securing safe and adequate blood supplies, they were involved in visiting people with HIV/AIDS; teaching their peers about healthy lifestyles; and attaining life skills to avoid drug abuse. Positive effects included greater self-esteem, maintaining communal solidarity and social cohesion.

The Federation's "Social awareness programme", managed by the Turkish Red Crescent Society and jointly organized with the Turkish Government's Ministry of Education, aimed to encourage teachers, students and parents to participate in blood donation campaigns. Similar programmes could be set up in other countries.

Mrs SOZANSKI (Inter-African Committee on Traditional Practices affecting the Health of Women and Children), speaking at the invitation of the CHAIRMAN, said that the Committee focused on harmful traditional practices as health hazards and the violation of basic human rights.

She drew attention to paragraph 2(6) of resolution WHA60.24 and highlighted the work of the Advisory Group on Health Promotion and its collaborative work with WHO, in particular its current Platform of Action on Local Wisdom and Traditional Knowledge as relevant to health promotion. She welcomed the resolution and the progress report, and commended WHO's aim to build capacity for health promotion.

E. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)

Dr TSHABALALA MSIMANG (South Africa) said that applying the strategy to accelerate progress in reproductive health was essential. The low coverage of family planning services in the African Region (13%) pointed to the need to include family planning in all sexual and reproductive health programmes, and to carry out such strategies as the Maputo Plan of Action on sexual and reproductive health and rights. The late presentation of women (50%) with cervical cancer at health facilities, resulting in low post-treatment rates of survival, showed that the Secretariat and other partners needed to support Member States in improving their cancer-screening services. Most African Member States and governments had the political will to improve sexual and reproductive health, as demonstrated by the Africa Health Strategy, which highlighted reproductive health.

The report contained little reference to the involvement of men in accelerating progress in reproductive health. Given the importance of gender relations and of women being able to exercise their sexual and reproductive rights, she suggested their inclusion as a sixth priority area. Any reproductive health strategy should also include maternal nutrition, in view of its importance to both mother and baby. Such a strategy should also include reproductive issues related to ageing, including challenges to male reproductive health in developing countries, where there might be less awareness of preventive and therapeutic programmes. She therefore urged the Secretariat to include those aspects in the implementation programme and to submit a progress report to the next Health Assembly.

Dr THAKSAPHON THAMARANGSI (Thailand) said that his country was on the way to achieving the Millennium Development Goal targets relating to reproductive health. In 2007, the total fertility rate had been low, at 1.7%, and the prevalence of HIV infection in pregnant women had been 0.76%. Thailand had also introduced free, universal access to services that prevented mother-to-child transmission of HIV. He welcomed WHO's efforts in reducing maternal and perinatal mortality and morbidity and major sexually transmitted infections, including HIV and human papillomavirus. He recognized the potential of prophylactic vaccines against human papillomavirus, but the cost of US\$ 350 for the required three doses made them unaffordable for developing countries. The most cost-effective options for prevention and control of cervical cancer were visual inspection with acetic acid application, every five years for women aged 30 to 45 years, and a Papanicolaou smear every five years for women aged between 50 and 60 years. He therefore urged the Secretariat to help Member States in strengthening their cervical cancer screening programmes rather than promote the use of the human papillomavirus vaccine.

Dr AL-MADWAKHI (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that conflicts, the shortage of resources, and the lack of public health data made it difficult to assess reproductive health needs. Every year, more than 55 000 mothers and 610 000 newborn babies died in the Region, and some 34% of pregnancies and 40% of births were not attended by skilled health personnel.

Many of the Region's countries were improving their technical expertise, health-care training and management of services delivery. He welcomed the collaboration between WHO and UNFPA with a view to transferring evidence-based guidance to regional and country levels as a step towards improving reproductive health care. Many countries in the Region had adopted an evidence-based approach in their strategic planning and had completed the first phase of setting up a reproductive health research directory. He urged WHO to increase its technical support in Member States through training in operations research and ethical practices. In order to accelerate reduction of maternal death in countries where it was unacceptably high and to move closer to achieving the targets of the Millennium Development Goals, the Regional Committee had endorsed a framework entitled "Strategic directions for accelerating the reduction of maternal mortality in the Eastern Mediterranean Region in 2005". However, further financial resources would be needed, particularly in countries in the Region with high maternal and neonatal mortality rates and sexually transmitted diseases,

including HIV/AIDS, in order to translate the global strategy on reproductive health into action. WHO would need to involve various donors in order to improve reproductive health in all countries.

Dr EZOE (Japan) commended WHO's efforts to accelerate progress towards the achievement of the Millennium Development Goals and targets in the field of reproductive health, a high priority in his country's international cooperation programme. Japan had supported activities for strengthening nursing and midwifery, and was providing support, through bilateral assistance programmes, for the preparation of guidelines and tools in reproductive health, a field in which WHO should continue to play a leading role.

Ms NANNONO (Uganda) said that lack of resources to implement the strategy for reducing maternal and neonatal mortality and morbidity, together with poor intersectoral coordination, were obstacles to attaining international development goals. The Health Assembly should consider coordinated funding mechanisms for implementing that strategy.

Dr BELAYNEH (Ethiopia), speaking on behalf of the 46 Member States of the African Region, said that the reproductive health strategy of those countries had prioritized lower rates of maternal mortality and the implementation of the strategy endorsed in resolution WHA57.12. She expressed appreciation for technical support provided to Member States in their efforts to set policies, develop tools for assessing progress, and integrate activities against HIV/AIDS into sexual and reproductive health services. Maternal mortality continued to be related to limited access to reproductive and sexual health services, skills shortages and poorly functioning systems of referral. Nutrition was also relevant, since obstetric outcomes were influenced by the mother's nutritional status. Improving access to health care was essential. Although access to basic surgery, blood supplies and medicines could avert a large proportion of maternal deaths, international aid had been inadequate. Without sustained financing of those health systems and strategies, the Millennium Development Goal targets for reproductive health would not be achieved. She welcomed the programme recommendations drawn up to accelerate progress in reducing maternal mortality in the African Region and she urged WHO and other international organizations to prioritize that progress in the Region.

