

# **COMMITTEE A**

## **FIRST MEETING**

**Monday, 18 May 2009, at 16:50**

**Chairman:** Dr F. MENESES GONZÁLEZ (Mexico)

### **1. OPENING OF THE COMMITTEE:** Item 10 of the Agenda (Document A62/1 Rev.1)

The CHAIRMAN welcomed participants and in particular the representatives of the Executive Board, Mr de Silva (Sri Lanka), Sir Liam Donaldson (United Kingdom of Great Britain and Northern Ireland), Mr Vallejos (Peru) and Mr Touré (Mali), who would report on the Board's discussion of agenda items before the Committee.<sup>1</sup> Any views they expressed would be those of the Board, and not of their respective governments.

#### **Election of Vice-Chairmen and Rapporteur**

The CHAIRMAN informed the Committee that Dr M. Ramatlapeng (Lesotho) and Dr M.B.H. Al-Thani (Qatar) had been proposed as Vice-Chairmen and Ms S.T. Aydin (Turkey) as Rapporteur.

**Decision:** Committee A elected Dr M. Ramatlapeng (Lesotho) and Dr M.B.H. Al-Thani (Qatar) as Vice-Chairmen and Ms S.T. Aydin (Turkey) as Rapporteur.<sup>2</sup>

### **2. ORGANIZATION OF WORK**

The CHAIRMAN said that, in view of the shortened duration of the Health Assembly and the heavy agenda, delegates should limit their statements to three minutes. If a delegate spoke on behalf of a group of countries, no delegate from a country in that group should take the floor.

Mr VOLF (Czech Republic), speaking on behalf of the Member States of the European Union, noted that the European Community and the Member States of the European Union had a shared competence in a number of matters on the Committee's agenda. He therefore requested that, in accordance with Rule 46 of the Rules of Procedure of the World Health Assembly, the European Commission should, as on previous occasions, participate as an observer, without vote, in the meetings of the subcommittees or subdivisions of Committee A dealing with all matters under agenda item 12.

**It was so agreed.**

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<sup>1</sup> By virtue of Rules 42 and 43 of the Rules of Procedure of the World Health Assembly.

<sup>2</sup> Decision WHA62(3).

Dr DELGADO (Bolivarian Republic of Venezuela), rising on a point of order, expressed concern that the verbatim and summary records of the various meetings were not being prepared within the official time limits laid down in Rules 90, 91 and 92 of the Rules of Procedure. It was important for such records to be made available to countries as quickly as possible so that all delegations could have access to the various statements made.

Mr SOLOMON (Office of the Legal Counsel) assured the delegate of Venezuela that all interventions would be properly and promptly reflected in the summary records of the Committee in accordance with the relevant rules.

### **3. TECHNICAL AND HEALTH MATTERS:** Item 12 of the Agenda

#### **Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits:** Item 12.1 of the Agenda (Documents A62/5 and A62/5 Add.1)

Ms HALTON (Australia), speaking as Chair of the Intergovernmental Meeting on Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and other Benefits, observed that when the Intergovernmental Meeting had commenced its work in 2007 it had been known that a pandemic would eventually occur, but the threat had not seemed imminent then. At the conclusion of its work, the situation was markedly different.

The Intergovernmental Meeting had spent two years devising a framework for the sharing of viruses and benefits. Several important elements were already operational, including the Influenza Virus Traceability Mechanism and the Advisory Mechanism, and work on benefit-sharing was well advanced, particularly in respect of the stockpiling of vaccines and antiviral agents. Although elements of the framework remained to be finalized, the goodwill that prevailed and the significant work accomplished to date strongly suggested that a trust-based system that took into account the needs of developing countries and operated in a truly equitable and transparent manner could be put in place.

Dr SADRIZADEH (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that as influenza A (H1N1) continued to spread global action was needed in order to confront the spectre of a pandemic and strengthen preparedness to deal with potentially more deadly future events. International sharing of clinical specimens and viruses, particularly in the case of new strains of H5N1 or H1N1 virus, was crucial to pandemic risk assessment and the development of vaccines. Failure to share influenza virus isolates with the WHO collaborating centres on influenza would threaten global security. Ensuring equitable access to influenza vaccines at affordable cost and equal sharing of benefits from scientific breakthroughs were just as important. Some of the pandemic vaccine produced should be allocated to countries in proportion to their population, with provisions made for countries with limited resources and special needs. He looked forward to the adoption of a resolution that would ensure that all Member States had fair and timely access to the international stockpile of vaccines to be established by WHO.

Dr DEMINA (Russian Federation) asked for her delegation's proposals on vaccine development to be taken into account. Her Government had established a commission to deal with outbreaks of illness caused by highly pathogenic influenza virus. Her country's regions were strengthening their capacities in pandemic preparedness and response. Information on influenza prevention was being provided to the population; airline passengers arriving from affected areas were being monitored; and laboratory capacity to detect influenza A (H1N1) viral DNA and to test for antiviral resistance was being strengthened.

Her Government was also promoting pandemic preparedness across the Commonwealth of Independent States, where, in line with the commitment made at the G8 summit in St Petersburg in 2006, 38 laboratories had been equipped and one reference centre established. The State Centre for

Research on Virology and Biotechnology at Novosibirsk was providing training and support for the countries of eastern Europe and central Asia to strengthen their preparedness and preventive activities.

Dr MESELE (Ethiopia) emphasized the valuable contribution that could be made by countries that were not vaccine producers in sharing their influenza viruses through the WHO Global Influenza Surveillance Network. Due credit and recognition should be given to researchers from developing countries who were providing influenza isolates for their contributions to the generation of scientific knowledge and promotion of global public health.

Ethiopia's efforts to strengthen influenza surveillance had also focused on the animal-human interface. The National Influenza Laboratory had bolstered its capacity to detect influenza virus and was working towards recognition by WHO as a national influenza centre. Ethiopia would shortly begin contributing viruses to the Global Influenza Surveillance Network. She commended the efforts undertaken by the Advisory Group and the Secretariat to establish a transparent mechanism for tracing influenza viruses submitted to the Network and noted the progress towards establishing an international stockpile of vaccines against influenza viruses of pandemic potential. She supported the configuration of the stockpile proposed in the report.

Dr ALI (Bangladesh) said that it was encouraging that the Intergovernmental Meeting had reached consensus on the important section 6 of the Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits. As negotiations on other critical issues, including the Standard Material Transfer Agreement, were still pending, he supported renewing the mandate of the Intergovernmental Meeting. It should give special consideration to the least developed countries and build on progress made so far. His country would support any outcome agreed by consensus.

Dr HUSSAIN (Bahrain) said that her country's plans for pandemic influenza preparedness and response aimed to limit the impact on health; minimize economic and social disruption; and further develop joint cooperation among relevant authorities. National surveillance and laboratory capacity had been strengthened, and a seasonal influenza vaccination was provided to all health-care workers, high-risk groups and the elderly. Health-care workers and the public received clear information on potential influenza threats, and on effective hygiene and other preventive measures.

Bahrain fully supported WHO's programmes and bilateral and international efforts to prepare for a pandemic of influenza. It undertook prompt and transparent reporting of outbreaks of human and zoonotic influenza, and supported the rapid sharing of clinical specimens and viruses through the WHO Global Influenza Surveillance Network. It provided timely and adequate supplies of vaccines and antiviral medicines under the Agreement on Trade-Related Aspects of Intellectual Property Rights, and supported the Intergovernmental Meeting process in the sharing of influenza viruses and access to vaccines and other benefits.

Mr SPENCER (Jamaica) congratulated the Director-General on the prompt response and dissemination of information on the influenza A (H1N1) outbreak. Jamaica's response plans had been implemented throughout the country's health network and included heightened surveillance systems; expansion of the clinical case definition of severe acute respiratory syndrome; increased surveillance at all ports of entry; provision of information on necessary precautions; training of health sector workers on early detection and diagnosis. Antiviral medicines had been stockpiled and PAHO had been identified as a source of extra supplies. An emergency management plan enabled ministries to coordinate information sharing and responses, with community education provided through various media.

Thanking PAHO and the Caribbean Epidemiology Centre for continued updated information, he cautioned that surveillance and preparedness needed to be maintained in order to be able to face a second wave of infection. Strong health systems were essential to early detection, diagnosis, response and mitigation. WHO should take stock of the global response to the current outbreak and work on any

weaknesses in the International Health Regulations (2005) in order to strengthen future response to pandemics.

Dr WAN NORAINI WAN MOHAMED NOOR (Malaysia) considered the role of the WHO Global Influenza Surveillance Network vital to preparation for a potential influenza pandemic. Malaysia's national influenza centres continued to strengthen the Network through regular reports of influenza activity, timely submission of viruses, and information on isolation of unusual viruses. His country contributed representative influenza isolates to the WHO collaborating centres for development of the WHO recommendations for influenza vaccine composition.

Her Government called on Member States to establish a framework that would ensure timely access by all countries to adequate and affordable vaccines and other benefits in the event of a pandemic. Commercial interests must not come before public health.

Dr SORY (Ghana), speaking on behalf of the 46 Member States of the African Region, commended the Organization's leadership in meeting the challenge of the recent influenza A (H1N1) outbreak, especially in sharing information and ensuring that country-response systems were established. Improved coordinating mechanisms were needed through the adoption of the guiding principles for the development of terms of reference for WHO Global Influenza Surveillance Network of laboratories and for the Advisory Group. Progress in establishing mechanisms for tracking influenza viruses also required improved linking to other databases and facilitating data entry.

An urgent review of the mechanisms ensuring equitable access to preventive vaccines was needed, particularly in light of the recent agreement between manufacturers of pneumococcal vaccine and certain countries to the effect that richer countries would also benefit from the lower vaccine price offered to African countries. That would render the vaccine unavailable to the GAVI Alliance for distribution in a large number of African countries and deprive African children, despite the fact that the trials took place in Africa, of their right to a vaccine that prevented millions of deaths each year.

Sharing of public health information was essential to the success of the WHO Global Influenza Surveillance Network. Response to an influenza pandemic was only as effective as the degree of country preparedness, the availability of stockpiled vaccines and distribution logistics. He commended the timely sharing of information and improved transparency by Mexico, the United States of America and other countries in response to the current global influenza A (H1N1) crisis. He urged Member States, and developing countries in particular, to increase surveillance for influenza viruses; upgrade their capacity for virus isolation; expand routine prevention and containment practice; and build multisectoral cooperation for emergency preparedness.

WHO should increase resources for producing safe and affordable influenza vaccines and seek mechanisms to promote access to vaccines, particularly for developing countries. He called for greater technical support to developing countries for improving emergency preparedness and response; for better regional and subregional dialogue on the global pandemic influenza action plan to increase vaccine supply; for strengthened research capacity into vaccine development; and for existing biological facilities to be adapted for the development and production of human vaccines, in support of the One World, One Health strategic framework.

WHO should continue to implement the agreed aspects of the strategic framework and work towards resolving outstanding issues, including the Standard Material Transfer Agreement and intellectual property rights. The Secretariat could set up an informal process to continue such work and report to the Executive Board at its 126th session in January 2010. In the interim, the Intergovernmental Meeting should be reconvened during the current Health Assembly to conclude its work and report back at the end of the current session.

Dr NASIDI (Nigeria) proposed that the Health Assembly should resolve to request the Director-General to work with Member States on implementing the elements of the Pandemic Influenza Preparedness Framework on which the Intergovernmental Meeting had reached consensus, and to support consultations among Member States on the key remaining elements. It should also request her to conclude negotiations on the outstanding issues through a select group of experts, the officers of the

Intergovernmental Meeting or an informal process, and to report to the Executive Board at its 126th session.

Professor AYDIN (Turkey) said that concerns about virus-sharing and inadequate access to benefits and resources could generally be resolved through goodwill and understanding among Member States and he expressed support for the intergovernmental process. Nevertheless, recent developments had shown that, in order to contain the influenza A (H1N1) virus, developing countries with limited surveillance, diagnostic and treatment capacity would require significant support. Existing proposals for benefit-sharing did not meet those needs. Whether the H1N1 virus were the agent that eventually caused a pandemic or whether it recombined with other strains, containment measures should be taken urgently.

Expressing appreciation for the efforts of WHO collaborating centres in sharing H1N1 isolates with national influenza centres, he emphasized that failure to obtain isolates promptly would be a serious obstacle to containing influenza outbreaks. Turkey had shared viruses during an outbreak of influenza A (H5N1) in humans in 2006 and would continue to support international efforts towards pandemic preparedness. Viruses and benefits should be shared by all countries on an equal footing.

Mr SU Haijun (China) expressed his country's commitment to pandemic influenza preparedness and sharing viruses promptly in the event of any influenza outbreak. He advocated equitable sharing of the public health and economic benefits arising from such sharing of viruses. His country would support developing countries in strengthening their capacity for influenza surveillance and pandemic preparedness, and he encouraged such countries to participate in related research undertaken by WHO collaborating centres. The Secretariat should continue to coordinate the sharing of live H1N1 virus, in order to facilitate laboratory testing and enable more Member States to benefit from virus-sharing mechanisms.

Ms BELTRAN (Philippines) expressed strong support for the sharing of influenza virus and international stockpiling of H5N1 vaccines, with recommendations that they be used for high-risk and priority groups. South-east Asian countries had adopted the Joint Ministerial Statement of the ASEAN+3 Health Ministers at a special meeting on influenza A (H1N1) (Bangkok, 8 May 2009), in which the ministers committed themselves to implementing national pandemic preparedness plans, strengthened surveillance, effective response, enhanced capacities for implementation of the International Health Regulations (2005), intersectoral communication and action, cross-border control strategies, the sharing of essential emergency supplies, and prompt sharing of information on epidemic situations. All Member States should have equitable access to influenza vaccines, with priority given to the countries in greatest need (for example, where populations were unlikely to have developed immunity). Strong medical-veterinary partnership was essential in order to deal effectively with zoonotic diseases. The Philippines had established a council on zoonoses for that purpose.

Dr WIBISONO (Indonesia) stressed the need to finalize the outstanding elements of the Pandemic Influenza Preparedness Framework. His country was willing to continue working to resolve the remaining issues, particularly concerning the draft standard material transfer agreement.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) recalled that health ministers of members of the Non-Aligned Movement had adopted a declaration on responsible practices for sharing of influenza viruses and access to vaccines and other benefits which had been taken into account by the Intergovernmental Meeting in December 2008. He expressed support for the drafting of a resolution along the lines suggested by the delegate of Nigeria and asked within what time frame the Director-General would be requested to continue work on the unresolved matters. Within the Region of the Americas there was great concern about the potential southerly spread of influenza A (H1N1) and thus it was important to resolve issues still pending from the Intergovernmental Meeting calmly and quickly.

Mr HERBERT (Saint Kitts and Nevis) said that middle-income status might disadvantage some Member States regarding access to vaccine. Gaps in vaccine distribution would be minimized if equity became the ethical principle that guided procedures for the stockpiling and distribution of vaccine. He acknowledged the work of PAHO's Emergency Operations Center in responding to the influenza A (H1N1) epidemic and its assurances that all Member States would have access to vaccine stockpiles. He expressed confidence that WHO would continue to work towards the sharing of vaccine benefits for all countries, as set out in the Medium-term strategic plan 2008–2013.

Mr TOBAR (Argentina) expressed concern about some of the remaining work of the Intergovernmental Meeting; in particular, the interim traceability mechanism should be linked to other databases and the entering of data should be simplified. It was essential to establish an international stockpile of vaccines against influenza A (H5N1) virus and other strains with pandemic potential, including H1N1. All possible donors should be approached in order to secure funding for access to vaccine in developing countries. A general framework to deal with diseases at the human-animal interface should also be established. The experience gained in fighting avian influenza should be used to sustain global response to other infections, including influenza A (H1N1).

Dr LEVENTHAL (Israel) said that, with the advent of influenza A (H1N1), prompt sharing of virus-sequencing and other information by the first three countries affected had enabled other countries to take quick, appropriate action. Such responses should serve as an example to other countries. The principle that global health was determined by the level of health in the weakest countries meant that it was in the interests of the entire international community for all countries to be well prepared. He emphasized regional and subregional cooperation, cooperation between neighbouring countries and solidarity to ensure provision of vaccines and antiviral agents at reasonable cost.

Dr ASIN-OOSTBURG (Suriname) said that her country intended to play a key role in the establishment of a regional laboratory for Caribbean countries and she was pleased to note that the Advisory Group would concentrate on strengthening laboratory capacity in developing countries for the identification of influenza viruses. Emphasizing the importance of affordable access to essential vaccines by small developing countries, she requested WHO's support in making available a stockpile of H5N1 vaccines for access by all Caribbean countries.

Mr VOLF (Czech Republic), speaking on behalf of the European Union, congratulated the Secretariat and the countries most affected by influenza A (H1N1) for handling the current crisis effectively and for cooperating closely with the international community. The global response had shown the Global Influenza Surveillance Network at its best and illustrated the importance of national cooperation. Although recent attention had focused on the pandemic potential of avian influenza originating in Asia, the sudden emergence and rapid spread of the influenza A (H1N1) virus had shown that a new virus with pandemic potential could emerge at any time, anywhere. Unrestricted and prompt sharing of information, viruses and diagnostic reagents was necessary for rapid risk assessment and formulation of strategies to slow the spread of the virus and limit its impact. Pandemic preparedness at all levels and rapid and transparent cooperation with the vaccine industry were required to meet those challenges. The European Union fully supported the efforts of the Global Influenza Surveillance Network to monitor the epidemiology of the virus and ensure that countries around the world were adequately prepared. He supported the proposal by the delegate of Nigeria regarding consultations among Member States on outstanding issues, and agreed that the Director-General should implement the elements on which consensus existed and report to the Executive Board at its 126th session.

Dr AL ZAHRANI (Saudi Arabia), thanking the Intergovernmental Meeting for its work, said that his Government was in favour of vaccine stockpiles and making vaccines available to all

countries, particularly developing countries. It encouraged epidemiological surveillance, consultations with WHO and the drawing up of dynamic national plans for virus tracking.

Mr MONTIEL (Bolivarian Republic of Venezuela) said that his country's national influenza centre was participating in the Global Influenza Surveillance Network and the influenza virus traceability mechanism, and was contributing virus strains for the development of annual vaccines. In accordance with WHO's guidelines, Venezuela had built up a stockpile of oseltamivir for the treatment of suspected cases of influenza caused by viruses with pandemic potential. He emphasized the need for equitable access to vaccines, medicines and other benefits, and thus to ensure that intellectual property rights and market interests did not prevent Member States from protecting public health, particularly in the most economically vulnerable countries. In Venezuela, procedures had been initiated for the acquisition of a pre-pandemic vaccine; a fund should be established to centralize and regulate prices and processes for the acquisition of vaccines, medicines and related techniques in order to respond to a global pandemic.

Dr SOPON IAMSIRITHAWORN (Thailand) welcomed the proposal to establish international stockpiles of pandemic vaccines. Efforts should be made to ensure that seed influenza A (H1N1) viruses were promptly and equally shared with public and private vaccine manufacturers in developed and developing countries without any intellectual property restrictions. Currently, more than 90% of global vaccine production capacity was found in North America and Europe. Equitable access to vaccines and antiviral medicines must be ensured so that in the event of a pandemic a huge death toll could be avoided, in particular in Africa, the Eastern Mediterranean and South-East Asia.

There had been a loss of trust in the WHO Global Influenza Surveillance Network as a result of the private interests of some vaccine producers, and Thailand called on the Director-General and all Member States to restore a spirit of trust to global health efforts, including the fight against pandemic influenza. Every effort should be made at the current Health Assembly to reach agreement on the sharing of influenza virus and benefits.

Dr FERDINAND (Barbados) congratulated the Intergovernmental Meeting on its work and supported the suggestion by the delegate of Nigeria for resolving the remaining issues. The distribution of vaccines and antiviral medicines should be as equitable as possible. She urged the Director-General to continue to encourage manufacturers to produce at maximum capacity. All countries should be asked to join in an agreement on benefit-sharing and have access to such resources.

Dr CAMARA (Gambia) commended the Secretariat's efforts to establish an international stockpile of vaccines against H5N1 virus and other influenza viruses of pandemic potential. The operation of the traceability mechanism should also include influenza A (H1N1) virus. He acknowledged the Secretariat's support for the strengthening of surveillance systems in Member States, particularly those of the African Region, and appealed for continued provision of emergency stocks of medicines, vaccines and personal protective equipment.

Mr LOFTIS (United States of America) welcomed the consensus achieved during the Intergovernmental Meeting with regard to benefit-sharing and the near consensus on definitions and terms of reference. He supported the proposal to request the Director-General to work with Member States to implement the elements already agreed upon and to facilitate discussions of remaining issues. The United States would be an active participant in that work, and it was to be hoped that agreement could be reached.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that his Government was committed to providing benefits, including vaccines, for countries with a public health need, and had provided financial support for that purpose through WHO and a series of pledging conferences aimed at improving avian and pandemic influenza preparedness. He agreed that

it was important to make progress on matters on which broad agreement existed, and cautioned against further unnecessary discussion.

A long-term vision was required in order to avoid the vicious cycle in which a pandemic strain emerged, costly vaccines were developed and stockpiled, the pandemic receded, and then another virus emerged. Such a vision had to include the development of broad-spectrum, long-lasting and cheap influenza vaccines that would act to prevent future pandemics. That could only be achieved through a collective approach that combined epidemiology, surveillance and basic science.

Mr HAYAKAWA (Japan) supported the suggestion made by the delegate of Nigeria and joined other speakers in stressing that the experience gained from dealing with influenza A (H1N1) virus should be applied in future work. Significant progress had been made on benefit-sharing, but some issues remained with regard to sharing of samples. He urged all affected countries to share samples, including those of influenza A (H5N1) virus.

Ms JÁQUEZ HUACUJA (Mexico) said that her country had notified WHO of an outbreak of influenza A (H1N1) both in compliance with the International Health Regulations (2005) and from moral duty. Efforts to combat viruses of pandemic potential called for transparency, responsibility and close cooperation. Mexico had agreed to share the influenza A (H1N1) virus so that the international scientific community could research and develop better medicines and vaccines. Such international cooperation could solve global health problems. She supported continued debate aimed at reaching a consensus on the outstanding elements in the Pandemic Influenza Preparedness Framework and supported the suggestion made by the delegate of Nigeria for consultations.

Dr DAVIES (International Organization for Migration) drew attention to the need for national pandemic influenza response plans to ensure access to vaccines and other benefits for migrant communities, whose access to health and social services was often limited. The rapid spread of influenza A (H1N1) had clearly demonstrated the relationship between human migration and health. Therefore it must be ensured that everyone living in a country had access to information, in the appropriate linguistic forms, and to health treatment, with efforts made to allay the fears of migrants that they might be deported if they sought medical help.

Professor Pei-Jer CHEN (Observer, Chinese Taipei), speaking at the invitation of the CHAIRMAN, said that Chinese Taipei, as a major player in the information technology industry, would welcome an opportunity to help to resolve the current difficulties in linking the interim virus traceability mechanism with other databases. Chinese Taipei was currently upgrading its production capacity for egg- and cell-based vaccines and would be pleased to contribute vaccines to an international stockpile or to any country in need.

Dr FUKUDA (Assistant Director-General ad interim), said that the Secretariat had clearly heard the message concerning the urgent need to provide vulnerable countries with greater support for building capacity, especially laboratory capacity; to increase access to vaccines, antiviral agents and other materials; to acknowledge the impediments to such access and ensure that public health concerns took precedence over commercial and other interests; and to continue pressing ahead with pandemic preparedness and response activities.

At the request of the CHAIRMAN, Dr NASIDI (Nigeria) repeated his earlier suggestion but removed the mention of “a select group of experts” in the light of the comments made by the delegate of the United Kingdom.

Mr ALBUQUERQUE E SILVA (Brazil) said that his Government could not support the suggestion made by the delegate of Nigeria as it gave the false impression that agreement had been reached on key issues. The Intergovernmental Meeting should be reconvened in order to resolve



several important matters on which Member States had yet to reach consensus. He therefore requested that any decision on the matter be left until the following day.

The CHAIRMAN said that the discussion of the item would continue at a subsequent meeting.

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

**The meeting rose at 19:05.**

## **SECOND MEETING**

**Tuesday, 19 May 2009, at 09:15**

**Chairman:** Dr F. MENESES GONZÁLEZ (Mexico)

**TECHNICAL AND HEALTH MATTERS:** Item 12 of the Agenda (continued)

**Implementation of the International Health Regulations (2005):** Item 12.2 of the Agenda (Document A62/6)

Professor RAHMAN (Bangladesh) said that the International Health Regulations (2005) had entered into force in his country in June 2008. A national strategy and guidelines for reporting public health emergencies of international concern had been drafted and incidents had been reported to WHO, such as the detection of a case of H5N1 influenza virus in 2008. His country was strengthening its disease surveillance; a web-based system connected all districts in Bangladesh with 24-hour hotlines for the reporting of unusual public health events. Bangladesh requested support from WHO to strengthen its laboratory network at the national, district and subdistrict levels and capacity at the country's points of entry.

Dr NAKORN PREMSRI (Thailand) commended the progress made in implementing of the International Health Regulations (2005) through WHO's support. However, during the 18 months following the entry into force of the Regulations in June 2007, only 11% of the public health events reported by national IHR focal points had constituted the notification or information sharing required by the Regulations. Clearly, the focal points were not yet a major source of early warning, a situation that called for urgent improvement.

The international outbreaks of influenza A (H1N1) showed that the Regulations were essential for tracking global epidemics. New cases had been notified daily through WHO's communication networks and the national IHR focal points had been working to inform the public. Timely communication among national IHR focal points and information sharing among countries were important in controlling global outbreaks of disease. Similar communication on the status of public health emergencies would minimize delays and ensure timely responses to the transmission of infectious diseases. To that end, a trustworthy system should be promoted for sharing information within specific geographical areas.

Scientifically proven control measures should be implemented by Member States at national points of entry, particularly in light of influenza A (H1N1). Exit screening in affected areas would reduce the risk of further spread of the disease. All Member States should establish systems for surveillance, early detection and containment of imported cases, with guidance from WHO.

Dr SANTIAGO (Philippines), commending the report, emphasized the need to strengthen both the application of the Regulations and the role of national IHR focal points as sources of early information on public health emergencies. Although such emergencies seriously affected economies, health should always take precedence over trade or industry issues. Countries should decide on their own entry and exit screening procedures in order to protect both national citizens and foreigners from infection. His Government recognized its responsibility to prevent viruses from entering or spreading through the country or spreading to others.

He requested clarification of the issues that should fall within the purview of the International Health Regulations (2005).

Dr ASLANYAN (Canada) commended WHO's facilitating the implementation of the Regulations. His Government was working with provincial and territorial authorities in order to further implementation of the Regulations. Capacity assessments had been completed at five points of entry and were proceeding as scheduled in the areas of surveillance and response at local, provincial and federal levels.

His country was fostering national and international partnerships as a key to understanding the obstacles to implementation. It would continue to collaborate with other Member States, PAHO and the Secretariat and provide technical support, notably to Mexico, in connection with influenza A (H1N1). Canada's approach to the outbreak of influenza A (H1N1) had been in keeping with the Regulations, illustrating the progress made since 2005.

Regarding prevention of the deliberate use of biological agents, the Health Assembly in resolution WHA55.16 recognized that an effective method of preparing for deliberately caused disease was to strengthen public health surveillance of and response to naturally or accidentally occurring diseases. Work relating to the Biological and Toxin Weapons Convention to reduce the risk of use of biological agents or toxins was relevant to WHO. Member States should participate in that Convention's Meeting of Experts later in the year, an important forum for health ministers and experts to discuss improving capacity, coordination and cooperation in managing biological risks.

Mr ABDOO (United States of America) welcomed the universal application of the International Health Regulations (2005), as they were essential to surveillance, reporting and response to global outbreaks of disease. The influenza A (H1N1) outbreak had demonstrated the importance of rapid, transparent sharing of information on disease outbreaks and collective action for their mitigation.

Member States should fulfil their obligations under the Regulations by sharing information on outbreaks of diseases, and on influenza A (H5N1), influenza A (H1N1) and other new influenza viruses; withholding such data would contravene the spirit of the Regulations and pose a threat to global health security. The United States would willingly work with international partners and share its experience of the implementation process.

Mrs MACHATINE (Mozambique), speaking on behalf of the 46 Member States of the African Region, said that the implementation of the Regulations in the Region was proceeding within the context of the regional strategy for integrated disease surveillance and response. To date, 17 countries were revising their national guidelines by incorporating the Regulations, and several Member States were implementing related core activities. National laboratory networks and quality assurance schemes had been established. Member States were at different stages of assessing their core capacities and developing plans of action, although most had begun to raise awareness of the Regulations among national IHR focal points, surveillance officers and other stakeholders. All countries had designated a national IHR focal point and provided the necessary contact details; 32 countries had fulfilled the requirement for full-time communication, with 14 complying with the requirement to report events to WHO using the International Health Regulations (2005) mechanism.

Communication channels had been established with other relevant sectors in 28 Member States. A competent responsible authority for the implementation of the Regulations had been identified in 30 countries; 17 had designated at least one expert to advise the Director-General, as prescribed by the Regulations. However, challenges remained, including high staff turnover among national IHR focal points and inadequate resources for core surveillance and response.

Member States were urged to revise their technical guidelines for integrated disease surveillance and response to include the Regulations; to comply with their requirements by, inter alia, adopting legislation; to notify WHO of events of public health importance; to equip the national IHR focal points with appropriate communication tools; to mobilize resources; and to strengthen collaboration between health and other sectors. The African Region reaffirmed its commitment to full implementation of the Regulations. It was important to strengthen core capacities before South Africa hosted the 2009 Confederation Cup and the 2010 World Cup.

Dr DEMINA (Russian Federation) said that implementing the International Health Regulations (2005) was a priority for her Government; the national IHR focal point was the Federal Service for the Protection of Consumers. In 2007–2008 work had been done to harmonize standards nationally, train staff, strengthen the national laboratory network, and streamline the rapid updating a system for events that might represent a public health emergency. Although monitoring had improved, implementation of the Regulations remained difficult: there was no common system for information exchange between Member States and the Secretariat on health events of international concern, and further information was needed on events concerning biological, chemical and radioactive materials and waste. Member States would benefit from regular information from the Secretariat on disease outbreaks and environmental hazards. Also lacking were a standard WHO process for issuing certificates to international transport enterprises and other competent bodies, international laboratory standards on which to base the issuing of ship sanitation control exemption certificates, and a common training WHO programme on the Regulations for national officials.

Dr SUGIURA (Japan) said that, with regard to the decision instrument contained in Annex 2 of the Regulations, it had emerged that Member States had varied interpretations on what events might constitute a public health emergency of international concern. The implementation process therefore needed universal indicators at the global level. Each Member State should develop core capacity by the most effective means which should be separate from the implementation of the Regulations. Japan was finalizing assessments and developing a plan of action. He understood that the Secretariat would provide specific indicators for monitoring capacity building and each Member State's evaluation should reflect those indicators.

Dr KESKINKILIÇ (Turkey) said that the recent outbreak of influenza A (H1N1) had demonstrated the importance of the International Health Regulations (2005), as countries were able to obtain and share crucial information daily.

With reference to paragraph 13 of the report, he considered that, as countries were still trying to implement the Regulations, it was too soon for the national IHR focal points to be a major source of early information to WHO on events or for Annex 2 of the Regulations to be used routinely in their assessment. The Secretariat had made available to Member States several useful guidelines, and the Regulations would not have the desired outcome if any Member State failed to implement them fully. Countries should share their knowledge and experiences in order to prevent threats to global public health.

Ms JÁQUEZ HUACUJA (Mexico) said that globalization, strengthened international relations and technological development had brought the benefits of greater international flow of people and goods, which had also caused the more rapid spread of diseases, all of which demonstrated the importance of implementing the International Health Regulations (2005).

Mexico remained faithful to the principles of public health and was committed to WHO actions and implementing the Regulations, as evidenced by her country's timely response to the recent outbreak of influenza A (H1N1), which would not have been possible without the support of the international community and WHO's Secretariat in particular. The experience had highlighted the Regulations as an effective mechanism and the importance of coordinated national and international surveillance in responding to epidemiological emergencies and preventing the spread of virus.

Dr MUSONGELA (Democratic Republic of the Congo) welcomed WHO's efforts to deal with the influenza A (H1N1) epidemic. In 2008 his country had started to implement the International Health Regulations (2005), and the national programme "*Hygiène aux Frontières*" had been designated as the national IHR focal point. Training had begun for staff in the health and agriculture ministries, and the Regulations were being publicized and integrated into the national surveillance and response system. The greatest challenge was in assessing core capacities.

The Economic Community of Central African States had recently convened a meeting in order to harmonize their strategies for combating the outbreak of influenza A (H1N1), and implementation

of the Regulations. Similar information sharing with WHO had accelerated detection and control of other diseases. He therefore appealed for the mobilization of partners for the acquisition of the capacities required by Annex 1 of the Regulations.

Mr VOLF (Czech Republic), speaking on behalf of the European Union, said that the outbreak of influenza A (H1N1) had proven the importance of the International Health Regulations (2005) for global health security and shown the need for their continued implementation. All Member States must do their utmost to meet the deadline for assessing core capacities.

Support from the Secretariat and the WHO Lyon Office for National Epidemic Preparedness and Response (Lyon, France) in the development of tools and training to build core capacities had been highly appreciated. The European Union therefore welcomed the report, which emphasized achievements and paved the way for continued progress. The European Union also looked forward to the publication of technical documents and guidelines relating to points of entry.

The Secretariat should focus on preparedness; a general framework for coordinating responses to major health threats at the global level would be useful. To that end, workshops, guidance and simulation exercises could help to identify appropriate measures.

There was a continued need for Member States to strengthen their capacities for early detection, surveillance and response; the lessons learnt from the recent outbreak of influenza A (H1N1) would be valuable in further developing and refining implementation strategies and documentation.

Dr GOUYA (Islamic Republic of Iran) said that implementation of the International Health Regulations (2005) called for close coordination at the regional and global levels. Any decision to limit travel or ban trade would have adverse economic consequences for countries, particularly crucial in the light of the influenza A (H1N1) epidemic. Member States should periodically discuss aspects of the Regulations at meetings coordinated by WHO. Regular meetings to build consensus on national IHR focal points were also needed.

Dr LEVENTHAL (Israel) supported the views expressed by the delegate of Iran. The time spent on negotiating the International Health Regulations (2005) had proved valuable, but gaps in their implementation remained. Full implementation was most important and would strengthen public health infrastructure. However, that would require international cooperation, intersectoral collaboration at national and regional levels, and possibly a WHO-sponsored mechanism in order to establish regional collaboration between countries that did not maintain diplomatic relations.

Exchange of data on threats to international public health would improve cooperation among countries regarding health. Subregional activities, involving WHO and its regional offices for Europe and the Eastern Mediterranean, had greatly helped Israel during the recent outbreak of influenza A (H1N1). That outbreak could pave the way for a committee to discuss its implications for the Regulations and whether amendments were needed to improve the international response to emerging diseases.

Dr AL JALAHMA (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, acknowledged the importance of the International Health Regulations (2005) in guiding countries on the health measures required by the current threat of influenza A (H1N1). The Region had made significant progress in the priority area of transparency and sharing of information. She requested the Secretariat to continue supporting all countries in their implementation of the Regulations so that crucial health information was made available, even if it were damaging to national and economic interests. That would ensure complete implementation of the Regulations by June 2010.

Dr MESELE (Ethiopia) highlighted the expanded scope of the revised International Health Regulations (2005), which rectified previous weaknesses in detection and response to disease outbreaks. In her country, a national IHR focal point had been designated, and assessment of the public health system had led to a broader management system for detection and response, with

emphasis on disease outbreaks and nutritional emergencies caused by drought. That system incorporated risk-based preparedness, capacity building and best practices from other countries that would enable her country to respond to a global health threat in accordance with the Regulations. A 24-hour emergency operations centre, supported by regional centres, had enhanced communications.

Ethiopia had benefited from WHO's support for laboratory activities and training of personnel in the safe handling and transport of infectious substances. In 2009, Ethiopia would take part in the WHO External Quality Assessment Project for the detection of influenza A viruses using polymerase chain reaction-based assays. The complexity of public health challenges, including natural disasters, civil conflict, population displacement, and technological accidents, required countries to mobilize resources, build and sustain programmes that remained long after specific threats had been removed.

Mr MONTIEL (Bolivarian Republic of Venezuela) said that the International Health Regulations (2005) had enabled training through regional workshops using the four multilingual modules. The National Liaison Centre maintained communication with the national IHR focal points and met requests for verification of events; information from the WHO web site was communicated to the appropriate national body. In 2008, case definitions had been translated and disseminated to regional epidemiological services and had been further reviewed in 2009. Training at the intermediate level for local detection and response had begun. He commended the report's comprehensive summaries of WHO's activities and cooperation for strengthening national capacities.

Dr GAMARRA (Paraguay) said that the International Health Regulations (2005) had greatly contributed to preparedness and response, harmonized infrastructure and human resources and ensuring surveillance of points of entry, particularly multilateral strengthening in the strategic Three Borders Landmark area. The countries of MERCOSUR (Common Market of the South) had been fully prepared to tackle the influenza A (H1N1) outbreak, had assessed cooperation and communication, and shared experiences on surveillance through videoconferences.

Dr FEISUL (Malaysia) said that his country had already evaluated the capacity and capabilities of three points of entry, and evaluation of a further 61 points was expected to be completed by June 2009. Malaysia had taken part in a communication exercise on the Regulations in the Western Pacific Region, at which 80 officers had been trained; a further 200 officers would receive training by the end of 2009. He called for a clear statement to be included in the decision instrument of the International Health Regulations (2005) (Annex 2) regarding the requirement to report an event within 48 hours of detection whether unverified or unresolved.

Dr MINNIS (Bahamas) said that recent influenza A (H1N1) outbreaks had led to strengthened capacity and multisectoral collaboration to meet the core requirements of the International Health Regulations (2005). Capacity building had been supported by WHO, PAHO and development partners. The Microbiology External Quality Assessment Programme in the African and Eastern Mediterranean regions would also benefit the member states of the Caribbean Community in the crucial area of laboratory capacity. The geographical dispersion of those latter countries posed a challenge to specimen management and early identification of new influenza viruses. The Bahamas, a small island country with multiple ports of entry, needed to find innovative ways to expand early warning systems.

His Government was committed to mobilizing resources for full implementation of the Regulations and he encouraged Member States to capitalize on the response to the recent influenza A (H1N1) outbreak in order to strengthen their collaboration with global and national health partners.

Dr WU Jing (China) said that his Government had improved its regulations for responding to public health emergencies; strengthened communications, prevention and control; implemented a new emergency response system for health; and participated in related cooperation activities with the Secretariat and Member States in the Western Pacific Region. A multisectoral prevention and control mechanism prioritized inbound and outbound inspection and quarantine, and surveillance of national

outbreaks and public awareness. Those actions had mitigated repercussions from the first wave of the influenza A (H1N1) outbreak. China had provided financial and technical support to countries in the Region during the outbreak.

To help to prevent a potential influenza A (H1N1) pandemic, all countries, with WHO's coordination, should strengthen information exchange and take different national conditions into account. Developed countries had an obligation to support developing countries in building capacity, and in stockpiling vaccines and antiviral medicines.

Dr FIKRI (United Arab Emirates) said that, having begun implementation of the International Health Regulations (2005) in 2007, his country had set up health centres in all regions and the national IHR focal points were in constant communication with WHO. The national surveillance centre was being enhanced in order to detect and classify potential threats and to report immediately any unknown diseases. Laboratories had been established to analyse samples and to monitor any influenza type A or other viruses that might trigger an outbreak. He thanked WHO for ensuring that the national laboratories were certified, thereby enabling his country to implement the Regulations more fully.

Mr HERBERT (Saint Kitts and Nevis) said that his country had completed its assessment of core capacity for surveillance and response and aimed to have a national plan in place by the appointed deadline. His Government supported the continued contribution of the Caribbean Epidemiology Centre to disease surveillance and response during the transition to the proposed new Caribbean Public Health Agency.

Professor VONGVICHIT (Lao People's Democratic Republic) said that there had so far been no case of influenza A (H1N1) in his country. Measures had been put in place for border surveillance, to deal with absenteeism from work and schools, and to run public awareness campaigns. The emergency equipment needed for surveillance activities was being identified for installation. The National Animal and Human Influenza Coordinating Office was working closely with WHO and development partners, was coordinating national agencies, and issued regular updates on the situation.

Dr FERDINAND (Barbados) said that the International Health Regulations (2005) provided opportunities to strengthen public health capacities and collaboration among Member States and with the Secretariat. Her Government was committed to their full implementation. Recent activities included developing national protocols for port health practice at points of entry; increasing human resources at existing international ports of entry; setting up quarantine centres at two main ports of entry for prompt assessment and monitoring of suspect cases; managing international waste at all points of entry; and developing a network of port health information for timely epidemiological decision-making.

The designation of Barbados as a port of entry for issuing ship sanitation control certificates attested to its commitment to full implementation of the Regulations by December 2009. She requested support from WHO and PAHO in order to incorporate those into domestic law.

Dr MOTEETEE (Lesotho) outlined her country's work towards implementation of the International Health Regulations (2005). The Government had appointed a national IHR focal point which submitted regular reports to WHO; had developed guidelines for preparedness and response plans; and carried out public awareness campaigns for the most common disease outbreaks. Port health surveillance, already in place at three international ports of entry, was building on previous experience of multisectoral collaboration, in preparedness for a potential influenza A (H1N1) epidemic.

Her country, however, lacked skills and resources, particularly in disease surveillance at district level. Laboratory capacity was limited and port health authorities lacked adequate quarantine facilities. With porous borders, outbreaks of epidemics remained a challenge, particularly in light of the need to control the spread of influenza A (H1N1). She thanked WHO, development partners and neighbouring countries for their collaboration and cooperation.

Dr CAMARA (Gambia) said that the global leadership of WHO arose from resolution WHA59.2 on the application of the International Health Regulations (2005) and was evident in the current influenza A (H1N1) threat. The questionnaire requesting information on progress in implementing the Regulations had been a wake-up call for most countries. The challenges that his country faced included rapid staff turnover; delayed revision of guidelines for integrated disease surveillance and response; delayed assessment of core capacities; and the need to stabilize internet connectivity for the national IHR focal point.

He called for WHO's continued support to his country, and proposed that the Secretariat spend more time and resources on consulting Member States on the development of surveillance and monitoring tools which should be available in hard copy to developing countries as well as on the WHO web site.

Mr HAGE CARMO (Brazil) said that his country had been developing the capacities required of complex systems for public health surveillance. Those included implementation of public health emergency centres and capacity assessment of epidemiological surveillance, health services, laboratories, and international points of entry, using the guidelines provided by the International Health Regulations (2005) and adopted by the MERCOSUR countries. His Government had used the decision instrument provided in the Regulations for management of public health emergencies. The Regulations were fundamental to protecting public health and should promote the sharing of information in a timely and transparent manner.

Mr TOBAR (Argentina) highlighted the importance of the International Health Regulations (2005) in light of the current influenza A (H1N1) outbreak. Priorities should include multisectoral coordination to improve information sharing. It was crucial to train people to tackle a major international public health emergency, particularly those working at international entry points. Transparent communication of health information was important but should not infringe medical privacy or confidentiality of personal medical data.

The Secretariat should continue to provide support to Member States as they endeavoured to improve their core capacities in disease surveillance and response, enhance existing infrastructure, and provide ongoing training. Disease detection and surveillance at airports and designated international entry points still needed improvement to be totally effective; Argentina was working on strengthening both through MERCOSUR and the Union of South American Nations, exchanging information and experiences with neighbouring countries and subregional groups. He encouraged the promotion of public awareness and proper implementation of the regulations in force.

Dr DAKULALA (Papua New Guinea) said that small, vulnerable developing countries urgently needed personnel and resources to strengthen disease surveillance, particularly of tourists and workers in the mining, petroleum and gas industries, who travelled to countries such as his from all over the world. His Government had a pandemic preparedness plan in place, but he was concerned at the inability of surveillance systems to detect influenza virus before it reached communities. He welcomed neighbouring countries' expressed commitment to help smaller developing countries and urged that it should continue. Multinational companies working in vulnerable rural settings should contribute towards the national pandemic response, and the Secretariat might consider promulgating such an approach.

Dr MUÑOZ PORRAS (Chile) said that the International Health Regulations (2005) had been passed into law in his country in December 2008, and disease surveillance and health measures were in place at all entry points for public health emergency response. As a member of MERCOSUR, his country was involved in drawing up instruments for evaluating basic monitoring capacities at ports and airports, and the national IHR focal point had been tried and tested during the current influenza A (H1N1) outbreak. His Government was committed to continued collaboration and cooperation with Member States to ensure continued effective monitoring.



Ms TOELUPE (Samoa) said that the recent outbreak had tested national capacities in many areas and her country intended to persevere in their improvement. She expressed appreciation for WHO's work on the International Health Regulations (2005), particularly in highlighting existing problems that limited the capacities of Member States to implement their obligations. She urged the Secretariat to support countries in resolving those issues. Global partnerships were crucial for meeting objectives and she requested WHO to continue its close working relationships with other United Nations and international organizations.

Mr SUTARJO (Indonesia) reported that his country had appointed a national IHR focal point and held a high-level meeting on reinforcing the implementation of the Regulations. Work had also been done on resource allocation, including for capacity-building and logistics. The emergence of influenza A (H1N1) had provided useful lessons on implementing the Regulations in line with best practice, for example in regard to coordination with authorities at points of entry. An effective referral system had served well, even though no case of influenza A (H1N1) had been found. Nevertheless, Indonesia consisted of 17 000 islands and faced challenges from porous borders; he requested WHO's support in implementing the Regulations, and ensuring that they were incorporated in local frameworks.

Mr NOLAN (European Commission) said that, within the European Union, communicable disease outbreaks would continue to be reported to WHO using the European Union's early warning and response system for the prevention and control of communicable diseases, through which all European Union Member States informed each other, the European Commission and WHO. That would ensure continued rapid and reliable reporting from all European Union Member States with existing tools, to which WHO had had full access since 2007.

Dr Hsu-Sung KUO (Observer, Chinese Taipei) emphasized that the Regulations' purpose of preventing disease from spreading across borders while minimizing impact on trade and travel. Following the recent outbreak of influenza A (H1N1), rigorous surveillance of more than 100 000 travellers entering or visiting Chinese Taipei from North America had been conducted over the previous three weeks. Fortunately, no case had been detected, despite nearby countries being affected, and harm to travel and trade had been minimized. Such surveillance would have been impossible without the decision of WHO to include Chinese Taipei in the framework of the Regulations. Issues relating to publishing information from Chinese Taipei in WHO publications and on its web site would, it was to be hoped, be resolved through continuing dialogue.

Dr RODIER (IHR Coordination Programme), responding to points made, said that from experience at country level the International Health Regulations (2005) were apparently functioning well. That had been demonstrated by the response to influenza A (H1N1), thanks to the network of focal points, procedures inherent in the Regulations, their transparent implementation, and capacity building for surveillance and response at national level within the three-year cycle established in the Regulations. Measures were being taken on infrastructure and human resources in laboratories, epidemiology and ports of entry. WHO strongly encouraged collaboration between countries and regional projects and would continue to provide technical support to countries in need, chiefly through its regional offices.

Specific indicators to evaluate progress had been developed and should have been discussed by a meeting of experts and national representatives in early May, but circumstances had prevented the meeting being held. Guidelines on points of entry were almost ready but required final discussion with other international organizations and with industry, particularly the air and maritime transport sectors. With regard to Annex 2 of the Regulations, an interim guide had been published on the WHO web site, together with the report of a meeting of experts held in October 2008; studies were under way to evaluate the functioning of Annex 2 and the system for communicating with national focal points and their use of that Annex. Finally, in resolution WHA61.2 the Health Assembly had decided that the functioning of the Regulations would be reviewed by the Health Assembly in 2010.

**The Board noted the report.**

**Prevention of avoidable blindness and visual impairment:** Item 12.3 of the Agenda (Document A62/7)

The CHAIRMAN introduced the item and drew attention to the draft resolution contained in document A62/7.

Dr AL RAJEHI (Saudi Arabia), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the draft action plan, which sought to scale up efforts by Member States, the Secretariat and international partners in preventing blindness and visual impairment by developing comprehensive eye health programmes at national and subnational levels, and to support the implementation of WHO's Eleventh General Programme of Work, 2006–2015 and Medium-term strategic plan 2008–2013. It also represented an important step towards implementing resolutions WHA56.26 and WHA59.25. He supported the draft action plan and urged other Member States to do likewise.

Mr RIAZ (Bangladesh), speaking on behalf of the Member States of the South-East Asia Region, said that the Region was committed to solving the critical health and social problem of blindness. Bangladesh had introduced a national programme for prevention of blindness and had reviewed and updated its national eye-care plan.

In many developing countries night blindness was no longer a public health problem among children under five years of age. However, lactating women were often still affected because vitamin A supplementation programmes had been targeted more at children than at postpartum women within 42 days of delivery. He therefore suggested adding a sentence to paragraph 25 of the draft action plan to the effect that, in the context of reports from developing countries on precipitation of night blindness among lactating women owing to lack of vitamin A administration in the postpartum period, both advocacy and research were needed to draw attention to and create an evidence base on that particular aspect.

The magnitude of visual impairment in the South-East Asia Region among those aged 40 years and over could be as high as 25%, but much could be done with modest investment if a proper plan of action could be applied. In 2000, the Region had developed a strategic plan, in line with VISION 2020: the Right to Sight, towards eliminating blindness and building capacity for preventing blindness from major known causes. However, the unit responsible for eye care within the Regional Office for South-East Asia concentrated mainly on injury and other areas of disability. He requested WHO to give more importance to prevention of avoidable blindness in order to achieve the objectives of VISION 2020: the Right to Sight, and to integrating basic eye care into primary health care, as Bangladesh had already done.

Dr NEROEV (Russian Federation) welcomed the draft action plan, the increased international efforts to prevent blindness and the progress made under the VISION 2020: the Right to Sight. He concurred with the emphasis on the main preventable or treatable causes of blindness and severe visual impairment, and underlined the role of national prevention committees in federal, decentralized systems. His country's national committee, established in 2003, coordinated health departments in all Russian regions on blindness prevention, with targeted programmes headed by leading ophthalmologists. Experience demonstrated the importance of WHO collaborating centres in national and international preventive efforts.

Although too little attention had been paid in the draft action plan to the role of primary health care, despite its prominence in the Declaration of Alma-Ata, which itself had taken account of the wide experience of the Union of Soviet Socialist Republics in eliminating serious diseases such as trachoma, the plan represented a real mechanism for international coordination of the prevention of blindness.

Dr HUWEL (Iraq) outlined the steps taken in his country to incorporate VISION 2020: the Right to Sight at all levels. In order to strengthen primary eye care and ensure integration with secondary and tertiary eye care, Iraq had staffed and equipped community health centres across the country; merged eye-care services with primary health care services; trained primary health care workers and teachers in eye-care essentials; strengthened early detection of cataracts and glaucoma; and provided eye-health services in schools. A national committee for the prevention of blindness and visual impairment, representing specialist physicians and other sectors, formulated specific policy and activities on eye health. The main causes of avoidable blindness were cataracts, glaucoma and eye infections, especially in neonates, and efforts were being made to address them.

Dr BERHAN (Ethiopia), speaking on behalf of the Member States of the African Region, welcomed the detailed recommendations of the draft action plan. The WHO Regional Committee for Africa had, at its fifty-seventh session, endorsed a strategy on accelerating the elimination of avoidable blindness, which had guided plans for blindness prevention within specific national contexts. The draft action plan reviewed the obstacles faced, the role of development partners and the progress made by Member States; he expressed appreciation of the technical and financial support provided by WHO and other development partners in defining strategies for intervention.

The impact of blindness reached far beyond the health of individuals and disproportionately affected countries in the African Region, with their scarce resources, weak health systems and inadequate capacity to implement health programmes on avoidable blindness and visual impairment. A critical impediment lay in the separation of structures; instead, existing initiatives should be streamlined, consolidated and integrated into national health systems. Such integration would permit more cost-effective and systematic response; more sustainable planning programming and budgeting; and greater prioritization of eye-health professionals within human resource development strategies. Furthermore, mechanisms for tracking avoidable blindness could be incorporated into broader national surveys and data collection.

Implementation of the resolution and the action plan, if adopted, would require sustained technical and financial support. He therefore encouraged Member States to approve the draft resolution in order to accelerate the overall slow progress on preventing avoidable blindness and visual impairment in the African Region. He called on WHO and other relevant international organizations to prioritize those challenges within their programmes.

Dr ALLEN YOUNG (Jamaica) acknowledged that national plans for preventing avoidable blindness and visual impairment should first review existing services before setting out an effective system for integration into primary and secondary health care. Blindness in Latin America and the Caribbean, with an estimated overall prevalence of 0.5%, was being addressed within the region in part under the Declaration of Port-of-Spain: Uniting to stop the epidemic of chronic noncommunicable diseases (September 2007). The prevalence rates of such conditions and associated problems for eye health were increasing.

In Jamaica, primary eye-care services needed easier movement of cases from a primary to secondary level of care. The strategic perspective of the Ministry of Health was in keeping with VISION 2020: the Right to Sight. The establishment of teams of well-trained ophthalmologists, ophthalmic nurses, optometrists, and ophthalmic technicians in the public sector, together with improved infrastructure, was crucial to effective eye care. She expressed appreciation to partners for their joint cooperation programmes, targeting poor and vulnerable groups through cataract removal.

More research was needed in order to provide epidemiological profiles of communities and information on the social determinants of blindness and visual impairment, which were essential in forecasting demand for eye-care services and planning delivery. She supported the draft resolution and the draft action plan, to which Jamaica would give priority.

Dr ZHOU Jun (China), observing that some 80% of China's 12.3 million blind or visually impaired people could be treated or cured, outlined his Government's programmes since 1999 on the prevention of avoidable blindness. Despite progress, challenges remained, notably the geographical

concentration of ophthalmologists in urban areas, and the lack of ocular services in one fifth of hospitals. Since the incidence of retinopathy and corneal opacity was increasing, particularly among young people, increased public awareness of eye health and a long-term mechanism to prevent and treat blindness were urgently needed. He supported the draft action plan, whose implementation would require appropriate national eye-health policies. The Secretariat should continue to support Member States in their national health plans to improve the treatment of blindness, and coordinate resources to provide technical and financial support where needed.

Mr HERBERT (Saint Kitts and Nevis) recognized that the burden of visual impairment was closely linked to the epidemic of chronic noncommunicable disease. Endorsing the draft resolution, he expressed appreciation of joint efforts with partner countries that had benefited scores of people in his country whose sight had been restored. PAHO could support countries in the Caribbean to sustain those efforts through capacity building in surveillance and information systems. Assessment was also needed of human resources and training requirements relevant to the region.

Dr SUGIURA (Japan) expressed appreciation of WHO's leading role in and advocacy of the prevention of avoidable blindness. Preventing avoidable blindness and visual impairment should be managed as a cross-cutting issue rather than a specific programme of disease control, given the strong connection between blindness and such diseases as diabetes. In that regard he highlighted resolution WHA61.14 on prevention and control of noncommunicable diseases. He expressed support for the draft resolution and draft action plan and the hope that the results of actions contained in the plan would be followed up.

Dr CHAOUKI (Morocco) outlined his country's priorities for the prevention of avoidable blindness, which included elimination of trachoma, neonatal conjunctivitis, cataracts, and blindness resulting from measles, rubella and vitamin A deficiency. In the longer term, programmes would also emphasize diabetic retinopathy and chronic glaucoma. A policy of decentralization adopted by the health ministry would optimize use of available health resources in fighting avoidable causes of blindness and strengthening community approaches. To that end, epidemiological data needed regular updating to monitor trends and assess the impact of strategies. Since VISION 2020: the Right to Sight sought to eliminate avoidable causes of blindness, it was also important to clarify the certification process for the elimination of each such cause. With WHO's support, Morocco was pioneering the process of certifying trachoma elimination. Implementation of the draft action plan should be based on a multisectoral approach and emphasize synergy among activities on the ground.

Dr AL JOWDER (Bahrain) said that investment in preventing visual impairment reduced international suffering, provided social and economic benefits, and contributed to achievement of the Millennium Development Goals. He outlined his country's initiatives to achieve the goals of VISION 2020: the Right to Sight, notably the formation of a National Committee for the Prevention of Blindness.

Mr COLMENARES (Bolivarian Republic of Venezuela) said that the plan of action would strengthen implementation of the global strategy for prevention and control of noncommunicable diseases. His country's initiatives included major joint programmes with partner countries to improve the visual health of at least 10 million people in Latin America. His Government aimed to provide comprehensive care and free health services to all Venezuelans disabled as a result of a congenital complication, disease or accident, and thus integrate such people fully into society. He detailed national achievements including the increased numbers of eye examinations performed; the number of eye-health professionals per unit of population; and the distribution of free eye medications.

He proposed the following amendments to the draft action plan. In subparagraph 5(d), the concept of "cooperation" should be added to those of "partnerships and coordination". In the plan, the text of paragraph 6 should be expanded to cover people with milder visual impairment, and WHO should conduct a study on their situation for submission to the Sixty-third World Health Assembly. In

paragraph 13, the concept of “cooperation” should be added to that of “alliances”. The wording of paragraph 50 should be made clearer. Paragraphs 60 and 61 should be expanded to cover support to Member States in conducting epidemiological studies. In paragraph 65, “with the assistance of Member States” should be added after “contribute”. In paragraph 66, “coordinate support for” should be changed to “support”. In paragraph 78, “in coordination with Member States” should be added after “jointly”. In paragraph 81, “participate in” should be replaced by “promote participation in” and the sentence should end at “impairment”.

Mr MONDESIR (Saint Lucia) said that Saint Lucia was burdened with two of the main causes of blindness, namely diabetes and glaucoma. He acknowledged support from partners in its agricultural sector and in educating its population to eat appropriate foods. Diabetes and glaucoma could have devastating effects in small island States like his country, and he urged WHO to involve itself in research into the causes.

Professor HORVARTH (Australia) welcomed WHO’s practical approach to the establishment of national plans and programmes rather than disease-specific activities. Australia’s framework for VISION 2020: the Right to Sight, launched in 2005, had established coordinated action on eye health and vision care, and involved all levels of Government, health professionals and community organizations. Internationally, Australia had committed significant funding in order to support its neighbours in addressing avoidable blindness in the Asia-Pacific region.

More needed to be done, however, for indigenous Australians. Aboriginal and Torres Strait Islander people were at increased risk of developing avoidable blindness and vision loss from conditions such as trachoma, and were less likely to access eye-care practitioners than other, city-dwelling Australians. His Government had committed Aus\$ 58.3 million over four years to improving access to eye care and ear health, particularly in rural and remote areas. That initiative would increase services to address trachoma and expand the Visiting Optometrist Scheme.

Dr BLOUNT (United States of America) welcomed the Secretariat’s support to Member States in combating avoidable blindness, and supported the draft action plan. The United States continued to conduct ground-breaking vision research and to develop nascent care and treatment options for visually impaired persons around the globe; through its technical agencies, it had participated with the Secretariat in the work of eliminating avoidable blindness since 1979. Cataracts affected the ageing populations of developed and developing countries alike; an estimated 20 million people in his country over the age of 40 years had a cataract in one or both eyes. Additionally, the growing prevalence of diabetes in the United States and worldwide, and its visual impairment complications, continued to be a concern.

Dr FEISUL (Malaysia) expressed support for the draft action plan. In Malaysia, evidence had shown the major cause of avoidable blindness in Malaysia to be complications from noncommunicable diseases such as diabetes and hypertension, an issue touched on by the delegate of Japan. Therefore, rather than treating blindness as a vertical programme, Malaysia had integrated it into existing systems for managing and controlling noncommunicable diseases. Further efforts in the area of avoidable blindness would be pursued under Malaysia’s new National Strategic Plan for Noncommunicable Diseases.

Dr BERNADAS (Philippines) supported the draft action plan as it provided a comprehensive range of strategies and initiatives to guide all Member States in reducing or eliminating blindness. In his country, steps to eliminate avoidable causes of blindness had included the establishment of national and local health-care committees. Capacities of primary eye-care providers were being improved through training, and by networking with specialized organizations. Periodic monitoring surveys had showed a reduction in prevalence of bilateral blindness from 1.07% in 1987 to 0.58% in 2003, and of bilateral poor vision from 1.95% in 1995 to 1.64% in 2003.

Dr GONZÁLEZ (Cuba) said that a recent survey had shown the rate of blindness from all causes in Cuba to be 2.3%, the most frequent causes being cataracts (50%), glaucoma (26%) and diabetic retinopathy (9%).

He described the joint undertaking already referred to by the delegate of Venezuela, known as *Misión Milagro* (Mission Miracle), which had been extended to 33 countries. By early April 2009 the project had performed some 1.6 million surgical operations, often on those patients least able to afford the operations. Cuba supported the draft plan of action, to which it would be pleased to contribute the experience gained from *Misión Milagro*.

Dr CICOGLA (Italy) welcomed the clear scope, purpose and analysis of the draft action plan. He particularly appreciated the fact that the draft action plan complemented the global strategy for the prevention and control of noncommunicable diseases endorsed by the Health Assembly in resolution WHA61.14.

He placed importance on WHO's development of standardized and feasible methodologies for the collection of comparable epidemiological and health data. His Government had legislated on blindness prevention and visual rehabilitation, providing for specific funding by all its regions, and coordinated by the ministry of labour, health and social policies. Funds were allocated to the Italian section of the International Agency for the Prevention of Blindness. His Government was setting up a national committee for the prevention of blindness under the VISION 2020: the Right to Sight initiative.

Dr CAMARA (Gambia) thanked WHO for spearheading global efforts to prevent avoidable blindness and visual impairment. The Gambia was sharing its achievements in eye care with neighbouring countries under the Health for Peace Initiative, which involved the Gambia, Guinea, Guinea-Bissau and Senegal; it was also providing technical support, for example in planning and conducting camps for cataract surgery. It also hosted a subregional eye-care training centre for health workers.

The Gambia's experience suggested a need to build or strengthen national capacities for eye-care programmes and incorporate those into development plans, and to increase monitoring and evaluation. He was in favour of sharing successful experience among countries, and supported its replication and scaling up in other regions.

Dr SAW LWIN (Myanmar) said that in his country a national VISION 2020: the Right to Sight plan had been operational since October 2000 in collaboration with global partners and local organizations. Myanmar had been battling blinding trachoma since 1964, and had achieved a maintenance level for the disease. Noting that the Secretariat urged Member States to encourage partnerships, he listed partners cooperating with Myanmar in seeking to prevent avoidable blindness.

He detailed figures of cases of blindness in his country, where the prevalence was 0.6%. The number of cataract surgeries, for example, had doubled between 2001 and 2008. Myanmar was thus on track for preventing avoidable blindness caused by cataract, and good progress was being made against the other causes. He fully supported the draft action plan.

Ms ALARCÓN LÓPEZ (Colombia) said that the draft action plan would benefit from some additional elements: strengthening local information systems in order to obtain reliable epidemiological data; further identifying risk factors and different pathologies; introducing variables to distinguish between urban and rural populations, and other differentiated information. Those elements would help to determine the causes and scale of blindness, according to age, sex and ethnic group; and to identify economically and socially vulnerable populations, and high-risk populations such as refugees.

Further elements were also needed: communication measures at community level to detect, track and evaluate programmes; introduction of the topic of avoidable visual impairment and blindness resulting from disasters; reference to retinopathy of prematurity as an easily preventable and treatable

pathology; the relevance of interinstitutional approaches to prevention; and the role of insurers in the treatment of avoidable blindness.

Dr GAMARRA (Paraguay) said that her country had set up a national committee with an interinstitutional approach; its national eye-health programme was adequately funded by the Ministry of Public Health and had been incorporated into primary health care in order to guarantee universality and equity. She supported the draft resolution and draft plan of action.

Dr LEE Han-sung (Republic of Korea) welcomed the draft action plan, whose successful implementation his Government would do its best to ensure. Its initiatives included ophthalmological examination and corrective surgery for the elderly, starting in 2003, and mandatory eye examination in health check-ups for infants, with some 540 000 infants being screened every year, which would help the early detection of blindness and visual impairment. His Government would also continue to support private-sector bodies and nongovernmental organizations in provision of eye care and health education in developing countries, and it would actively strengthen its international cooperation.

Dr MUÑOZ PORRAS (Chile) welcomed the report and supported the draft plan of action. In Chile, the principal causes of blindness were covered by health insurance schemes. In order to implement that guarantee of coverage, primary ophthalmological care units had been established to deal with the most common pathologies, such as cataracts, and detect the more severe cases that needed referral to specialists. It was no longer considered inevitable that age was synonymous with blindness, as had been the belief, particularly in rural areas.

Dr WANICHA CHUENKONGKAEW (Thailand), welcoming the draft plan of action, made the following observations. With regard to paragraph 5(b), ample international evidence had been compiled that obviated the need for countries to assess their own evidence of cost-effectiveness.<sup>1</sup> Paragraph 5(e), concerning information on trends and progress, should include the lessons from countries' successes and failures. Paragraph 58 should also include a reference to the need for more paramedics, who could do valuable work in the screening of diabetic retinopathy, if supervised remotely by ophthalmologists. Paragraph 59 should also cover diabetes given its increasing prevalence and of the contribution of diabetic retinopathy to blindness worldwide. Paragraph 68 should also refer to childhood blindness, which had a lifelong impact on quality of life and productivity; and paragraph 73 should include contributing factors such as drug use by pregnant women.

Dr ASIN-OOSTBURG (Suriname) described the provision of eye care in her country. Most ophthalmic care was provided in a centralized academic hospital that was also responsible for providing decentralized services to remote areas. A training programme had increased the number of eye doctors in the country and reduced the needs for training abroad. Since 2005 Suriname had been participating in *Misión Milagro* (Mission Miracle), for which she thanked partner countries. She supported the draft resolution and action plan, and looked forward to WHO's continued support.

Mr VENKATACHALAM (India) supported the draft resolution and action plan. India's national programme aimed to reduce the prevalence of blindness to 0.3% by 2020 by establishing eye-care facilities in every district; expanding human resources for eye-care services; improving service delivery and the participation of voluntary organizations and private practitioners; and enhancing community awareness. Achievements during the period 2002–2007 included a significant increase in cataract operations (to more than 5.4 million per year) and the supply of ophthalmic equipment; the training of 1250 eye surgeons; the provision of spectacles for 1.4 million poor

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<sup>1</sup> Jamieson DT et al (Eds). *Disease Control Priorities in Developing Countries (2nd Edition)*. New York: Oxford University Press, 2006.

schoolchildren; the collection of 130 000 donated eyes; and the upgrading of five medical colleges. By 2012 India would have consolidated the control of cataract blindness and initiated activities nationwide to address other causes of avoidable blindness.

In regard to actions proposed in the draft action plan, India had already taken steps. An allocation of US\$ 250 million for 2007–2012 had been set aside for eye-care activities; World Sight Day was celebrated every year in October; and fortnights for eye donations were organized. The National Programme for the Control of Blindness coordinated activities with other sectors in order to achieve extensive coverage. A national research centre in New Delhi was helping to upgrade the skills of eye-care professionals and integrate research findings into programme review and planning.

Dr MOTEETEE (Lesotho) said that Lesotho was committed to reducing the prevalence of blindness from 5.0% to 0.5% by 2010 with support from WHO and other partners. Its programme sought to integrate primary eye care into the primary health care system and had made significant progress in developing educational materials on blindness prevention, training ophthalmic nurses, providing mobile outreach services and supplying diagnostic equipment and surgical sets. The cataract surgery rate had risen substantially and mass eye screenings were being conducted. However, shortages of skilled human resources and gaps in data collection had hindered planning and implementation of the prevention programme; reporting tools were being improved. Lesotho was grateful for the support it had received from WHO and other partners.

Dr VIOLAKI (Greece) fully supported the draft resolution but proposed a minor amendment: at the end of paragraph 2 the phrase “for health plans, policies and programmes” should be added.

Mr GARMS (International Agency for the Prevention of Blindness), speaking at the invitation of the CHAIRMAN, said that his organization, WHO’s partner in the VISION 2020: the Right to Sight initiative, federated more than 100 member organizations active in the prevention of visual impairment. Its collaboration with WHO had demonstrated the importance of international partnerships for the improvement of eye health. The draft action plan would bolster global efforts to eliminate avoidable blindness, and his organization would continue to support WHO in that endeavour.

Professor SCHALLER (International Pediatric Association), speaking at the invitation of the CHAIRMAN, said that hundreds of thousands of children were blind or visually impaired, many of them as a result of infectious diseases or congenital conditions amenable to prevention or treatment. Most of the affected children in the developing world were blind because they had not been vaccinated against measles and had an inadequate intake of vitamin A. In a single eye hospital in Sierra Leone, it had been estimated that 80% of the blind children had lost their vision as a result of vitamin A deficiency. His organization was grateful to WHO for raising awareness of preventable blindness as a significant cause of childhood disability. It would inform the global network of paediatricians; urge the inclusion of children’s needs in national plans, policies and programmes for eye health and prevention of blindness; and continue striving to ensure that every child had access to primary health care, including measles immunization and supplementation of vitamin A.

The CHAIRMAN said that the draft resolution, incorporating the proposed amendments, would be considered at a subsequent meeting.

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



### **THIRD MEETING**

**Tuesday, 19 May 2009, at 15:30**

**Chairman:** Dr F. MENESES GONZÁLEZ (Mexico)

#### **1. TECHNICAL AND HEALTH MATTERS:** Item 12 of the Agenda (continued)

**Prevention of avoidable blindness and visual impairment:** Item 12.3 of the Agenda (Documents A62/7 and A62/7 Add.1) (continued)

Dr ALWAN (Assistant Director-General) thanked Member States for their support of the draft action plan and their useful comments, which would be taken into account in its implementation. WHO's blindness prevention strategy had always been based on a primary health care approach, and the progress made by countries had been due mainly to investment in primary health care. Indeed, objective 2 of the action plan relied heavily on integrating blindness-prevention interventions and eye care into the primary health care system.

The delegate of Bangladesh had emphasized the importance of dealing with vitamin A deficiency. The subject, referred to in paragraphs 9 and 59 of the plan, would be given proper attention, particularly in relation to the action recommended for the Secretariat. The issue of post-partum administration of vitamin A would be assessed as part of implementation of the plan.

The delegate of the Bolivarian Republic of Venezuela had spoken of the need to widen the scope of the plan beyond prevention and management and the correction of visual errors. That point came under another WHO programme, on disability and rehabilitation. The Secretariat was currently reviewing scientific findings on the subject and would launch a world report on disability and rehabilitation in 2010 with a major focus on the rehabilitation and empowerment of the visually impaired. Another important observation concerned the provision of support to Member States for the conduct of epidemiological studies. That point was covered in paragraphs 15, 61 (objective 2) and 90 (objective 5) of the draft action plan. A reference to support from Member States with regard to data collection would be added to paragraph 65, and editorial comments would be incorporated into paragraphs 66, 78 and 81.

In response to a specific question, he said that the word "stakeholders" in paragraph 50 referred to partners involved in prevention of blindness activities.

The delegate of the Gambia had stressed the importance of strengthening monitoring and evaluation capacity. That was a key issue, and the aim of objective 5. The sharing of success stories, as suggested, was the theme of paragraph 94.

In response to the delegate of Colombia, he said that the strengthening of surveillance and data information systems was addressed in paragraph 90, and the importance of a multisectoral approach to blindness prevention in paragraph 80. Paragraph 89 referred to the need for data disaggregated by age, gender and socioeconomic status. The need to deal with blindness prevention in emergency situations and national disasters would be part of objective 2 (paragraphs 57 and 58). In response to the delegate of Thailand, international experience in the area of evidence and cost-effectiveness would be taken into account in the implementation of the plan. Mention had been made of the importance of tackling diabetic retinopathy; that was one of the priorities of the action plan (objective 2, paragraph 53) and WHO had already initiated a project on the subject.

Training formed a key component of the action plan, as indicated in paragraph 22; human resources development was a core element of the WHO strategy, and concrete actions were referred to in paragraphs 58, 62 and 63.

The CHAIRMAN drew attention to the draft resolution contained in paragraph 5 and to the amendment proposed by the delegate of Greece.

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

**Primary health care, including health system strengthening:** Item 12.4 of the Agenda (Documents EB124/2009/REC/1, resolutions EB124.R8 and EB124.R9 and Annex 7, and A62/8)

Dr GUSEVA (Russian Federation) said that, in the context of global economic crisis, investment in health would always yield positive results. The Russian Federation supported the efforts of WHO to promote primary health care throughout the world. In her country, primary health care was the basis of the health-care system and, despite changes introduced in 2005, the principles of primary health care remained inviolate. She described four principles. The first was universal coverage: compulsory medical insurance was being extended to all citizens, and medical support (emphasizing screening, medicinal prevention, treatment and rehabilitation) was provided free of charge. The second was ensuring access to medical support and modern diagnostic services using outpatient and polyclinic environments in preference to hospitals. Training systems were being adapted and young specialists were being encouraged to serve in rural or remote areas. Thirdly, public health policy: according to *The world health report 2008*,<sup>2</sup> strengthening health systems could reduce the overall burden of disease by 70%. Since many people neglected their health, medical check-ups were being provided in the workplace in cooperation with their employers. In 2009 a campaign for healthy lifestyles had been launched to combat alcohol, tobacco, substance and drug abuse. Networks of health centres have been created together with units for disease prevention and child health in medical establishments in every region, and programmes to combat diseases of social significance, such as tuberculosis and cancer, have been completed. The fourth principle consisted of a patient-oriented approach to managing primary health care, in which the clinical status of the patient was the determining factor. Efforts were being made to optimize primary health care delivery and improve case management. She supported the draft resolution.

Dr SADRIZADEH (Islamic Republic of Iran) applauded the Director-General's call for the renewal of primary health care. In 1978, the Declaration of Alma-Ata had placed health equity on the international political agenda and primary health care had later become unanimously accepted as a key to health for all. Most of the principles and values of primary health care remained valid, despite the emergence of health challenges related to urbanization, climate change and social stratification. Member States should reorient health systems towards primary health care and thereby improve response to people's needs at community level.

In the early 1980s, his country had based its health system on primary health care services, to which more than 95% of the population currently had access. Achievements included an increase in life expectancy from 63 years in 1990 to 71 years in 2006. Health-sector reforms, carried out from 2004 to 2006 in collaboration with the World Bank, had promoted policies to support poor people, and improved planning and management through decentralization of the health sector. Health financing and governance had also been reviewed.

Dr FERDINAND (Barbados) said that Member States had reaffirmed the principles and values of primary health care: equity, solidarity, social justice, multisectoral action and community participation. Leadership and commitment were also needed to ensure the optimum balance of promotion, prevention and curative care. Barbados had incorporated health system strengthening into the planning process. With the introduction of the pneumococcal conjugate vaccine into childhood

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA62.1.

<sup>2</sup> *The world health report 2008: Primary health care – now more than ever*. Geneva, World Health Organization.

immunization schedule in January 2009 the childhood immunization record was expanded to include many more details of children's health status and development. Her Government remained committed to the principles of primary health care and supported the draft resolution contained in resolution EB124.R8.

Dr MASKEY (Nepal), speaking on behalf of the Member States of the South-East Asia Region, supported the agenda for action set out in the report. As indicated in *The world health report 2008* and the report of the Commission on Social Determinants of Health,<sup>1</sup> the primary health care approach remained the best means of strengthening health systems, achieving the health-related Millennium Development Goals and, ultimately, equitable health for all. The focus should shift from service delivery to a development approach that promoted community and civil society participation and self-care. The growth of health inequities within and between countries and the mounting burden of noncommunicable diseases made revitalization of primary health care essential. Thus effective delivery would need strengthened referral linkages, integrated planning of human resource and decentralized services.