Dr CHOI Chong-hee (Republic of Korea) said that her Government was promoting preventive health care to women and children through a network of medical organizations and public health centres. Systematic medical records were kept of all births. In order to reduce mortality among infants and children tests were being supported for congenital metabolic disorders and medical expenditure for premature and congenitally deformed babies was being increased. The Government had designated a day for pregnant women in order to create a favourable social environment, and had supported private organizations working to improve maternal and child health in developing countries.

Dr CHITUWO (Zambia) thanked WHO for its support towards attaining the international development goals and targets. His Government, with its partners, was working to improve access to health-care services by increasing the resource allocation for reproductive health, by introducing a two-year programme of direct entry into midwifery and through a retention scheme for doctors and midwives working in rural areas. In conjunction with the international organization Ipas and WHO, it would improve access to safe abortion. Zambia was also establishing one-stop centres to improve the health care of women and children who had suffered sexual and gender-based violence. With support from WHO, it was piloting screening and treatment of cervical cancer using visual inspection with acetic acid.

Mrs MAFUBELU (Assistant Director-General) thanked delegates for their comments. She congratulated Member States on the progress they had made in the five key areas identified in the strategy and expressed appreciation of the political will demonstrated in the area of sexual and reproductive health. The Secretariat would continue to support Member States in meeting the

challenges they faced. It promoted a comprehensive approach to preventing and controlling cervical cancer, including visual inspection using acetic acid, and was supporting cervical cancer screening using that method in five sub-Saharan African countries. The Organization would continue to encourage Member States to ensure the involvement of men and the empowerment of women in sexual and reproductive health since those factors were critical to success in that area. WHO remained concerned by unacceptably high maternal mortality. The issues identified by the Committee would be taken into account in the implementation of the strategy and in the next progress report to be submitted to the Health Assembly.

F. Infant and young child nutrition: biennial progress report (resolution WHA 58.32)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Bahrain, Belize, Burkina Faso, Cook Islands, Egypt, Fiji, Gambia, Iran (Islamic Republic of), Jamaica, Kiribati, Libyan Arab Jamahiriya, Malawi, Maldives, Marshall Islands, Mexico, Micronesia (Federated States of), Morocco, Nigeria, Oman, Palau, Papua New Guinea, Philippines, Qatar, Samoa, Sao Tome and Principe, Saudi Arabia, Solomon Islands, Syrian Arab Republic, Tonga, United Arab Emirates and Vanuatu and its administrative and financial implications, which read as follows:

The Sixty-first World Health Assembly,

Having considered the report on infant and young child nutrition: biennial progress report;¹

Reaffirming the significance of the adoption by the Health Assembly of the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22), and resolutions WHA35.26, WHA37.30, WHA39.28, WHA41.11, WHA43.3, WHA45.34, WHA47.5, WHA49.15, WHA54.2, WHA55.25, WHA58.32 and WHA59.21 on infant and young child nutrition;

Reaffirming, in particular, resolutions WHA54.2, WHA55.25 and WHA58.32, which recognize the importance of exclusive breastfeeding for the first six months of life, the Global Strategy for Infant and Young Child Feeding, and the evidence-based public health risks associated with intrinsic contamination of powdered infant formula;

Recalling resolution WHA49.15 on infant and young child nutrition, which recognizes the need to ensure that the commitment and support for breastfeeding and optimal infant and young child nutrition are not undermined by conflicts of interest;

Affirming that early initiation and exclusive breastfeeding is the natural and optimal means to achieve food security and optimal health for infants and young children, and concerned that the rates have remained low;

Welcoming the biennial progress report¹ and noting the salient points that need further consideration, specifically persistent malnutrition – one of the most severe public health problems, as indicated by the alarmingly high rates of under-five mortality – and the need to improve implementation and monitoring of the International Code of Marketing of Breast-milk Substitutes;

Aware that powdered infant formula is not a sterile product and that it can contain pathogenic bacteria, and welcoming the WHO/FAO guidelines on safe preparation, storage and handling of powdered infant formula;²

¹ Document A61/17 Add.1.

² World Health Organization in collaboration with the Food and Agriculture Organization of the United Nations. *Safe preparation, storage and handling of powdered infant formula*. Geneva, World Health Organization, 2007.

Encouraged by the work of FAO and WHO through the Codex Alimentarius Commission on the revised proposed draft Code of Hygienic Practice for Powdered Formulae for Infants and Young Children,

1. URGES Member States:

- (1) to strengthen implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions by scaling up efforts to monitor and enforce national measures in order to protect breastfeeding while keeping in mind the Health Assembly resolutions to avoid conflicts of interest;
- (2) to continue action on the Global Strategy for Infant and Young Child Feeding and the Innocenti Declaration of 2005 on infant and young child feeding and to increase support for early initiation and exclusive breastfeeding for the first six months of life, in order to reduce the scourge of malnutrition and its associated high rates of under-five morbidity and mortality;
- (3) to implement, through application and wide dissemination, the WHO/FAO guidelines on safe preparation, storage and handling of powdered infant formula in order to minimize the risk of bacterial infection and, in particular, ensure that the labelling of powdered formula conforms with these guidelines;
- (4) to consider, as a risk-reduction strategy, where applicable and in accordance with national regulations, the provision of donor milk through human milk banks for vulnerable infants, in particular premature, low-birth-weight and immunocompromised infants;
- (5) to take action through food-safety regulatory measures to reduce intrinsic contamination of powdered infant formula by *Enterobacter sakazakii* and other pathogenic microorganisms during the manufacturing process;

2. REQUESTS the Director-General:

- (1) to develop time lines for monitoring progress so that comprehensive reports on implementation of the International Code of Marketing of Breast-milk Substitutes and food safety matters can be submitted to the Health Assembly every even year;
- (2) to continue to promote breastfeeding and infant and young child nutrition as essential for achieving the Millennium Development Goals, in particular those relating to the eradication of extreme poverty and hunger and to the reduction of child mortality.