The report should have referred to the term "inequities" rather than "inequalities" (paragraphs 2 and 15) and made explicit reference to linkages between primary, secondary and tertiary levels (e.g. paragraph 11).

He proposed the following amendments to the draft resolution contained in resolution EB124.R8. In the first preambular paragraph, the word "central" should be replaced by "pivotal" and, in the final preambular paragraph, "decentralization" should be inserted after "multisectoral action". In subparagraph 1(1), "health-related" should be inserted before "Millennium Development Goals". In subparagraph 1(2), "efficient" should be inserted after "equitable". The words "while ensuring effective referral to secondary and tertiary care" should be added at the end of subparagraph 1(3). In subparagraph 1(4), "and reemphasize empowering of communities, especially women" should be inserted after "all people". Subparagraph 1(5) should be amended by inserting "and retain" after "train", and "including non-professional community health workers with appropriate skill mix" after "numbers of health workers". In subparagraph 1(6), the word "integrated" should be inserted after "developed". In subparagraphs 2(1) and 2(2), "and strengthening" should be added after "renewal". The words "in achieving universal coverage, access and strengthening health systems" should be added at the end of subparagraph 2(3). A new paragraph 2(4)bis should be inserted to read "to ensure health system strengthening and revitalizing primary health care as a priority programme in the programme budget 2010–2011".

He further proposed the following amendments to the draft resolution contained in resolution EB124.R9. The words "and the WHO global strategy for prevention and control of noncommunicable diseases" should be added at the end of subparagraph 2(3); and in subparagraph 2(4), "including disease prevention and health promotion" should be inserted after "primary health care".

Dr IMAMECIOGLU (Turkey) said that primary health care was a sound basis for the whole health system, not just for simple health-service delivery or for a "first-step" level of care. *The world health report 2008* had focused on the reforms needed in universal coverage, service delivery, public policy and leadership. It was vital to continue strengthening health systems in order to attain the health-related Millennium Development Goals and to meet other global health challenges. The Commission on Social Determinants of Health had documented the relationship between poverty, environment and health, the need to tackle the inequitable distribution of power, wealth and resources, and to improve living conditions. Thus the planning of activities should take into account the Tallinn Charter: Health Systems for Health and Wealth (June 2008). Modern primary health care should also

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<sup>1</sup> World Health Organization, Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva, World Health Organization, 2008.

meet the demands of ageing populations, should include health promotion and end-of-life services, and crucially, provide for a sustained supply of trained health workers.

Turkey had been committed to comprehensive reform since 2003 and good progress had been achieved thanks to increased allocation and more efficient use of resources. All citizens were covered by a single health-insurance scheme and could access primary health care services through their identification number. He supported the draft resolution contained in resolution EB124.R8, which had been cosponsored by Turkey.

Dr MOHAMMAD (Oman) said that, after a period of neglect, primary health care should take on new importance in order to deal with the epidemiological transition with the increasing burden of noncommunicable diseases. Meeting the needs of all citizens was the basis of primary health care, and that objective required adequate financial and human resources and support for secondary and tertiary health systems. He supported the draft resolution contained in resolution EB124.R8.

Dr KAMWI (Namibia) said that the principles and values of primary health care had been the cornerstone of health-service delivery in Namibia. An assessment conducted in 2008 had shown improvements in health status since the country's independence. However, a survey in 2006–2007 had indicated a significant deterioration in maternal and infant mortality rates. In collaboration with its development partners, Namibia's strategic plan 2009–2013 aimed to produce synergies between domestic and external funding, strengthen existing infrastructure and improve cost-effectiveness and service coverage. WHO should continue to lead in the renewal of primary health care and provide technical support to countries in attainment of the Millennium Development Goals.

Dr SANOU (Burkina Faso), speaking on behalf of the Member States of the African Region, said that the thirtieth anniversary of the Declaration of Alma-Ata was a call for the renewal of primary health care. In its resolution AFR/RC56/R6 in 2006, the Regional Committee for Africa had approved the renewal of that approach as a means of attaining the Millennium Development Goals, with further assessments undertaken at the International Conference on Primary Health Care and Health Systems in Africa (Ougadougou, 28–30 April 2008). Obstacles identified included inadequate financial resources and health-service coverage; insufficient human resources, especially specialized staff; weak health systems; weak cost-sharing systems that limited access to services; and the disruption to health activities caused by epidemics. The Ouagadougou conference had enabled countries to define their future activities with development partners through a multisectoral approach and greater community involvement. There was a need to update health policies; to set priorities; to promote intersectoral and public-private collaboration; to improve human resources for health; to improve the availability and accessibility of health services; and to strengthen information and surveillance systems. It was also necessary to promote health research; to implement strategic plans for health financing; and to improve public awareness of health matters. The definition of strategy for the implementation of the Ougadougou Declaration on Primary Health Care Systems in Africa: Achieving Better Health for Africa in the New Millennium (April 2008), and the establishment of a primary health care observatory should facilitate the monitoring of activities.

He supported the draft resolutions set out in resolutions EB124.R8 and EB124.R9. The former should be strengthened by including a reference to communicable diseases in subparagraph 1(8) and to the recommendations contained in the findings of the Commission on Social Determinants of Health in subparagraph 2(2).

Dr CAMPBELL-FORRESTER (Jamaica) said that, since the signing of the Declaration of Alma-Ata, Jamaica had maintained its focus on primary health care, and she supported calls for its renewal. Her country had well-developed systems of primary health care, specialist care, well-integrated vertical programmes and dedicated health professionals, reflecting a health situation that

had improved considerably during the twentieth century. According to UNFPA's *State of world population 2008*,<sup>1</sup> Jamaica's expenditure on health had been estimated at 2.7% of its gross domestic product; however, financial support for primary health care was currently threatened by the global recession. Renewal of primary health care was the most efficient way to maintain achievements and make progress towards the Millennium Development Goals.

A first step towards universal coverage had been taken in April 2008 with the abolition of user fees for public-sector health services; a recent review had indicated an increase of 10% to 30% in use of the services, and the policy would be continued despite resource constraints. She acknowledged the much-needed support provided by PAHO.

Her Government embraced the report's four broad policy areas. Expressing support for the draft resolution contained in resolution EB124.R8, she proposed that it should be amended to call for the formulation of a plan of action in the four broad policy areas. The plan should include effective support for countries and should be submitted to the Sixty-third World Health Assembly.

Dr CHAUHAN (India) said that health system strengthening should be accompanied by advances in drinking-water supply and sanitation, nutrition, education and decentralization of service delivery. India was rejuvenating public health-service delivery through its National Rural Health Mission, a multipronged approach involving partnerships with interested groups. In its first three years, the Mission had achieved dramatic progress, in line with the attainment of the Millennium Development Goals and had added thousands of medical professionals and community health workers to the health-care system. India would willingly share its experience.

Dr HUSSAIN (Bahrain) said that since the adoption of the Declaration of Alma-Ata her Government had been fully committed to primary health care, which had developed nationally through a network based around the family and the community. Her Government provided free comprehensive health care for all citizens and the Ministry of Health collaborated with key governmental and nongovernmental partners in health system development. Health indicators had improved markedly over the previous decade. However, current health challenges included an ageing population, a rise in the burden of noncommunicable diseases, and increasing community demands. Reorganized health services would emphasize the needs of the individual and community participation, changes that would require major investments in human resources, physical infrastructure, and information and communication technology.

Health and equity in health were essential to the growth of nations, and countries should reinforce the principles of primary health care in their health systems. She supported the draft resolution contained in resolution EB124.R8.

Mr PRAZ (Switzerland) said that, given persisting inequalities, new public-health challenges and the financial crisis, the world's health systems needed efficient management to meet people's needs and expectations. He supported the approach taken in draft resolution EB124.R8, which called for refocusing health systems on primary health care and was applicable to both Switzerland and the developing countries that it supported. He also supported the draft resolution contained in resolution EB124.R9, which was consistent with national health policy on traditional and complementary medicine.

Health systems should be based on the principles of equity, solidarity and social justice. Essential political commitment should be reflected in the strengthening of health institutions and staff at the local level; the strengthened capacities of health ministries in sustaining an integrated, multisectoral approach; and the provision of necessary human and financial resources. Support for primary health care at the international level should include financial support; priorities might need to

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<sup>1</sup> *State of World Population 2008: Reaching common ground: culture, gender and human rights*. New York, United Nations Population Fund, 2008.

be redefined and budgets reallocated accordingly. WHO itself should focus on primary health care, and ensure that sufficient resources were provided in that area. Exchanges of experience between countries were essential in order to prepare a compendium of best practices.

Ms JÁQUEZ HUACUJA (Mexico) noted that the report also emphasized involvement of other sectors in the formulation of public health policies. Achieving an ideal balance between health promotion, disease prevention, curative care and palliative care in primary health care was not a simple task; it required commitment from not only the health sector, but all public and private sectors.

Primary health care was crucial, as it was the first point of contact between individuals, families and communities and the national health system. Her Government had made prevention a priority and believed that the coordination of all stakeholders was needed in order to strengthen the country's health services. Access to health care was a constitutional right and social inequality should not impede access to health care, that was itself a prerequisite for the enjoyment of other rights and for the building of equitable society. Public policies and sectoral programmes should both reflect the centrality of health issues.

Dr HERBERT (Saint Kitts and Nevis) said that primary health care had formed the basis of health-service delivery in his country since the introduction of universal adult suffrage in 1952. Every resident lived within five miles of a community health centre, which offered a range of health services. Universal coverage, equality and equitable access were not problems; the Government's major challenges were to sustain the progress made in health and to maintain health expenditure in the face of rising food and oil prices, the financial crisis, and climate change. The donor community should take into account vulnerability to external shocks when assessing the situation of Caribbean island nations. Their middle-income status should not be used as an excuse to deny development funding. He supported the draft resolutions.

Dr CAMARA (Gambia) said that, following a disappointing review of achievement of primary health care targets in Africa carried out by the Regional Office for Africa in 2003, challenges had been identified that required urgent action. In 2006, the Regional Committee for Africa had endorsed the revitalization of the primary health care approach as a way of accelerating achievement of the Millennium Development Goals. In 2008, it had adopted a resolution on the implementation of the Ouagadougou Declaration on Primary Health Care Systems in Africa: Achieving Better Health for Africa in the New Millennium. In strengthening its primary health care systems, the Gambia would emphasize human resources for health; the referral system; health financing; health information systems; and community ownership and participation. WHO should provide technical support at the country level by ensuring an adequate mix of skills and resources at its country offices.

Dr HUWEL (Iraq) said that primary health care was essential to the success of any health system. In Iraq, primary, secondary and tertiary health care services had been integrated and a family medicine and referral system established. His Government sought to involve communities and all sectors in formulating health policy; strengthen personnel capacities; and enhance financial management of the health sector. Health legislation was being reviewed periodically.

Dr AL KAWARI (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that they accorded particular importance to strengthening health systems, as evidenced by community initiatives based on primary health care and implemented over the past two decades. Such initiatives had increased the involvement of women in health-care provision and took important account of the determinants of health; those had been identified at the Sixty-first World Health Assembly and should be included in all health policies and activities. Health-sector workers should be trained and health management and administration improved. The Secretariat should provide Member States with financial resources to support the basic health needs of their populations. The countries of the Region had different income levels, and some, such as Palestine,

were suffering major crises: support should be provided in order to strengthen their health systems even in the midst of crises.

Dr NOH (Malaysia) endorsed the draft resolution on the revitalization and renewal of primary health care and the four broad policy areas. The values and principles of primary health care underpinned Malaysia's strengthening of its health-delivery system and provision of comprehensive primary care throughout the life cycle, going beyond the elements expounded in the Declaration of Alma-Ata. Referral to secondary care was also effective. In support of the Beijing Declaration on Traditional Medicine (November 2008), traditional and complementary medicine had been integrated into the national health-care system. She supported WHO's efforts to document good practices in the implementation of primary health care.

Ms WANG Xiaopin (China) supported the strategies proposed by WHO to strengthen health systems by bolstering primary health care. Faced with the challenges of economic transition and social development, her Government was expanding and improving the primary health care system. In 2009, her Government had set the goal of providing universal access to primary health care services. The establishment of a sound primary health care system was one of the five priorities for reform. She encouraged the Secretariat to compile a compendium of Members' experience and best practices.

She supported the draft resolutions on primary health care and traditional medicine. China attached equal importance to Western medicine and to traditional medicine which it was developing and had found to be useful in the prophylaxis and treatment of chronic diseases, the prevention of acute and communicable diseases, and first aid. Access to essential health-care services, including traditional medicine, was a fundamental right and an obligation of governments. Standards and policies should be developed to promote research and development in traditional medicine, with the sharing of information and standardized qualifications and skills of specialized staff. She noted that a consensus existed on traditional medicine, as reflected in the Beijing Declaration on Traditional Medicine.

Ms NAVARRO LLANOS (Plurinational State of Bolivia) said that the right to health was recognized as a fundamental human right in her country's new Constitution, approved in January 2009, and in the national development plan. Her Government was carrying out initiatives to promote health and to prevent risks, and aimed to eradicate malnutrition within five years, assuming that the expected international support was provided. Training in human resources was focusing on the social determinants of health. A further initiative was promoting exclusive breastfeeding up to the age of six months and to be extended up to the age of two years. However, efforts had sometimes been thwarted by the use of commercial products banned in developed countries and then marketed in vulnerable developing countries.

In relation to the draft resolution contained in resolution EB124.R8, she said that subparagraph 1(5) should incorporate the notion not only of training adequate numbers of health workers but of seeking alternatives to prevent the migration of skilled personnel, trained in less developed countries and then "exported" free of charge. Subparagraph 2(2) should refer to strengthening not only the Secretariat's capacities but also those of the regional and national offices.

She expressed support for the draft resolution contained in resolution EB124.R9. The traditional medicine of the Bolivian indigenous peoples, along with other elements of the United Nations Declaration on the Rights of Indigenous Peoples (September 2007), had been fully acknowledged in the country's new Constitution; and the traditional knowledge of indigenous peoples was being incorporated in health services.

Dr SHIMIZU (Japan) reaffirmed his Government's belief that the primary health care approach to strengthening health systems would benefit all people, especially the most vulnerable. He emphasized the efforts made by Japan in the areas of health financing, human resources and health information, and firmly supported the draft resolution contained in resolution EB124.R8.

Dr VEGA MORALES (Chile), speaking on behalf of the members of the Union of South American Nations, said that its regional integration objectives included universal access to social security and health services. Its members promoted the values of primary health care that had grown out of the Declaration of Alma-Ata, with an emphasis on prevention, multisectoral action and community participation, as the best way to achieve shared, sustainable and equitable health development. The Union therefore firmly supported the draft resolution contained in resolution EB124.R8, as amended by the delegate of Jamaica.

Dr KIBARU (Kenya), acknowledging the role of strong health systems in progressing towards attainment of the Millennium Development Goals, said that it was crucial to improve human resources, financing, planning, performance monitoring, community health systems, infrastructure, medicines and other essential supplies, information technology, surveillance systems, and service delivery. Primary health care systems should adopt a holistic approach in order to make the best use of limited resources, especially in African countries. She supported the draft resolution contained in resolution EB124.R8.

Dr SULAIK (Philippines) described his Government's reforms and strengthening of national health systems including service delivery, regulation, financing and governance, aimed at ensuring equitable, universal access to affordable health care. Improved health systems and health outcomes had resulted from goal-based policies, increased public spending, and partnership between government, civil society and development agencies.

Dr SEIFERT (Czech Republic) spoke on behalf of the European Union and its 27 Member States. The candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as the Republic of Moldova and Armenia aligned themselves with his statement. He welcomed the renewed focus on primary health care as a means of strengthening health systems. Well-planned, financed and staffed primary health care was essential to the attainment of the Millennium Development Goals and the achievement of equity, solidarity, social justice and universal access. Enhanced primary health care would require equitable and sustainable financing mechanisms, and skilled professionals trained to operate in a multidisciplinary environment. Training in health promotion and disease prevention was especially important in order to tackle the alarming increase in noncommunicable diseases.

WHO's work on primary health care should build on its development of key concepts, structures and stewardship mechanisms for health systems, rather than as a separate area of endeavour. The Health Assembly should revive the optimism generated by the Declaration of Alma-Ata, and the European Union therefore urged it to adopt the draft resolution contained in resolution EB124.R8.

Mr FISKER (Denmark) said that efficient primary health care was essential in order to reduce health inequities; to respond to the global burden of chronic noncommunicable diseases and the emergence of new infectious diseases; and to provide comprehensive, life-long care. The strengthening of health services should not be undertaken in isolation but integrated instead across levels of care, medical specialties and the public and private sectors. Denmark welcomed efforts to harmonize the work of the GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank with regard to health system strengthening. WHO had a clear role in supporting developing countries to improve their health sector plans. He endorsed the draft resolution contained in resolution EB124.R8.

Dr SILLANAUKKEE (Finland) said that strengthened primary health care was essential and should be developed on the basis of the principles and values of the Declaration of Alma-Ata. The challenges for all Member States would include sustainable universal coverage, equitable access and financing, placing people's needs at the centre of service delivery, and multisectoral action to deal with factors outside the remit of the health sector.



The impacts of all major policies on health, and on its determinants, and on the functioning, financing and delivery of health services should be considered, with health professionals educating the public and helping policy-makers in other sectors to grasp how health was affected by their decisions and actions. Finland would continue working with WHO and support its leadership in health systems development.

Dr WAKEFIELD (United States of America) said that her Government remained strongly committed to promoting a primary health care approach, especially through capacity building in countries and in the production of data and evidence to inform health policy. Primary health care services were essential to all nations, and should be expanded in every community in order to achieve equitable access and better health outcomes.

Financial and political commitment to primary health care must be renewed; however, many Member States lacked the resources and technical capacity to enact some of the policy changes suggested in the report. She encouraged WHO to provide a more precise and concise definition of primary health care. Also, primary health care called for a shift from priority disease-centred programmes to a wider range of problems, and while the United States supported those efforts, a focus must be maintained on accountability and results within that broader framework. One notable omission from the report was the recognition of health research and the development of robust health information systems as vital to any approach to primary health care; many Member States lacked good-quality data for decision-making on public health priorities or improvements to delivery. She supported the draft resolutions contained in resolutions EB124.R8 and EB124.R9.

Dr ALI PATE (Nigeria) recognized that improved health outcomes required strengthened health systems through revitalized primary health care, which should become the platform for integrated service delivery and focus on community participation. In keeping with the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (April 2008), his Government was supporting efforts to extend a community-based insurance scheme to the most vulnerable members of society, with a target of universal coverage by 2015. Further, it was launching a community-based midwifery service aimed at reversing negative trends in maternal mortality, especially in rural areas. He supported the draft resolutions contained in resolutions EB124.R8 and EB124.R9.

Dr LEE Han-sung (Republic of Korea) said that, even though significant progress had been made in promoting the values and principles articulated in the Declaration of Alma-Ata, much work remained to be done. The draft resolution contained in resolution EB124.R8 would advance the objectives of renewal of primary health care and the strengthening of health systems.

Dr AL KUWARI (Qatar) recalled that his country had hosted a regional symposium on health systems strengthening in 2008, and that primary health care had been prioritized in the follow-up to the Doha Declaration on the TRIPS Agreement and Public Health. Qatar promoted universal, equitable access to primary health care services, with adequate resources and emphasis on prevention. The draft resolution contained in resolution EB124.R8 would, it was to be hoped, lead to the strengthening of health systems in all Member States.

Ms REISSMANN (Canada) expressed strong support of the draft resolution contained in resolution EB124.R8, but suggested that the word “ensure” in subparagraph 1(6) should be replaced by “encourage” in order to acknowledge the flexibility needed by Member States with federated health system models.

Dr GAMARRA (Paraguay) said that her country viewed primary health care as the key to universal access, equity and integrated care. In resource-limited settings, it was the best option for taking action on the social determinants of health in order to change lifestyles and for promoting decentralization and solidarity. She endorsed the draft resolution contained in resolution EB124.R8 and expressed appreciation for the report’s acknowledgement of the value of traditional medicine,

noting that her country's indigenous peoples had a wealth of knowledge to contribute with regard to medicinal plants.

Mr MOREWANE (South Africa) said that his Government, concerned that access to primary health care services was undermined by shortages of human resources, medicines, equipment and infrastructure, had moved to provide fixed and mobile clinics and community health centres. The health sector was working with stakeholders in other sectors in order to address the social determinants of health. His Government was revitalizing primary health care services through the founding principles of the Declaration of Alma-Ata, while also positioning those services to meet current challenges, in line with the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (April 2008). He supported the draft resolution contained in resolution EB124.R8.

Dr BUSS (Brazil) said that primary health care was essential in order to ensure equitable, universal access to health services. Speaking on behalf of the Community of Portuguese-speaking Countries, he supported the draft resolution contained in resolution EB124.R8 and urged more active leadership from WHO in efforts to strengthen health systems. To that end, he suggested a new subparagraph to follow subparagraph 2(2), reading: "to prepare implementation plans for each of these four broad policy directions, to ensure that these plans span the work of the entire Organization and to report on these plans to the Sixty-third World Health Assembly".

Mr NICOLA (Portugal), supporting the amendment proposed by the delegate of Brazil, expressed his appreciation of the timeliness of the draft resolution contained in resolution EB124.R8. Portugal's efforts to strengthen primary health care included increased human resources, improved management and enhanced cooperation among health institutions. However, change and innovation in the national health system were needed in order to raise quality and meet needs and expectations. WHO had provided invaluable support to his Government in the elaboration of a national health plan, and *The world health report 2008* had provided guidance and inspiration on new policy directions.

Ms TOELUPE (Samoa), affirming the value of primary health care as a means of strengthening health systems, supported the two draft resolutions.

Dr KARAGULOVA (Kazakhstan) expressed her country's appreciation of the participation of many Member States at the thirtieth anniversary celebration of the Declaration of Alma-Ata held in Almaty. The draft resolution contained in resolution EB124.R8, which Kazakhstan supported, might be further improved by dividing the third preambular paragraph into two paragraphs: the first would read "Reaffirming the Declaration of Alma-Ata (1978) and the United Nations Millennium Declaration (2000)"; the second would read "Recalling the Ottawa Charter for Health Promotion (1986) and subsequent relevant resolutions of WHO regional committees and Health Assemblies".

Dr MOTEEETEE (Lesotho) recalled that her country had endorsed the Declaration of Alma-Ata. However, following a deterioration in health indicators in the 1990s, coupled with high prevalence of HIV/AIDS, high rates of HIV/tuberculosis coinfection and a rising burden of noncommunicable diseases, Lesotho had needed innovative strategies in order to reverse the decline. Her country had reaffirmed its commitment to strengthening primary health care by becoming a signatory to the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa in 2008. The primary health care approach would accelerate the achievement of the Millennium Development Goals.

Community health-care workers were essential to the successful implementation of health programmes, particularly in respect of HIV/AIDS, and she welcomed the four policy directions set out in the report. Her Government had abolished user fees at the primary health care level, provided financial incentives for community health workers, and decentralized delivery of services. However, more could be done to improve community empowerment, training and retention of human resources and strengthened accountability for service provision. She supported both draft resolutions.

Dr LADDA DAMRIKARNLERD (Thailand) supported the four broad policy areas outlined in the report. Thailand had established over 30 years a nationwide network of units which ensured universal access to essential health services. Health volunteers were trained to promote and communicate health information in rural areas and carry out public health interventions. She supported the draft resolution contained in resolution EB124.R8 as amended by the delegates of Jamaica and Nepal.

Dr AMMAR (Lebanon) said that, in order to effect real impact on primary health care, proper implementation plans should be established for each of the stated policy directions. Accordingly, he supported the draft resolution contained in resolution EB124.R8, with the amendment proposed by the delegate of Jamaica.

Mr SPRENGER (Netherlands) said that national public health institutes should be explicitly mentioned in the draft resolution since they had been important in collecting data on access to primary health care, quality of health care, and in surveillance, as the recent influenza threat had shown. In addition, midwives should play a greater role in primary health care, and he therefore suggested that in subparagraph 1(5) of the draft resolution contained in resolution EB124.R8, “including primary health care nurses, midwives, allied health professionals and family physicians” should be inserted after “to train adequate numbers of health workers”.

Dr LOKADI (Democratic Republic of Congo) said that in 2006 his country’s sectoral strategy for strengthening health systems comprised six elements: development of health districts, including universal coverage through a network of health centres with referral systems; intersectoral cooperation that addressed social determinants of health, and increased community participation; reform of structure, policy, management and delivery of health services; reform of finance; public–private partnership; research aimed at building an evidence base; and development of human resources. He supported the draft resolution contained in resolution EB124.R8.

**The meeting rose at 18:00.**

## **FOURTH MEETING**

**Tuesday, 19 May 2009, at 18:00**

**Chairman:** Dr F. MENESES GONZÁLEZ (Mexico)

**TECHNICAL AND HEALTH MATTERS:** Item 12 of the Agenda (continued)

**Primary health care, including health system strengthening:** Item 12.4 of the Agenda (Documents EB124/2009/REC/1, resolutions EB124.R8 and EB124.R9 and Annex 7, and A62/8) (continued)

Dr WATERBERG (Suriname) said that his country had responded to the four broad policy areas outlined in the report. The Government had further strengthened its primary health care system by upgrading and decentralizing infrastructure, training community health-care workers in outreach activities, and improved community participation in promoting healthy lifestyles. A general health scheme to ensure that the entire population had access to all health services through universal coverage was being finalized. He proposed strengthening the draft resolution contained in resolution EB124.R8 by deleting “and end-of-life services” in subparagraph 1(3) and inserting “and palliative” after “curative”.

Dr MAOATE (Cook Islands) emphasized the importance of primary health care in reducing health inequalities, in particular on isolated islands. When the number of health workers was limited, community participation was essential as a means of strengthening health systems. He supported the draft resolution with one amendment: the phrase “mindful of the need ... international financial crisis” in subparagraph 1(2) was unnecessarily restrictive and should be deleted.

Dr MINNIS (Bahamas) said that investment in primary health care represented value for money. Primary health care services fostered health promotion and protection, disease prevention and control, and longer life expectancy; minimized inequities in health; and promoted safe motherhood. The strengthening of public health information systems to support evidence-based decision-making at all levels remained a priority for the Bahamas. Information and communication technologies strengthened primary health care and promoted universal access to health services through remote diagnostic services and referrals, particularly in archipelagic countries such as his own.

Primary health care services should not have to compete with hospitals for budgetary allocations; instead their value to the health sector must be recognized, and sustained financial investment in public health and primary health care systems must remain high on the agenda of policy-makers. He supported the draft resolution contained in resolution EB124.R8.

Ms CHASOKELA (Zimbabwe) said that in 2000 her country had decided to rebuild its health-care delivery system on the basis of primary health care and to ensure that health-care providers incorporated the approach’s core values into their practice. It had taken account of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (2008) and had added mental, oral and eye health to the original elements covered by the Declaration of Alma-Ata (1978). Educational and research institutions had also joined efforts to increase access to health services, which also included traditional medicine. Strengthening of human resources and health infrastructure was urgently needed. She urged the Director-General to incorporate the values and principles of primary health care in all WHO’s work and to develop a plan of action on primary health care. That should include guidelines for implementation and monitoring, and provision of support to Member States, for

capacity building, reorientation of health services, education, and mechanisms for retaining health-care personnel. Additional finance should be provided to the African Region for implementation of the plan. Zimbabwe would continue to strengthen the capacity of village health workers, who played a crucial role in health education and promotion, and in countering outbreaks of disease, such as that of cholera in August 2008. She supported the draft resolution contained in resolution EB124.R8.

Ms LO (International Federation of the Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that primary health care must begin with people. She emphasized the right of all to better health, and accessible and affordable health care for the most vulnerable communities. The International Federation intended to scale up its training of community volunteers for health-care activities at the grass-roots level. Volunteers played a key role in meeting health challenges and required support. Governments should invest in strengthening civil society at the local level. In partnership with governments, national Red Cross and Red Crescent societies promoted the health of marginalized members of society. She called on governments and the Secretariat to institutionalize the participation of those national societies and other civil society organizations in policy dialogue on primary health care. Her organization was committed to taking primary health care back to its original values, principles and approaches.

Dr Cheng-hua LEE (Observer, Chinese Taipei) suggested that building primary health care capacity should take into account stages of economic development. In the 1960s, when gross domestic product had been US\$ 1000 per capita, Chinese Taipei had started to establish health stations in every township, had used public funds to hire doctors and nurses, and had promoted vaccination, control of communicable diseases and improved reproductive health. When gross domestic product had reached US\$ 5000 per capita, the private sector had been encouraged to build hospitals, and educational programmes for health professionals had been advocated. Universal health insurance had been introduced in 1995. Different measures had thus been taken depending on the socioeconomic level reached.

Dr SEYER (World Medical Association), speaking at the invitation of the CHAIRMAN and also on behalf of the International Council of Nurses, the International Pharmaceuticals Federation and the World Dental Federation, which together formed the World Health Professions Alliance, emphasized the importance of well-functioning health-care systems: not only were the promotion and protection of health essential to sustained social and economic development but also the health-care sector itself had become a pillar of many national economies. She welcomed the strategy of building health-care systems around primary care that would help deliver treatment, provide new perspectives for health-care professionals and strengthen development. Nevertheless, the strategic directions and priorities set out in the report needed to be broadened. Universal care could only be provided when health-care systems were built up as a comprehensive system founded on, but not limited to, primary care structures.

Mr GARAY AMORES (European Commission) said that, in order to make progress towards achieving the principles of primary health care and to strengthen the delivery of health services with universal and equitable coverage, the European Commission encouraged the Member States of the European Union and the wider international community to maintain their commitments in the context of the current financial crisis. The principles of aid effectiveness should be applied, in particular the alignment and predictability of official development assistance, in order to support national health strategies, including the principles and objectives outlined in the draft resolution.

Dr COLLINS (Global Forum for Health Research), speaking at the invitation of the CHAIRMAN, welcomed the renewed interest in developing primary health care, observing that it was

an opportunity to identify gaps in knowledge and make research more relevant, particularly in the four policy areas identified in *The world health report 2008*.<sup>1</sup> Providing universal coverage remained a financial challenge in most low-income and middle-income countries and more research was needed in order to identify barriers to health-care access and ways of overcoming financing and other constraints. Participatory research was needed in order to foster community participation and involve people in the process of finding solutions to their health problems. The concept of primary health care recognized the impact on health of other sectors. Creating multisectoral and multidisciplinary partnerships to improve health and equity was at the heart of the “research for health” approach espoused by the Global Forum. Health resource allocation in most countries was still biased towards hospitals and specialist care. Governments and international and other organizations involved in funding research should increase their commitment to research into primary health care.

Professor SCHALLER (International Pediatric Association), speaking at the invitation of the CHAIRMAN, said that sound primary health care was fundamental to maternal, newborn and child health. Some 10 million neonates and children still died each year from causes that were preventable or readily treatable, principally: failure of newborn survival, diarrhoeal diseases, pneumonia, malaria and HIV/AIDS. Primary health care interventions, such as oral rehydration therapy, zinc supplementation, early recognition and treatment of pneumonia, insecticide-treated bednets and antimalarial treatment of childhood fevers, were proven and cost-effective. Such interventions would prevent a significant percentage of child deaths, reduce the maternal mortality ratio, and hasten progress towards achievement of the Millennium Development Goals. Furthermore, improving the health of the world’s mothers and children would contribute to both national and global development. Her Association welcomed the draft resolution contained in resolution EB124.R8 and was committed to working with WHO and other partners in order to realize the promise of Alma-Ata.

Professor DE MAESENEER (The Network: Towards Unity for Health), speaking at the invitation of the CHAIRMAN, said that his organization contributed to primary health care, for example in Latin America through its support for departments of family medicine and primary health care, and training of family physicians in Africa. Its “15 by 2015” campaign encouraged major donors to allocate 15% of the funds they intended to invest in vertical disease programmes up to 2015 towards the strengthening of local primary health care in developing countries. He welcomed the draft resolution contained in resolution EB124.R8, but suggested that subparagraph 1(5) would be more specific if it was reworded to read: “to train, through improved educational programmes and continuous professional development, adequate numbers of health workers for primary health care teams, including midwives, family physicians, primary care nurses, community health workers and allied professionals who are able to work in a multidisciplinary context, in order to respond effectively to people’s health needs and expectations”. He also suggested that, in subparagraph 2(5), the Director-General should be requested to devise an implementation strategy and create the structures needed to ensure follow-up.

Dr ALWAN (International Federation of Medical Students Associations), speaking at the invitation of the CHAIRMAN, stressed that health was a fundamental right that transcended physical, cultural, religious, political, economic and social boundaries. Health-care professionals had a duty to ensure that no individual was denied that right and must take the lead in alleviating health problems in their communities. Medical students who participated in community outreach were more likely to be aware of local needs and to possess the skills needed to practise medicine in community settings. Unfortunately primary health care was inadequately emphasized in medical school curricula. More investment in medical school resources and training facilities, increased enrolment, and wider access to specialized education were needed.

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<sup>1</sup> *The world health report 2008: Primary health care – now more than ever*. Geneva, World Health Organization, 2008.

Professor VAN WEEL (World Organization of Family Doctors), speaking at the invitation of the CHAIRMAN, said that strong primary health care saved both lives and money and was also an important force in creating self-sustaining local communities. Primary health care must be tailored to local contexts. It was therefore necessary that health professionals were well prepared for work in specific community settings, which could also encourage them to remain longer in those settings, thereby hindering the “brain drain”. His organization was committed to working with WHO and with national governments to promote and improve health care worldwide.

Mr SERAG (Christian Medical Commission Churches’ Action for Health), speaking at the invitation of the CHAIRMAN, voiced concern about the fifth preambular paragraph of the draft resolution contained in resolution EB124.R8. The idea that vertical approaches and integrated health systems approaches were mutually reinforcing countered the principle of not compartmentalizing interventions, which underlay primary health care. In order to generalize the concept of primary health care, Member States should, for example, prioritize people and public health over commercial interests; recognize their central role and responsibility in ensuring universal access to health care; ensure gender equity in the delivery of primary health care; empower the participation of local communities and grass-roots organizations; and allocate a minimum of 5% of national income and 15% of national budgets to health services.

The Secretariat should recognize that redressing health inequities needed economic and political change globally. It should also mobilize resources to enable poor countries to implement approaches to primary health care; support Member States in enacting legislation that recognized health as a fundamental right; and broaden the mandate of the Commission on the Social Determinants of Health to include the monitoring of the implementation of its recommendations, with development of indicators.

Dr ETIENNE (Assistant Director-General) said that she had noted the strong support of Member States for the renewal of primary health care and the four policy directions set out in the report, that there should be exchanges between countries, and that the Secretariat should step up its efforts. Given the calls for the preparation of plans for implementation, she acknowledged the need for a benchmarking framework that would allow progress to be monitored. Indeed, work on the latter had already started.

Several specific recommendations would enhance the Secretariat’s work on primary health care. The Secretariat would make every effort to act on those recommendations and meet Member States’ expectations. At the same time, the successful implementation of primary health care reforms would require vigilance on the part of Member States in ensuring that the policy directions were reflected in decision-making at global, regional and national levels. It was WHO’s collective responsibility to ensure that the proposed reforms drove the health agenda.

The CHAIRMAN said that the two draft resolutions would be revised, incorporating the various proposed amendments, and distributed for consideration at a subsequent meeting.

**It was so agreed.**

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

**The meeting rose at 18:55.**

## **FIFTH MEETING**

**Wednesday, 20 May 2009, at 09:30**

**Chairman:** Dr F. MENESES GONZÁLEZ (Mexico)

### **1. FIRST REPORT OF COMMITTEE A (Document A62/48)**

Ms AYDIN (Turkey), Rapporteur, read out the draft first report of Committee A.

Dr WANICHA CHUENKONGKAEW (Thailand), referring to the resolution on prevention of avoidable blindness and visual impairment, in relation to the previous day's discussion of the draft action plan, asked when the delegates' comments and editorial suggestions would be incorporated in the document.

Dr ISLAM (Secretary) assured delegates that their comments and editorial suggestions would be taken into account in finalizing the action plan, and that bilateral discussions would be held with Member States. Details of the process would be forthcoming.

**The report was adopted.<sup>1</sup>**

### **2. MEDIUM-TERM STRATEGIC PLAN 2008–2013, INCLUDING PROPOSED PROGRAMME BUDGET 2010–2011:** Item 11 of the Agenda (Documents MTSP/2008–2013 (Amended (draft)), PPB/2010–2011, A62/4, A62/4 Add.1 and A62/4 Add.2)

Dr VALLEJOS (representative of the Executive Board) said that the draft Proposed programme budget 2010–2011 had been reviewed by the Programme, Budget and Administration Committee before being considered, in conjunction with the draft amended Medium-term strategic plan 2008–2013, by the Executive Board at its 124th session in January 2009.<sup>2</sup> The Board had commended the work done and expressed appreciation of the level of detail, clarity and transparency in the two documents. That work included improved indicators for Organization-wide expected results and the innovation of splitting the programme budget into three segments.

Although there had been concern about the growing imbalance between assessed and voluntary contributions, appreciation had been expressed of the increased use of the new core voluntary contributions account, which enabled flexible funding to the Organization, and of multiyear pledges of voluntary funds by the Member States. The relatively high share of the budget allocated to strategic objectives 1 and 2 had been questioned and a call made for more equitable distribution across strategic objectives, including 4, 7 and 9 and those associated with noncommunicable diseases. Furthermore, concern had been expressed about the Organization's ability to raise sufficient income in the current financial situation and its capacity to implement the budget fully. It had been requested that the draft

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<sup>1</sup> See page 199.

<sup>2</sup> See document EB124/2009/REC/1, summary record of the sixth meeting, section 1.



Proposed programme budget should be adjusted accordingly before submission to the Sixty-second World Health Assembly.

Dr DIAS VAN-DÚNEM (Angola), speaking on behalf of the 46 Member States of the African Region, reiterated observations made at the fifty-eighth session of the Regional Committee for Africa (Yaoundé, 1–5 September 2008), and discussed by the Executive Board at its 124th session in January 2009. The global budget distribution did not reflect the concerns of the Region for increased resources for maternal and child health and for noncommunicable diseases; the Secretariat had undertaken to address those specific concerns in the Proposed programme budget 2010–2011. Regarding the apparent contradiction between a lack of resources at country level for programme implementation and a carry-over of US\$ 1600 million from the previous biennium, the Secretariat had clarified that that carry-over had resulted from an imbalance in the distribution of earmarked funds and their late receipt, rather than from a lack of absorption capacity.

He expressed concern that in the global economic crisis there would be insufficient resources for implementation of a programme budget for 2010–2011 and for maintaining sustainable health development. He asked the Secretariat to provide the technical capacities and additional financial resources to WHO country offices in the African Region in order to meet operational and implementation costs; increase significantly the proportion of the total budget spent at country level; monitor expenditures quarterly; and report back to the Sixty-third World Health Assembly.

All strategic objectives in the Proposed programme budget 2010–2011 should retain an allocation of 30% for headquarters and 70% for the regions. Despite zero budget growth, more efficient allocation of resources would strengthen technical and financial capacities at the country level. Government health budgets were also fundamental to addressing health challenges. He urged Member States to remove the conditions attached to voluntary contributions in order to improve the implementation of the Medium-term strategic plan 2008–2013. He endorsed the draft resolution in document A62/4, taking into account the need for appropriate measures for implementation of the Proposed programme budget 2010–2011 and a flexible approach for the African Region.

Ms ENGELSTAD (Norway) said that WHO needed to increase health funding and ensure a better return on that funding. She welcomed the overall increase in the Proposed programme budget 2010–2011, which was urgently needed to achieve global health objectives and the health-related Millennium Development Goals. She noted proposed increases in WHO special programmes and collaborative arrangements, and for outbreak and crisis response, compared to a 10% reduction in base programmes; such a reduction might send the wrong message, given the pressure of global financial crisis on health funds. However, there was still room for considerable growth on the previous year. She expected that with gains in efficiency and increased resources, the Organization would deliver still more. Operations at country level should be strengthened and ongoing efforts to improve budgetary control and transparency encouraged.

She commended the establishment of a core voluntary contributions account because increased flexibility would improve budgetary control and reduce the need to carry over funds from one budgetary year to the next. Norway would continue contributing to that account and encouraged other donors to do likewise as an increase in non-earmarked contributions was the best way to improve budgetary efficiency.

Mr VOLF (Czech Republic), speaking on behalf of the European Union and its 27 Member States, said that the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey; the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro, and Serbia; and Armenia and Ukraine aligned themselves with his statement. The European Union was pleased that the Director-General had noted, at the 124th session of the Executive Board in January 2009, the concerns of Member States about the need to consolidate growth and strengthen implementation. That need should be emphasized in order to maximize efficient use of resources. The reduced Proposed programme budget was more realistic; however, allocating

funding evenly across the strategic objectives would be difficult. He noted that the results and indicators in the Medium-term strategic plan 2008–2013 did not seem to have been adjusted to the revised Proposed programme budget 2010–2011.

The Proposed programme budget 2010–2011 showed an increase compared to the current biennium. It seemed that the current accumulated carry-over of US\$ 1600 million would still be present in the subsequent biennium; that reflected larger organizational problems that required a long-term solution. He asked for clarification of “required carry-over” and said that the concept should not be introduced as an acceptable way of doing business.

Earmarked and unpredictable funding, in conjunction with increasing demands for accountability, efficiency and results-based allocation, placed considerable pressure on budgeting and management. The Organization’s increased dependency on voluntary contributions and short-term financial commitments weakened the objectives of results-based budgeting and achieving accountability. Donors’ priorities should not supersede country needs, agreed targets and national priorities nor replace the concept of country ownership as defined in the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (4 September 2008). The European Union supported the Director-General’s efforts to ensure more flexible funding, including the core voluntary contributions account.

The Secretariat had taken into account Member States’ views with regard to reduced funding for the base programmes, with a relatively smaller reduction for maternal and child health and for noncommunicable diseases. However, the large increase for WHO special programmes and collaborative arrangements had generated a greater disparity in overall allocation of funding to the strategic objectives, compared to the current biennium. The increased allocation to strategic objective 1 (communicable diseases) and the reduced allocation to strategic objectives 3 and 4 (noncommunicable diseases and maternal and child health, including sexual and reproductive health) did not reflect the global disease burden, the targets of the Organization on women’s health or the reduction in the maternal mortality ratio targeted in Millennium Development Goal 5. Reduced maternal mortality ratio, and women’s access to reproductive health were crucial to development and should be a clear priority for WHO. He strongly recommended that that should be reflected in the Proposed programme budget 2010–2011.

He expressed concern about the lack of progress in almost half the indicators in the current budget: lack of funding could only be a partial explanation. Performance assessment for the 2006–2007 biennium had shown expenditure levels to be often well below available resources, which highlighted the need for improved and transparent links between the implementation of set targets and the allocation of funds. The Programme, Budget and Administration Committee at its recent meeting had urged WHO to draw up a plan of action to improve implementation levels.<sup>1</sup>

He welcomed the new structure of the budget and the clearly identified segment for WHO’s special programmes and collaborative arrangements, which left partnerships with separate governing structures outside the budget. However, definitions should remain consistent: if key elements did not retain consistency between budget periods, transparency would be at risk. He was concerned that partnerships still made up 20% of the overall budget, which raised questions about governance, accountability and the relevance of setting budget ceilings. He asked the Director-General whether there was an upper limit to the share of partnerships in the total budget.

The European Union endorsed the Proposed programme budget 2010–2011. It was essential that the budget should be financed in its entirety, unspent funds used effectively, and strong support given for global health needs to counter the adverse health effects of the global financial crisis. The European Union’s Member States would do their best to maintain their current levels of voluntary contributions, particularly in the light of a total budget of which only 20% came from assessed contributions.

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<sup>1</sup> Document A62/43.

Dr MOHAMMAD (Oman) welcomed the fact that comments made by the Executive Board and Member States on the Medium-term strategic plan 2008–2013 had been taken into account by the Secretariat in its revision and expressed appreciation for the transparency shown in preparing the Proposed programme budget 2010–2011. Despite welcome increases in budgetary levels, he noted that lack of flexibility was hampering the allocation of funds, even in emergency situations, and some bienniums had seen surplus funds remaining. Some contributions and resources, because of their nature, were not reflected in the programme budget. Attention should be given to how funds from various sources could be used to tackle issues such as climate change and the recent outbreak of influenza A (H1N1). WHO must optimize its budgeting in order to achieve the best possible results, with a view to meeting the Millennium Development Goals, especially those related to health and to maternal and child health in particular.

Dr SADRIZADEH (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the consideration given to comments by Member States and the Executive Board in revising the Proposed programme budget 2010–2011, the greater transparency, and future benefits to monitoring and management.

The financing of WHO by largely voluntary, earmarked contributions posed challenges for the timely implementation and effective management of resources. For the Organization's credibility, integrity and operational capacity, a significant portion of its budget must be drawn from assessed and flexible voluntary contributions. Welcoming the consistency of budget increases over the previous 10 years, he noted a gap between the target budget and partners' support in critical areas such as maternal and child health. Maternal and child mortality and morbidity were still high in his Region, owing mainly to inadequate resources and use of existing services, and the effects of sanctions and conflicts. Improved coordination and allocation of resources would tackle such obstacles, especially in areas which attracted lower levels of funding from partners. He expressed concern that targets of the Millennium Development Goals, particularly those on maternal and child health, might not be met.

The global financial crisis threatened humanitarian funding and health. Referring to the structural adjustment programmes that had followed the financial crisis of the 1980s, he warned against the long-term adverse effects to health systems in the developing world arising from budget cuts. He emphasized an increased WHO presence in countries in order to accelerate Member States' efforts to achieve the targets set out in the Proposed programme budget 2010–2011.

Ms BLACKWOOD (United States of America) said that her country continued to advocate budgetary discipline, efficient implementation and programme prioritization. She welcomed the decision to avoid an increase in assessed contributions and to project a reduction in funding for base programmes, particularly given the current global economic situation. It was particularly positive that the Secretariat had included a baseline level for outbreak and crisis response in the Proposed programme budget 2010–2011; she would welcome greater detail of the amount proposed, acknowledging the inherent difficulty of predicting such figures. She commended the separate section on partnerships, which had led to public health achievements internationally and WHO had been integral to those successes; she looked forward to the direct involvement and input of WHO's governing bodies in overseeing partnership arrangements.

Expressing concern regarding the continued reliance on regular funds to subsidize the administrative expenses of programmes funded by voluntary contributions, she said that WHO should pursue a policy for cost recovery of extrabudgetary contributions that took account of actual overhead costs. She expressed concern over the slow pace of implementation of some aspects of the Medium-term strategic plan 2008–2013, particularly with regard to maternal and child health. Indicators, such as increased coverage with skilled care for child birth, had shown only modest progress despite substantial investment, and she urged the Secretariat to do more with Member States in those areas.

She welcomed the clear identification of projected miscellaneous income in conjunction with assessed contributions, which was consistent with WHO's Financial Regulations and allowed Member States to base budget decisions on both sources of funding. She further welcomed efforts to reduce travel and procurement costs. With regard to the safety and security of staff and premises, she said that

the comprehensive security management plan being prepared by the United Nations Secretariat would significantly influence how WHO and other United Nations bodies approached the issue, but requested further consideration and development of substantive proposals regarding the funding options that WHO had identified.

Mr NIBLETT (United Kingdom of Great Britain and Northern Ireland), welcomed the inclusion in the Medium-term strategic plan 2008–2013 of indicators on climate change and patient safety; the structure, content and transparency of the Proposed programme budget 2010–2011; and efforts by the Director-General to reflect the concerns of the Executive Board regarding the surplus outstanding at the end of the previous biennium. The revised Proposed programme budget approached implementation at a level that avoided generating a surplus but did not reduce funding. Health-related activities should not be decreased, in spite of economic crisis, but it was vital that the money allocated to various programmes by the Health Assembly could be spent, in which regard he sought assurances from the Secretariat.

He expressed concern that resources allocated for strategic objective 4 (whose indicators and targets included reproductive health and achievement of the Millennium Development Goals related to maternal and child health) would not allow those targets to be met. Substantial resources should be committed to ensuring that every pregnancy was wanted, every birth safe, and every newborn healthy. He expressed similar concerns about funding for strategic objective 3 on noncommunicable diseases, which accounted for 59.7% of deaths worldwide but only 3% of the Proposed programme budget 2010–2011. WHO needed predictable and flexible funding to fulfil its mandate and, when performance management justified it, the United Kingdom would seek to increase its core voluntary contribution to the Organization and he encouraged other Member States to do likewise.

Dr DODDS (Canada) expressed support for the revised Medium-term strategic plan 2008–2013 and the Proposed programme budget 2010–2011 and welcomed the increased transparency and accountability. The ambitious Proposed programme budget was appropriate despite the difficulties of accurately predicting available resources for the biennium 2010–2011. She encouraged the Executive Board to work with both major donors and the Secretariat to further improve allocation and predictability of resources, and budget planning procedures.

Dr HUWEL (Iraq) drew attention to the resolutions adopted at the 33rd Ordinary Session of the Arab Health Ministers' Council (Damascus, 11–12 March 2009). Those resolutions covered various issues, including: adopting primary health care and a family-based medicine system; quality assurance in health services; accreditation of health institutions; patient safety and evidence-based approaches to medicine; activities to follow up on tobacco control; activities to strengthen nursing and midwifery; and preventing avoidable blindness.

Mr RONSE (Belgium) said that WHO must be effective in order to meet global challenges requiring strong health systems, a responsibility shared by international organizations, their constituents and their partners. Belgium was committed to that aim, for example through "good multilateral donorship".

The worrying imbalance between flexible core and earmarked voluntary contributions had resulted in higher transaction and other costs for the Organization, donors and recipients, and diverted policy attention from its core mandate. The additional administrative and decision-making burden at all levels for programmes with earmarked funding hindered the coherence of activities for development. Belgium had therefore opted exclusively for making flexible core contributions, and to modernizing its development aid, in line with the Paris Declaration on Aid Effectiveness and the repeated calls from recipient bodies. That policy sought transparent budgeting that clearly distinguished between core and earmarked funds so that underfunded programmes could be easily identified, and with support for results-based management, evaluation and reporting systems. Good multilateral donorship required predictable funding and timely payment of contributions. His country was committed to WHO's objectives, and to developing and implementing policies for continued

technical assistance to Member States, even in a period of financial stringency. An increase in core contributions would enable WHO to play its important role to the full.

Ms THANTIDA WONGPRASONG (Thailand) expressed support for the amended Medium-term strategic plan, and for using the six core functions of WHO to guide the work of the Secretariat and to strengthen Member States' health systems through primary health care principles and integrated service delivery. Concerns included the lack of resources and weakness of health systems in many Member States; the weakness of some WHO regional offices, which adversely affected the Secretariat's support to Member States; and inadequate management capacity, flexibility and efficiency among WHO staff in some regional offices.

Between 1998 and 2007, the proportion of the total budget accounted for by earmarked voluntary contributions had risen to more than 70%, greatly restricting WHO's flexibility in managing its resources across strategic objectives. That growing proportion showed that most of WHO's operations responded to the interests of donors, rather than to global health priorities and the needs of Member States. She supported moves towards a larger percentage of flexible core contributions and negotiation with donors. With regard to the target of 30% of the Proposed programme budget 2010–2011 being allocated to WHO headquarters, she highlighted the observation by the Programme, Budget and Administration Committee that funding for headquarters was currently too high: its budgetary allocation should be proportional to its actual operational activities.

Regarding the Medium-term strategic plan, she said that indicator 1.1.2 under strategic objective 1 was unrealistic in the case of the introduction of *Haemophilus influenzae* type b vaccine because the vaccine was expensive; Thailand lacked evidence on the burden of disease due to *Haemophilus influenzae* type b. With regard to indicator 3.1.3 under strategic objective 3, she supported increased national budgets for mental health, given the lack of funding in many developing countries, including Thailand, and the benefits of treatment and resulting productivity. Under strategic objectives 4 and 5, the number of countries targeted in several indicators should be doubled in order to reflect the importance of maternal and child health, as should the number of countries targeted in indicators 6.3.2 and 6.3.3, given her country's strong support for a comprehensive ban on smoking in public places. WHO could use tax increases on tobacco and alcohol as another indicator under strategic objective 6.

The Organization-wide expected result 11.2 covered support for countries to implement the International Medical Products Anti-Counterfeiting Taskforce strategy. However, since concerns about the composition of that Taskforce and conflicts of interest had been raised by the Executive Board at its 124th session<sup>1</sup> and the Health Assembly's agenda item on combating counterfeit medicines had been deferred, that reference should be removed, in line with WHO's promotion of good governance and transparency. WHO should distinguish between two issues: inadequate pharmaceutical quality, which posed a health threat to populations, and violation of intellectual property rights, where the Taskforce had explicit goals. The extent of the problem of counterfeit medicines was still unclear, because some studies had been based on biased sampling and had shown that the problem was apparently widespread. WHO should only reference peer-reviewed, published literature that was explicitly free of any conflict of interest and any sponsorship by the pharmaceutical industry. Failure to enforce the mandatory reporting of conflict of interest by authors in any scientific journal undermined public trust and confidence; caution should be employed in citing any scientific findings.

She urged WHO to implement the Medium-term strategic plan 2008–2013 and requested strong monitoring and evaluation of progress and problems encountered with respect to each strategic objective.

Dr VENKATACHALAM (India) remarked that, rather than concurring with a number of comments already made on the Medium-term strategic plan, he would make just one observation. The plan appeared to endorse the operation of the International Medical Products Anti-Counterfeiting

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<sup>1</sup> Document EB124/2009/REC/2, summary record of the ninth meeting.

Taskforce whereas the Executive Board, at its 124th session in January 2009, had asked the Secretariat to prepare two revised reports, one on counterfeit medical products and the other on the role, function and membership of the Taskforce. Since those revised reports had not yet been considered by the Member States, a line should be added to the Medium-term strategic plan to the effect that their views on those two issues must not be prejudged.

Dr BHUTTO (Pakistan) said that her country appreciated the transparent and interactive process that had led to the Medium-term strategic plan. She outlined Pakistan's achievements so far, and the challenges ahead, with regard to the various individual strategic objectives within the plan. She emphasized that political commitment existed for reducing the burden of communicable diseases, in particular poliomyelitis, and indicated that the extensive collaboration with the Ministry of the Environment had led to initiatives against environmental threats to health. Conflict jeopardized progress towards strategic objectives 1 and 3, and disability and premature deaths were major concerns. With regard to strategic objective 11, rational use of medicines needed strengthening and efforts were being made to cover medical equipment and products under existing legislation; greater national capacity and support were needed for data collection and improved procurement.

Mr COX (Barbados) observed that the indicators for Organization-wide expected results outlined in the Medium-term strategic plan provided opportunities to refocus priorities where necessary. The Proposed programme budget emphasized reliance on specified voluntary contributions, which would affect management and achievement of the expected results if such contributions were reduced as a consequence of the current economic climate.

In addition, with the nominal value of assessed contributions remaining constant, the budget's declining real value would jeopardize delivery on performance targets, if the level of expected voluntary contributions failed to materialize.

A total of 44.9% of the Proposed programme budget 2010–2011 was allocated to strategic objectives 1 and 2, concerning communicable diseases. Distribution needed to be more equitable across other strategic objectives, in particular numbers 3, 4, 6, 7, 8 and 9. A mechanism to deal with unpredictable funding of emergency response operations was needed, as well as a greater focus on improving implementation and monitoring of the Proposed programme budget.

Ms BULLINGER (Switzerland) drew attention to strategic objective 13, in particular the funding of expenditure on security, infrastructure and the Capital Master Plan. Switzerland had repeatedly commented on the need to budget for such expenses. It was thus regrettable that the shortfall of funds for those expenditures had not been corrected in the budget for 2010–2011. Out of a projected total of US\$ 89 million, only US\$ 10 million would be provided, with undesirable consequences for the Organization. Switzerland called on WHO to examine all possibilities of funding; to make detailed proposals to the Sixty-third World Health Assembly; and allow Member States to make fully informed decisions. Paragraph 20(d) of document A62/4 Add.1 appeared to offer an option that should be explored further. In that connection, she suggested that 1% of the insured value of WHO's buildings should be allocated every year to a fund for maintenance, renovations and infrastructure, in line with practice in Switzerland's private real-estate sector.

Dr SEFULARO (South Africa) welcomed the amended Medium-term strategic plan, and in particular WHO's commitment to technical support for the implementation of the WHO Framework Convention on Tobacco Control. However, the specific indicators in the Proposed programme budget and amended Medium-term strategic plan were limited to certain aspects of tobacco control. He requested the Director-General to develop and use indicators that were in line with the Framework Convention's guidelines, including those being developed for consideration by the fourth session of the Conference of the Parties to the Framework Convention on Tobacco Control. As South Africa currently held the presidency of the Conference, he wished to signal his country's availability to work with the Director-General. He further requested the Director-General to align the WHO workplan with that of the Framework Convention, thereby assuring WHO's support for the treaty.

Ms TOYOTA-IMAMURA (Japan) observed that ample consideration should be given to achieving the best possible results with limited budgetary allocations. Because the global financial crisis was greatly affecting vulnerable people in particular, Japan would increase its voluntary contribution for 2010.

She praised the Secretariat's efforts to prioritize projects, but emphasized that the budget reduction must not impede the execution of WHO's core mandate or lower the quality of project activities. She also emphasized careful monitoring of programme results, by using the proposed indicators. In addition, specific efficiency savings should be presented to Member States both as qualitative explanations and with quantitative data, in line with other international organizations. That would be important for explanations to taxpayers in the donor countries. Given the heightened interest in global health, Japan was confident that fulfilling that responsibility would contribute to securing sufficient resources. The interim performance assessments reported to the Programme, Budget and Administration Committee should reflect those explanations and data.

With regard to the budget for the biennium 2008–2009, she recalled that the Global Management System had been supposed to bring efficiency savings of US\$ 5 million per year, and she looked forward to a report on that issue.

She endorsed the shifting emphasis from headquarters to the regional offices. However, the role of headquarters, which included the preparation of standards and coordination, should be balanced with that of the regional offices, which was to support countries.

She also emphasized the development in the various regions of projects based on principles of good governance and accountability.

Dr JAYANTHA (Sri Lanka) said that ways had to be found of decentralizing the budget to the regions in order to improve planning in the countries. That would call for increased flexibility. The introduction of the Global Management System should provide that possibility. Secondly, there was a need to establish criteria for sharing the budget between headquarters, the regions and the countries.

Mr FENG Yong (China) welcomed the amendments to the Medium-term strategic plan and the Proposed programme budget to promote financial transparency, and supported the decisions to adjust the overall budget level and to maintain the level of the assessed contributions. He agreed that the revisions should observe the guiding principles of continuity and compatibility across bienniums; however, in the revised version most of the indicators in the Organization-wide expected results had been modified, deleted or replaced. He expressed concern that such revision might lead to disparity of indicators across the three bienniums.

The Proposed programme budget distinguished between those partnerships to be included and those not, thereby enhancing transparency. The Secretariat should be able to define objective and stable criteria for ensuring continuity and comparability across bienniums.

Dr TSESHKOVSKIY (Russian Federation) said that, in the light of the comments made by the Programme, Budget and Administration Committee and the discussions by the Executive Board in January 2009, his Government was satisfied with the amendments to the report.

With regard to the Proposed programme budget 2010–2011, he fully understood the need for the 10% reduction. However, that reduction was being applied across the board, and thus previous imbalances between objectives would continue. In particular, strategic objectives 3, 4, 7 and 9 remained underfunded.

In the amendments to the Medium-term strategic plan, work remained on strategic objective 3. The impact of climate change on those countries required further research in the amended version. There had been insufficient emphasis on enhancing primary health care as the cornerstone of WHO's work, and the need to take an integrated approach to combating both chronic noncommunicable diseases and communicable diseases.

Dr ESTRELA (Brazil) said that Brazil's voluntary contributions to WHO spoke for its full commitment to the process of establishing and implementing the global strategy on public health, innovation and intellectual property.

Brazil had serious doubts about the use of the expression "counterfeit medicines" in strategic objective 11. During the 124th session of the Executive Board the Group of Latin American and Caribbean Countries had stated their concerns on those issues, and the Secretariat had been asked for a report on counterfeit medical products. That item was not on the agenda of the present Health Assembly, and Brazil and other countries were deeply concerned that the Secretariat would focus work, as was stated in the Medium-term strategic plan, on "an international programme to combat counterfeit medicines". The definition of a counterfeit product was given in the Agreement on Trade-Related Aspects of Intellectual Property Rights and was related to trademarks. Countries also had misgivings about the International Medical Products Anti-Counterfeiting Taskforce, which attempted to impose a revision of WHO's position on the issue of counterfeiting in order to inhibit legitimate trade in good-quality and affordable generic medicines. The Secretariat's role was to support Member States in strengthening their regulatory capacities, based on concerns of health surveillance and regulation, not to promote the enforcement of intellectual property rights, which did not fall within its competence.

Observing that Brazil defended the primacy of public health over trade interests, he requested the Secretariat to revise the version of the Medium-term strategic plan in order to clarify the debate within the Organization about the quality of medicines; and to delete all reference to counterfeiting from that text.

Dr ASIN-OOSTBURG (Suriname) said that the Proposed programme budget revealed an imbalance in the allocation of funds. She emphasized the burden of chronic noncommunicable diseases and their contribution to maternal and child mortality. She proposed increased allocations for noncommunicable diseases, and called for flexibility in the allocation of funds from voluntary donors.

She concurred with most of the strategic objectives set forth in the Medium-term strategic plan, but, with reference to strategic objective 11, joined other countries in recalling that the Executive Board, at its 124th session, had questioned the strategy of the International Medical Products Anti-Counterfeiting Taskforce in regard to conflict of interest and the composition of the Taskforce. Reference to counterfeit medicines should therefore be removed from the version of the Medium-term strategic plan under consideration.

Mr TOBAR (Argentina) also referred to strategic objective 11, in which it was stated that the Secretariat would focus on "providing support to countries for producing, using and exporting products of assured quality, safety and efficacy, through strengthening of national regulatory authorities and an international programme to combat counterfeit medicines". He proposed that that paragraph should be modified to read "applying an international programme to ensure the desired and appropriate quality of medicines", since Argentina considered that, as had been stated by Brazil, supported by Venezuela, combating counterfeiting was a matter of enforcement of intellectual property rights, which lay outside the remit of WHO.

Ms NAVARRO LLANOS (Plurinational State of Bolivia) said that, like other developing countries, Bolivia was concerned about the inclusion in the Medium-term strategic plan of topics that had not been discussed by Member States, in particular the Secretariat's focus, under strategic objective 11, on an international programme to combat counterfeit medicines. As such action had not been agreed by Member States it should not be included in the document.

Mr AITKEN (Assistant Director-General) thanked delegates for their support of the budget. Their comments had been noted and would be followed up during its implementation. In regard to contributions, he had noted a wish for more flexibility and predictability that was partly related to concerns about the funding of strategic objectives 3 and 4, and in some cases 7, 9 and 10. Implementation patterns showed that WHO was not yet able to fund those areas sufficiently from



voluntary contributions. The key was indeed flexibility and predictability: the less targeted the contributions, the more they could be moved to fund areas of the approved budget. Many speakers had called for better implementation rates and efficiency, with the resulting gains used for the benefit of programmes. As requested by the delegate of Japan, the Secretariat would report back on efficiency measures in the coming biennium. An annual report on progress in implementation would also be provided.

On the subject of targets, WHO needed to strike a balance between continuity, as emphasized by the delegate of China, and the possibility of adapting targets in the light of specific events. The Secretariat would report to the Programme, Budget and Administration Committee of the Executive Board in January 2010 and would reflect on how targets could be modified in response to developments. WHO would seek to move towards the goal of a 70%–30% split between the regions/countries and headquarters in the budget for 2010–2011. He understood the concerns about the growing role of partnerships in the budget. In response to comments by the delegate of the Czech Republic, the Secretariat would look into the idea of a possible limit on the share of partnerships in the budget and report back on the subject. In regard to core voluntary contributions, referred to by the delegate of Belgium, he said that WHO, with assessed contributions accounting for under 20% of the budget and core voluntary contributions for only about 5%, lacked a long-term financing system that was fit for the purpose. It would examine how core contributions could be increased and countries encouraged to support core programmes. On the subject of security and the Capital Master Plan, he had noted the concerns of many countries, including Switzerland. The Secretariat would examine the issue in greater detail and report back to the Sixty-third World Health Assembly. The whole question of financing security in the United Nations system was being discussed by the United Nations General Assembly.

The DIRECTOR-GENERAL thanked Member States for their interventions and advice. She outlined some of the principles that guided her in her duties: improved transparency and accountability, and the use of a results-based approach to the planning, budgeting and resource allocation process; and budget discipline, efficiency and a satisfactory implementation rate. The allocation of resources between strategic objectives and between country offices, regional offices and headquarters was difficult; she could not please everyone but would not shirk from difficult decisions, guided by the discussions and decisions of the Member States. She always paid special attention to the corporate priorities they set through the Medium-term strategic plan and resolutions, with emphasis on the needs of developing countries. She agreed with the delegate speaking on behalf of the European Union that the budget environment was a very complex matter. Contradictions existed – between the aspirations and expectations of Member States and income realities, between corporate priorities and the individual agendas of particular States or even of some WHO staff members, and between the 80% of highly earmarked resources and the 20% of the regular budget, which greatly limited flexibility. Flexibility and long-term predictable funding were essential and she thanked all the countries following that path. How did Member States wish to fund the work of WHO? In a recent meeting with her counterparts in some other organizations she had discovered, much to her surprise, that their regular budget accounted for 90% of the overall figure, as against only 20% in WHO. That issue would need further discussion.

She had noted that use of the word counterfeit in “counterfeit medicines” had posed a problem for many countries. She would try to avoid the term. WHO would never implement any action related to intellectual property since that was not its job, but she insisted that substandard medicines constituted a huge public health problem, especially in developing countries, which often had weak regulatory authorities. Substandard medicines could endanger health, stimulate drug resistance and compromise the authority and credibility of both health agencies and doctors. She hoped that all would agree that WHO should play an important role, but only in the public health dimension of substandard medicines. It should work with other United Nations agencies and with regional and global entities, its contribution being to provide public health advice. It should not do the work of other agencies.

“Carry-over” was another term she disliked because it seemed to refer to surplus money, namely money that could be spent but had not been spent in time. It was composed of a mix of different

monies. Some 80% of the budget consisted of voluntary donations, which meant that even she herself had no control over when, how and which regional or country offices received the resources. Moreover, as had been mentioned, highly earmarked resources could entail high transaction costs. The introduction of a cost-recovery system had been suggested so as to ensure that the regular budget did not subsidize voluntary contributions. In addition, most voluntary donations were not received at the beginning of the year or biennium but at a moment that reflected the donor country's financial cycle, which might be the end of a WHO biennium. It would be appreciated that WHO needed a reasonable "carry-forward" – that was the term she preferred – in order to maintain continuity. The Organization should not be obliged to dismiss staff because there was no money and then recruit when the funds arrived. She had been advised that WHO needed an estimated carry-forward of US\$ 1000 million for the entire Organization. The whole question would be given close attention. It should not be forgotten that the "carry-over" included partnership money that could not be allocated to core programmes but depended on a separate governing body. She promised to monitor developments closely and to make sure that money not meant to be spent in the current biennium was carried forward.

The CHAIRMAN said that the item would be kept open to give delegates time to examine the proposed draft appropriation resolution for the financial period 2010–2011, which would be tabled for discussion and approval by the Committee on 21 May 2009.

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

### 3. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

**Commission on Social Determinants of Health:** Item 12.5 of the Agenda (Documents EB124/2009/REC/1, resolution EB124.R6 and Annex 7, and A62/9)

Sir Liam DONALDSON (representative of the Executive Board), introducing the item, said that the Commission on Social Determinants of Health had been established by former Director-General Dr Lee Jong-wook in 2005 and chaired by Professor Sir Michael Marmot. Its programme of work had been wide-ranging; besides examining submitted papers and analyses, members of the Commission had visited many countries and held meetings with health ministers, experts and some heads of State. It had reawakened interest and commitment in an important field of public health.

The Executive Board had considered the final report and made three recommendations for action: the improvement of daily living conditions; the tackling of the inequitable distribution of power, money and resources; and the measurement and understanding of the problem and assessment of the impact of action. It had detailed further recommendations for action in each category and had provided examples of potential roles for the various parties. In welcoming the report, the Board had considered the implications for Member States and the Secretariat; had stressed the intersectoral approach to the social determinants of health; and identified the need for additional financial and technical support to help Member States apply the Commission's recommendations. The Committee was invited to consider the draft resolution contained within resolution EB124.R6 on reducing health inequities through action on the social determinants of health.

Mr VON KESSEL (Switzerland) supported the draft resolution and welcomed the importance attached to health equity by WHO, which Switzerland shared both at the national level and in its aid to disadvantaged countries. Like the Commission, Switzerland emphasized the role of education and training among such determinants. Access to basic medical care for all, including the most vulnerable, must be ensured through a universal and egalitarian medical insurance system. In his country about 30% of the population – mainly the poor, the homeless and asylum seekers – were eligible for reduced premiums for sickness insurance. Health care should also be provided to groups of other cultures in a way that respected different cultural representations and values. In Switzerland, efforts were made to

facilitate access to health care for migrants. Its health policy was oriented in a similar way to the resolution but it did not yet have a solid scientific and political tradition in regard to the social determinants of health. The draft resolution would help Switzerland to define its position. The report would help Switzerland to improve its health system, at present too centred on treatment and the sick individual. The Secretariat should help Member States to develop appropriate measures aimed at the social determinants of health and measure the progress achieved.

Dr JAYANTHA (Sri Lanka), speaking on behalf of the Member States of the South-East Asia Region, commended the work of the Commission on Social Determinants of Health and supported the draft resolution, suggesting a number of proposals to strengthen the text.<sup>1</sup>

The Region saw social determinants of health as a priority and had held several regional consultations on the matter. Several Member States had endorsed the report by the Secretariat but emphasized the need to address issues related to global governance.

Dr GOPEE (Mauritius), speaking on behalf of the Member States of the African Region, commended the Commission's work. The activities proposed would focus on core recommendations addressing social determinants of health, achieving the Millennium Development Goals, and on inequities in the availability and affordability of health services. A multipronged strategy should mobilize stakeholders outside the health sector.

Mauritius had already attained some of the targets of the Millennium Development Goals through policies such as free health care and free education. The principle of "putting people first" had guided economic strategy and had led to relevant public health legislation, including the introduction of a mobile clinic service, screening programmes, and measures to curb the harmful effects of tobacco and alcohol.

Reforms towards universal coverage were more essential than ever as health remained a key determinant of sustainable development. Health policies and targets should therefore encompass diverse social and economic factors and reinforce intersectoral collaboration. In many African countries inadequate health information systems had impeded health equity; without basic data systems, including registration and monitoring, policies to address social determinants of health would not achieve their aims. African countries would require coordinated action among all partners, and strengthened health systems that focused on humanitarian emergencies, epidemics and revitalized public health care.

Dr JARAMILLO NAVARRETE (Mexico) commended the draft resolution. The Commission had stated that it was feasible to close gaps in health inequities within a generation; fulfilling such an aim would indeed be a challenge.

He also commended the report's emphasis on the need for a multisectoral approach and called on a wide range of agencies, institutions, governments and other stakeholders to act on the social determinants of health. Factors such as poverty and social and economic inequality had direct repercussions on public health. Combating marginalization, inequality and poverty would require committed action from partners both nationally and internationally. A selective policy would not be effective and support would be needed from the Secretariat and all Member States. He appealed to health ministers to lead, share experiences and enact policies that fostered social development and the right to a healthy life.

Dr STEHLIKOVÁ (Czech Republic), speaking on behalf of the European Union and its 27 Member States, said that the candidate countries, Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Bosnia and Herzegovina, Montenegro, and Serbia, and the Republic of Moldova, Armenia

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<sup>1</sup> These proposals were later elaborated on by the delegate of Thailand in the sixth meeting of Committee A.

and Ukraine aligned themselves with her statement. She welcomed the reports and expressed support for the draft resolution. She also welcomed WHO's commitment to extend its work beyond publication of the report, and to supporting actions in all Member States and the sharing of experience. The Organization should continue to mainstream the social determinants of health and formulate global, regional and national implementation strategies. The Secretariat should take account of the impact of social determinants on mental health; work with Member States to develop a "health in all policy" approach; incorporate that in its own practices; and promote coherence within the wider United Nations family and other partners. The role of primary health care in ensuring universal and equitable access to comprehensive health care was crucial. Objective indicators for monitoring and evaluation were also needed.

A concentrated effort was needed, in spite of global financial crisis, to close the health equity gap in a generation, so that everyone might aspire to a high level of health regardless of their social situation or where they lived.

Ms FERNANDEZ DE LA OZ (Spain) congratulated the Commission on its work, and endorsed the draft resolution. Reducing social and health inequities was a priority for her Government and would be when it took over the presidency of the European Union in January 2010. The presentation of the final report of the Commission in Madrid on 28 May 2009 would provide an opportunity for her Government to announce its priorities, widen the debate and increase the prominence of social determinants of health on the political agenda. Spain was working to reduce current inequities, particularly health inequities, in vulnerable groups such as the Roma community.

Dr NOH (Malaysia) welcomed the prioritization of social determinants of health, which reflected her own country's policies, which provided the leadership and governance of equity through intersectoral collaboration, with emphasis on the vulnerable. She welcomed WHO's support for capacity building in the monitoring of targets for health equity and endorsed the draft resolution.

Mr VINEET (India) expressed appreciation for the work of the Commission. Its three overarching recommendations should be the cornerstone of national policies but could only be effectively implemented when a cross-cutting, "health in all policy" approach was adopted by governments.

Experience in India had shown that health inequities could be tackled by empowering people through inclusion, creating opportunities for participation and building local leadership. It would share such success stories among Member States across all regions. The Secretariat should build on the Commission's work through technical support for identifying and quantifying health inequities and associated social determinants, and setting goals and measuring progress.

The Millennium Development Goals could only be achieved if key social determinants of health, such as early childhood development, were effectively addressed. The Secretariat should promote holistic policies for child survival and health; develop a network of collaborative research, of individuals and institutions across countries to share information, experiences and best practice; and support Member States to strengthen capacity and to measure and evaluate social determinants and health inequities. He emphasized the need for impact assessment in rural areas and among disadvantaged sections of society, and supported the draft resolution.

Dr SADRIZADEH (Islamic Republic of Iran) commended the comprehensive report. Tackling the problems of social determinants of health within and between countries called for global solidarity, political commitment and intersectoral coordination. WHO should act as a catalyst in ensuring that social determinants of health were at the top of the global agenda. Increased efforts to revitalize primary health care and tackle the social determinants of health were needed in order to achieve the Millennium Development Goals. The Secretariat should work closely with Member States through policies to reduce health inequities. Iran had been a pioneer of primary health care, valued equity in health, and integrated health considerations into relevant public policies.

The Asian Parliamentary Assembly at its third plenary session (Jakarta, 26–29 November 2008) had adopted a resolution on achieving health equity that, inter alia, urged promotion of policies on health equity and interparliamentary cooperation. The Assembly decided to establish a subcommittee that would review the situation regarding social determinants in Asian countries, identify the main inequities and provide recommendations. His Government would host an international meeting on social determinants of health in Tehran on 29 and 30 June 2009. He supported the draft resolution.

Mr FORLAND (Norway) said that the Commission's report was an important achievement. In order to tackle social inequities in health, policies had to be built on a universal welfare system supplemented by targeted policies. The report showed that universal welfare schemes were most beneficial to the poor and prevented people from ending up in high-risk situations. Although in the global context Norway had relatively few health inequities, inequities were unfair and unjust and that must be recognized in order to take action on the scale called for by the Commission. He supported the draft resolution. The strategies devised by the Commission would also help in reaching the Millennium Development Goals and alert all levels of the global health community to the importance of fighting inequity. He welcomed the proposal by the Government of Brazil to host a global conference on the social determinants of health in 2010.