1. Resolution Infant and young child nutrition: biennial progress report (resolution WHA58.32)	
2. Linkage to programme budget	
Strategic objective: 9. To improve nutrition, food safety and food security throughout the life-course, and in support of public health and sustainable development.	Organization-wide expected result: 9.2 Norms, including references, requirements, research priorities, guidelines, training manuals and standards, produced and disseminated to Member States in order to increase their capacity to assess and respond to all forms of malnutrition, and zoonotic and non-zoonotic foodborne diseases, and to promote healthy dietary practices. 9.3 Monitoring and surveillance of needs and assessment and evaluation of responses in the area of nutrition and diet-related chronic diseases strengthened, and ability to identify best policy options improved, in stable and emergency situations. 9.4 Capacity built and support provided to target Member States for the development, strengthening and implementation of nutrition plans, policies and programmes aimed at improving nutrition throughout the life-course, in stable and emergency situations.

4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.

9.5 Systems for surveillance, prevention and control of zoonotic and non-zoonotic foodborne diseases strengthened; food-hazard monitoring and evaluation programmes established and integrated into existing national surveillance systems, and results disseminated to all key players.

9.6 Capacity built and support provided to Member States, including their participation in international standard-setting in order to increase their ability to assess risk in the areas of zoonotic and non-zoonotic foodborne diseases and food safety, and to develop and implement national food-control systems, with links to international emergency systems.

4.5 Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.

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

This resolution is fully consistent with the expected results mentioned above. Implementation of the resolution will be monitored through the following agreed indicators for strategic objective 9: number of standards, guidelines, best practices and training manuals developed; data bank maintained using appropriate indicators for assessing infant and young child feeding policies, programmes and practices as currently used in WHO's global databank on infant and young child feeding; and number of countries implementing the Global Strategy for Infant and Young Child Feeding.

In respect of the requirements for burden estimates and dissemination of the WHO guidelines, implementation of the resolution will also be monitored against the existing indicators and targets developed for strategic objective 9. New baseline figures will be established for office-specific expected results.

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\$ 3.6 million will be required over three years

(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) US\$ 1.8 million

Although some normative and monitoring work will be carried out at headquarters, the majority of activities will be undertaken at country and regional levels. Priority will be given to countries that have highest under-five mortality rates; where implementation of the WHO Global Strategy for Infant and Young Child Feeding is inadequate; that are not giving appropriate effect to the International Code of Marketing of Breast-milk Substitutes; and that are not taking sufficient measures on food-safety matters.

(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009? US\$ 300 000

(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)

Potential sources are foundations and voluntary contributions from Member States.

4. Administrative implications

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

As indicated above, normative activities and coordination will be conducted at headquarters, while dissemination and data collection will be carried out at country level through the regional offices.

(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)

In order to strengthen the provision by WHO of technical guidance to Member States and enable the constant monitoring and assessment of implementation of the resolution:

- a technical officer and a staff member in the general service category will be needed for 36 months for activities related to nutrition;
- a technical officer (50% full-time equivalent) will be needed for 36 months for the dissemination of guidelines, including some training activities, and for the elaboration of relevant training materials;
- a technical officer (50% full-time equivalent) will be needed for 36 months to run the country-based initiative for global burden of foodborne diseases and to coordinate the integration of the burden estimate for *Enterobacter sakazakii* infections; and
- a staff member in the general service category (50% full-time equivalent) will be needed for activities related to food safety.

(c) Time frames (indicate broad time frames for implementation)

Implementation of some activities under this resolution has already started in the current biennium; however, full implementation will take place in 2009 and during the biennium 2010–2011.

Dr OTTO (Palau) commended the report, expressing appreciation of the increasing number of developing Member States taking part in the work done by the Codex Alimentarius Commission. He congratulated WHO and FAO on the progress represented by their activities, which included the preparation of joint guidelines on infant formula and the provision of joint recommendations on research into risks associated with *E. sakazakii*; and he further noted that WHO was designating a collaborating centre for research, reference and training on work on *E. sakazakii*. In view of the comments about malnutrition in the report, he looked forward to further efforts to improve infant and young child nutrition. He thanked the delegate of the United States of America for agreeing to reinstate the text in support of breastfeeding in the resolution on a global immunization strategy discussed earlier in Committee A. He read out a statement by the Association of Pacific Island Legislatures, representing the Governments of 12 Member States of the Pacific islands, which wholly endorsed breast milk as providing the best nutrition for infants in those islands, and which expressed strong support for the promotion of breastfeeding. The Association urged that any information that confused mothers and carers of infants or that questioned breastfeeding be prohibited.

Dr CIPIL (Turkey) emphasized the importance of nutrition for growth, development and health. No fewer than 30% of the world's children under five suffered from nutrition-related problems, and programmes for infant and young child nutrition should be supported. National reproductive health policies should include infant and young child nutrition. Baby-friendly hospitals and health institutions and the promotion of breastfeeding should be expanded. Health staff should be given continuous training on the subject, and efficient consultancy on nutrition should be developed. Standard guidelines on nutrition should be set through international cooperation, and legislation introduced to govern the production, preparation, processing, preservation and marketing of supplementary foods.

Turkey had several programmes on breastfeeding and supplementary foods, including one for nutrition of babies of 6–24 months and young children. In addition, a communiqué had been issued on the Turkish Codex Alimentarius for supplementary foods for infants and young children, providing a legal framework for the preparation of processed cereal-based and non-cereal-based foods of that type.

She supported the draft resolution.

Ms VALDEZ (United States of America) suggested the following amendments to the draft resolution, based on the wording in resolution WHA58.32. In the third preambular paragraph, the words “associated with intrinsic contamination of powdered infant formula” should be replaced by “of intrinsic contamination of powdered infant formula and the potential for introduced contamination, and the need for safe preparation, handling and storage of prepared infant formula”. In paragraph 1(3) “the ... guidelines” should be replaced by “the standard guidelines and recommendations of the Codex Alimentarius Commission”. In paragraph 1(5) the words “regulatory” and “intrinsic” should be deleted, adding at the end of the paragraph “as well as during storage, preparation and handling”. Paragraph 2(1) should be replaced by “to continue monitoring progress through reports to the Health Assembly each even year along with the report of the status of implementation of the International Code of Marketing of Breast-milk Substitutes and the relevant resolutions of the Health Assembly on progress in the consideration of matters referred to the Codex Alimentarius Commission for its action”.

The CHAIRMAN asked the delegate of the United States to submit a written text to the Secretariat.

Dr MAIGA (Mali) said that the global food crisis had resulted in spiraling prices for basic foodstuffs in Africa, together with increased social instability as families were uncertain of being able to feed their children. Malnutrition in children under five was responsible for more than 60% of mortality and morbidity in that age range. The key to reducing this figure lay in breastfeeding for the first six months of life. In the African Region, after six months, breastfeeding should be complemented, with families using local foods rather than expensive formula or pre-packaged imported products, which were a burden on the family budget and a possible source of bacterial contamination. A group of 28 African countries, including Mali, had received support in developing a national programme for infant and young child nutrition. Baby-friendly hospitals were being introduced in many countries, including her own, as part of the efforts to combat HIV/AIDS. The guidelines on HIV/AIDS and infant and young child nutrition had been revised, with training provided for trainers on the subject at national and regional levels. The International Code of Marketing of Breast-milk Substitutes had been incorporated into national law in many countries of the African Region, including her own. She supported the draft resolution.

Mr ANDERSEN (Norway), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, supported the draft resolution. It was important to support the focus on nutrition and the link to Millennium Development Goal 4, the reduction of child mortality. The new WHO Child Growth Standards should be implemented and monitored at national level. Recent evidence showed that exclusive breastfeeding dramatically reduced mother-to-child transmission of HIV as well as infant deaths from other causes. That should be taken into account in activities related to breastfeeding and HIV/AIDS. WHO and the Codex Alimentarius Commission should continue to give priority to the work on food safety standards in respect of foods intended for infants and young children. Priority should also be given to action to protect, support and promote breastfeeding and better nutrition, including the follow-up to the International Code of Marketing of Breast-milk Substitutes and the Baby-friendly Hospital Initiative.

Mrs MADZIMA (Zimbabwe), speaking on behalf of the 46 countries of the African Region, said that her Region was working to achieve all eight Millennium Development Goals, the first six of which depended on nutrition. Goals 1 and 4 related directly to infant and young child nutrition and to pregnant women and lactating mothers. Much remained to be done to prevent malnutrition, which was a major cause of morbidity, mortality and stunted growth in children under five in the Region. Proper nutrition was therefore central to human well-being and consequently to economic development and poverty reduction. Communicable diseases caused high child morbidity and created specific challenges for nutrition. Infants and young children were most vulnerable in communities where food security could not be assured. She thanked WHO for its publication, in October 2006, of a consensus statement on HIV and infant feeding, which emphasized that exclusive breastfeeding for the first six months of life would ensure in the best rate of infection-free survival for most HIV-exposed infants. Several countries had made progress in total and exclusive breastfeeding rates and in legislation on the International Code of Marketing of Breast-milk Substitutes, but data on feeding practices were still lacking.

The current global food crisis, exacerbated by the drive towards biofuel production, was likely to increase the number of severely malnourished children in Africa. Ready-to-use foods were important for the rehabilitation of malnourished children and for improving growth rates in the 6–24 month age group, but their long-term effects had not been studied. WHO should work with relevant partners to draw up standards, guidelines and recommendations on the subject. WHO and other United Nations agencies should provide technical and financial support for the local production of those foods in order to encourage a sustainable supply.

Protection from formula and other complementary foods that might be contaminated or nutritionally inadequate was of paramount importance. Expressing concern at the advertising and marketing of foods for infants and young children that contravened the International Code and WHO resolutions, she called upon Member States, the Secretariat and partners to work together to ensure a sustainable and safe supply of good-quality foods. For most countries, the challenge in infant and young child nutrition arose following successful exclusive breastfeeding for the first six months of life. Interventions for the 6–24 month age group were crucial. The Secretariat should also investigate the reasons for the persistent high rates of stunting in Africa. She urged the Secretariat to support Member States in implementing the new Child Growth Standards, especially at community level.

The Secretariat should consider the possibility of increasing financial and technical resources for the African Region in order to take a comprehensive approach to infant and young child health. She encouraged Member States to allocate more resources for preventing hunger, ensuring food safety for children, and, above all, promoting, protecting and supporting infant and young child feeding and the nutrition of vulnerable people. She supported the draft resolution, calling for further research on the feasibility of providing donor milk through human milk banks.

Dr TSHABALALA MSIMANG (South Africa) said that her Government was committed to implementing interventions for safe infant and young child nutrition. Powdered milk was not sterile, and its production was subject to human error, as the recent recall by one company of infant formula in Africa had shown. She emphasized the value of the food fortification programme that South Africa had been implementing since 2003. However, she warned against sugar-saturated drinks and other ready-to-use foods, and underlined the high levels of stunting in Africa. Further options should be investigated to make breast milk safer, including the use of heat-treated breast milk and the safe use of donated breast milk in milk banks.

Paragraph 1(4) of the draft resolution addressed a critical element in increasing the safety of breastfeeding. However, for many countries it was a new approach, and more consultation and research were needed for it to make a meaningful contribution to infant feeding. She proposed amending the paragraph so that it read: “to investigate, as a risk-reduction strategy, the possible use and, in accordance with national regulations, the safe use of donor milk through human milk banks for vulnerable infants, in particular premature, low-birth-weight and immunocompromised infants.” She urged the Director-General to intensify support for implementing the International Code of Marketing of Breast-milk Substitutes and for research on the safe use of donated milk and options for making breast milk safer.

Dr SASIDHORN TANGSAWADEE (Thailand) said that the healthy growth of infants and young children was of great importance to her country. Breastfeeding promotion and a baby-friendly hospital programme had been introduced in all public hospitals, and the relevant regulations were in line with the International Code of Marketing of Breast-milk Substitutes. For example, modified milk and follow-up formula foods had to state “Not for children under six months of age”; and sugar was prohibited in milk and food for infants and young children. Since 2005, the Thai Food and Drug Administration had been in discussions on *E. sakazakii* with milk manufacturers and other stakeholders, all of whom had agreed to follow WHO/FAO guidelines on the safe preparation, storage and handling of milk for infants. The Thai standard relating to *E. sakazakii* would shortly be put into effect, in compliance with Codex recommendations. Supporting the draft resolution, she suggested a new paragraph 2(5) urging the Director-General to review the current global situation of infant and child nutrition and to report thereon to the Sixty-second World Health Assembly.