**The meeting rose at 12:30.**

## **SIXTH MEETING**

**Wednesday, 20 May 2009, at 14:35**

**Chairman:** Dr F. MENESES GONZÁLEZ (Mexico)

**TECHNICAL AND HEALTH MATTERS:** Item 12 of the Agenda (continued)

**Commission on Social Determinants of Health:** Item 12.5 of the Agenda (Documents EB124/2009/REC/1, resolution EB124.R6 and Annex 7, and A62/9) (continued)

Dr MUSTAFA (Sudan) thanked the Regional Office for the Eastern Mediterranean for its support to Sudan in developing its knowledge base. Community-based initiatives in the Region had led to an improvement in overall health indicators. He supported the draft resolution contained in resolution EB124.R6 but proposed the following amendments: addition of the words “and enhancing intersectoral action” at the end of subparagraph 3(3) and of the words “and research capacity” in the first line of subparagraph 3(8) after the words “health information systems”.

Ms BREBNER (Samoa) supported the three main recommendations contained in the report and encouraged WHO to work closely with partner agencies in order to put health at the centre of development agendas. She particularly welcomed the emphasis on primary health care and supported the draft resolution.

Mr MONTIEL (Bolivarian Republic of Venezuela), referring to the recommendations and action areas proposed by the Commission in its report, said that the structural causes of social inequities between countries and within countries should be recognized. The wealthier countries had exploited the world's resources in their own interests, using a model that had sparked the current financial crisis, which was having a relatively greater impact on poorer countries. In terms of the inequitable distribution of power, money and resources, the proposed specific action areas revealed the same patterns and errors and a simplistic approach to tasks and responsibilities which did not address the structural causes. A model was required in which the right to health prevailed over economic interests.

In the face of the financial crisis, Member States had a moral duty to their people to formulate new proposals. His Government was constructing a different model which constituted Bolivarian socialism, and based on democracy, respect for human rights, equity, justice, solidarity, freedom and equality, and aimed at maximum stability and social security.

Mr COX (Barbados) said that his Government was committed to the right of all Barbadians to free tax-funded health care at the point of access. The Ministry of Health fostered multisectoral approaches in formulating public health policy; it was increasing resources to the priority areas of an expanding elderly population and chronic noncommunicable diseases. Barbadians were under threat from the current global economic crisis, as poorer nations that had contributed little to the crisis would suffer the most. He supported the monitoring of social determinants of health and health equity indicators on a global scale, as well as the draft resolution.

Dr PILLAY (South Africa) observed that the first two recommendations contained in the report called for significant changes in the social and economic orders of all Member States and, therefore, in the world order. Health ministers could not single-handedly achieve those aims, and other multilateral agencies such as the United Nations, the World Bank, IMF and WTO should also be involved, in the

interests of the most vulnerable, rather than the most powerful, nations. He supported the draft resolution and requested the Director-General to submit the Commission's report to the United Nations General Assembly and meetings with the above-mentioned multilateral agencies.

Dr SULAİK (Philippines), supporting the draft resolution, said that his country, guided by the Commission's recommendations, had started to address the myriad factors affecting the performance of its health system. It had established prototypes of local health systems, sharing and maximizing use of resources for better health in municipalities, isolated or disadvantaged areas. WHO's Urban Health Equity Assessment and Response Tool had proved useful in analysing intercity and intracity health inequities and designing health-related strategies that would lead communities towards self-reliance.

Dr UGARTE UBILLUZ (Peru), supporting the draft resolution, emphasized the relevance of recommendations to improve living conditions and to promote harmonious rural and urban development in order to generate full employment and specifically child development policies. The recommendation to provide basic access to resources such as water was crucial, as it was linked to climate change and policies on universal access to health services. His Government had recently passed a law providing universal health insurance that was fully in line with the Commission's recommendations. It supported the equitable distribution of power and broad social participation and agreed on the importance of investing in appropriate, transparent information systems in order to generate data on determinants.

Ms KANNIKAR BUNTEONGJIT (Thailand), speaking on behalf of the Member States of the South-East Asia Region, said that important recommendations by the Commission had been omitted from the draft resolution. She elaborated on the amendments proposed in the previous meeting by the delegate of Sri Lanka.<sup>1</sup> Two new preambular paragraphs should read:

“Noting the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action;

Mindful of the needs for global governance mechanisms to support Member States in provision of basic services essential to health and the regulation of goods and services with a major impact on health, and the needs for market responsibility;”.

In paragraph 2, a new subparagraph should be inserted to read: “to adopt health equity as a core global development goal and use a social determinants of health framework to monitor progress, and to devise global governance mechanisms in addressing the social determinants of health and reduce health inequities;”.

In paragraph 3, a new subparagraph (1) should be inserted: “to tackle the health inequities within and across countries through political commitments on “closing the gap in a generation” as a national agenda, and establish national institutional mechanisms to coordinate and manage intersectoral action for health in order to mainstream health equality in all policies, and where appropriate by using health and health equity impact assessment tools;”. Subparagraph 3(2) should be deleted and replaced with the following text: “to take into account health equity in all national policies and to establish and strengthen universal comprehensive social protection policies, universal health care, and universal availability of and access to goods and services essential to health and well-being, in order to effectively address social determinants of health;”.

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<sup>1</sup> See summary record of the fifth meeting of Committee A, section 2.

At the beginning of subparagraph 4(3), new text should be inserted to read: “to institutionalize social determinants of health as a guiding principle, and”, with the rest of the subparagraph remaining unchanged. Two new subparagraphs should be inserted into paragraph 4, to read:

“to support the primary role of the Member States in the provision of basic services essential to health and the regulation of goods and services with a major impact on health of the population;

to study the feasibility and benefit of various modes of good global governance to support Member States in providing goods and services essential to health and regulation of goods and services with a major impact on health, and report back to the Sixty-fifth World Health Assembly;”.

The connotation of the term “global governance” was that found on the WHO web site.

Dr BUSS (Brazil) said that his country had created its National Commission on the Social Determinants of Health, which he had chaired. Its final report in 2008 had proposed changes to health policies and in economic and social policies that affected health. The Union of South American Nations (UNASUR) had, in April 2009, created a South American commission on the social determinants of health, which had already begun work. He supported the draft resolution and the amendments proposed by the delegates of Iran, Sri Lanka, and Thailand. Brazil was offering to host the international meeting mentioned in the draft resolution.

Dr MOHAMMAD (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Regional Office was taking the social determinants of health into account as it addressed such problems as social and sexual inequality, illiteracy, social exclusion, unemployment, lack of social protection and differences in access to primary health care. An education database had been set up as part of an information network aimed at tackling specific social determinants of health. Equal commitment by all governments, particularly the ministries concerned, was essential. Regional offices must also be supported and financed so that similar actions could be taken at the national level.

Dr SHEVYREVA (Russian Federation) said that her Government attached great importance to the provision of free medical care to all citizens. However, experience worldwide had shown that disease prevention was more effective; it was essential for citizens to follow prophylactic programmes and be educated to act responsibly to protect and improve their health. Governmental measures included a healthy-lifestyle training programme that covered areas such as reduced use of alcohol and tobacco. She supported the draft resolution, especially the provisions relating to education on healthy lifestyles, immunization and health risk factors.

Mr ABDOO (United States of America), supporting the draft resolution, said that his country was very interested in examining and addressing the social and economic determinants of health outcomes. Many Member States lacked not only information on how to improve health for all, but resources for using that information. Two of the Secretariat’s core functions were to provide Member States with evidence on which to base policy decisions and to offer technical support for their implementation. He therefore commended the report’s proposals to improve data collection within Member States and to boost WHO’s technical capacities for assessing the social determinants of health.

Ms DAVIES (United Kingdom of Great Britain and Northern Ireland) said that redressing inequality in life expectancy was a matter of social justice and that, in the current global crisis, continued collaboration was essential in order to find ways of responding to the social determinants of health. She supported the draft resolution and looked to the Secretariat for leadership and support in implementing it.



Dr CHEN Ningshan (China), expressing support for the draft resolution, endorsed the proposed action areas, particularly with regard to oversight and assessment. Efforts to prevent and control diseases were increasingly influenced by social determinants of health. Her Government's actions to reduce inequalities between rural and urban areas and among the country's various regions and peoples included a reform of the public health system in order to provide universal access to essential health care.

Dr HUWEL (Iraq) expressed support for the draft resolution, implementation of which should focus on areas such as malnutrition, breastfeeding, control risk factors, community partnership, health education and advocacy, and coordination and cooperation with other community sectors.

Dr VEGA MORALES (Chile), speaking on behalf of the 12 Member States of the Union of South American Nations, said that one of the Union's five strategic objectives was to reduce health inequities within a generation by addressing social determinants. The countries' initiatives would include the creation of national health commissions, as Brazil had done.

She supported the draft resolution and trusted that WHO would prioritize the work required under strategic objective 7 of the Medium-term strategic plan 2008–2013. She proposed, however, the following amendments: replacing subparagraph 3(8) by the following text: "to develop, make use of, and if necessary, improve health information systems in order to monitor and measure the health of national populations, with data disaggregated according to age, gender, ethnicity, race, caste, occupation, education, income and employment so that health inequities can be detected and the impact of policies on health equity measured"; and replacing subparagraph 4(10) by the following text: "to convene a global event, with the assistance of Member States, before the Sixty-fifth World Health Assembly in order to discuss renewed plans for addressing the alarming trends of health inequities through addressing social determinants of health and report back on progress to the Sixty-third World Health Assembly".

Mr FISKER (Denmark) expressed full support for the draft resolution. Factors such as education, employment conditions, traditions and social networks influenced behaviour and could be linked to a poor lifestyle and poor health, but knowledge of how and to what extent such factors impinged was limited, as were possibilities for intervention. Health systems alone could not compensate for poor living conditions. Monitoring of health, and research into the causal connection between social determinants and health should be intensified in order to ascertain ways of improving health by influencing those determinants.

Miss GUTIÉRREZ RUIZ (Costa Rica), supporting the draft resolution, said that, although Costa Rica had been applying the principles of equity to health policies for more than 50 years, health inequities remained, mainly to the detriment of certain geographical areas and minority groups. Poverty, an important social determinant of health, affected women and rural inhabitants more than others. Her country's Ministry of Health was also responsible for the social sector.

The Costa Rica Consensus initiative was concerned with securing international cooperation, especially for middle-income countries, by investing in social structure and reducing military expenditure; for example Costa Rica had no army. The Secretariat could provide important support for framing policies to influence social determinants, as well as methodologies for analysis and monitoring. Collaboration between Member States was crucial for training research institutions in the collection of data on the impact of social determinants on health; and for exchanging experience regarding national systems for monitoring health equity. International support was vital for sustained investment in rural development and for implementing social and economic policies.

Dr ASLANYAN (Canada), fully endorsing the action areas specified in the report and supporting the draft resolution, said that prompt and specific action was needed: the conferences held on the subject and the wealth of documentation produced demonstrated readiness among stakeholders to collaborate on reducing health inequalities. Almost one quarter of Canada's development assistance

went on health, with investments in economic development, the environment, education and training for children and young people reinforcing efforts within the health sector and improving health outcomes.

Dr LEE Han-Sung (Republic of Korea), supporting the draft resolution, said that his Government was working to improve the accessibility, quality and efficiency of the health-care system, especially in underserved areas. Future policies in his country would reflect the Commission's recommendations.

Dr DEMIRALP (Turkey), supporting the draft resolution, emphasized sound health systems, primary health care and universal coverage as a basis for addressing the social determinants of health. He noted the Commission's recommendation on generating and sharing new evidence. An analysis of good policy examples and assessment of their applicability in various contexts should be made available. Public and international investment for equity and health should be increased and coordinated for the implementation of action plans.

In 2002 Turkey had begun implementing an action plan to provide health insurance for the entire population and strengthening primary health care. The Ministry of Health had also launched the health transformation programme, in cooperation with the Ministry of Labour and Social Security, for more efficient resource allocation and improved health of the population.

Mr LANZA (Plurinational State of Bolivia) said that neoliberal policies had greatly undermined the health of peoples, the principles enshrined in the Declaration of Alma-Ata (1978) and basic human rights. His country's new constitution (adopted in January 2009) provided for structural reforms, the precedence of health over commercial agreements, and the active involvement of social sectors. The new plurinational State would focus on health promotion and risk prevention and build a system for health not disease, with efforts concentrated in rural and poorer areas. He supported the draft resolution and called on WHO to incorporate the social determinants of health in all health programmes; provide the resources required for the action areas; and coordinate its efforts with other organizations of the United Nations system.

Dr DAKULALA (Papua New Guinea) fully supported the draft resolution. However, he asked for clarification on the focal points for action in Member States, and whether the health sector would be the key custodian. Alternatively, responsibility could be placed centrally, as in his own country within the national planning department, with the health sector playing a leading role.

Dr DAHN (Liberia) said that her country, like most in the African Region, lacked information on the social determinants of health. Ministry of Health policies focused on gender and poverty, provided for equitable distribution of health services, equity and social justice and emphasized efficiency, sustainability and accountability. At county level, micro-planning was needed to resolve problems associated with Liberia's past. The implementation of county plans was monitored through quarterly review meetings. Health facilities were accredited annually, and an annual health sector conference took stock of achievements and developed future plans. National indicators were monitored through the health information system. Major challenges included insufficient trained human resources, especially health professionals; loss of qualified health staff owing to low salaries; and the inaccessibility of parts of the country.

Dr GAMARRA (Paraguay), supporting the draft resolution, said that the risk factors for noncommunicable diseases, the main causes of morbidity and mortality in the world, were socially determined. Those diseases accounted for the loss of some 50% of years of life in Latin America, but the morbidity rate might well be higher.

Dr SHIMIZU (Japan) said that, in countries with lower levels of social protection, vulnerable people were more affected by social determinants of health. Activities in developing countries to

address those social determinants affecting vulnerable people should be increased, complementing efforts to strengthen health systems, such as health promotion and social protection. He supported the draft resolution and looked to strong leadership from WHO in its implementation.

Mr TOBAR (Argentina) said that the Commission's recommendation of a comprehensive approach to early childhood development was essential. He agreed with the action areas set forth in the report. The health sector should be adjusted as appropriate, with social determinants included in the policy and programmatic functions of health ministries, and all social groups fairly represented in decision-making.

Dr MOSCA (International Organization for Migration) said that, in the context of the social determinants of health, conditions surrounding migration could increase vulnerability to ill-health, particularly for involuntary migrants and persons whose papers were not in order, since the legal status of migrants determined their level of access to health and social services. Stigmatization was also a factor to be considered. The health sector needed to involve other sectors of government and society in addressing the root causes of ill-health.

The health needs of migrants should be integrated into relevant migration and development policies with provision for accessible and affordable health services irrespective of their legal status. Inclusive approaches could lead to the improved health of societies and further their stability and development. His Organization urged adoption of the draft resolution and looked forward to working with WHO, partner agencies and governments in implementing the action areas. He suggested that health ministries appoint a focal point to initiate dialogue.

Ms DELORME (World Medical Association), speaking at the invitation of the CHAIRMAN and on behalf of the World Health Professions Alliance, expressed support for the draft resolution and welcomed the Commission's holistic approach to the social determinants of health. However, more attention should have been paid to health professionals whose front-line presence held the key to addressing the social determinants of health and inequalities. Their knowledge and experience should be fully taken into account in the follow-up to the report through a comprehensive consultation with civil society. The development of healthy and productive work environments would have a positive impact on the recruitment and retention of health professionals, and ultimately on patient outcomes. She called on Member States to support the Alliance and other health organizations in their campaign for positive practice environments, focusing on improvements in the health-care workplace.

Ms OLIFSON (Global Forum for Health Research), speaking at the invitation of the CHAIRMAN, welcomed the valuable points in the report regarding research and training. Since investment in research for health equity was essential for development, she welcomed subparagraph 3(7) of the draft resolution regarding methods and evidence tailored to national contexts. However, research continued to be plagued by biases linked to gender, race and ability, which further deepened health inequities. The Health Assembly might consider including in the draft resolution reference to the need to generate evidence produced in a non-discriminatory manner.

Dr EVANS (Assistant Director-General), recalling the title of the Commission's report,<sup>1</sup> stressed that vision and values were the starting point but measurement and monitoring were other important tools. He had taken note of comments regarding the needs of disadvantaged, vulnerable population groups and the need for equity gauges and global monitoring, as well as research to ascertain success and innovation. Actions on the social determinants must engage the health sector and include health promotion, disease prevention, treatment and palliative care for both infectious and

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<sup>1</sup> Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization, 2008.

noncommunicable diseases, as well as steps related to health systems issues such as the fair financing of health care, and the production, deployment and retention of the health workforce.

Action beyond the health sector, however, was required and the need for health in all policies had been emphasized, in particular with regard to social protection, education and fair and decent employment. Global collaboration and capability were crucial to correcting inequities in health. The matter was closely compatible with the Committee's earlier discussions on primary health care.

He thanked the Chair of the Commission, the 19 Commissioners, and Member States that had not only hosted meetings but offered valuable technical expertise. Some Member States had also provided generous financial support, without which the work of the Commission would not have been possible. The Secretariat looked forward to implementing the Commission's recommendations.

The CHAIRMAN suggested that the Secretariat prepare a revised text of the draft resolution, taking account of the amendments proposed, for consideration at a later stage.

**It was so agreed.**

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

**Monitoring of the achievement of the health-related Millennium Development Goals:** Item 12.6 of the Agenda (Document A62/10)

Sir Liam DONALDSON (representative of the Executive Board) recalled that the Director-General had been requested by the Sixty-first World Health Assembly to report annually on progress relating to the achievement of the health-related Millennium Development Goals,<sup>1</sup> and the Executive Board had considered an earlier version of her report at its 124th session.<sup>2</sup> Health was at the heart of the Millennium Development Goals and central to reducing poverty. While Goals 4, 5 and 6 were specifically focused on health, all the Goals had health-related aspects, and could not be achieved without strengthened health systems and progress on food security, gender equality, empowerment of women, wider access to education, and better stewardship of the environment. He referred the Committee to WHO's publication entitled *World health statistics 2009* on implementation of health-related Goals and other core statistics.

Dr STEHLIKOVÁ (Czech Republic), speaking on behalf of the European Union, said that the candidate countries Croatia, Turkey and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates, Albania, Bosnia and Herzegovina, Montenegro, Serbia, as well as Armenia, the Republic of Moldova and Ukraine aligned themselves with her statement. The food crisis and the deepening financial crisis had exacerbated problems for poor people, placing in jeopardy the global health achievements of the previous two decades. Efforts should focus on safeguarding that progress and on achieving those Goals for which progress was most off track, in particular Target 5.A on reducing the maternal mortality ratio, and Target 5.B on achieving universal access to reproductive health by 2015. Progress would depend on the willingness to tackle the root causes of the vulnerability of women, including sexual violence and inequality.

The report made sombre reading: additional efforts would be needed if the Goals were to be attained by 2015. The European Union remained committed to its official development assistance targets and was pleased that the Director-General had responded to the concerns about maternal mortality expressed by members of the Executive Board at its 124th session. It was, however, disappointed at the comparatively small allocation proposed for work towards attaining Goal 5 in the Programme budget 2010–2011.

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<sup>1</sup> Resolution WHA61.18.

<sup>2</sup> See document EB124/2009/REC/2, summary records of the sixth meeting, section 2, and the seventh meeting.

Expressing support for WHO's leadership role in accelerating progress towards the health-related Millennium Development Goals, she called for an approach that enabled all developing countries to make progress on sustainable health systems, in cooperation with WHO and with international support.

Mr FEYDER (Luxembourg) concurred that achievement of the health-related Millennium Development Goals relied on progress towards the other Goals, especially those on hunger and gender equality. Although the report described some advances, the continued high incidence of malaria and maternal mortality was disturbing. Future progress depended on sustainable health systems based on primary health care principles and geared towards the social determinants of health as well as determination. Governments must have the political will to define such policies and ensure funding, both national and international. Donor countries must increase the share of their development support for health without detriment to their other commitments. WHO should support training, streamline existing systems, and coordinate the health sector across the organizations of the United Nations system and civil society in order to ensure universal access to health care for all. In line with the Paris Declaration on Aid Effectiveness, developing countries had a responsibility to update their development strategies, including their health strategy. Fresh impetus might emerge from the forthcoming Annual Ministerial Review of the Economic and Social Council.

Dr AHMADZAI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, drew attention to the common factors hindering achievement of the health-related Millennium Development Goals, namely weak political will and community leadership; lack of comprehensive planning; inefficient, unsustainable health systems lacking accessibility, accountability and financial and human resources; extreme poverty; high levels of illiteracy; inadequate coordination among major stakeholders; weak monitoring systems, with a lack of reliable and consistent data; and sometimes vulnerability to complex emergencies. Countries in the Region had had some success in reducing child mortality, but many would fail to meet the related targets. Greater efforts were required to improve maternal health. HIV/AIDS, tuberculosis and malaria claimed an ever-larger number of lives each year, especially among young people, and it was hard to establish accurate estimates owing to substantial gaps in information on behaviours and prevalence in high-risk populations.

Dr FERDINAND (Barbados) said that, although her country had attained many of the Millennium Development Goals well in advance of the 2015 deadline, challenges remained. Policies had been tailored to strengthening health systems and tackling issues related to, inter alia, human and financial resources; gender equality and equity; information systems for evidence-based decision-making; and environmental threats to health. The Government would pursue a more ambitious range of MDG-Plus targets attuned to local development, which it could attain with WHO's support.

Dr AL ARAYYED (Bahrain) said that dealing with increases in chronic diseases, and also climate change, demographic changes and poverty reduction, was central to efforts to achieve the health-related Millennium Development Goals. Bahrain had reduced child mortality through regular monitoring and immunization, and improved maternal health through antenatal care, together with regular postnatal visits to ensure the safety of neonates. It had also eradicated malaria and significantly reduced tuberculosis mortality.

Mr APARICIO ÁLVAREZ (Spain) said that his country was firmly committed to international cooperation and development. It was convinced of the need to build partnerships and stronger national health systems capable of reducing the global disease burden through primary prevention, health promotion and primary health care. Public health policy must reach into all areas, especially in relation to HIV/AIDS. His Government sought to eliminate all discrimination against people living with HIV; its prevention programmes had achieved positive results among injecting drug users, despite continued challenges in areas such as irresponsible sexual behaviour. The entire international community must show solidarity in achieving the Millennium Development Goals.

Dr AYDINH (Turkey) said that the Secretariat must provide support to countries struggling to cope with global economic crisis, rising unemployment and falling revenues since governments could shift their priorities away from public health. Under the Organization's guidance they could learn from experience and integrated approaches and progress towards achievement of the Millennium Development Goals. Turkey was ready to share its knowledge and experience and welcomed the report.

Dr CHARNCHAI PINMUANG-NGAM (Thailand) said that his country was well on the way to achieving Millennium Development Goals 4 and 5, with the world's highest annual reduction in under-five mortality between 1990 and 2006, and reduced rates of maternal mortality. Universal, equitable access to efficient and well-staffed services for primary health care was crucial. However, there was a serious imbalance in levels of investment: global health initiatives invested heavily in HIV/AIDS but ignored efforts to combat poverty, malnutrition and maternal mortality, focusing on treatment and care rather than prevention.

Global health initiatives must be harmonized in order to manage resources transparently at country level and to observe national priorities in the face of shortages of food and fuel, the financial crisis and the recent outbreak of influenza A (H1N1). Without strong political and financial commitment, a decline in government revenues and development support would lead to reduced health budgets and undermine progress towards the health-related Millennium Development Goals. Target 5.B, achieving universal access to reproductive health, required access to safe medical abortion, not often available in most developing countries.

Dr NAGAI (Japan), endorsing the report, expressed concern about maternal and neonatal health care and acknowledged the urgent need for international action, under WHO's leadership, towards achieving the health-related Millennium Development Goals. Success needed the strengthening of health systems based on comprehensive primary health care, human resource development and the supply of reliable information on current status and future trends.

Dr NOH (Malaysia) said that her country was accelerating progress towards the health-related Millennium Development Goals through intersectoral social policies that emphasized strengthened primary health care. A health information centre was responsible for strategic planning and monitoring progress, while a national health financing plan was in place to increase resources. Targets to reduce child mortality and improve maternal health had been reached, and positive results achieved in reversing the spread of HIV and the incidence of tuberculosis and malaria. Malaysia welcomed opportunities to exchange expertise in those areas with international partners.

Dr SADRIZADEH (Islamic Republic of Iran), welcoming the growing body of evidence on the positive effects of exclusive breastfeeding on babies up to six months of age, said that the relevant data should be included in the indicators for monitoring progress towards attainment of Millennium Development Goal 4. As for the other Goals, he endorsed the report's emphasis on international efforts to combat multidrug-resistant tuberculosis, HIV-associated tuberculosis and neglected tropical diseases, and on building stronger health systems, with a renewed commitment to primary health care.

Dr CHEN Ningshan (China) said that the significant progress made at the global level towards attainment of the Millennium Development Goals risked being undermined by the financial crisis, climate change, food insecurity and a heavy disease burden. Her Government had improved legislation, service provision, planning and investment, which had in turn improved the access to essential health care required to achieve the health-related Goals. However, challenges remained: successes in reducing maternal and child mortality were offset by the significant variance in mortality rates between urban and rural areas, and progress was insufficient in combating HIV/AIDS and tuberculosis. China agreed with the Secretariat on the areas where greater efforts were needed, and would continue strengthening cooperation with national and international organizations in order to fulfil its commitments.

Ms BOIKANYO (Lesotho) said that her Government, concerned about high maternal and under-five mortality and the prevalence of HIV and HIV/tuberculosis co-infection, had strengthened the health system, with some positive results, thanks to the support of WHO and other international partners. Free primary health-care provision together with HIV/AIDS and tuberculosis testing and counselling had increased the numbers of people seeking treatment and care. Accelerated immunization had significantly increased coverage of children under the Expanded Programme on Immunization, while a national reproductive health policy had helped to reduce maternal mortality.

Strategic HIV/AIDS and tuberculosis plans focusing on prevention and infection control had improved the survival chances of children in particular. Lesotho, although malaria-free, subscribed to the Southern African Development Community's approach of closely monitoring prevalence trends in the light of global warming and significant population movements. A gender-sensitive approach to maternal and neonatal health care was improving health outcomes.

Professor MWAKYUSA (United Republic of Tanzania), endorsing the report, said that his country's progress towards Millennium Development Goals 4 (reduce child mortality) and 6 (combat HIV/AIDS, malaria and other diseases) was encouraging. A health indicator survey conducted in 2008 had shown declines in infant and child mortality compared with 2006. In the same period, the prevalence of HIV infection and malaria (measured as parasitaemia) had fallen and the cure rate for tuberculosis exceeded the global target rate of 85%. The slow progress in relation to Goal 5 (improve maternal health), despite the adoption of the Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007–2010, was a matter of concern. A plan to accelerate progress towards the achievement of Goals 4 and 5 was being implemented in collaboration with partners.

Dr ELEBASSI (Sudan) said that, although some countries were making reasonable progress towards the Millennium Development Goal targets, others were encountering serious obstacles that lay beyond the health sector, including conflicts, disasters and poverty. Support should focus on those countries in accordance with their indicators. The strategies and interventions required to make progress were clear and evidence-based, yet failed to be effectively implemented. United Nations organizations, including WHO, and the Global Fund to Fight AIDS, Tuberculosis and Malaria all supported strategic programmes, which further constrained fragile health systems lacking human resources. WHO, as the lead agency in the health sector, should lead in ensuring the implementation of the Paris Declaration on Aid Effectiveness: ownership, harmonization, alignment, results and accountability (2005). It should start streamlining its vertical programmes and take the renewal of primary health care as an opportunity to introduce the necessary changes.

Dr HERBERT (Saint Kitts and Nevis) said that development needed due attention to food security, gender equality, environmental sustainability and improvements in health, education and social protection services. Achievement of the health-related Millennium Development Goals depended on the strength of the health system, and his country owed its progress towards some of the Goals to its investment in people and infrastructure since the 1950s. However, progress had been hampered by diversion of financial resources from the health sector at times of emergencies.

The Government had therefore decided that expenditure on social programmes, including delivery of health-care services, should no longer be reduced in that way. The label "middle-income country" was affecting access of his and neighbouring countries to financial markets. Classification of small island nations, which had special developmental needs, should be reassessed. Taking note of the Secretariat's report, he requested that the challenges and indicators relating to the vulnerability of such countries should be included in future reports.

Mr BLAND (United Kingdom of Great Britain and Northern Ireland) said that his Government's commitments to accelerating progress towards achievement of the Millennium Development Goals were made even more important by the global economic situation. As indicated by the Director-General in the fourth plenary meeting, there was still unfinished business: health

inequities represented the difference between life and death for many vulnerable groups. Millennium Development Goal 5 was causing most concern, with little progress between 1990 and 2005. It was simply not acceptable that a woman died every minute because of complications of pregnancy and childbirth. The United Nations Secretary-General and Mrs Sarah Brown had spoken eloquently on that topic in plenary. Progress would require rapidly improved access to reproductive health services.

He urged WHO to reinvigorate the family planning agenda; that meant tackling sensitive areas such as the elimination of unsafe abortion. Maternal mortality and access to safe abortion were powerful indicators of the way women were valued – indicators that also made an important contribution to Goal 3 (promote gender equality and empower women). WHO needed to show consistent leadership and should continue to work with the wider United Nations family. The shortened Health Assembly should focus on core business and global health emergencies, which included the achievement of the Millennium Development Goals. That focus must be maintained in moving forward to 2015.

Mr COLMENARES (Bolivarian Republic of Venezuela) said that the report provided guidance on how activities could be strengthened, consolidated and reoriented in order to make progress towards achieving the Millennium Development Goals. The report had not, however, alluded to the current global financial crisis, one of the greatest obstacles to progress.

In her address at the 23rd Forum on Global Issues in Berlin in March 2009 the Director-General had warned that the financial crisis could wipe out gains made so far and imperil the opportunity to overcome social injustice. In developing countries, the crisis was threatening lives. His Government was doing its utmost to ensure that the country's social progress to date would continue.

Dr HUWEL (Iraq) said that countries should incorporate activities to achieve the Millennium Development Goals in their national strategic and operational plans. Programmes to prevent and control noncommunicable diseases should be integrated with activities to achieve Goal 6. Action to ensure environmental sustainability and the renewal of the primary health care approach were also important. International and national partnerships needed further development.

Dr JALLOW (Gambia) stated that his country's annual reports on progress towards achievement of the Millennium Development Goals were prepared by the National Planning Commission. The 2007 report had shown that targets for poverty reduction, gender equality and HIV/AIDS were unlikely to be met at the current rate of progress, whereas prospects for achieving the targets for maternal health, primary education, hunger reduction and access to basic amenities by 2015 were better.

The current strategy to reduce poverty emphasized improvements in maternal health and child nutrition, strengthening of secondary education and elimination of gender disparities in schools, preservation of the environment, and prevention and control of HIV/AIDS. However, monitoring of national and local progress towards the achievement of the Goals lacked an effective planning framework, an obstacle compounded by inadequate institutional capacity and resources which constrained effective delivery of interventions.

Dr MUÑOZ PORRAS (Chile) said that the outlook for the achievement of the Millennium Development Goals by the target date was not encouraging. Maternal mortality ratios had stagnated in many countries and even risen in others. He urged the Secretariat to examine the progress, the interventions and the obstacles encountered in each Member State, with a view to guiding future national and international action. The Secretariat, Member States and international cooperation should prioritize achievement of the health-related Goals over the coming five years. He proposed that the Secretariat should be requested to report on the activities undertaken to accelerate that progress in those countries that had shown major delays to date.

Dr ZAMPALIGRE KABORE (Burkina Faso) expressed appreciation of the Secretariat's provision of support to Member States in their efforts to achieve the Millennium Development Goals.



His Government was encouraged by the results that had emerged from the population and health survey in 2003 and the 2006 census. Under-five and maternal mortality had fallen between those two dates. Prevalence of HIV/AIDS had fallen markedly between 1997 and 2008. The cure rate for tuberculosis had risen between 2004 and 2008 but the detection rate remained weak. Challenges remained and he urged the Secretariat to continue to strengthen its support for action to achieve the Goals, especially in the context of the current global financial crisis.

Dr CHAUHAN (India) said that India's eleventh five-year plan directed special attention towards vulnerable population groups. To make progress towards achievement of the Millennium Development Goals, government and state allocations to health had been increased significantly with enhanced training of medical and paramedical staff. India recognized the need to harmonize its various monitoring mechanisms in order to reduce costs and increase efficiency. State and district quality-assurance cells were being established, and health indicators were being harmonized towards a single comprehensive format for periodic reporting on all diseases. The results of such reports could be shared with WHO country and regional offices, which would be a more efficient and cost-effective way of monitoring progress than the establishment of a global observatory.

Dr CAMPBELL-FORRESTER (Jamaica) acknowledged that health was at the heart of the Millennium Development Goals. They would not be achieved without progress on food security, gender equality, empowerment of women, wider access to education and better stewardship of the environment. The challenges presented by weak health systems, the epidemiological transition, and emerging health threats would become increasingly prominent.

Jamaica was lagging behind on targets for child and maternal mortality, and prevalence of HIV and tuberculosis. More than half of midwifery posts were unfilled and the role of community midwives required review. HIV/AIDS, illegal abortion and its complications, and domestic and gang violence contributed significantly to maternal deaths. The diversion of global funds to HIV/AIDS programmes had depleted the financing available for other programmes, including those for safe motherhood, and middle-income countries at the lower end of the scale experienced real difficulties in gaining access to donor funding. It might be timely to re-examine the relevant indicators in the current financial crisis. Jamaica was working to improve the monitoring of progress towards the achievement of the Goals, and to promote gender equality in all health interventions.

Jamaica had reported in 2008 that it might not achieve all the Goals by 2015. Investment would be needed to accelerate progress, reduce violence and combat noncommunicable diseases. Despite the challenges, Jamaica remained committed to strengthening primary health care as a means of accelerating progress towards the achievement of the Goals.

Dr MOURCHIDI BOURHANE (Comoros), speaking on behalf of the Member States of the African Region, said that despite overall progress towards the achievement of the Millennium Development Goals, performance between and within countries varied considerably, and progress was threatened by uncertainties and the global financial crisis. Challenges to the achievement of Goal 1 (eradicating extreme poverty and hunger) included the lack of food security, HIV/AIDS, low incomes and the absence of reliable data on underweight persons. As for Goal 4 (reduce child mortality), coverage with proven low-cost interventions was insufficient to have a significant impact on mortality. There had been little progress in the Region towards Goal 5 (improve maternal health), and the risk of developing avoidable complications during pregnancy and childbirth remained unacceptably high, especially in sub-Saharan Africa. Universal coverage for reproductive health services, including family planning, was far from being a reality and targets were unlikely to be met by 2015.

Challenges to the attainment of Goal 6 (combat HIV/AIDS, malaria and other diseases) included the failure to halt the HIV/AIDS epidemic and lack of access to antiretroviral therapy. Progress was being made against malaria, particularly regarding the 2020 universal coverage targets. Tuberculosis incidence had doubled in the previous 10 years, a situation exacerbated by the HIV/AIDS epidemic. Progress towards Goal 7 (ensure environmental stability) was slowest in sub-Saharan Africa, where more than one third of the population remained without access to clean drinking-water. The

unavailability of essential medicines and rising prices hampered access and jeopardized the achievement of Goal 8 (develop a global partnership for development).

He endorsed the report's strategies for accelerating progress towards the achievement of the Goals. Emphasis should be placed on the social determinants of health and an integrated approach and additional resources would be needed to improve health and equity. He reiterated the call made by the MDG Africa Steering Group for the achievement of the Millennium Development Goals in Africa for further support from partners.

Ms KOCHEN (Argentina) said that, despite progress, it was unlikely that all the Millennium Development Goals could be attained by 2015. Policies were sound, in particular the emphasis placed on primary health care, and action would be needed to ameliorate regional disparities (often masked by average figures) if equity was to be achieved. The rising burden of noncommunicable diseases and the implications for mortality, which were not covered by the Goals, must also be taken into account in developing health policies.

In Argentina, infant mortality rates had dropped significantly since 1990 and the maternal mortality ratio had fallen slightly while the incidence of HIV/AIDS had shown a slight decrease between 2003 and 2007. Re-emerging diseases such as dengue were posing new challenges. The tuberculosis prevalence target had not been met. Five provinces had been declared free of transmission of Chagas disease, but the country was still far from being certified as free of that disease.

**The meeting rose at 17:25.**

## SEVENTH MEETING

Wednesday, 20 May 2009, at 18:35

**Chairman:** Dr F. MENESES GONZÁLEZ (Mexico)

### 1. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

#### **Monitoring of the achievement of the health-related Millennium Development Goals: Item 12.6 of the Agenda (Document A62/10) (continued)**

Dr SULAİK (Philippines) expressed support for the renewed commitment to primary health care as the framework for future efforts to achieve the Millennium Development Goals. The Philippines had initiated a range of health service reforms including a monitoring system that led to multisectoral adjustments to activities; it was on track to meet the targets for reducing infant and child mortality and combating HIV/AIDS, tuberculosis and malaria. However, drastic action would be needed to achieve the targets set for primary education, safe drinking-water and reducing maternal mortality. With the backing of strong partnerships and concerned groups, efforts were continuing to increase public spending and update policies in the areas mentioned.

Ms ENGELSTAD (Norway) welcomed the commitment to primary health care, strengthened health systems, equity, solidarity, and the gender perspective. She also supported the call for additional resources and more effective support for country-led action. A common set of reliable data was essential as a basis for action for achievement of the Millennium Development Goals. In line with its normative function, WHO should increase its focus on developing and applying improved measurement methods and supporting capacity-building in that area at country level. The report confirmed the importance of recent initiatives by countries such as hers and partners to accelerate progress towards Millennium Development Goal 5, which lagged the furthest behind. Those efforts also encompassed Target 5.B, with emphasis on the need for family planning and the reduction of adolescent pregnancies. All those issues were closely linked to gender equality.

In 2009, WHO had included for the first time exclusive breastfeeding as an indicator in its statistics.<sup>1</sup> The next logical step would be to include that indicator in the tracking system for Millennium Development Goal 4. The United Nations Economic and Social Council's Annual Ministerial Review in July 2009 would provide opportunities to further progress on that issue. Importance should be given to tackling the most severe gaps in care for mothers and neonates and, especially in the current financial crisis, to social protection programmes for the most vulnerable groups.

Dr BIN IBRAHIM (Ghana) said that in 2008, following a national survey which had shown his country's unacceptably high rate of maternal mortality, maternal death had been declared a national emergency. A multisectoral task force had been established to assess and coordinate programmes to combat maternal morbidity and mortality. Maternal health services were being provided free of charge. The health insurance authority would register all pregnant women and enrol them in the national health insurance scheme without charge. Furthermore, midwifery schools were being

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<sup>1</sup> *World health statistics 2009*. Geneva, World Health Organization, 2009.

established in all regions in order to ensure the availability of skilled birth attendants, and family planning services had been expanded.

Mr ROSALES LOZADA (Plurinational State of Bolivia) said that his Government's measures to achieve the Millennium Development Goals had included the incorporation of specific provisions into the new Constitution.

The report showed that progress towards achieving the health-related Goals was slow. Worsening inequality between developed and developing countries had caused serious social tensions. In developing countries, extreme poverty and lack of access to basic services and health care continued for more than half the world's population. In order to achieve the Goals, urgent measures were needed, including the fulfilment of financial commitments by developed countries. Referring to paragraph 22 of the report, which stated that WHO would promote the implementation of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, he said that developed countries should not impose conditions on economic resources allocated to achieving the Goals. Policies and strategies in the health sector should focus on health promotion and disease prevention, while the provision of basic services should be geared to the express needs of the most overlooked and vulnerable groups in society. WHO should continue to monitor progress towards achieving the Goals, as information on intermediate targets and progress was needed in order to plan further activities.

Dr BUSS (Brazil) welcomed the coordination and cooperation between WHO and other United Nations bodies, and requested the Director-General to strengthen such cooperation, focused on those countries most in need of international support in meeting the Goals. Brazil had begun a programme of technical cooperation for health and development in poorer countries within the framework of the Millennium Development Goals. The Health Assembly should call on developed countries to fulfil the commitment to allocate 0.7% of their gross national product to official development assistance. Reducing expenditures on waging futile wars, which claimed precious lives, and on bailing out global financial speculators would generate funds, perhaps sufficient to achieve the Goals.

Dr DEMINA (Russian Federation) welcomed the progress made to date towards the Millennium Development Goals, particularly in relation to combating HIV/AIDS, tuberculosis and malaria and reducing child and infant mortality, partly through immunization. In the period 2006–2009 the Russian Federation had contributed financially to international efforts to fight avian influenza and prepare for a possible influenza pandemic. Her Government had increased its international funding to control diseases such as poliomyelitis, malaria, tuberculosis and HIV/AIDS, and would donate significantly to research into developing an HIV vaccine. The country's scientific base was being modernized with new equipment and facilities, and epidemic response teams were strengthening the Russian Federation's leading role in the fight against infectious diseases in eastern Europe and central Asia. Workshops were being organized in the countries of the Commonwealth of Independent States, and a network of laboratories for monitoring influenza had been established, all in close cooperation with WHO and other international organizations.

Ms JÁQUEZ HUACUJA (Mexico) said that the Millennium Development Goals committed Member States and guided national objectives for social development at all levels of government, academia and civil society. Although each State was responsible for its own development, shared responsibility and fulfilment of the economic and social commitments made in United Nations forums were essential. Mexico had undertaken to achieve universal access to health care for its population and had incorporated the Goals into its national health programme for 2007–2012.

Dr LOKADI (Democratic Republic of the Congo) emphasized the need for properly functioning health systems based on primary health care if countries were to meet the Millennium Development Goals by 2015. Most of the population of his country lived in precarious conditions and abject poverty, the outcome of 20 years of political and military upheaval exacerbated by the global financial crisis. Access to basic health care remained limited: fewer than 10% of people eligible for

antiretroviral therapy were receiving it, and only 50% of health districts had introduced the package of malaria control and reproductive health measures. The Director-General should vigorously advocate to mobilize the extra resources that Member States in conflict and post-conflict situations needed to rebuild their economic, social and health systems.

Ms BRIDGES (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN and also on behalf of the International Council of Nurses, expressed appreciation for the progress made towards achieving some health-related Millennium Development Goals, such as reducing child mortality, but remained concerned about the lack of progress on reducing maternal mortality and other Goals. Weak health systems, further undermined by migration and the shortage of nurses, midwives and other health professionals, were impeding efforts to meet the Goals by 2015.

Progress could be accelerated through a greater focus on equity, solidarity and gender, mainstreaming health in all policies and building on primary health care. Nurses and midwives had a crucial role to play in that endeavour, and the Secretariat, governments and other partners should attend to the human resources crisis through effective recruitment and retention strategies that offered positive working conditions, appropriate remuneration and other incentives.

Ms LINNECAR (Consumers International), speaking at the invitation of the CHAIRMAN and stating that the World Council of Churches associated itself with her intervention, said that prevention was the key to reducing neonatal mortality (Millennium Development Goal 4), and breastfeeding, when started within one hour of birth and continued exclusively for six months, had been conclusively demonstrated to be the best means of preventing deaths caused by neonatal infections, diarrhoea and pneumonia. Breastfeeding reinforced other interventions proven to prevent child deaths, such as immunization. Early initiation of breastfeeding also helped to reduce maternal mortality (Goal 5), especially after delivery. The inclusion of an indicator on exclusive breastfeeding would help to ensure coherence in WHO's policies. To ensure policy coherence throughout the United Nations system, however, the Health Assembly should advocate inclusion of data on early and exclusive breastfeeding in the list of indicators for tracking progress on Goals 4 and 5.

Ms HASLEGRAVE (Global Forum for Health Research), speaking at the invitation of the CHAIRMAN, said that the assessments of progress had revealed that some countries were far off track; that global or national averages often masked large disparities within and between populations; and that greater attention should be paid to health inequities in identifying the most critical areas. In view of the forthcoming 10-year review of progress made in achieving the Goals, which would take place in 2010, she drew attention to Millennium Development Goal Target 5.B, on universal access to reproductive health. The achievement of that target would significantly reduce unplanned pregnancies and minimize recourse to unsafe abortions.

Professor Chok-wan CHAN (International Paediatric Association), speaking at the invitation of the CHAIRMAN, said that paediatricians in his Association were committed to the promotion of breastfeeding with zinc supplements, control of vaccine-preventable diseases, and environmental health. The Association encouraged its members to influence their governments on child health issues and policies, and it had formed effective partnerships for maternal, newborn and child health with obstetricians and gynaecologists, nurses and midwives.

Ms HEWAT (Corporate Accountability International), speaking at the invitation of the CHAIRMAN, emphasized that economic interests must not prevail over health. Tobacco use was an issue in which commercial interests had long predominated over the public interest until adoption of the WHO Framework Convention on Tobacco Control, which required ratifying Parties to protect health policies against tobacco-industry interference. However, effective implementation of the Framework Convention was still urgently needed, and preventing the spread of tobacco use to developing countries would save lives and promote strong economies.

Another area crucial to alleviating poverty and improving health outcomes in the developing world was water supply and sanitation. The commercial interests of the private water industry could not be presumed to converge with public health interests. She urged WHO to promote safeguards against conflicts of interest between the public sector and private water corporations and to apply such protections to its own activities.

Ms MAFUBELU (Assistant Director-General), responding to the points raised with regard to Millennium Development Goals 4 and 5, said that the Secretariat shared the concerns expressed. If current trends continued, some countries would be unable to meet the Millennium Development Goals by 2015. It was particularly worrisome that Goal 5 lagged farthest behind. However, she commended those Member States that had attained their targets or made progress towards achieving Goals 4 and 5, and encouraged them to maintain the momentum. The Secretariat would facilitate the sharing of experiences, best practices and lessons learnt by those countries, and would increase its support for measures to ensure that the targets for those two Goals were met by 2015. The joint statement issued in September 2008 by WHO, UNFPA, UNICEF and the World Bank during the United Nations General Assembly High-level Event on the Millennium Development Goals formed the basis of WHO's joint work plan for accelerated delivery of reproductive, maternal and neonatal care. The joint work plan would focus on seven action areas, among which was the urgent need for skilled health workers, particularly midwives. WHO would work in cooperation with governmental development partners, civil society, professional organizations and other partners within existing national coordination mechanisms. WHO reaffirmed its leadership in global efforts to improve sexual and reproductive health, and would not shy away from tackling sensitive issues in that regard.

Dr EVANS (Assistant Director-General) said that the discussion had reflected widespread agreement that the analysis of progress in the report was helpful. It would allow Member States to keep an eye on Millennium Development Goals 1, 4, 5 (with both its targets), 6, 7 and 8, which had indicators either directly or indirectly related to health. Clear support had also been expressed for the set of issues recognized in the report as needing improvement: equity, solidarity, gender sensitivity, intersectoral policies, primary health care, strengthening health systems and financing.

The point had been made that, with respect to monitoring trends, more attention must be paid to weak country health information systems. One delegate had mentioned the importance of country health observatories; WHO was actively promoting that concept through its regional offices. WHO was also continuing to try to improve global reporting, mainly on the basis of strengthened country health information systems and health indicator reports. In addition to reporting on the Millennium Development Goals to the United Nations community, WHO would also report annually on world health statistics to a broader audience. The *World health statistics 2009* report, launched that day, encompassed the Millennium Development Goals and relevant indicators, such as exclusive breastfeeding and health system strengthening, and also reported on chronic noncommunicable diseases, risks to health, overall mortality, causes of death and the burden of disease.

Some of the suggestions made would help to guide the focus of the next report to the Health Assembly. They included innovation in the use of information at country level through electronic reporting and other ways to inform policy more effectively, and analysing countries' experiences more directly. He had noted the request for WHO to look at specific challenges relating to complex emergencies, fragile States and small island States, and the implications of the current financial crisis.

The CHAIRMAN said that he took it that the Committee wished to take note of the report.

**The report was noted.**

**Climate change and health:** Item 12.7 of the Agenda (Documents EB124/2009/REC/1, resolution EB124.R5, and A62/11)

Sir Liam DONALDSON (representative of the Executive Board), introducing the item, said that the Board, like Member States, was concerned about the potential impact of climate change on health. Increased heat waves, floods and drought could result in malnutrition due to decreased crop production, changes in the distribution of infectious diseases, and more frequent respiratory diseases and allergies owing to higher concentrations of ground-level ozone and particulate matter and changes in pollen distribution. Exposure to climate change, and the health effects of climate change, would be unevenly distributed throughout the world, thus potentially widening inequities between rich and poor countries. The Health Assembly, in resolution WHA61.19, had requested the Director-General to consult Member States on the preparation of a workplan for scaling up WHO's technical support to Member States for assessing and addressing the implications of climate change for health and health systems, and to submit a draft to the Executive Board at its 124th session. The Board had discussed that draft, which had been prepared after extensive consultations, building on regional committee resolutions and regional frameworks for action and incorporating suggestions from Member States submitted electronically and at a meeting attended by 22 countries in Geneva in October 2008.

The Board had welcomed the workplan and emphasized WHO's provision of support for stronger engagement by the health sector. Board members had emphasized action to protect the health of vulnerable populations, especially in developing countries and small island developing States, and the value of sharing experiences. Resolution EB124.R5 had been adopted, requesting the Director-General to implement the actions contained in the workplan<sup>1</sup> and to report annually, beginning in 2010, through the Executive Board to the Health Assembly on progress.

Dr BERNADAS (Philippines) supported the workplan and its four objectives. The Philippines was addressing the health issues associated with climate change through experience in managing frequent natural disasters and disease outbreaks, using local expertise in environmental health and infectious diseases. The Government had begun to upgrade the infrastructure of hospitals to ensure their resilience to natural disasters. The Philippines was a recipient under the Millennium Development Goals Achievement Fund of a programme to strengthen its institutional capacity to adapt to climate change.

Mr COX (Barbados) said that the effects of climate change on health were of particular concern to small island developing States such as his own, which were vulnerable to extreme events. Hurricanes affected coastal ecosystems and key infrastructure, thereby undermining the country's adaptation and intervention policies. Climate change could threaten freshwater resources in Barbados, as rising sea levels would increase saline contamination of aquifers, and the frequency and severity of droughts. A multisectoral approach was needed, as climate change affected not only health but also key sectors such as tourism and agriculture.

More research was needed to understand the links between climate change and health. Partnerships between the public and private sectors and the establishment of focal points within health ministries were vital. His Government looked forward to additional, predictable sources of funding to deal with the adverse effects of climate change on health as one of the outcomes of the fifteenth session of the Conference of the Parties to the United Nations Framework Convention on Climate Change, to be held in Copenhagen in December 2009. He welcomed the Board's adoption of resolution EB124.R5.

Dr SHIMIZU (Japan) expressed appreciation for the workplan. He reaffirmed the importance of accurate data, research and clear scientific evidence in tackling the effects of climate change on health.

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<sup>1</sup> Submitted to the Health Assembly as document A62/11.

Emphasizing the use of existing measures and systems for devising a workplan, rather than elaborating new strategies, he urged WHO to assume a strong leadership role on the issue.

Dr LEE Han-Sung (Republic of Korea) said that the climate was changing more rapidly in the Republic of Korea than in many other countries, and its impact on health would deepen in proportion to population ageing. His Government therefore supported the workplan, which would strengthen public health response and place health issues at the centre of climate change policies. Forecasting measures were being applied in areas such as communicable diseases, air pollution, extreme heat and meteorological disasters, with research and surveillance to avert the health risks associated with such conditions. The aim was to minimize the impact of climate change on health, in cooperation with WHO's headquarters and regional offices, by enhancing awareness of risks and sharing information among Member States.

Ms TZIMAS (Germany) said that most of the negative effects of climate change on human health would be felt in countries whose health-care systems were still being developed and in economically depressed regions with little capacity for adaptation and which had, moreover, contributed minimally to global carbon dioxide emissions. With support from WHO, many countries had developed national adaptation strategies and incorporated them in their health-care systems. Germany had made significant funding available for seven WHO national projects on health adaptation to climate change in south-eastern Europe and central Asia; the initial results of those projects would be presented at the WHO Fifth Ministerial Conference on Environment and Health, to be held in Parma, Italy, from 24 to 26 February 2010. She welcomed the Board's resolution.

Mr CALVETE OLIVA (Spain) said that his Government was committed to developing policies for climate change mitigation and adaptation and to mainstreaming health in all European Union policies and was placing health at the centre of the climate change debate. In that regard, the Secretariat's headquarters and regional offices could help by ensuring communication and coordination between Member States. His Government's strategies reflected the areas identified by WHO as fundamental to protecting health from climate change, including public information, preparedness and response, research, and activities of particular importance for Spain. He emphasized strengthened coordination and collaboration among the various actors responsible for public health at the global level.

Dr AYDINH (Turkey) welcomed the workplan. The issue of climate change and health was a priority for Turkey which had ratified the Kyoto Protocol and established a coordination board to oversee compliance with its obligations under the treaty. Other efforts included raising public awareness through the media; conducting scientific research; establishing a database on diseases related to climate change; and strengthening collaboration with international organizations. The countries that were historically responsible for the rise in levels of greenhouse gas should drastically reduce their emissions. He welcomed the Board's resolution.

Professor MWAKYUSA (United Republic of Tanzania), speaking on behalf of the Member States of the African Region, said that scientific evidence indicated that the recent extreme weather events and the rise in average temperatures around the world had been caused by human activity. Climate-induced natural disasters had already included floods and droughts, displacing thousands of people, depleting fresh-water resources and accelerating the transmission of infectious diseases; in 2008 alone, such floods had affected more than 300 000 people in Madagascar, 100 000 in Mozambique and more than 62 000 in Namibia, prompting outbreaks of disease. The snow that had once capped Mount Kilimanjaro and Mount Kenya had melted, causing rivers to dry up. Droughts had affected several countries, especially in the Horn of Africa and the Sahel, exacerbating malnutrition. The food crisis in Ethiopia was deepening.

Developed countries had produced most greenhouse gas emissions, but developing nations were bearing the brunt of climate change: many had weak infrastructures and needed assistance to prepare



and respond. A framework for the protection of health from climate risks in Africa, prepared in July 2008, called for actions such as raising awareness and prioritizing public health concerns and health protection; strengthening health systems; inclusion of health in the development strategies of other sectors; and strengthening the institutional capacity of the health community to provide guidance and leadership. Lack of funding for core activities within and between countries was hindering coordinated international responses in areas such as adaptation, mitigation and capacity building; he urged industrialized nations to fund and transfer the necessary technologies. He supported the proposed workplan, which was in line with the Libreville Declaration on Health and Environment in Africa adopted at the First Inter-Ministerial Conference on Health and the Environment in Africa in August 2008.

Ms CHASOKELA (Zimbabwe) said that Zimbabwe had suffered the effects of climate change; cyclones, floods and recurrent droughts had become increasingly intense over the previous decade, and the eventual impact on health-care delivery was of great concern. She therefore endorsed the four objectives set out in the workplan and called for urgent and specific action to protect the environment, in cooperation with other sectors. She also welcomed the Board's resolution, and awaited with interest the outcome of the United Nations Climate Change Conference to be held in Copenhagen in December 2009.

Ms TOLSTOÏ (France) commended the positive outcome of the Board's session in January 2009. She welcomed the workplan and its objectives for WHO, especially raising awareness, generating knowledge and accumulating scientific evidence, all in collaboration with other international organizations. She commended the political commitment of African partners on the issue, as demonstrated by the Libreville Declaration. The joint WHO/UNEP Health and Environment Linkages Initiative, launched at the First Inter-Ministerial Conference on Health and the Environment in Africa (Libreville, August 2008), exemplified cooperation and progress; a guide for evaluating the needs of African countries was due to be tested soon in Cameroon, Gabon, Kenya and Mali. France would provide technical support during that pilot scheme and wished to enhance its cooperation with the Secretariat on the project.

Dr JORGENSEN (Denmark), recalling that the Intergovernmental Panel on Climate Change had found that climate change would have negative health consequences, welcomed the workplan drawn up by the Secretariat in close cooperation with Member States and expressed support for the approach of putting the protection of human health at the centre of the climate change debate. An ambitious global agreement at the United Nations Climate Change Conference to be held in Copenhagen in December 2009 should lead to reduced global warming and ensure better adaptation to climate change. Effective adaptation was especially needed in the most vulnerable developing countries, where it would build on enhanced knowledge and capacity in the health sector. Recalling that the Conference was less than seven months away, he emphasized worldwide commitment to finding ways to avoid the harsh consequences of climate change.

Ms NGHATANGA (Namibia) recalled that in both 2008 and 2009 Namibia had experienced devastating floods, which had led to outbreaks of cholera and other diseases. Her Government was grateful to WHO and other partners for their prompt response and for the technical and material support provided. She urged the Secretariat to continue its technical assistance to helping countries to develop their national capacities to respond to disasters. She welcomed resolution EB124.R5.

Mr MAOATE (Cook Islands) also supported resolution EB124.R5 and the workplan. Like most low-lying island States, the Cook Islands were particularly vulnerable to extreme weather patterns and rising sea levels and had recently experienced several damaging storms. He encouraged the Secretariat to devise a framework for risk assessment and adaptation to climate change, in order to enable Member States to assess rapidly the burden of current, new and re-emerging diseases; the demographics, geography and climate of each country; the resources and their capacity to respond to

such challenges; and availability of, and the role of international cooperation. Countries could then assess their status and draw up adaptation strategies. He looked forward to implementation of the workplan and the report scheduled for 2010.

Mr MONTIEL (Bolivarian Republic of Venezuela) commended the Board's resolution and the workplan, which aimed to strengthen the capacities of countries faced with the consequences of climate change. However, the workplan should also deal with the causes of the global ecological crisis. The financial crisis and climate change were not just anomalies of the market or quirks of nature but indicators of the failure of societies and economic systems; even countries that were the smallest emitters of greenhouse gases would be seriously affected by climate change. Participants at the Fifth Summit of the Bolivarian Alternative for the Americas had pointed out at the Fifth Summit of the Americas that capitalism had spawned the environmental crisis. Action should be based on instruments such as the United Nations Framework Convention on Climate Change and the Kyoto Protocol as well as those set out in the report.

Resolution EB124.R5 was unsatisfactory because it failed to identify the rationale for the workplan, or to provide the directions or guidelines to Member States or the Secretariat that would ensure effective implementation of the workplan.

Dr AHMED (Maldives), speaking on behalf of the countries Member States of the South-East Asia Region, said that most would be seriously affected by global warming and climate change, irrespective of their geography. Ecological changes had already resulted in unprecedented outbreaks of disease, such as dengue fever in the highlands of Bhutan. Given the limited resources available over the four-year time frame, the four objectives of the workplan should be prioritized according to criteria such as clear and direct benefits to the countries in need; prompt action to meet most urgent needs; and the effectiveness of interventions. Objective 4 was crucial to strengthening national response capacities, and should be given highest priority and 75% of the total budget. He endorsed the six actions under that objective. The next most important was objective 3, as impact mitigation and adaptation must be guided by evidence-based policies. He urged WHO to invest in coordinated research in order to generate the necessary evidence. A long-term vision of action by the Secretariat and Member States was needed in order to deal effectively with climate change. He proposed a major programme review and submission of a report to the Sixty-fifth World Health Assembly in 2013 on long-term strategy. As annual progress reports were not necessary, he would have preferred the Director-General to have been asked to report every two years, beginning in 2011, with a major programme review to be reported in 2013.

Mr SIRIKIAT LIANGKOBKIT (Thailand) added that in the South-East Asia Region climate change had already had a major impact which was likely to increase in severity. Priority should be given to objective 4, with immediate action taken. A major programme review would be essential in order to assess and improve on actions taken.

Mr ABDOO (United States of America) said that persuasive evidence existed on the impact of climate change on health. The United States Environmental Protection Agency had recently issued a report on the health impact of greenhouse gases: it drew on the most up-to-date scientific evidence available, and asserted that climate changes, which were already harming health and welfare, would only worsen in the absence of regulatory action. It also stated that, in order to combat the risks associated with global climate change, all contributors must do their part, regardless of the size of their contribution to the global problem. His Government supported many domestic and international programmes that protected human health from climate-sensitive risk factors by improving local health institutions, strengthening global disease surveillance systems, advancing climate science, and integrating climate considerations into sustainable development projects. The workplan, which his Government supported, should emphasize the collection and dissemination of reliable data on which Member States could base their policy decisions. The Secretariat should use relevant assessments of the Intergovernmental Panel on Climate Change to guide implementation of the workplan.

Dr JARAMILLO NAVARRETE (Mexico) said that scientific evidence, in particular from the Intergovernmental Panel on Climate Change, emphasized the need for governments and individuals to pay sustained attention to the grave threat posed by climate change to current and future generations. His Government welcomed the workplan, stressed climatic factors as determinants of health, and would actively promote the development of healthy environments, health education and efforts to protect human health from the effects of climate change.

Dr CHAUHAN (India) welcomed WHO's efforts to raise awareness of the serious threats that climate change posed to both global health and the achievement of the health-related Millennium Development Goals, and to strengthen health systems in response. The Organization had a valuable role to play in coordinating scientific, technical and capacity-building efforts; however, the United Nations Framework Convention on Climate Change was the proper forum to substantively address climate change, including mitigation measures, which remained primarily the responsibility of the developed world. India was committed to working with the Secretariat and other partners in the efforts to protect health from climate change.

Dr DEMINA (Russian Federation) said that climate change was a serious global threat that would potentially increase the burden of infectious diseases. Her Government was implementing policies to mitigate climate change, notably by developing alternative types of fuel in order to reduce greenhouse gas emissions. Sources of atmospheric pollution were being monitored, as were the results of the laboratory research being carried out as part of health surveillance activities, with environmental protection programmes established in many regions. The Russian Federation welcomed the workplan and fully supported the Secretariat's efforts to help Member States to enhance their capacity to assess and address the implications of climate change for health and health systems.

Dr ZHANG Lingping (China) said that in recent years her Government had taken measures to lessen the impact of climate change on health, including formulating a national plan of action on the environment and health; controlling outbreaks of climate-related communicable diseases and health problems caused by extreme weather; implementing health emergency plans in response to natural disasters; and increasing education activities. China supported the resolution and workplan, including the call for greater technical support for lower income countries and small island States, and stood ready to work with the international community on climate change.

Dr JALLOW (Gambia) said that the African Region generally lacked early warning systems; had limited capacity for assessing and monitoring health vulnerability, risks and impact; lacked policies and guidelines; and needed to significantly raise awareness of the effects of climate change on health and provide information on weather variability and climate changes.

For the first time ever, her country had recently experienced flash floods in low-lying areas. Infrastructure had been damaged and families evacuated. There had been a surge in diarrhoeal and other water-borne diseases, and the capacity of health services had been stretched to the limit. Those problems largely resulted from the lack of health impact assessment and failure to consult the health sector during the planning of major human settlements. She welcomed the outcome of the First Inter-Ministerial Conference on Health and the Environment in Africa (Libreville, August 2008), and was grateful for the continued guidance that Member States were receiving on the protection of human health from the effects of environmental degradation. She endorsed resolution EB124.R5.

Dr GAMARRA (Paraguay) said that her country was highly vulnerable to the health effects of climate change and had already experienced epidemics of yellow fever and dengue fever as a result of rising temperatures, frequent rainfall and deforestation. Climate change in Paraguay was also threatening animal and plant species that were genetic resources of global importance. She welcomed the objectives of the workplan, especially objective 2, and expressed the hope that more countries would become Parties to the United Nations Framework Convention on Climate Change in order to further international efforts to mitigate climate change.

Ms MOTSUMI (Botswana) said that Botswana was already experiencing prolonged drought, rising temperatures, desertification and water shortages as a result of climate change, which, coupled with poor hygiene, had increased the risk of diseases such as diarrhoea, ringworm and scabies. Her Government had taken action on vector control, pollution management, land use, water management and education; and local authorities and communities were forming disaster-preparedness committees in order to plan, implement and monitor measures to protect themselves from the effects of disasters resulting from climate change. She asked the Secretariat to provide support to Botswana in enhancing its capacity in those efforts, and welcomed the Board's adoption of resolution EB124.R5.

Ms HENDRY (United Kingdom for Great Britain and Northern Ireland) expressed strong support for the workplan. Climate change was the greatest threat to global health in the twenty-first century, but mitigating action, such as promoting cleaner transport or energy generation, would both improve health and reduce greenhouse gas emissions. Health ministers should collaborate with colleagues in other sectors, and those attending the fifteenth session of the Conference of the Parties to the United Nations Framework Convention on Climate Change should seek to work together in a cooperative spirit in order to reach agreement on the ambitious action needed to protect human health.

Dr SADRIZADEH (Islamic Republic of Iran) said that the international community had the knowledge and tools needed to tackle the direct and indirect impact of climate change on health security. The challenge was to raise awareness of that impact and place health protection at the centre of climate change agendas at the national level. Implementation of preparedness and response strategies should begin at local and national levels in order to minimize the impact and cope with the additional disease burden. He welcomed the Board's resolution EB124.R5.

Dr HUWEL (Iraq) said that the importance of climate change and its impact on health would require all countries to work together, establish common frameworks and international standards, and conduct multisectoral scientific studies. Stressing the importance of Millennium Development Goal 7, he said that such joint action would have to be undertaken in consultation with the relevant environmental authorities in each country. Schools should include the issue as part of health education and promotion programmes.

Ms NAVARRO LLANOS (Plurinational State of Bolivia) said that rising global temperatures would have major consequences for developing countries and would create conditions for the spread of malaria and other vector-borne diseases that were common in tropical and subtropical regions. Water shortages or flooding would lead to the emergence or re-emergence of diseases such as cholera. Climate change would also have adverse effects on harvests, causing food shortages for millions of people and leading to malnutrition.

Less than 20% of the world's population had caused more than 75% of all greenhouse gas emissions and developing countries would suffer the most. The developed countries owed a climatic debt, which they should pay by modifying unsustainable and irresponsible consumption lifestyles and by introducing structural changes in their economic, financial and trade systems. Those countries needed to reduce their greenhouse gas emissions drastically through plans more ambitious than those proposed to date in the negotiations preceding the fifteenth session of the Conference of the Parties to the United Nations Framework Convention on Climate Change. Above all, they should fulfil their obligation under Article 4 of that Convention to provide financial resources to developing countries to cover costs relating to health and implementation of the workplan.

Mr PRAPLAN (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that the Federation's national societies had seen the health impacts of changing weather patterns in their countries. He emphasized adaptation, improving the ability of communities to respond to the adverse effects of climate change. Those communities that lacked access to health care would suffer most from increased burden of disease. Work on climate change had been prioritized at the Federation's 30th International Conference, early warning systems

had been established, and capacity to respond to changing patterns of infectious disease was being enhanced. His Organization looked forward to working with WHO and other partners to protect the most vulnerable from the effects of climate change.

Dr ALWAN (International Federation of Medical Students Associations), speaking at the invitation of the CHAIRMAN, said that his organization was focusing on the damaging effects that the unprecedented rate of climate change would have on health globally. He called on WHO and national governments to help communities to minimize those effects, primarily through reduced carbon emissions and more sustainable ways of living. The provision of support to national health systems was crucial in order to assess risks monitor health vulnerability and control neglected tropical diseases. His organization endorsed the view that health should be fully considered in the negotiations leading to the United Nations Climate Change Conference to be held in December 2009 and wished to be fully involved in promoting that message. Medical students should be included in education and capacity-building efforts aimed at minimizing the effects of climate change.

Dr NEIRA (Protection of the Human Environment) welcomed the extensive support expressed for the workplan. There was broad consensus on the importance of basing actions on research and scientific evidence, and on working with international organizations to raise the issue of health in the negotiations preceding the forthcoming United Nations Climate Change Conference. She welcomed the guidance on prioritization of activities. The Secretariat would prioritize activities aimed at protecting island States, which were particularly vulnerable to climate change. It would also continue working with other sectors and striving to highlight the health benefits of strategies for reducing greenhouse gas emissions. Mindful of the urgency of the issue, particularly for the most vulnerable countries, the Secretariat would work energetically to implement the workplan. With regard to the suggestion about the reporting period, in her view it would be preferable to report on an annual basis, given the political importance of the issue and the rapidity with which climate change was occurring.

In response to a question from Mr ABDIO (United States of America), the CHAIRMAN confirmed that the resolution being referred to was a resolution of the Executive Board, not of the Health Assembly. Consequently, no action on the Committee's part was needed. He took it that the Committee wished to take note of resolution EB124.R5 and the workplan contained in document A62/11.

**The Committee noted resolution EB124.R5 and the workplan contained in document A62/11.**

**The meeting rose at 20:50.**

## EIGHTH MEETING

Thursday, 21 May 2009, at 09:30

**Chairman:** Dr F. MENESES GONZÁLEZ (Mexico)

- 1. MEDIUM-TERM STRATEGIC PLAN 2008–2013, INCLUDING PROPOSED PROGRAMME BUDGET 2010–2011:** Item 11 of the Agenda (continued from the sixth meeting) (Documents MTSP/2008–2013 (Amended (draft)), PPB/2010–2011, A62/4, A62/4 Add.1, A62/4 Add.2 and A62/4 Add.3) (continued from the fifth meeting, section 2)

The CHAIRMAN drew attention to a draft resolution on appropriation for the financial period 2010–2011, which read:

The Sixty-second World Health Assembly,

1. NOTES the total effective budget under all sources of funds, that is, assessed and voluntary contributions, of US\$ 4 539 914 000, presented in three segments:

Programme budget segment	US\$
Base programmes	3 367 907 000
Special programmes and collaborative arrangements	822 007 000
Outbreak and crisis response	350 000 000
<b>Total effective budget</b>	<b>4 539 914 000</b>

2. RESOLVES to appropriate for the financial period 2010–2011 an amount of US\$ 1 023 840 000, financed by net assessments on Members of US\$ 928 840 000, estimated Miscellaneous Income<sup>1</sup> of US\$ 15 000 000, and transfer to Tax Equalization Fund of US\$ 80 000 000, as shown below:

Appropriation section	Purpose of appropriation	Appropriations financed by net assessments and Miscellaneous Income (US\$)
1	To reduce the health, social and economic burden of communicable diseases	74 035 000
2	To combat HIV/AIDS, malaria and tuberculosis	40 762 000
3	To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment	38 038 000

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<sup>1</sup> Miscellaneous Income is replaced by “Other Sources” in revisions to the Financial Regulations due to become effective on 1 January 2010 [following adoption of resolution WHA62.6].

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	46 497 000
5	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	16 090 000
6	To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	31 368 000
7	To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	15 456 000
8	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	30 198 000
9	To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development	18 748 000
10	To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research	130 799 000
11	To ensure improved access, quality and use of medical products and technologies	27 631 000
12	To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	179 551 000
13	To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	294 667 000
	<b>Subtotal</b>	<b>943 840 000</b>
	Transfer to Tax Equalization Fund	80 000 000
	<b>Grand total</b>	<b>1 023 840 000</b>

3. FURTHER RESOLVES that:

(1) notwithstanding the provisions of Financial Regulation 4.3, the Director-General is authorized to make transfers between the appropriation sections up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made; all such transfers shall be reported in the financial report for the financial period 2010–2011; any other transfers required shall be made and reported in accordance with the provisions of Financial Regulation 4.3;

(2) amounts not exceeding the appropriations voted under paragraph 2 shall be available for the payment of commitments incurred during the financial period 1 January 2010 to 31 December 2011 in accordance with the provisions of the Financial Regulations; notwithstanding the provisions of the present paragraph, the Director-General shall limit the commitments to be incurred during the financial period 2010–2011 to sections 1 to 13;

(3) the amount of the contribution to be paid by individual Members shall be reduced by the sum standing to their credit in the Tax Equalization Fund; that reduction shall be adjusted in the case of those Members that require staff members to pay income taxes on their WHO emoluments, taxes which the Organization reimburses to said staff members; the amount of such tax reimbursements is estimated at US\$ 16 274 400, resulting in a total assessment on Members of US\$ 945 114 400;

4. DECIDES that the Working Capital Fund shall be maintained at its existing level of US\$ 31 000 000.

5. NOTES that the voluntary contributions required to meet the portion of the effective working budget not financed through net assessments on members is US\$ 3 596 074 000.

Ms OTGONJARGAL (Mongolia), referring to strategic objective 3 of the Medium-term strategic plan 2008–2013, said that in her country the lack of technical resources for rehabilitation and prevention of secondary disabilities posed major problems. She requested expert support from the WHO country office in order to counter a severe shortage of qualified rehabilitation staff and therapists. Guidance and support should be provided to Member States to develop and implement policies, strategies and regulations in respect of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities, including visual impairment and blindness. She further requested that funds be reallocated to conducting research on cost-effective interventions for the prevention and management of chronic noncommunicable diseases.

In the absence of further comments, the CHAIRMAN said that he took it that the Committee wished to approve the draft resolution.

**The draft resolution was approved.<sup>1</sup>**

The CHAIRMAN drew attention to a draft resolution on the Medium-term strategic plan 2008–2013, including Proposed programme budget 2010–2011 contained in document A62/4.

**The draft resolution was approved.<sup>2</sup>**

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA62.9.

<sup>2</sup> Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA62.11.



## 2. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

**Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits:** Item 12.1 of the Agenda (Documents A62/5 and A62/5 Add.1) (continued from the first meeting, section 3)

The CHAIRMAN drew attention to a draft resolution on pandemic influenza preparedness, proposed by the delegations of Argentina, Bangladesh, Bhutan, Brazil, Chile, Cuba, Ghana, Guatemala, India, Indonesia, Iran (Islamic Republic of), Maldives, Myanmar, Sri Lanka, Timor-Leste and Venezuela (Bolivarian Republic of) and based on the outlined proposal by the delegate of Nigeria in the Committee's first meeting, which read:

The Sixty-second World Health Assembly,

Having considered the reports on Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits;<sup>1</sup>

Recalling resolution WHA60.28 on Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits which requested the Director-General to convene an intergovernmental meeting;

Recognizing that the Intergovernmental Meeting reached agreement on most elements of the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits;<sup>2</sup>

Reaffirming the need for long-term solutions for pandemic influenza preparedness and response;

Recognizing also that further work needs to be done on some key remaining elements of the Pandemic Influenza Preparedness Framework,

REQUESTS the Director-General:

(1) to work with Member States to take forward the agreed parts of the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits as contained in the report of the outcome of the Intergovernmental Meeting;<sup>3</sup>

(2) to facilitate and support further negotiations among all Member States to conclude the remaining elements, including the Standard Material Transfer Agreement (SMTA) and its annex, and report the outcomes of such negotiations to the Executive Board at its 126th session in January 2010.

Mr VOLF (Czech Republic), speaking on behalf of the European Union and its Member States, requested use of the phrase "Member States and regional economic integration organizations". He held firm to the position that the work of the Intergovernmental Meeting on Pandemic Influenza Preparedness had concluded, as stated in the report annexed to document A62/5 Add.1. The words "negotiations among all Member States" should accordingly be deleted. Any future process should be open to all interested Member States and serious efforts should be made to resolve remaining issues.

To encourage the Director-General to take the process forward, he proposed that paragraph (2) be replaced by a text requesting the Director-General: "to further work with Member States and experts on concluding the remaining elements, and to report to the 126th session of the Executive

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<sup>1</sup> Documents A62/5 and A62/5 Add.1.

<sup>2</sup> Document A62/5 Add.1, Annex.

<sup>3</sup> Document A62/5 Add.1, Appendix.

Board in January 2010.” Furthermore, he suggested inserting the following words at the end of the third preambular paragraph: “and concluded its work on 16 May 2009”.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that, although he would have liked to sponsor the draft resolution, he had declined to do so because to approve a half-finished and half-hearted resolution would be to succumb to interests other than health and to narrow policies made in other sectors.