Mrs VIREM (France), supporting the draft resolution, proposed adding at the end of paragraph 1(4) the words, “and to promote appropriate hygienic measures during the storage, preparation and handling of human milk”.

Mrs OCHIENG PERNET (Switzerland) applauded the work of WHO and FAO in the field of infant and young child nutrition, noted the progress made in the Codex Alimentarius Commission and welcomed the adoption of the revised standard for Processed Cereal-Based Foods for Infants and Young Children and the Standard for Infant Formula and Formulas for Special Medical Purposes intended for Infants. Both standards expressly referred to the International Code of Marketing of Breast-milk Substitutes and WHO’s Global Strategy for Infant and Young Child Feeding. She noted with pleasure that the Codex Committee on Food Hygiene had drawn up a Code of Hygienic Practice for Powdered Formulae for Infants and Young Children. Referring to paragraph 23 of the report, she observed that Switzerland was one of the 12 (not two) Member States contributing to the FAO/WHO Fund for Enhanced Participation in Codex. She fully supported the important amendments proposed by the delegate of the United States, based on resolution WHA58.32. In addition, she proposed replacing “under-five” by “infant” in the sixth preambular paragraph and in paragraph 1(2), as the latter term was more appropriate in the context of the International Code.

Dr GUZMAN-ALA (Philippines) said that her country was implementing the Global Strategy for Infant and Young Child Feeding, including by scaling up breastfeeding in the community through support groups; by adhering to a policy of refusing to accept infant formula donations even in disaster situations; by setting up mother- and baby-friendly workplace initiatives; by equipping two hospitals with human milk banks; and by improving the monitoring of its national “milk code.” She fully supported the draft resolution.

Dr EZOE (Japan) said that his country supported the activities of the Codex Alimentarius Commission. Work being undertaken by Japan towards improved infant and young child nutrition included the promotion of breastfeeding, the preparation and dissemination of guidelines on powdered infant formula and bilateral cooperation for projects designed to combat malnutrition in those regions of the world where it remained a problem. He supported the draft resolution.

Dr BLOOMFIELD (New Zealand) confirmed that New Zealand’s national guidelines were currently being updated to incorporate those of WHO and FAO.

Regarding the draft resolution, on which it was important to achieve consensus, he expressed support for using previously agreed language. Recalling that the WHO/FAO guidelines referred to in paragraph 1(3) were generic in nature, he said that local conditions should be taken into account when they were adopted at country level. He proposed inserting, at the end of paragraph 1(5), the words “and monitor the effectiveness of these measures”. The amendment should apply irrespective of the inclusion or otherwise of the text proposed by the delegate of the United States of America.

Dr AL-HAMAD (Kuwait) supported the draft resolution and called on other Member States to follow suit. Adequate nutrition was essential in bringing down the rates of infant mortality.

Dr MUKONKA (Zambia) said that child malnutrition was an important global problem. Zambia had introduced several measures to implement the Global Strategy for Infant and Young Child Feeding. It had enacted a law to control the marketing of breast-milk substitutes and conducted training programmes on the International Code of Marketing of Breast-milk Substitutes and on its own Food and Drugs Regulation 2006. It had incorporated into national practice WHO's recommendations on the feeding of infants up to 24 months, including through training in the prevention of mother-to-child transmission of HIV. It had also begun to revitalize the Baby-friendly Hospital Initiative. He supported the draft resolution and shared the concerns expressed by the delegates of Zimbabwe and South Africa.

Ms ARENDT LEHNERS (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, welcomed the progress report, but the role of infant and young child feeding in the fight against child malnutrition should have been given a more prominent position on the agenda of the Health Assembly.

The Lancet's series on maternal and child undernutrition, launched in January 2008, had identified the interventions proven to be most effective in reducing stunting and micronutrient deficiencies in women and children, namely, breastfeeding counselling, vitamin A supplementation and zinc fortification.

In order to achieve the targets for exclusive and continued breastfeeding outlined in the Global Strategy for Infant and Young Child Feeding, prenatal and antenatal support must be available to mothers from trained health professionals and peer counsellors, and remain available during the whole of the breastfeeding period. Lactation consultants across the world had confirmed the vital importance of such counselling. She supported the draft resolution.

Dr BRONNER (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, welcomed the progress report. The infant food manufacturers had a long-standing commitment to producing nutritionally balanced infant formula and complementary foods, and to promoting optimal feeding practices that fostered the growth of millions of children worldwide. Industry-sponsored research had contributed to knowledge about the nutritional needs of infants and young children and the benefits of breastfeeding. The manufacturers were also committed to the principles of the International Code of Marketing of Breast-milk Substitutes, and supported national measures to give them effect. She welcomed the revised Standard on Infant Formula and Formulas for Special Medical Purposes intended for Infants and the revised Standard on Processed Cereal-Based Foods for Infants and Young Children, as well as the draft Code of Hygienic Practice for Powdered Formulae for Infants and Young Children. The infant food manufacturers strongly supported the Millennium Development Goals aimed at reducing infant and young child mortality and child malnutrition, and would welcome multisectoral cooperation towards their attainment.

Ms EL RASSI (Consumers International), speaking at the invitation of the CHAIRMAN, said that, as the founder of the International Baby Food Action Network, her organization had done its utmost to promote breastfeeding, the most natural and effective means of providing food security for infants and young children, combating obesity and reducing rates of mortality and morbidity. Since 2004, it had become concerned about the high levels of intrinsic contamination found in powdered infant formula products, including those sold in sealed packaging. Contamination by pathogens such as *E. sakazakii* could cause serious and sometimes fatal diseases including septicaemia, meningitis and necrotizing enterocolitis. Her organization's list of infant formula products withdrawn from sale since 2002 showed that most withdrawals had occurred in developed nations, for reasons still unknown. In all countries, there were some infections among infants, probably caused by *E. sakazakii*, that were not being recorded. They should all be included in national monitoring systems for dietary-related

illnesses. Much had been done by WHO and FAO to reduce the prevalence of pathogens in infant formula foods and to ensure that the standards laid down by the Codex Alimentarius Commission were enforced. However, more effort was needed to eliminate the risks at the production stage.