After more than two years, the Intergovernmental Meeting had failed to reach agreement, in spite of the imminent threat of a potentially devastating influenza pandemic, and to the detriment of public spirit and spiritual commitment to global health. The Intergovernmental Meeting had sprung from mistrust in the WHO Global Influenza Surveillance Network, under which developed countries alone had gained from the sharing of viruses in good faith by all Member States. The vaccine industry, rather than pay for the seed virus, had exploited that good faith. The sole interest of some researchers had been to publish and selfishly file patents related to the virus gene sequence. The losers were the developing countries and it was therefore legitimate that they should claim their rights to viruses and vaccines. Over the two years of the intergovernmental process, both developed and developing countries had negotiated through lawyers specialized in intellectual property, joined by influential nongovernmental organizations and the private sector. In defending their interests and putting the world at risk, the negotiators had shown little compassion or considerate spirit.

The events of the previous six weeks had shown that a new framework might not be needed. Since the beginning of the influenza A (H1N1) outbreak, extensive efforts had been seen to be made in the transparent sharing of virus and gene sequences by all governments, thanks to the leadership shown by Mexico, the United States of America and Canada, and in spite of any resulting economic loss. Access to all gene sequences had been provided through databases; and WHO collaborating centres were preparing seed strains to share with manufacturers.

The Director-General had displayed strong leadership and commitment in mobilizing the international community and taking firm action to tackle the pandemic threat.

He wanted to end discussion of the issue and proceed with existing WHO processes for virus sharing. Adopting a resolution would not guarantee a positive impact on global health. Alternatively, he could accept the draft resolution if the agreed parts of the Pandemic Influenza Preparedness Framework were annexed to it, so that all Member States understood what had been agreed. A phrase should also be added granting the Director-General flexibility to take decisions based on global public health interests in times of emergency and changing situations. In addition, paragraph (2) should be replaced by text requesting all Member States to share viruses according to the same mechanisms they used to share seasonal influenza viruses and requesting the Director-General to design a simple, one-page material transfer agreement to be attached to each transfer of material without prior requirement for signature.

Adoption of either alternative would mean no further negotiation or intergovernmental meetings, thus allowing public health to take precedence over economic and legal interests. It was time for all public health leaders to bring back the committed public health spirit of the Organization.

Mr LOFTIS (United States of America) expressed support for the amendments proposed by the delegate of the Czech Republic, given the importance of pursuing the issue and allowing the Director-General to play a leading role. The proposals were in line with the original proposal by the delegate of Nigeria, which he also supported.

Dr SORY (Ghana), speaking on behalf of the Member States of the African Region, expressed full support for the draft resolution.

Mr COTTERELL (Australia) expressed support for the draft resolution and the earlier version on which it was based, both of which recognized that the development of a transparent and equitable system for sharing influenza viruses, and providing access to vaccines and other benefits, were vital to global pandemic influenza preparedness and response. As debate in the Intergovernmental Meeting

had shown, trust in the previous system had broken down under the pressure of a newly emerging and highly pathogenic H5N1 strain of influenza virus. Experience with, and the continuing threat from, influenza A (H5N1) had demonstrated that a better system was needed to ensure that any country affected by an outbreak could quickly access available countermeasures, including antiviral medicines and vaccines.

The Intergovernmental Meeting had made tremendous progress towards renewing the system and restoring trust, with consensus reached on governance, transparency and benefit-sharing arrangements. The most important of unresolved issues concerned the terms of the Standard Material Transfer Agreement. Member States placed great trust in the Director-General in preparing for and responding to influenza pandemics. The spirit of the draft resolution was that the Director-General should work with Member States to take forward the agreed parts of the Pandemic Influenza Preparedness Framework and settle outstanding issues with Member States. With the work of the Intergovernmental Meeting concluded, the question of procedure and the mandate given to the Director-General remained. Given that the draft resolution under consideration would charge the Director-General with facilitating and supporting any future procedure, he sought her views on how it could most effectively and practically be managed.

Mr ALBUQUERQUE E SILVA (Brazil) said that, despite the commendable diplomatic efforts made to reach agreement, key elements of the Pandemic Influenza Preparedness Framework, including the Standard Material Transfer Agreement, remained unresolved. Nevertheless, collective goods provided by international regimes, such as the document under negotiation, gained strength and legitimacy if they resulted from evidence-based multilateral negotiations. He reminded all delegates of the “single undertaking principle”, by which nothing was considered agreed until everything was agreed. Although consensus was proving elusive, the draft resolution outlined by the delegate of Nigeria had provided a constructive basis for both further work and the draft resolution under consideration, of which Brazil was a sponsor. Brazil had agreed to the proposal to take forward the agreed sections of the Pandemic Influenza Preparedness Framework.

Ms LANTERI (Monaco) expressed support for the amendments proposed by the delegate of the Czech Republic, which seemed to offer the most effective way of moving forward.

Dr LEVENTHAL (Israel) expressed full support for the comments made by the delegate of Thailand. Drawing attention to the imminence of an influenza A (H1N1) pandemic, he commended the Director-General’s timely leadership, exercised in accordance with the authority given to her through the International Health Regulations (2005). He was increasingly convinced of the redundancy of establishing another intergovernmental working group, preferring a focus on results not resolutions that would hinder the Director-General’s work. Nevertheless, the suggestion made by the delegate of the Czech Republic could serve as a fallback position.

Dr INOUE (Japan) appreciated all the efforts made in the two years of the intergovernmental process, and remained committed to removing the last remaining obstacles. The draft resolution provided a good basis for discussion. He supported the amendments to paragraph (2) suggested by the delegate of the Czech Republic as those offered the Director-General more flexibility.

Mr SUDHIR (India) recalled the useful discussions in the resumed Intergovernmental Meeting session on 15 and 16 May; agreement had been reached on several elements of the Pandemic Influenza Preparedness Framework. That work needed to be concluded because the Standard Material Transfer Agreement would provide the legal underpinnings of an international mechanism to implement a fairer, more transparent and more efficient system for sharing viruses and giving access to vaccines and other benefits. Rather than waste that hard work, Member States should continue to drive the process to its logical conclusion. He therefore urged adoption of the draft resolution. His country continued to place high trust in the Director-General’s ability to chart the most effective way forward.

Dr NASIDI (Nigeria) supported the draft resolution and the amendments proposed by the delegate of the Czech Republic. It might simplify matters for the Director-General, in whom he had every confidence, if the phrase “negotiations among all Member States” in paragraph (2) were replaced by “negotiations with Member States on a regional basis”. Nigeria wished to be added to the list of sponsors. The world was threatened by a deadly virus, and the continent most under threat was Africa. There was no time for long negotiations; the world needed to rise together and fight a possible threat that could kill more people than any weapon known to mankind.

Dr WIBISONO (Indonesia) associated himself with the statement made by the delegate of Brazil, and appreciated the comments by the delegate of the United States of America. The need for a long-term solution for pandemic influenza preparedness and response was generally accepted. Most elements of the Pandemic Influenza Preparedness Framework had been agreed, and there was a commitment to do the necessary work on key remaining elements, including the Standard Material Transfer Agreement. Indonesia had high expectations of the important role of the Director-General in bringing the process to a conclusion.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) observed that, while countries currently faced a possible pandemic of influenza A (H1N1), they remained attentive to a possible outbreak of influenza A (H5N1). Throughout history, one strain or another of influenza had attacked humanity. Consequently, countries needed a long-term perspective, and the agreements to be reached on sharing of viruses, production of vaccines and other benefits should not be rushed into. Matters still pending should be discussed multilaterally in order to reach a satisfactory solution.

Mr AHMADI (Islamic Republic of Iran) emphasized continued work in order to finalize the Pandemic Influenza Preparedness Framework and the Standard Material Transfer Agreement. Iran trusted the Director-General to undertake all necessary work before a final round of negotiations among Member States.

Mr ALBUQUERQUE E SILVA (Brazil), acknowledging that the amendment to paragraph (2) of the draft resolution proposed by the delegate of the Czech Republic was helpful, suggested an alternative version that might begin by requesting the Director-General “to facilitate and support a process to finalize the remaining elements” followed by the rest of the paragraph as it stood in the draft resolution, but deleting the words “of such negotiations”. Given that the words “among all Member States” had been deleted from the proposed text, he asked whether all Member States could still join in the process, whether invited or not.

The DIRECTOR-GENERAL said that the last two years of the Intergovernmental Meeting process had been difficult but rewarding, taking its toll in hours of work but opening participants’ minds and hearts to the true meaning of fairness, transparency and equity. She thanked all involved for having given the world a wake-up call.

The past four weeks, spent under the threat of an imminent pandemic, had seen an unprecedented and total commitment by countries to transparency, sharing of timely reporting, sharing of information, sequences and viruses, and the provision of diagnostic kits and laboratory equipment. Discussions with manufacturers of patented and generic medicines and with vaccine manufacturers from the developed and the developing world were ongoing. Technology transfer to countries such as Thailand had provided them with the capacity to make their own vaccines.

She thanked Member States for the trust they had placed in her; she intended to serve them in accordance with the principles of integrity, accountability and openness. It appeared that there was a consensus not to continue the Intergovernmental Meeting, because the threat of the influenza A (H1N1) virus had brought a sense of urgency to the process. If that were the case, then Member States would need to consider the amendments to paragraph (2) of the draft resolution proposed by the delegates of the Czech Republic and Brazil because, if the words “negotiations” and

“all Member States” were not deleted, then nothing short of an Intergovernmental Meeting would satisfy Member States’ expectations.

If she were entrusted to take the negotiations forward, she would respect geographical, gender and North–South balance, drawing on the skills of public health officials, diplomats and scientists. If Member States accorded her the necessary flexibility, she would be able to work with all possible speed in the hope of finalizing a Standard Material Transfer Agreement that would meet Member States’ expectations in time for its submission to the Executive Board in January 2010.

The CHAIRMAN suggested that the Committee should recognize the Director-General’s unstinting efforts to prepare the world to deal with the impending possibility of an influenza pandemic.

**The Committee responded with a standing ovation.**

Mr KAZI (Bangladesh) said that, if the words “all Member States” were deleted, then a reference to the least developed countries should be retained as specific provisions for those countries had been removed from the framework text. Although the least developed countries had not objected to the deletions, which had occurred as part of the informal meeting process, they argued for a legitimate voice in the negotiations. They understood that WHO did not recognize the least developed countries as a separate grouping, unlike many other international organizations, but hoped that the Director-General and others would at least acknowledge their aspirations. Some of the pharmaceutical companies from those countries were contributing to the building of stockpiles, and had aspirations to manufacture vaccines at a future stage. Thus the least developed countries felt that their industries, their manufacturers and their experts should remain tangibly involved in the process.

The DIRECTOR-GENERAL explained that it was important to distinguish between the formal and the informal process. The informal process had been organized by Member States, with members of the Secretariat’s staff being invited as observers. She took note that language referring to the least developed countries had been deleted. Whatever process she was asked to undertake by Member States, she would perform in a participatory, fair and transparent manner. She would always follow the principles of democracy and show consideration for the interests of high-, middle- and low-income countries. She could not promise to deliver miracles, and what was being asked of her was an extraordinarily difficult task, but she would take instruction from all the Member States.

Dr HUWEL (Iraq) commended the draft resolution but expressed some concerns. It was important to ensure the availability of laboratory materials and appliances and medicines for all countries, and the upgrading of laboratory capabilities in order to strengthen surveillance systems and facilitate early detection. The production, availability and distribution of vaccines and industrialization expertise should be equitably adjusted; although mentioned in the resolution the point needed to be clarified. In addition, research and development regarding vaccines should be enhanced.

Dr NASIDI (Nigeria) proposed that paragraph (2) be amended in keeping with the comments by the Director-General and the suggestions by the delegates of the Czech Republic and Brazil. Replacing the words “among all Member States” by “with Member States on a regional basis” would facilitate the negotiation process.

Mr TOBAR (Argentina), supported by Mr MONTIEL (Bolivarian Republic of Venezuela), expressed full confidence in the Director-General’s leadership but called for guarantees of equity both between public health officials and between rich and developing countries. Meetings and processes should be open to all Member States that wanted to participate.

Mr SUDHIR (India) asked the Director-General to clarify whether the formulation “all Member States” implied an open-ended format so that, for instance a country not on the list prepared by WHO could attend if it wished to do so.

Dr WIBISONO (Indonesia), commending the Director-General's leadership, said that it would be helpful if she could clarify her understanding of the emerging consensus.

The DIRECTOR-GENERAL, responding to the concerns expressed by the delegates of India and Argentina, said that since a number of Member States did not want an intergovernmental meeting she would need to draw up a geographically-diverse, representative list of countries, working in the "spirit of Geneva", and in accordance with her oft-stated principles. She recognized that the list would not be perfect. If one or two countries not included wanted to attend, there would be no objection, but her long experience of public life had taught her that any committee with more than 25 members would not be able to operate effectively or produce concrete results. Accordingly, she proposed a pragmatic formulation of paragraph (2) of the draft resolution that would reflect the spirit of the amendments and comments put forward at the current meeting: "to facilitate a process to finalize the remaining elements, including the Standard Material Transfer Agreement (SMTA) and its annex, and to report the outcome to the Executive Board at its 126th session in January 2010."

Support for the draft resolution as amended by the Director-General and full confidence in her leadership were expressed by Mr ALBUQUERQUE E SILVA (Brazil), Dr SUWIT WIBULPOLPRASERT (Thailand), Mr SUDHIR (India), Ms LANTERI (Monaco), Ms JÁQUEZ HUACUJA (Mexico), Dr WIBISONO (Indonesia), Mr VOLF (Czech Republic), speaking on behalf of the European Union, Dr SORY (Ghana), speaking on behalf of the 46 Member States of the African Region, Professor RAHMAN (Bangladesh), Mr AHMADI (Islamic Republic of Iran), Dr INOUE (Japan), Dr ZAFAR-UL-HAQ LODHI (Pakistan), Dr AL JALAHMA (Bahrain), Ms STEEN (Norway), Dr SHEVYREVA (Russian Federation), Ms EPHREM (Canada), Dr KONG Lingzhi (China), Dr AL-BILBISI (Jordan), Dr TANGI (Tonga), speaking on behalf of 14 small island States, Mr MIGUIL (Djibouti), Dr KESKINKILIÇ (Turkey), Dr HUWEL (Iraq), Dr FEKHIH (Tunisia), Mr MONTIEL (Bolivarian Republic of Venezuela), Dr FIKRI (United Arab Emirates), Dr AL-SAKKAF (Yemen), Dr BOUARE (Mali), Dr OULD EL HADJ SIDI (Mauritania), Ms CEESAY (Gambia), and Ms DJOMBE DJANGANI (Equatorial Guinea).

Dr NASIDI (Nigeria) expressed gratitude to Ms Halton (Australia), who had chaired the Intergovernmental Meeting with neutrality and balance and successfully mobilized Member States to achieve a positive outcome. He also commended the Secretariat's hard work and the Legal Counsel's guidance.

Mr TOBAR (Argentina) supported the Director-General's suggested amendment but proposed that the word "open" be inserted before the word "process".

Mr LOFTIS (United States of America) supported the Director-General's suggestion. It was an excellent way to move forward while leaving flexibility to deal with influenza A (H1N1) and, as several Member States had remarked, to prepare for a possible influenza A (H5N1) pandemic.

Mr COTTERELL (Australia) fully supported the amendment suggested by the Director-General and thanked the delegate of Nigeria for his tribute to Ms Halton. He further commended the excellent work done by the officers of the Intergovernmental Meeting and the particular efforts of the Member States.

Dr OJHA (Nepal) supported the Director-General's suggestion and commended her efforts in an area that equally affected both rich and poor countries.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) supported the draft resolution which, in his view, would make for fair and transparent results.

The DIRECTOR-GENERAL asked Argentina if the word “transparent” rather than “open” would be acceptable.

Mr TOBAR (Argentina) affirmed, with the proviso that all Member States were informed when the invitation was issued so that they could ask the participating countries from their region for information about the process.

The DIRECTOR-GENERAL paid tribute to all who had contributed to the outcome of the process, including Ms Halton, the members of the Intergovernmental Meeting’s Bureau, the Member States and the Secretariat. All their hard work would not be lost.

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

Dr SILBERSCHMIDT (Switzerland) recalled that, at the High-Level Consultation on Influenza on 18 May, the United Kingdom’s Minister of Health and other participants had raised the question of pandemic phases. WHO’s pandemic planning did not set out in detail the measures to be taken in a pandemic of mild or unknown severity. In defining the phases nobody had fully considered the situation currently being faced. A declaration of Phase 6 would depend solely on geographical criteria and he queried whether that was an adequate response to the current situation. As stated by several ministers during the consultation, the Director-General should be given the necessary flexibility. So far she had handled the situation very well and could be trusted to take the right decisions and provide proper guidance.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) wished to ensure that his country’s comments about the handling of the pandemic at the High-Level Consultation were recorded in the formal proceedings of the Health Assembly. In handling a pandemic it was essential for decisions to be seen as credible, otherwise public confidence would be eroded and severe criticism expressed by the media. In planning at national and international levels, the strong point had been made that the current pandemic differed from seasonal influenza: there existed no general immunity, which implied that it would be widespread, with many people affected and large numbers of severe cases and deaths in comparison with seasonal influenza. That might happen but present levels were below those of seasonal influenza. To claim that a pandemic situation had been reached would destroy public confidence in WHO’s handling of the situation. He strongly supported the views of Switzerland: the Director-General should be given leeway to develop a more appropriate definition for the declaration of a pandemic, if that should prove necessary. In regard to vaccines, the long-term strategy should not be ignored: scientists should be asked to develop a broad-spectrum influenza vaccine against many strains of influenza virus, that conferred long-term immunity and was cheap to produce, and in so doing shift the emphasis from containment to prevention.

Dr NASIDI (Nigeria) emphasized that the issue was not the severity of the disease but the geographical spread. He therefore supported the proposal put forward by the previous two speakers to the effect that the Director-General be given more flexibility in making decisions in consultation with the Expert Committee.

Mr WU Jing (China) also supported the proposal. However, the severity of the disease and its social impact should be taken into account when deciding on whether to move from Phase 5 to Phase 6.

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<sup>1</sup> Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA62.10.

Dr TANGI (Tonga) said that it was important to clarify whether giving the Director-General flexibility in making decisions was compatible with the International Health Regulations (2005).

The DIRECTOR-GENERAL affirmed that the decision-making process had followed transparent discussions and consultations with the Emergency Committee and was in line with the International Health Regulations (2005). During both the High-Level Consultation and the current discussion, many Member States had warned against using geographical spread as the only yardstick. At present the situation was having a greater impact in the northern hemisphere and it was therefore questionable whether it could be termed a global pandemic. The definition had been informed by advice from scientists from many countries. Moreover, it was the first time the world had witnessed the unfolding of a pandemic and it was important to learn from it. She was aware that public perception of the magnitude of the problem, as reflected in the media, might not tally with the scientific definition. WHO therefore needed to clarify its position, which was not an easy task. Achieving a balance between the role of science and people's expectations would require flexibility. She would not shy away from difficult decisions, and would take into account the nature of the virus itself, including its severity, and the spread of the disease. She reiterated that all the necessary public health measures in terms of preparedness, prevention and protecting the public had already been activated under Phase 5. Before moving to Phase 6, however, she would need to be satisfied that it was a global phenomenon that was likely to be sustained. She was therefore carefully monitoring the situation in the southern hemisphere where some cases had been reported by countries but without the level of transmission seen in the first countries to be affected. There would be no compromise on people's health nor on taking appropriate steps to work with the pharmaceutical and vaccine industry, where preparations were continuing with a sense of urgency.

**Primary health care, including health system strengthening:** Item 12.4 of the Agenda (Documents EB124/2009/REC/1, resolutions EB124.R8 and EB124.R9, and A62/8) (continued from the fourth meeting)

The CHAIRMAN invited the Committee to consider the following revised draft resolution on primary health care, including health system strengthening, incorporating amendments proposed by the delegations of Bolivia (Plurinational State of), Brazil, Burkina Faso, Canada, Chile, Cook Islands, Jamaica, Kazakhstan, Lebanon, Nepal, Netherlands, Suriname and Thailand:

The Sixty-second World Health Assembly,

Welcoming the efforts of the Director-General, and recognizing the ~~central~~ **pivotal [Nepal]** role that WHO plays, in promoting primary health care globally;

Having considered the report on primary health care, including health system strengthening;<sup>1</sup>

~~Recalling the Declaration of Alma-Ata (1978), the Ottawa Charter for Health Promotion (1986), the United Nations Millennium Declaration (2000) and subsequent relevant resolutions of WHO's regional committees and Health Assemblies;~~ **[Kazakhstan]**

**Reaffirming the Declaration of Alma-Ata (1978) and the United Nations Millennium Declaration (2000); [Kazakhstan]**

**Recalling the Ottawa Charter for Health Promotion (1986) and subsequent relevant resolutions of WHO regional committees and Health Assemblies<sup>2</sup> [Kazakhstan]**

<sup>1</sup> Document A62/8.

<sup>2</sup> Resolutions WHA54.13, WHA56.6, WHA57.19, WHA58.17, WHA58.33, WHA60.22, WHA60.24, WHA60.27, WHA61.17 and WHA61.18.



Recalling also the discussions at the series of summits and global, regional and national conferences that have reaffirmed the commitment of Member States to primary health care and strengthening health systems;<sup>1</sup>

Noting the growing consensus in the global health community that vertical approaches, such as disease-specific programmes, and integrated health systems approaches are mutually reinforcing and contribute to achieving the health-related Millennium Development Goals;

Recognizing the need to draw on the experiences, both positive and negative, of primary health care in the years since the Declaration of Alma-Ata and the Millennium Declaration;

Welcoming *The world health report 2008*,<sup>2</sup> published on the thirtieth anniversary of the international conference of Alma-Ata, that identifies four broad policy directions for reducing health inequalities and improving health for all: tackling health inequalities through universal coverage, putting people at the centre of care, integrating health into broader public policy, and providing inclusive leadership for health; and also welcoming the final report of the Commission on Social Determinants of Health;<sup>3</sup>

Reaffirming the need to build sustainable national health systems, strengthen national capacities, and honour fully financing commitments made by national governments and their development partners, as appropriate, in order to better fill the resource gaps in the health sector;

Reaffirming also the need to take concrete, effective and timely action, in implementing all agreed commitments on aid effectiveness and to increase the predictability of aid, while respecting recipient countries' control and ownership of their health system strengthening, more so given the potential effects on health and health systems of the current international financial and food crises and of climate change;

Strongly reaffirming the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action, **decentralization [Nepal]** and community participation as the basis for strengthening health systems;

1. URGES Member States:

(1) to ensure political commitment at all levels to the values and principles of the Declaration of Alma-Ata, keep the issue of strengthening health systems based on the primary health care approach high on the international political agenda, and take advantage, as appropriate, of health-related partnerships and initiatives relating to this issue, particularly to support achievement of the **health-related [Nepal]** Millennium Development Goals;

(2) to accelerate action towards universal access to primary health care by developing comprehensive health services and by developing national equitable, **efficient [Nepal]** and sustainable financing mechanisms, ~~mindful of the need to ensure social protection and protect health budgets in the context of the current international financial crisis;~~ **[Cook Islands]**

(3) to put people at the centre of health care by adopting, as appropriate, delivery models focused on the local and district levels that provide comprehensive primary

<sup>1</sup> Including summits on health system strengthening, such as the G8 Hokkaido Toyako Summit (2008), International Conference on Global Action for Health System Strengthening (Tokyo, 2008), International Conference dedicated to the 30th Anniversary of the Alma-Ata Declaration of WHO/UNICEF on primary health care (Almaty, 2008), and G15 Summit (2004); WHO regional meetings on primary health care, such as those at Buenos Aires (2007), Beijing (2007), Bangkok (2008), Tallinn (2008), Ouagadougou (2008), Jakarta (2008) and Doha (2008); and conferences on health promotion, such as Ottawa (1986), Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico City (2000), Bangkok (2005) and the MERCOSUR Task Force on Health (since 1995).

<sup>2</sup> *The world health report 2008: Primary health care – now more than ever*. Geneva, World Health Organization, 2008.

<sup>3</sup> Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva, World Health Organization, 2008.

health-care services, including health promotion, disease prevention, curative care and ~~end-of-life services~~ **palliative care**, [Suriname] that are integrated and coordinated according to need; **while ensuring effective referral to secondary and tertiary care**; [Nepal] [Thailand]

(4) to promote active participation by all people, **and reemphasize the empowering of communities, especially women**, [Nepal] in the processes of developing policy and improving health and health care, in order to support the renewal of primary health care;

(5) to train **and retain** [Nepal] **OR to train and avoid migration of** [Plurinational State of Bolivia] adequate numbers of health workers, **including primary health care nurses, midwives, allied health professionals and family physicians**, [Netherlands] able to work in a multidisciplinary context, **including non-professional community health workers with appropriate skill mix** [Nepal] [Thailand] in order to respond effectively to people's health needs;

(6) to ~~ensure~~ **encourage** [Canada] that vertical programmes, including disease-specific programmes, are developed, **integrated** [Nepal] and implemented in the context of integrated primary health care;

(7) to improve access to appropriate medicines, health products and technologies, all of which are required to support primary health care;

(8) to develop and strengthen health information and surveillance systems, **including for infectious diseases**, [Burkina Faso] relating to primary health care in order to facilitate evidence-based policies and programmes and their evaluation;

(9) to strengthen health ministries, enabling them to provide inclusive, transparent and accountable leadership of the health sector and to facilitate multisectoral action as part of primary health care;

## 2. REQUESTS the Director-General:

(1) to ensure that WHO reflects the values and principles of the Declaration of Alma-Ata in its work and that the overall organizational efforts across all levels contribute to the renewal **and strengthening** [Nepal] of primary health care, **in accordance with the findings of the Commission on Social Determinants of Health** [Burkina Faso];

(2) to strengthen the Secretariat's capacities, **including capacities of regional and country offices**, [Plurinational State of Bolivia] to support Member States in their efforts to deliver on the four broad policy directions for renewal **and strengthening** [Nepal] of primary health care identified in *The world health report 2008*;

**New (3) to prepare implementation plans for each of the four broad policy directions, to ensure that these plans span the work of the entire Organization, and to report on these plans to the Sixty-third World Health Assembly; [Brazil]**

(3) to collate and analyse past and current experiences of Member States in implementing primary health care and facilitate the exchange of experience, evidence and information on good practice **in achieving universal coverage, access and strengthening health systems** [Nepal] [Thailand];

(4) to foster alignment and coordination of global interventions for health system strengthening, basing them on the primary health care approach, in collaboration with Member States, relevant international organizations, international health initiatives, and other stakeholders in order to increase synergies between international and national priorities;

**(4bis) to ensure health system strengthening and revitalizing primary health care as a priority programme in the Programme budget 2010–2011; [Nepal] [Thailand]**

(5) to report to the Sixty-third World Health Assembly, and subsequently every two years to the Health Assembly, through the Executive Board, on progress regarding this resolution, including reporting on the effectiveness of WHO in its support to countries in the implementation of primary health care-;

**(6) to develop a plan of action on the four policy directions for submission to the Sixty-third World Health Assembly, namely universal coverage reforms to improve health equity; service delivery reforms to make health systems people-centred; leadership reforms to make health authorities more reliable; and public policy reforms to promote and protect the health of communities. [Jamaica] [Chile] [Lebanon]**

The financial and administrative implications for the Secretariat were as follows:

1. **Resolution** Primary health care, including health system strengthening.

2. **Linkage to programme budget**

Strategic objective: Organization-wide expected result:

Strategic objectives 1–11 (all technical objectives). All Organization-wide expected results under strategic objectives 1–11.

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

This resolution requires a broad re-examination of WHO’s programmatic priorities with a view to ensuring the Organization is well positioned to support Member States as they seek to strengthen their health systems based on the primary health care approach. There are likely to be implications for the Organization-wide expected results and indicators in the Medium-term strategic plan 2008–2013, which will be presented to the governing bodies for their consideration as appropriate.

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)**

Although the scope of this resolution is a long-term one, the cost implications considered here are only for the period 2008–2013; any future costs will be presented to Member States for their consideration at the appropriate time. Given the comprehensive nature of the primary health care approach, the costs implied by WHO’s implementation of the resolution will essentially be accounted for by a cost-neutral revisiting of the workplans under each strategic objective, aligning them with the policy directions given by the resolution.

However, specific funding needs to be allocated for (i) coordination of organizational alignment and capacity building, (ii) cross-cutting strategic activities and initiatives (e.g. reviews of primary health care policy, consultations, and monitoring progress of efforts to revitalize primary health care) and (iii) stepping up support to and exchange between countries.

Biennium	Task	Estimated cost (US\$ thousands)
2008–2009	• Organizational alignment and capacity building	800
	• Cross-cutting strategic initiatives	1 000
	• Country support and exchange	100
2010–2011	• Organizational alignment and capacity building	500
	• Cross-cutting strategic initiatives	500
	• Country support and exchange	1 000
2012–2013	• Organizational alignment and capacity building	100
	• Cross-cutting strategic initiatives	300
	• Country support and exchange	600

(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\$ 1.9 million (see note above).

- (c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?**

50%, or US\$ 950 000.

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

The additional amount will need to be mobilized in the form of voluntary contributions; initial consultations have already begun with funding sources and prospects are positive.

#### **4. Administrative implications**

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

All levels of the Organization will be involved.

- (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)**

To the extent possible, secondments (supported by Member States) are being used for portions of the additional work. The need for any additional WHO staff in 2010 and beyond will be reviewed during 2009.

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

A progress report will be submitted to the Health Assembly every two years, starting with the Sixty-third World Health Assembly in 2010.

Dr SEIFERT (Czech Republic), speaking on behalf of the Member States of the European Union, expressed support for the draft resolution and for most of the proposed amendments. With regard to subparagraph 1(2), Nepal's proposed amendment was acceptable, but not the deletion proposed by the Cook Islands. In subparagraph 1(3), the wording suggested by Suriname should be retained, "with other levels of care" should be inserted after "integrated" and the wording proposed by Nepal and Thailand should be deleted. In subparagraph 1(5), he preferred Nepal's suggestion that the words "and retain" should be inserted after "to train" to the wording proposed by Bolivia. In subparagraph 1(8), Burkina Faso's proposed amendment should be deleted. He supported Brazil's proposed amendment to subparagraph 2(3). Subparagraph 2(4bis) proposed by Nepal and Thailand should be amended to read: "to ensure adequate funding for health system strengthening and revitalizing primary health care in the Programme budget 2010–2011". Subparagraphs 2(5) and 2(6) expressed the same idea and could be combined to read:

"to prepare implementation plans for the four broad policy directions: (1) dealing with inequalities by moving towards universal coverage; (2) putting people at the centre of service delivery; (3) multisectoral action and health in all policies; (4) inclusive leadership and effective governance for health to ensure that these plans span the work of the entire Organization, and to report on these plans through the Executive Board to the Sixty-third World Health Assembly, and subsequently on progress every two years thereafter".

Dr PHUSIT PRAKONGSAI (Thailand) proposed that subparagraph 1(5) should be amended to read: "to train and retain adequate numbers of health workers with an appropriate skill mix, including primary health care nurses, midwives, allied health professionals and family physicians able to work in a multidisciplinary context in cooperation with nonprofessional community health workers in order to respond effectively to people's health needs". He also concurred with the amendment proposed by the Czech Republic to subparagraph 2(4bis).

Ms LANTERI (Monaco), supported by Dr LEE Han-Sung (Republic of Korea), referring to subparagraph 1(2) and the deletion proposed by the Cook Islands, said that the reference to ensuring social protection and protecting health budgets should be retained, but that “in the context of the current international financial crisis” was too specific and should be deleted. She endorsed the amendment proposed by Brazil and the suggestions by the Czech Republic that subparagraphs 2(5) and 2(6) should be amalgamated and the wording of subparagraph 2(4bis) amended.

Ms CHASOKELA (Zimbabwe), supported by Mr RAKUOM (Kenya), endorsed the proposed amendments to subparagraph 1(5) put forward by the Netherlands and Thailand.

Mr ABDOO (United States of America) supported the phrasing of subparagraph 1(5) as proposed by Nepal. He also preferred the formulation of new subparagraph 2(3) to that of subparagraph 2(6) and requested that the wording containing those elements be read out.

Ms BENNETT (Australia) expressed a preference for Nepal’s proposed wording for subparagraph 1(5). She also supported the proposed reformulation of a number of subparagraphs under paragraph 2 and requested that the new text be read out.

Dr AL JALAHMA (Bahrain) supported the amendments in the revised resolution but wished, in subparagraph 1(2), to retain the words “in the context of the current international financial crisis”.

Dr BLOOMFIELD (New Zealand) supported the amendments in the revised resolution. However, in subparagraph 1(5), he preferred the words “to train and retain” proposed by the delegate of Nepal, and supported the additional amendments put forward during the discussion. In paragraph 2, he supported the proposal by the delegate of the Czech Republic to combine the new subparagraph 2(3) with subparagraphs 2(5) and 2(6), and he requested that the proposed new text be read out.

Mr MAOATE (Cook Islands), responding to the delegates of the Czech Republic, Monaco and Bahrain on subparagraph 1(2), said that he did not expect the current international financial crisis to be the only event that would continue to affect the financial markets. He agreed with the suggestion of the delegate of Monaco to leave out “in the context of the current international financial crisis” and retain the first half of the deleted part of the sentence.

Dr AL ZAHRANI (Saudi Arabia) supported the revised draft resolution, particularly subparagraph 1(8). Subparagraph 1(5) should be amended to read “to encourage the training of adequate numbers of health workers and health professionals, particularly family physicians, midwives and primary health care nurses”, in order to meet health needs effectively.

Dr SHIMIZU (Japan) agreed with the proposal by the delegate of New Zealand. He did not agree with the deletion proposed by the delegate of the Cook Islands to subparagraph 1(2) and preferred to finish the sentence after “protecting health budgets”. Regarding the proposal by the delegates of Nepal and Thailand in subparagraph 1(3), he preferred deleting “to secondary and tertiary care” from their text and inserting only “while ensuring an effective referral system”.

Mr COLMENARES (Bolivarian Republic of Venezuela) suggested adding the words “and implementing” after “processes of developing” in subparagraph 1(4).

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

The CHAIRMAN drew attention to a revision of the draft resolution on traditional medicine, incorporating amendments to resolution EB124.R9, proposed by Nepal, which read:

The Sixty-second World Health Assembly,

Having considered the report on the primary health care, including health system strengthening;<sup>2</sup>

Recalling resolutions WHA22.54, WHA29.72, WHA30.49, WHA31.33, WHA40.33, WHA41.19, WHA42.43, WHA54.11, WHA56.31 and WHA61.21;

Recalling the Declaration of Alma-Ata which states, inter alia, that “The people have the right and duty to participate individually and collectively in the planning and implementation of their health care” and “Primary health care relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community”;

Noting that the term “traditional medicine” covers a wide variety of therapies and practices, which may vary greatly from country to country and from region to region;

Recognizing traditional medicine as one of the resources of primary health-care services that could contribute to improved health outcomes, including those in the Millennium Development Goals;

Recognizing that Member States have different domestic legislation, approaches, regulatory responsibilities and delivery models related to primary health care;

Noting the progress that many governments have made to include traditional medicine into their national health systems;

Noting that progress in the field of traditional medicine has been achieved by a number of Member States through implementation of the WHO traditional medicine strategy 2002–2005;<sup>3</sup>

Expressing the need for action and cooperation by the international community, governments, and health professionals and workers, to ensure proper use of traditional medicine as an important component contributing to the health of all people, in accordance with national capacity, priorities and relevant legislation;

Noting that the WHO Congress on Traditional Medicine took place from 7 to 9 November 2008, in Beijing, China, and adopted the Beijing Declaration on Traditional Medicine;

Noting that African Traditional Medicine Day is commemorated annually on 31 August in order to raise awareness and the profile of traditional medicine in the African region, as well as to promote its integration into national health systems,

1. URGES Member States, in accordance with national capacities, priorities, relevant legislation and circumstances:

(1) to consider adopting and implementing the Beijing Declaration on Traditional Medicine in accordance with national capacities, priorities, relevant legislation and circumstances;

(2) to respect, preserve and widely communicate, as appropriate, the knowledge of traditional medicine, treatments and practices, appropriately based on the circumstances in each country, and on evidence of safety, efficacy and quality;

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<sup>1</sup> Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA62.12.

<sup>2</sup> Document A62/8.

<sup>3</sup> Document WHO/EDM/TRM/2002.

- (3) to formulate national policies, regulations and standards, as part of comprehensive national health systems, to promote appropriate, safe and effective use of traditional medicine;
- (4) to consider, where appropriate, including traditional medicine into their national health systems based on national capacities, priorities, relevant legislation and circumstances, and on evidence of safety, efficacy and quality;
- (5) to further develop traditional medicine based on research and innovation, giving due consideration to the specific actions related to traditional medicine in the implementation of the Global strategy and plan of action on public health, innovation and intellectual property;
- (6) to consider, where appropriate, establishing systems for the qualification, accreditation or licensing of traditional medicine practitioners and to assist traditional medicine practitioners to upgrade their knowledge and skill in collaboration with relevant health providers;
- (7) to consider strengthening communication between conventional and traditional medicine providers and, where appropriate, establishing appropriate training programmes for health professionals, medical students and relevant researchers;
- (8) to cooperate with each other in sharing knowledge and practices of traditional medicine and exchanging training programmes on traditional medicine, consistent with national legislation and relevant international obligations;

2. REQUESTS the Director-General:

- (1) to provide support to Member States, as appropriate and upon request, in implementing the Beijing Declaration on Traditional Medicine;
- (2) to update the WHO traditional medicine strategy 2002–2005, based on countries' progress and current new challenges in the field of traditional medicine;
- (3) to give due consideration to the specific actions related to traditional medicine in the implementation of the Global strategy and plan of action on public health, innovation and intellectual property **and the WHO global strategy for prevention and control of noncommunicable diseases; [Nepal]**
- (4) to continue providing policy guidance to countries on how to integrate traditional medicine into health systems, especially to promote, where appropriate, the use of traditional/indigenous medicine for primary health care, **including disease prevention and health promotion, [Nepal]** in line with evidence of safety, efficacy and quality;
- (5) to continue providing technical guidance to support countries in ensuring the safety, efficacy and quality of traditional medicine;
- (6) to strengthen cooperation with WHO collaborating centres, research institutions and nongovernmental organizations in order to share evidence-based information and to support training programmes for national capacity building in the field of traditional medicine.