Ms RUNDALL (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that breastfeeding remained the most effective means of reducing child morbidity and mortality, and was also the most sustainable and environmentally friendly option available. In the context of the global food crisis, she supported the Global Strategy for Infant and Young Child Feeding in its promotion of breastfeeding and indigenous foods over highly-packaged baby food, especially since the nutritional and health value of such products was often exaggerated.

Her organization's field offices continued to report violations of the International Code of Marketing of Breast-milk Substitutes, which was crucially important for the protection of parents' rights to independent information. Advice provided by companies was, according to one survey, consistently inaccurate and misleading. She expressed her regret that the industry and the European Commission appeared not to be interpreting the European Directive on Infant Formulae and Follow-on Formulae in line with the International Code. Member States must ensure that the Code was reflected in their national regulations, and she urged WHO to help them to honour their responsibilities to the Code.

Her organization was concerned about donations of breast-milk substitutes in the early days of response to an emergency. Although media coverage often implied that such donations were essential, without careful planning they could be detrimental to nutritional status and survival rates. She drew the Committee's attention to a statement from a United Nations joint meeting with nongovernmental organizations and health ministries in March 2008 on the subject of infant feeding in emergencies, according to which donations should not be permitted and the International Code must be applied as a minimum in emergency situations. Operational guidance for emergency workers in that respect was currently available in several languages from the Emergency Nutrition Network.

She supported the draft resolution.

Ms ARENDT LEHNERS (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, delivered a statement on behalf of La Leche League International. Despite the crucial importance for health of nutrition and nurturing during the first three years of life, only one in every three infants was exclusively breastfed for the first four months. Outlining the advantages to both baby and mother of early initiation and exclusive breastfeeding, she emphasized mothers' need for support from professional and lay sources. The tradition of breastfeeding had been disrupted in modern times. In the 52 years since La Leche League had been set up as a neighbourhood resource, it had spread to 68 countries, providing information and encouragement to mothers from other women who had breastfed.

She supported the draft resolution.

Dr SCHLUNDT (Nutrition for health and development) thanked the speakers for their comments and commitment to WHO's policy on infant and young child nutrition, especially the promotion of breastfeeding. He had noted their approval of WHO's work with FAO on the Codex Alimentarius and of the new guidelines for the preparation of powdered infant formula. Guidelines for the use of ready-to-use infant foods were currently being drafted, with a consultation planned for October 2008. The Secretariat was continuing to work with countries in monitoring child growth in the light of the new WHO Child Growth Standards and the crisis in food prices. He noted the suggestion for more research on the feasibility of establishing human milk banks; a review was currently in progress of the existing guidelines. The Secretariat continued to support the Baby-friendly Hospital Initiative, which was one of the nine operational targets of the Global Strategy for Infant and Young Child Feeding.

Dr DAYRIT (Secretary), noting that amendments to the draft resolution had been proposed by the delegations of the United States of America, Switzerland, South Africa, France, New Zealand

and Thailand, read out the proposed amended text. In the third preambular paragraph, “intrinsic” should be replaced by “preparation, handling, storage and”. In the sixth preambular paragraph, and in paragraph 1(2), “under-five” should be replaced by “infant”. In paragraph 1(3), “these guidelines” should be replaced by “the standards, guidelines and recommendations of the Codex Alimentarius Commission”.

Ms VALDEZ (United States of America) said that the amendment she had proposed to the third preambular paragraph was slightly different. The paragraph should conclude: “evidence-based public health risks of intrinsic contamination of powdered infant formula and the potential for introduced contamination, and the need for safe preparation, handling and storage of prepared infant formula”.

Dr TSHABALALA-MSIMANG (South Africa) said that she had proposed two additional subparagraphs in paragraph 2:

“(3) to intensify support for the implementation of the International Code of Marketing of Breast-milk Substitutes;

(4) to support urgently research on the safe use of donated milk and options of making breast milk safer, given the current challenges facing countries in the implementation of safe infant feeding practices”.

Dr KEAN (Executive Director, Office of the Director-General) said that the Secretariat would be able to issue an amended text of the resolution the following morning, once all the proposals from delegations had been heard.

Ms VIREM (France) repeated the amendment she had proposed earlier in the meeting.

Mrs MADZIMA (Zimbabwe) did not agree with the deletion of the words “under-five” in paragraph 1(2), because the Global Strategy for Infant and Young Child Feeding included young children.

Dr SASIDHORN TANGSAWADEE (Thailand) preferred to retain the term “under-five”.

Dr OTTO (Palau) agreed with the wording of the third preambular paragraph proposed by the delegate of the United States of America. The term “under-five” should be retained, since it was used in the biennial progress report. In the sixth preambular paragraph, he suggested ending the sentence after “under-five mortality”. A new subparagraph would then begin: “Noting further ...”.

Dr BLOOMFIELD (New Zealand) suggested that the Committee consider the proposed amendments one by one.

Dr KEAN (Executive Director, Office of the Director-General) suggested a suspension of the meeting in order for the Secretariat to review the amendments.

The meeting was suspended at 18:08 and resumed at 18:38.

Dr DAYRIT (Secretary) read out the proposed amendments to the draft resolution. He added that the delegate of Thailand was requesting the insertion of a new paragraph 2(5), “to review the global current situation of infant and child nutrition and report to the Sixty-third World Health Assembly”.

Dr OTTO (Palau) repeated his proposal to retain “under-five” in the sixth preambular paragraph, which proposal was supported by Mrs OCHIENG PERNET (Switzerland).

As the CHAIRMAN noted that members of the Committee agreed to the proposal, Dr DAYRIT (Secretary) confirmed that the term “under-five” would also be retained in paragraph 1(2).

Dr TSHABALALA MSIMANG (South Africa) suggested adding in paragraph 1(3) a reference to resolution WHA58.32, which referred to labelling and the need to indicate that formula was not a safe product.

Dr DAYRIT (Secretary) said that paragraph 1(3), as amended, would read: “to implement, through application and wide dissemination, the WHO/FAO guidelines on safe preparation, storage and handling of powdered infant formula in order to minimize the risk of bacterial infection and, in particular, ensure that the labelling of powdered formula conforms with the standards, guidelines and recommendations of the Codex Alimentarius Commission and resolution WHA58.32.”

Ms VALDEZ (United States of America) said that the words “taking into account” should be inserted before “resolution WHA58.32”. The labelling of powdered formula could not conform to the Health Assembly resolution.

Dr DAYRIT (Secretary) read out paragraph 1(4), as amended: “to investigate, as a risk-reduction strategy, the possible use and, in accordance with national regulations, the safe use of donor milk through human milk banks for vulnerable infants, in particular premature, low-birth-weight and immunocompromised infants, and to promote appropriate hygienic measures for storage, conservation, and use of human milk.”

Paragraph 1(5), as amended, would read: “to take action through food safety measures and to reduce contamination of powdered infant formula by *Enterobacter sakazakii* and other pathogenic microorganisms during the manufacturing process as well as during storage, preparation and handling, and monitor the effectiveness of these measures.”

Dr BLOOMFIELD (New Zealand) proposed revising the latter paragraph to read: “to take action through food safety measures, including appropriate regulatory measures, to reduce the risk of intrinsic contamination of powdered infant formula by *Enterobacter sakazakii* and other pathogenic microorganisms during the manufacturing process, as well as the risk of contamination during storage, preparation and handling, and monitor the effectiveness of these measures”.

Dr DAYRIT (Secretary) read out the proposed new paragraph 2(1): “to continue monitoring progress through reports to the Health Assembly each even year, along with the report on the status of implementation of the International Code of Marketing of Breast-milk Substitutes and the relevant resolutions of the Health Assembly, on progress in the consideration of matters referred to the Codex Alimentarius Commission for its action”.

Mrs MADZIMA (Zimbabwe) suggested including in that paragraph a requirement to report on the status of implementation of the Global Strategy for Infant and Young Child Feeding. The reporting requirements in paragraphs 2(1) and 2(5) should be combined. She also proposed that the report of the WHO Consultation on Nutrition and HIV/AIDS in Africa (Durban, South Africa, April 2005) should be submitted to the Sixty-second World Health Assembly. In response to a query by Dr BLOOMFIELD (New Zealand), she explained that the consultation report was relevant to infant and young child nutrition.

Dr BLOOMFIELD (New Zealand) agreed. Paragraph 2(5) should request the Director-General to report “on this matter” at the Sixty-third World Health Assembly, which would be held in an even year.

Dr MAIGA (Mali) said that developing countries lacked public health databases to enable them to monitor the health status of infants and young children. She therefore proposed an additional paragraph to the draft resolution: “to strengthen national information systems to provide the necessary factual basis to guide health policies”.

Dr KEAN (Executive Director, Office of the Director-General) explained that, in the absence of a quorum, the Committee could not approve the revised draft resolution until the subsequent meeting. The full text of the revised version would then be available.

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

The meeting rose at 19:20.

SIXTH MEETING

Saturday, 24 May 2008, at 09:30

Chairman: Dr A.R. SICATO (Angola)

1. THIRD REPORT OF COMMITTEE B (Document A61/47)

The CHAIRMAN drew attention to the draft third report of Committee B. Two corrections should be made to the text of the decision concerning agenda item 16.3. The heading “ACTION BY THE HEALTH ASSEMBLY” should be deleted. In the first line of the paragraph, the words “The Health Assembly may wish to nominate” should be replaced by “The Sixty-first World Health Assembly nominated”.

Dr JAYANTHA (Sri Lanka), Rapporteur, read out the draft third report of Committee B.

The report, as amended, was adopted.¹

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

Progress reports on technical and health matters: Item 11.14 of the Agenda (Documents A61/17 and A61/17 Add.1) (continued from the fifth meeting)

F. Infant and young child nutrition: biennial progress report (resolution WHA58.32) (continued from the fifth meeting)

The CHAIRMAN invited the Committee to consider the revised text of the draft resolution, which incorporated amendments proposed during an informal consultation. It read as follows:

The Sixty-first World Health Assembly,

Having considered the report on infant and young child nutrition: biennial progress report;

Reaffirming the significance of the adoption by the Health Assembly of the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22), and resolutions WHA35.26, WHA37.30, WHA39.28, WHA41.11, WHA43.3, WHA45.34, WHA47.5, WHA49.15, WHA54.2, WHA55.25, WHA58.32 and WHA59.21 on infant and young child nutrition;

Reaffirming, in particular, resolutions WHA54.2, WHA55.25 and WHA58.32, which recognize the importance of exclusive breastfeeding for the first six months of life, the Global Strategy for Infant and Young Child Feeding, and the evidence-based public health risks of intrinsic contamination of powdered infant formula, the potential for introduced contamination and the need for safe preparation, handling and storage of prepared infant formula;

Recalling resolution WHA49.15 on infant and young child nutrition, which recognizes the need to ensure that the commitment and support for breastfeeding and optimal infant and young child nutrition are not undermined by conflicts of interest;

¹ See page 259.

Affirming that early initiation and exclusive breastfeeding is the natural and optimal means to achieve food security and optimal health for infants and young children, and concerned that the rates have remained low;

Welcoming the biennial progress report¹ and noting the salient points that need further consideration, specifically persistent malnutrition – one of the most severe public health problems, as indicated by the alarmingly high rates of under-five mortality;

Noting further the need to improve implementation and monitoring of the International Code of Marketing of Breast-milk Substitutes;

Aware that powdered infant formula is not a sterile product and that it can contain pathogenic bacteria, and welcoming the WHO/FAO guidelines on safe preparation, storage and handling of powdered infant formula;²

Encouraged by the work of FAO and WHO through the Codex Alimentarius Commission on the revised proposed draft Code of Hygienic Practice for Powdered Formulae for Infants and Young Children,

1. URGES Member States:

(1) to strengthen implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions by scaling up efforts to monitor and enforce national measures in order to protect breastfeeding while keeping in mind the Health Assembly resolutions to avoid conflicts of interest;

(2) to continue action on the Global Strategy for Infant and Young Child Feeding and the Innocenti Declaration of 2005 on infant and young child feeding and to increase support for early initiation and exclusive breastfeeding for the first six months of life, in order to reduce the scourge of malnutrition and its associated high rates of under-five morbidity and mortality;

(3) to implement, through application and wide dissemination, the WHO/FAO guidelines on safe preparation, storage and handling of powdered infant formula in order to minimize the risk of bacterial infection and, in particular, ensure that the labelling of powdered formula conforms with the standards, guidelines and recommendations of the Codex Alimentarius Commission and taking into account resolution WHA58.32;

(4) to investigate, as a risk-reduction strategy, the possible use and, in accordance with national regulations, the safe use of donor milk through human milk banks for vulnerable infants, in particular premature, low-birth-weight and immunocompromised infants, and to promote appropriate hygienic measures for storage, conservation, and use of human milk;

(5) to take action through food-safety measures, including appropriate regulatory measures, to reduce the risk of intrinsic contamination of powdered infant formula by *E. sakazakii* and other pathogenic microorganisms during the manufacturing process as well as the risk of contamination during storage, preparation and handling, and monitor the effectiveness of these measures;

¹ Document A61/17 Add.1, section F.

² World Health Organization in collaboration with the Food and Agriculture Organization of the United Nations. *Safe preparation, storage and handling of powdered infant formula*. Geneva, World Health Organization, 2007.

2. REQUESTS the Director-General:
 - (1) to continue monitoring progress through reports to the Health Assembly each even year, along with the report on the status of implementation of the International Code of Marketing of Breast-milk Substitutes and the relevant resolutions of the Health Assembly, on progress in the consideration of matters referred to the Codex Alimentarius for its action;
 - (2) to continue to promote breastfeeding and infant and young child nutrition as essential for achieving the Millennium Development Goals, in particular those relating to the eradication of extreme poverty and hunger and to the reduction of child mortality;
 - (3) to intensify support for the implementation of the International Code of Marketing of Breast-milk Substitutes;
 - (4) to provide support urgently for research on the safe use of donated milk and options of making breast milk safer, given the current challenges facing countries in the implementation of safe infant feeding practices;
 - (5) to provide support for strengthening of national information systems in order to provide a factual basis for policies in this area;
 - (6) to review the global current situation of infant and child nutrition and report to the

Dr BLOOMFIELD (New Zealand) said that the informal discussions held the previous evening had generated a substantial number of amendments to the draft resolution. They were reflected in the text before the Committee. One amendment had been inadvertently omitted, however, and a few delegations had since suggested some further minor amendments to improve clarity. Paragraph 2(4), as it stood, could be taken to imply that all breast milk was unsafe. To avoid potential misinterpretation, the words “donated milk and options of making breast milk safer” should be replaced by “expressed and donated breast milk”.

Dr KANDUN (Indonesia) said that, if his understanding of paragraph 22 of document A61/17 Add.1 was correct, *E. sakazakii* should be deleted as a separate entity in paragraph 1(5) of the draft resolution and subsumed under pathogenic microorganisms pending consideration of the revised Code of Hygienic Practice for Powdered Formulae for Infants and Young Children by the Codex Alimentarius Commission in July 2008.

Dr AL-HAMAD (Kuwait) proposed adding the phrase “according to the national rules and regulations and religious beliefs” at the end of paragraph 2(4).

Mrs MADZIMA (Zimbabwe) supported the amendment proposed by the delegate of Kuwait and suggested adding the word “cultural” as well.

She had misgivings about deleting reference to *E. sakazakii* in paragraph 1(5) given the need for consistency with the language used in previous resolutions.

Dr OTTO (Palau) agreed with the delegate of Zimbabwe that *E. sakazakii* had been identified specifically in previous resolutions. He supported the amendments proposed by the delegates of New Zealand, Kuwait and Zimbabwe.

Dr KANDUN (Indonesia) said that he understood the arguments put forward by Zimbabwe and Palau but requested clarification on the relationship between the Health Assembly and the Codex Alimentarius Commission.

Dr BLOOMFIELD (New Zealand) said that he preferred to retain the current wording of paragraph 1(5), including the reference to *E. sakazakii*. The amendment proposed by the delegate of Kuwait to paragraph 2(4) was commendable, but he suggested a minor change: given the context of a request to the Director-General, the words “according to” should be replaced by “mindful of”.

Dr AL-HAMAD (Kuwait) endorsed that change but sought assurance that the reference to “religious beliefs” would be included.

Mr TARYAM (United Arab Emirates) supported the proposal by the delegate of Kuwait, recognizing the need to introduce a reference to rules and regulations and to religious beliefs in paragraph 2(4).

Dr DAYRIT (Secretary) read out the amendments proposed. Paragraph 2(4) would read: “to provide support urgently for research on the safe use of expressed and donated breast milk, given the current challenges facing countries in the implementation of safe infant feeding practices, mindful of the national rules and regulations and cultural and religious beliefs”.

Dr BLOOMFIELD (New Zealand) proposed the following additional amendments: replacing in paragraph 2(5), as previously suggested by the delegate of Mali, the phrase “provide a factual basis” with “improve the evidence base”; and he reiterated the proposal made by the delegate of Zimbabwe at the previous meeting to insert in paragraph 2(6), between commas, the words “including nutrition and HIV” after “the situation of infant and child nutrition”.

Dr DAYRIT (Secretary) read out the additional proposed amendments. Paragraph 2(5) would read: “to provide support for strengthening of national information systems in order to improve the evidence base for policies in this area”. Paragraph 2(6) would read “to review the global current situation of infant and child nutrition, including nutrition and HIV, and report to the Sixty-third World Health Assembly”.

The draft resolution, as amended, was approved.¹

The Committee noted the progress reports.

3. FOURTH REPORT OF COMMITTEE B

Dr JAYANTHA (Sri Lanka), Rapporteur, read out the draft fourth report of Committee B.

The report was adopted.²

4. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of Committee B completed.

The meeting rose at 10:00.

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA61.20.

² See page 260.