Mr COLMENARES (Bolivarian Republic of Venezuela) introduced amendments, the first of which was to split subparagraph 1(6) into two separate subparagraphs:

- “1(6) to assist traditional medicine practitioners to upgrade their knowledge and skill in collaboration with relevant health providers, on the basis of the traditions and customs of peoples and communities;
- 1(6bis) to consider, where appropriate, establishing a system of registration of traditional medicine practitioners which would be appropriate to the traditions and customs of peoples and communities”.

In subparagraph 1(7), the words “with content related to traditional medicine” should be added after “appropriate training programmes”. He proposed to add, in subparagraph 2(4), the words “taking into

account the traditions and customs of peoples and communities” after “including disease prevention and health promotion”; in subparagraph 2(5), at the end, the words “taking into account the traditions and customs of peoples and communities”; and in subparagraph 2(6) the words “taking into account the traditions and customs of peoples and communities” after “to share evidence-based information”.

Mr ABDOO (United States of America), referring to subparagraph 1(6), said that he considered it important to retain the words “establishing systems for the qualifications, accreditation or licensing of traditional medicine practitioners”. He preferred to adopt subparagraph 1(6) as it had appeared in the original draft resolution. He accepted the amendment to subparagraph 2(4), provided that it appeared at the end of the subparagraph. With regard to subparagraphs 2(5) and 2(6), he preferred to approve the resolution with the subparagraphs as originally drafted, without the amendments proposed by the delegate of the Bolivarian Republic of Venezuela.

Mr COLMENARES (Bolivarian Republic of Venezuela), agreed to accept subparagraph 1(6) as it stood, provided that the words “on the basis of the traditions and customs of peoples and communities” were added. With regard to subparagraph 2(4), he accepted the suggestion by the delegate of the United States of America to place the amendment at the end of the subparagraph. With regard to subparagraphs 2(5) and 2(6), he reiterated his preference to include the suggested amendments “taking into account the traditions and customs of peoples and communities”.

Mr ABDOO (United States of America) said that he could accept the suggested amendments to subparagraphs 2(5) and 2(6).

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

**The meeting rose at 12:20.**

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<sup>1</sup> Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA62.13.



## NINTH MEETING

Thursday, 21 May 2009, at 14:45

Chairman: Dr F. MENESES GONZÁLEZ (Mexico)

### 1. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

**Commission on Social Determinants of Health:** Item 12.5 of the Agenda (Documents EB124/2009/REC/1, resolution EB124.R6, and A62/9) (continued from the sixth meeting)

The CHAIRMAN drew attention to a revised version of the draft resolution in resolution EB124.R6, which incorporated the amendments proposed during the Committee's earlier discussion and read:

The Sixty-second World Health Assembly,

Having considered the report on the Commission on Social Determinants of Health,<sup>1</sup>

**Noting the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action [Sri Lanka] [Thailand];**

Noting the 60th anniversary of the establishment of WHO in 1948, and its Constitution, which affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Noting the 30th anniversary of the International Conference on Primary Health Care at Alma-Ata in 1978, which reaffirmed the essential value of equity in health and launched the global strategy of primary health care to achieve health for all;

Recalling the principles of "Health for All", notably the need for intersectoral action (resolution WHA30.43);

Confirming the importance of addressing the wider determinants of health and considering the actions and recommendations set out in the series of international health promotion conferences, from the Ottawa Charter on Health Promotion to the Bangkok Charter for Health Promotion in a Globalized World, making the promotion of health central to the global development agenda as a core responsibility of all governments (resolution WHA60.24);

Noting the global consensus of the United Nations Millennium Declaration to achieve the Millennium Development Goals by 2015 and the concern at the lack of sufficient progress towards many of these goals in some regions at the half-way point;

Welcoming in this regard resolution WHA61.18, which initiates annual monitoring by the Health Assembly of the achievement of health-related Millennium Development Goals;

Noting *The world health report 2008*<sup>2</sup> on primary health care and its focus on ways to improve health equity by reforming health and other societal systems;

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<sup>1</sup> Document A62/9.

<sup>2</sup> World Health Organization. *The world health report 2008: primary health care – now more than ever*. Geneva, World Health Organization, 2008.

Mindful about the fact that responses to environmental degradation and climate change include health equity issues and noting that the impact of climate change is expected to negatively affect the health of vulnerable and disadvantaged populations (resolution WHA61.19);

Mindful about the facts concerning widening gaps in life expectancy worldwide;

Attaching utmost importance to the elimination of gender-related health inequities;

Recognizing that millions of children globally are not reaching their full potential and that investing in comprehensive supports for early child development that are accessible to all children is a fundamental step in achieving health equity across the lifespan;

Acknowledging that improvement of unfavourable social conditions is primarily a social policy issue;

Noting the need to improve coordination among global, national and subnational efforts in tackling social determinants of health through work across sectors, while simultaneously promoting social and economic development, with the understanding that such action requires the collaboration of many partners, including civil society and private sector;

**Mindful of the need for global governance mechanisms to support Member States in provision of basic services essential to health and the regulation of goods and services with a major impact on health, and the need for market responsibility, [Sri Lanka] [Thailand]**

1. EXPRESSES its appreciation for the work done by the Commission on Social Determinants of Health;

2. CALLS UPON the international community, including United Nations agencies, intergovernmental bodies, civil society and the private sector:

(1) to take note of the final report of the Commission on Social Determinants of Health and its recommendations;<sup>1</sup>

(2) to take action in collaboration with WHO's Member States and the WHO Secretariat on assessing the impacts of policies and programmes on health inequities and on addressing the social determinants of health;

(3) to work closely with WHO's Member States and the WHO Secretariat on measures to enhance health equity in all policies in order to improve health for the entire population and reduce inequities;

**(4) to adopt health equity as a core global development goal and to use social determinants of health indicators framework in order to monitor progress, and to devise global governance mechanisms in addressing the social determinants of health and to reduce health inequities; [Sri Lanka] [Thailand]**

3. URGES Member States:

**(1) to tackle the health inequities within and across countries through political commitment on "closing the gap in a generation" as a national agenda, and establish national institutional mechanisms to coordinate and manage intersectoral action for health in order to mainstream health equity in all policies, and, where appropriate, by using health and health equity impact assessment tools; [Sri Lanka] [Thailand]**

~~(+)~~(2) to develop and implement goals and strategies to improve public health with a focus on health inequities;

~~(2)~~(3) to take into account health equity in all national policies **and to establish and strengthen universal comprehensive social protection policies, universal health care, and universal availability of and access to goods and services essential to health and**

<sup>1</sup> Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health*. Geneva, World Health Organization, 2008.

~~well-being, in order to effectively that address social determinants of health and to ensure equitable access to health promotion, disease prevention and health care;~~  
**[Sri Lanka] [Thailand]**

~~(3)~~**(4)** to ensure dialogue and cooperation among relevant sectors with the aim of integrating a consideration of health into relevant public policies **and enhancing intersectoral action [Sudan];**

~~(4)~~**(5)** to increase awareness among public and private health providers on how to take account of social determinants when delivering care to their patients;

~~(5)~~**(6)** to contribute to the improvement of the daily living conditions contributing to health and social well-being across the lifespan by involving all relevant partners, including civil society and the private sector;

~~(6)~~**(7)** to contribute to the empowerment of individuals and groups, especially those who are marginalized, and take steps to improve the societal conditions that affect their health;

~~(7)~~**(8)** to generate new, or make use of existing, methods and evidence, tailored to national contexts in order to address the social determinants and social gradients of health and health inequities;

~~(8)~~**(9)** to develop, make use of, and if necessary, improve health information systems **and research capacity [Sudan]** in order to monitor and measure the health of national populations, with data disaggregated according to ~~the major social determinants in each context (such as [Chile] age, gender, ethnicity, race, caste, occupation, [Chile] education, income and [Chile] employment and socioeconomic status) [Chile]~~ so that health inequities can be detected and the impact of policies ~~monitored in order to devise appropriate policy interventions to minimize on [Chile] health inequities equity measured [Chile];~~

4. REQUESTS the Director-General:

(1) to work closely with partner agencies in the multilateral system on appropriate measures that address the social determinants of health and promote policy coherence in order to minimize health inequities; and to advocate for this topic to be high on global development and research agendas;

(2) to strengthen capacity within the Organization with the purpose of giving sufficient priority to relevant tasks related to addressing the social determinants of health in order to reduce health inequities;

**(3) to institutionalize social determinants of health as a guiding principle and [Sri Lanka] [Thailand]** to implement measures, including objective indicators for the monitoring of social determinants of health, across relevant areas of work and promote addressing social determinants of health to reduce health inequities as an objective of all areas of the Organization's work, especially priority public health programmes;

**(4) to support the primary role of Member States in the provision of basic services essential to health and the regulation of goods and services with a major impact on health of the population; [Sri Lanka] [Thailand]**

~~(4)~~**(5)** to ensure that ongoing work on the revitalization of primary health care addressing the social determinants of health is aligned with this, as recommended by *The world health report 2008*;

~~(5)~~**(6)** to provide support to Member States in implementing a health-in-all-policies approach to tackling inequities in health;

~~(6)~~**(7)** to provide support to Member States, upon request, in implementing measures with the aim of integrating a focus on social determinants of health across relevant sectors and in designing, or if necessary redesigning, their health sectors to address this appropriately;

~~(7)~~**(8)** to provide support to Member States, upon request, in strengthening existing efforts on measurement and evaluation of the social determinants of health and the causes of health inequities and in developing and monitoring targets on health equity;

~~(8)~~**(9)** to support research on effective policies and interventions to improve health by addressing the social determinants of health that also serve to strengthen research capacities and collaborations;

~~(9)~~**(10)** to provide support to the regional directors in developing a regional focus on issues related to the social determinants of health and in engaging a broader range of countries in this issue, in accordance with the conditions and challenges of each region;

~~(10)~~**(11)** to convene a global event, with the assistance of Member States, before the Sixty-fifth World Health Assembly in order to ~~highlight the developments, progress and~~ **discuss [Chile] renewed plans for addressing the alarming trends of health inequities and to increase global awareness on** **through addressing [Chile] social determinants of health, including health equity and report back on progress to the Sixty-third World Health Assembly [Chile];**

**(12) to study the feasibility and benefit of various modes of good global governance to support Member States in providing goods and services essential to health and regulation of goods and services with a major impact on health, and report back to the Sixty-fifth World Health Assembly; [Sri Lanka] [Thailand]**

~~(11)~~**(13)** to report on progress in implementing this resolution to the Sixty-fifth World Health Assembly through the Executive Board.

Dr STEHLIKOVÁ (Czech Republic), speaking on behalf of the European Union, supported the original draft resolution contained in resolution EB124.R6. She proposed several amendments to the revised text. In the final preambular paragraph, “Mindful of the need for” should be replaced by “Mindful of the need to strengthen”, and the word “market” should be replaced by “corporate”. The beginning of subparagraph 2(4) should be amended to read: “to integrate health equity into the core global development goals”, and the word “devise” should be replaced by “strengthen”. Subparagraph 3(1) should be amended to read: “to tackle the health inequities within and across countries through political commitment on the main principles of ‘closing the gap in a generation’, and to ensure mechanisms to coordination and manage ...”. In subparagraph 3(3), the words “universal health care, and universal availability of” should be replaced by: “including universal access to health promotion, disease prevention and health care,”. In subparagraph 3(9), “data disaggregated according to” should be replaced by “disaggregated data such as”; “when national law and context permits” should be inserted after “employment”. Subparagraph 4(3) should be amended to begin: “to make social determinants of health a guiding principle for the implementation of measures ...”. The word “ensuring” should be inserted after “Member States in” in subparagraph 4(4). In subparagraph 4(11), “Sixty-third” should be replaced by “Sixty-fifth”. In subparagraph 4(12) “ensuring the provision of” was preferable to “providing”.

Mr ABDON (United States of America) expressed a strong preference for the original draft resolution contained in resolution EB124.R6. However, for the sake of consensus he offered the following amendments to the text under consideration. The final preambular paragraph should be deleted. Subparagraph 2(4) should be replaced by: “to consider health equity in discussions of the global development goals and develop indicators to monitor progress in addressing the social determinants of health and reducing health inequities”. The beginning of subparagraph 3(1) should be replaced by: “to tackle health inequities within and across countries and promote mechanisms to coordinate and manage ...”. Subparagraph 3(3) should be reworded: “to consider taking into account health equities in all national policies and to consider establishing and strengthening access to universal comprehensive social protection policies, universal health care, and promote availability of and access to goods and services essential to health and well-being to address social determinants of health”. Subparagraph 4(3) should be replaced by: “to make social determinants of health a guiding principle and promote addressing social determinants of health to reduce health inequities as an objective of all areas of the Organization’s work”. In subparagraph 4(4), the words “in the provision of” should be replaced by “in promoting access to”; the words “and the regulation of goods and

services with major impact on health of the population” should be deleted. Subparagraph 4(12) should be deleted.

Dr THAKSAPHON THAMARANGSI (Thailand), supported by Dr JAYATILLEKA (Sri Lanka), said that he could agree to many of the amendments put forward by the delegate of the Czech Republic, but would have difficulty with some of the suggestions of the previous speaker, in particular the proposal to delete the final preambular paragraph. The new wording of subparagraph 2(4) proposed by the delegate of the United States was quite different from that of the text before the Committee. He emphasized the relevance and importance of subparagraph 4(12).

Mr BULL (Norway), referring to the final preambular paragraph, suggested the addition of a footnote to the effect that global governance should be interpreted in accordance with the definition given on the WHO web site.

Mr ADBOO (United States of America) said that he was not in a position to go further on the text than he had done already, with the exception of the final preambular paragraph, which might be reworded to begin: “Mindful of existing global governance mechanisms to support Member States ...”. He supported the addition of a footnote, which should include the definition of global governance given on the WHO web site.

Ms BENNETT (Australia) said that she would prefer to delete the final preambular paragraph and subparagraph 4(12), but would be prepared to accept the final preambular paragraph with the addition of a footnote in which global governance was well described. She could accept either of the amendments to subparagraph 4(3) and 4(4) proposed by the Czech Republic or the United States, but not the text as it stood.

Mr VOLF (Czech Republic) said that the European Union would need more time to consult on the amendments suggested.

The CHAIRMAN invited interested delegations to consult informally with a view to producing an acceptable text for subsequent consideration by the Committee.

**It was so agreed.**

(For approval of the draft resolution, see section 3 below.)

**Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis:** Item 12.9 of the Agenda (Documents A62/20 and A62/20 Add.1)

The CHAIRMAN, introducing the item, drew attention to the draft resolution proposed by the delegation of China, which read:

The Sixty-second World Health Assembly,

Having considered the reports on the prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis;<sup>1</sup>

Noting the progress made since 1991 towards achieving the international targets for 2005, the acceleration of efforts following the establishment of the Stop TB Partnership in response to

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<sup>1</sup> Documents A62/20 and A62/20 Add.1.

resolution WHA51.13, and more recently following resolution WHA58.14 encouraging Member States to ensure availability of sufficient resources to achieve the internationally agreed goal relevant to tuberculosis contained in the United Nations Millennium Declaration by 2015;

Aware that the development of the Stop TB strategy as a holistic approach to tuberculosis prevention and control and represents a significant expansion in the scale and scope of tuberculosis-control activities as a part of strengthening health systems within the context of primary health care and addressing social determinants of health;

Noting that the Stop TB Partnership's Global Plan to Stop TB 2006–2015 sets out the activities oriented towards implementing the Stop TB strategy and achieving the international targets for tuberculosis control set by the Stop TB Partnership – in line with the target of the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration to “have halted by 2015 and begun to reverse the incidence of major diseases” – of halving tuberculosis prevalence and death rates by 2015 compared with 1990 levels;

Noting that the care and control of tuberculosis have progressed significantly during the past decade and the incidence of new cases is estimated to have fallen slightly each year since 2003;

Aware that a significant proportion – an estimated 37% – of tuberculosis cases worldwide remain un-notified and receive either no treatment or inappropriate treatment;

Recognizing that emergence and spread of multidrug-resistant and extensively drug-resistant tuberculosis is facilitated by not detecting sufficient cases of tuberculosis and not treating them appropriately;

Concerned that the highest levels of multidrug-resistance reported in WHO's fourth global report on anti-tuberculosis drug resistance<sup>1</sup> – an estimated half a million multidrug-resistant cases occurring globally, including 50 000 cases of extensively drug-resistant tuberculosis – pose a threat to global public health security;

Noting that less than 3% of the estimated total number of multidrug-resistant and extensively drug-resistant cases of tuberculosis receive treatment according to WHO recommended standards;

Concerned that the insufficient demand from countries for internationally quality-assured anti-tuberculosis medicines resulting in an inadequate supply through the Green Light Committee mechanism has been a major bottleneck to treating multidrug-resistant and extensively drug-resistant tuberculosis and that quality-assured fixed-dose drug combinations, developed as a tool to prevent the emergence of resistance, are not widely used;

Aware that the delays in implementing the Global Plan to Stop TB 2006–2015 will result in increasing numbers of tuberculosis cases and deaths, including those due to multidrug-resistant and extensively multidrug-resistant tuberculosis and to the impact of HIV, and therefore in delays in achieving by 2015 the international targets for tuberculosis control and the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

Recalling resolution WHA60.19 on tuberculosis control in which the Health Assembly urged Member States to develop and implement long-term plans for tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis prevention and control in line with the Global Plan to Stop TB 2006–2015, within the overall health development plans, and resolution WHA58.33 on achieving universal coverage;

Welcoming the Beijing Call for Action on tuberculosis control and patient care given jointly by representatives of 27 Member States carrying a high burden of multidrug-resistant

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<sup>1</sup> Document WHO/HTM/TB/2008.394.

and extensively drug-resistant tuberculosis, civil society, the private sector and others to address the alarming threat of multidrug-resistant and extensively drug-resistant tuberculosis,<sup>1</sup>

1. URGES all Member States:

- (1) to achieve universal access to diagnosis and treatment of multidrug-resistant and extensively drug-resistant tuberculosis as part of the transition to universal health coverage, thereby saving lives and protecting communities, by means of:
  - (a) developing a comprehensive framework for management and care of multidrug-resistant and extensively drug-resistant tuberculosis, including community-based care, that identifies and addresses the needs of persons living with HIV, the poor and other vulnerable groups, as well as the underlying social determinants of tuberculosis and multidrug-resistant and extensively drug-resistant tuberculosis;
  - (b) aiming to ensure the removal of financial barriers to allow all tuberculosis patients equitable access to tuberculosis care, that their rights are protected, and that they are treated with respect and dignity in accordance with the local legislation;
  - (c) making available sufficiently trained and motivated staff in order to enable diagnosis, treatment and care of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis, as an integral part of efforts to address the overall health workforce crisis;
  - (d) strengthening laboratory systems, through increasing capacity and adequate human resources, and accelerating access to faster and quality-assured diagnostic tests;
  - (e) engaging all relevant public and private health-care providers in managing tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis according to national policies, and strengthening primary health-care networks for effective support to patients;
  - (f) ensuring that national airborne infection-control policies are developed (as part of general infection prevention and control programmes) and implemented in every health-care facility and other high-risk settings and that there is sufficient awareness of tuberculosis infection control in the community;
  - (g) ensuring uninterrupted supply of first- and second-line medicines for tuberculosis treatment, which meet regulatory authority standards or those of the WHO Prequalification programme and that quality-assured fixed-dose combination medicines are prioritized within a system that promotes treatment adherence;
  - (h) strengthening mechanisms to ensure that tuberculosis medicines are sold on prescription only and that they are prescribed and dispensed by accredited public and private providers;
  - (i) undertaking effective advocacy, communication and social mobilization and spreading community awareness about policies and plans for prevention and control of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis;
- (2) to use all possible financing mechanisms in order to fulfil the commitments made in resolutions WHA58.14 and WHA60.19, including the commitment to ensure sustainable domestic and external financing, thereby filling the funding gaps identified in the Global Plan to Stop TB 2006–2015;
- (3) to increase investment by countries and all partners substantially in operational research and research and development for new diagnostics, medicines and vaccines to

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<sup>1</sup> Document A62/20 Add.1, Annex.

prevent and manage tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis;

2. REQUESTS the Director-General:

(1) to provide technical support to Member States in order to develop and implement response plans, based on a comprehensive framework for management of care, for the prevention and control of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis;

(2) to provide support to Member States in developing and implementing strategies to engage all relevant public, voluntary, corporate and private health-care providers in the training for and scaling up of prevention and control of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis;

(3) to advise and support Member States to bring the standards of national drug regulatory agencies in line with international standards, thus enabling national pharmaceutical manufacturers to produce material of sufficiently high quality to be sold in the local and international markets;

(4) to provide support to Member States for upgrading laboratory networks to be able to undertake diagnosis and monitoring of multidrug-resistant and extensively drug-resistant tuberculosis and facilitate systematic evaluations of newer and faster diagnostic technology;

(5) to strengthen the Green Light Committee mechanism to help to expand access to concessionally-priced and quality-assured first- and second-line medicines, to encourage and assist the local pharmaceuticals in high-burden countries to get qualification within the Green Light Committee mechanism;

(6) to support monitoring and evaluation of the implementation of the measures outlined in this resolution;

(7) to report through the Executive Board to the Sixty-second and Sixty-third World Health Assemblies on overall progress made.

The CHAIRMAN pointed out that the reference to the Sixty-second World Health Assembly in subparagraph 2(7) was an error.

Mr SU Haijun (China) observed that there were an estimated 500 000 new cases of multidrug-resistant tuberculosis and more than 50 countries had reported cases of extensively drug-resistant tuberculosis. Globally, only 3% of patients with multidrug-resistant tuberculosis received treatment in accordance with WHO standards. Patients with either type of tuberculosis often suffered discrimination and incurred high expenses in the search for effective treatment.

Earlier that year the Beijing Call for Action on tuberculosis control and patient care had urged all countries to accelerate action on effectively preventing, treating and controlling multidrug- and extensively drug-resistant tuberculosis and to improve their diagnostic capabilities.

The international community should give the issue more attention and he urged all delegations to support the draft resolution. The Secretariat should provide technical support to and work with Member States in order to establish an effective funding mechanism for the control of multidrug- and extensively drug-resistant tuberculosis.

Dr ASLANYAN (Canada) stated that the prevalence of resistance to tuberculosis in Canada remained low, but expressed concern that drug-resistant strains would spread, should the disease not be prevented and controlled internationally. Tuberculosis patterns were monitored in Canada and, in order to control resistance, the country would continue to support WHO and the Stop TB Partnership.

Canada wished to cosponsor the draft resolution, but with the following amendments. A new paragraph should be inserted after the sixth preambular paragraph, reading: "Recognizing [that] the rates of tuberculosis are disproportionately high in indigenous populations;"; and after the original eighth preambular paragraph a new paragraph should be inserted to read: "Recognizing that there is an



urgent need to invest in research for the development of new diagnostics, medicines and vaccines as well as operational research to prevent and manage tuberculosis, including multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis;”.

In subparagraph 1(1)(g), the words “WHO prequalification or rigorous” should be inserted between “meet” and “regulatory”, and the adjectival “quality-assured” be removed. At the beginning of subparagraph 2(6) the words “to work with countries to develop country indicators and” should be inserted.

Dr HUWEL (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed support for the draft resolution but stressed the need for technical and financial support in order to enable countries to improve laboratory techniques, ensure effective treatment and provision of medicines, and strengthen the capability of health-care personnel.

Additional support would be needed for studies that would complement directly observed treatment, short-course (DOTS). He stressed the need for the early detection of multidrug- and extensively drug-resistant tuberculosis in order to prevent the further spread of disease.

Mr CIZA (Burundi), speaking on behalf of the Member States of the African Region, said that many countries in the Region faced the scourge of multidrug- and extensively drug-resistant tuberculosis and that more than 30 countries had reported increased numbers of cases in recent years. The African Region had adopted the DOTS strategy but the cure rate was less than 75%, mainly due to lack of compliance and the lack of knowledge of the results of treatment. Capabilities in the Region for identifying and following up treatment of cases of resistant disease were limited (only Algeria and South Africa could identify resistant organisms), and second-line anti-tuberculosis medicines were too costly for most national programmes.

Some action to counter multidrug- and extensively drug-resistant tuberculosis had been taken: the Regional Office had established a surveillance system and appointed a specialist adviser to coordinate responses; a regional framework had been issued; courses had been organized; at least 10 countries had benefited from second-line medicines at affordable prices through the Green Light Committee Programme; and at least 10 countries had surveyed the extent of drug-resistant tuberculosis or were so doing. Challenges remained, specifically determining the burden of disease and availability of resources.

He supported the draft resolution but stressed that WHO should mobilize funding for prevention and control of resistant disease in the Region and ensure access to front- and second-line medicines that were effective and quality-assured. Speaking as the delegate of Burundi, he asked for greater precision in subparagraph 2(3) and 2(5) about the advice and support to be given Member States in bringing their national drug regulatory agencies into line with international standards, and about the assistance to pharmaceutical companies in countries with a high burden of disease.

Dr GUSEVA (Russian Federation) said that her country was doing a great deal to counter tuberculosis, particularly by increasing funding. Preventive measures were being prioritized, with timely identification of new cases of tuberculosis, especially multidrug-resistant cases, upgraded laboratory facilities and better trained medical staff. The organizational model for limiting the spread of drug-resistant tuberculosis, including access and free treatment, was being revised and its application in pilot regions had resulted in a reduced incidence. Oversight of prevention and control measures was in place at federal and regional levels. As a result, the situation in the country had stabilized. She supported the draft resolution.

Dr KIBARU (Kenya) said that Kenya wished to sponsor the draft resolution. Multidrug- and extensively drug-resistant tuberculosis were a major concern for developing countries and both forms were difficult and expensive to manage. To that end, he urged Member States to adopt the draft resolution that would result in greater support to countries in their responses to the looming epidemic.

Dr LEE Han-Sung (Republic of Korea), noting that multidrug- and extensively drug-resistant tuberculosis represented a public health threat of international concern, expressed support for the draft resolution. The text should, however, put more emphasis on the effective surveillance.

Dr GOUYA (Islamic Republic of Iran), recognizing that the number of cases of multidrug- and extensively drug-resistant tuberculosis was increasing globally, commented on the complexity of both diseases. Many cases were in developing countries where access to diagnostic and care facilities was inadequate and expensive, and many could be attributed to the effect of coinfection with HIV.

He proposed improving national diagnostic facilities, capacity-building and training; establishing global and regional networks of laboratories; sharing experience internationally on diagnosis and treatment; supporting studies on drug-resistant forms of tuberculosis; and supporting countries in order to improve access to sustainable and affordable second-line medicines.

Ms YUAN (United States of America) welcomed the report, with its timely information on the current spread of multidrug-resistant and extensively drug-resistant tuberculosis, especially in eastern Europe, central Asia and Africa. There were barriers to diagnosis and treatment in many Member States and the capacity of health systems would need strengthening, in particular to increase human resources for health and improve training, improve access to quality-assured antituberculosis medicines, expand laboratory systems, and improve the safety of health-care facilities. WHO should nevertheless set realistic goals since the target for treatment of 70 000 cases of multidrug-resistant tuberculosis in 2009 (paragraph 16 of the report) might be overambitious. Further, WHO should ensure that efforts to prevent and control multidrug-resistant and extensively drug-resistant tuberculosis were tailored to the particular needs of Member States and regions.

In subparagraph 1(1)(a) of the draft resolution, she proposed that the words “including community-based care, that” be replaced by “that includes a directly-observed treatment, short-course (DOTS) strategy and community-based and patient-centred care, and”. The amendment to subparagraph 1(1)(g) proposed by the delegate of Canada should be further amended to read: “which meet WHO prequalification or stringent regulatory authority standards”. In subparagraph 2(3), “sufficiently high” should be replaced by “assured”.

Dr SAKCHAI CHAIYAMAHAPURK (Thailand) said that ensuring the high quality of directly-observed treatment, short course (DOTS), one of the six principles of the STOP TB strategy, was crucial for the control of multidrug-resistant and extensively drug-resistant tuberculosis. Reliable epidemiological data were not available in many countries, and health-information systems, including patient registries, would need to be significantly improved in order to guide evidence-based policy interventions. Similarly, considerable investment would be needed in laboratory capacity in order to improve diagnosis of tuberculosis and determine drug sensitivity of *Mycobacterium tuberculosis*.

He proposed the following amendments to the draft resolution. Two additional paragraphs should be inserted after the ninth preambular paragraph. The first should read “Concerned that disease transmission occurs mostly in the community where there is a lack of appropriate infection control”. That text would support subparagraph 1(1)(i). The second should read: “Recognizing an urgent need for substantial increases in funding for research and development of new diagnostics, medicines and vaccines for tuberculosis, while ensuring affordability of these new products by de-linking the cost of research and development and the prices of health products”. That text was consistent with specific action 5.3(a) of the Global strategy and plan of action on public health, innovation and intellectual property.<sup>1</sup>

In subparagraph 1(1)(a), the words “such as prisoners, mineworkers, migrants, drug users and alcohol dependents” should be added after “vulnerable groups”. Two new subparagraphs should be added at the end of subparagraph 1(1), which would read: “establishing national targets in order to

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<sup>1</sup> Document A62/16 Add.1, Annex.

accelerate access to treatment according to WHO guidelines for patients with multidrug-resistant and extensively drug-resistant tuberculosis” – that wording would address the low rate of access to treatment mentioned in the ninth preambular paragraph – and “strengthening health-information systems for monitoring the epidemiological profile and achievements in the prevention and control of multidrug-resistant and extensively drug-resistant tuberculosis”. A new subparagraph 1(2) should be added to read: “to enhance the quality and coverage of DOTS to achieve a 70% detection rate and an 85% treatment success rate, thereby preventing secondary multidrug-resistant tuberculosis. The remaining subparagraphs in paragraph 1 should be renumbered accordingly.

A new subparagraph 2(6) should be added to read “to explore and promote a range of incentive schemes for research and development, including the de-linkage of the cost of research and development from the price of medical products”. The remaining subparagraphs in paragraph 2 should be renumbered accordingly. In existing subparagraph 2(7), “Sixty-second and Sixty-third World Health Assemblies on overall progress made” should be replaced by “Sixty-third and Sixty-fifth World Health Assemblies on progress on Stop TB, including multidrug-resistant and extensively drug-resistant tuberculosis”.

Dr SUGIURA (Japan) commended WHO’s efforts to prevent and control multidrug-resistant and extensively drug-resistant tuberculosis. Japan had supported those efforts through voluntary contributions to WHO and to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and through technical cooperation and human resource development provided by the Japan International Cooperation Agency and the Research Institute of Tuberculosis in Tokyo. In July 2008, participants in the 6th Technical Advisory Group Meeting to Stop TB in the Western Pacific Region (Tokyo, 22–24 July 2008) had recognized the need for technical support for introduction of new technologies, such as diagnostic procedures for multidrug-resistant tuberculosis. The Stop TB Japan Action Plan, which had been announced at the International Tuberculosis Symposium (Tokyo, 24–25 July 2008), was designed to provide continuous support to global tuberculosis control efforts based on the Japanese experience of technical support and human resource development. It was important to recognize that, even though new solutions should be sought, high-quality DOTS was still the most important measure to prevent multidrug-resistant and extensively drug-resistant tuberculosis. He therefore proposed amending the draft resolution by adding “by directly-observed treatment, short-course (DOTS)” at the end of the seventh preambular paragraph. With that amendment he could support the draft resolution, and said that he looked forward to WHO’s leadership in combating multidrug-resistant and extensively drug-resistant tuberculosis.

Dr AL JALAHMA (Bahrain) said that, with tuberculosis still a worldwide problem despite the availability of highly effective medicines and vaccines, WHO’s efforts to combat the disease were greatly appreciated. The tuberculosis control programme in Bahrain had been strengthened in 2008 as tuberculosis had re-emerged. A policy of screening people with tuberculosis for HIV infection and vice versa had been introduced. Bahrain was also implementing the DOTS strategy to curb the development of resistance. A national plan had been drawn up to reduce the incidence and prevalence of tuberculosis by 2012. Bahrain supported the principles set out in the draft resolution and stood ready to join other Member States in activities to achieve better prevention and control of multidrug-resistant and extensively drug-resistant tuberculosis.

Mr VOLF (Czech Republic), speaking on behalf of the European Union, said that it was encouraging that the incidence rate for tuberculosis had been declining since 2003 and it appeared that the relevant target in Millennium Development Goal 6 would be achieved before 2015. However, death rates were not falling so fast, especially in the European and African regions. Action to contain and reduce the spread of drug-resistant tuberculosis was urgently needed.

The European Union supported the Global Plan to Stop TB 2006–2015 as a tool to define needs, and would continue to act in favour of vulnerable populations; to contribute to health-system strengthening based on primary health care; to engage all care providers; and to empower people with tuberculosis and their communities. Tuberculosis and HIV prevention and control programmes should

be integrated into the health system at all levels. An action plan to fight tuberculosis in the European Union had been published by the European Centre for Disease Prevention and Control in 2008. It included proposals for combating multidrug-resistant and extensively drug-resistant tuberculosis. Work on an operational plan was continuing.

The Stop TB Partnership required renewal in the European Region. In its Seventh Research Framework Programme (2007–2015), the European Union supported innovative research in collaboration with international partners in the areas of diagnostic agents, medicines and vaccines.

He acknowledged WHO's technical guidance for the programmatic management of multidrug-resistant tuberculosis. The European Union was supporting national efforts to improve the availability of appropriate diagnostic tests, access to effective quality-assured second-line treatments, and capacity-building. Collaboration between institutions was crucial: for example, the WHO Regional Office for Europe and the European Centre for Disease Prevention and Control had recently issued their first joint surveillance report on tuberculosis control, an essential tool for monitoring progress.

The Berlin Declaration on Tuberculosis (October 2007) had created a momentum that must be maintained. A joint meeting on tuberculosis organized by the European Commission, the European Centre for Disease Prevention and Control and the WHO Regional Office for Europe was planned for June–July 2009 in Luxembourg, and should support follow-up to the Declaration, including commitments to resources for all aspects of tuberculosis control.

Mr ARISTIZABAL (Colombia) observed that prevention and control of tuberculosis, and in particular multidrug-resistant and extensively drug-resistant tuberculosis, required more administrative, technical, scientific and financial support to many countries. In Colombia, special care was needed for specific disadvantaged population groups, such as displaced persons, indigenous people and prisoners. Global research was needed to assess interventions for disease control, including new diagnostic procedures and resistance surveillance, and to assess new medicines and clinical trials in accordance with WHO parameters. He supported the draft resolution.

Dr ADMASU (Ethiopia) supported the draft resolution, which provided sound and detailed recommendations for action. At the ministerial meeting (Beijing, 1–3 April 2009), 27 Member States with a high burden of multidrug-resistant and extensively drug-resistant tuberculosis, including Ethiopia, had endorsed the Beijing Call for Action on tuberculosis control and patient care. Member States had pledged to work towards universal access to diagnosis and treatment and to increase and sustain domestic and external funding.

Ethiopia was implementing a community DOTS service using a wide network of health extension workers to undertake detection, referral, provision of DOTS, contact tracing, reporting and support to volunteer DOTS observers. In cooperation with its development partners, Ethiopia was also increasing its laboratory capacity at the federal and regional levels. However, the actions proposed in the draft resolution would require sustained technical and financial support and he urged WHO and other relevant international bodies to give priority to those concerns.

Dr BALOCH (Pakistan) endorsed the draft resolution, and requested the Health Assembly to recommend urgent, extensive mobilization of resources by countries, donors and technical agencies to cope with the complex and costly management of drug-resistant tuberculosis.

Mr VOLF (Czech Republic), speaking on behalf of the Member States of the European Union, supported the draft resolution and suggested that subparagraph 1(1)(e) be amended to read: "... extensively drug-resistant tuberculosis and TB/HIV coinfection according to national health policies, and strengthening primary health care in early detection, effective treatment and support to patients". Subparagraph 1(1)(i) should read: "... social mobilization, avoiding stigmatization and discrimination, and spreading ...", and paragraph 2(2) "... and extensively drug-resistant tuberculosis and all aspects of HIV co-infection;"

Mr MONTIEL (Bolivarian Republic of Venezuela) stressed early detection and treatment of tuberculosis according to internationally recommended standards, and ensuring patients' compliance with treatment. His Government continued to prioritize universal access to diagnosis and high-quality, free treatment. It had achieved 100% DOTS coverage, with increasing success rates each year. Antituberculosis medicines were administered free of charge under trained supervision: the absence of over-the-counter sales significantly reduced the risks of self-medication and the emergence of resistant strains of *Mycobacterium tuberculosis*. Supplies of first-line medicines would be ensured by local manufacturing facilities. The annual incidence of multidrug-resistant tuberculosis was steady, with no cases of extensively drug-resistant tuberculosis recorded to date; however, the Government was alert to the risk from cross-border transmission through legal and illegal immigration and favoured a policy of keeping track of patients by means of bilateral information-sharing agreements.

Dr MUSTAFA (Sudan) endorsed the report and supported the draft resolution, requesting addition of a new subparagraph in paragraph 1, reading: "to strengthen health information and surveillance systems to ensure detection and monitoring of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis".

Dr GILPIN (International Organization for Migration) drew attention to the increase in cross-border migration caused by conflicts and the global financial crisis, and the vulnerability of poor and marginalized migrants to infectious diseases. The prevention and control of multidrug-resistant and extensively drug-resistant tuberculosis called for a regional response to make sure that all migrants, irrespective of their legal status, had access to diagnosis and treatment, and to community-based initiatives that emphasized their continued treatment until fully cured. In the interests of both migrant and host communities, his organization was keen to work with Member States, the Secretariat and other stakeholders to establish rapid diagnosis and treatment services in cross-border regions.

Mr GOGUADZE (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that governments and other stakeholders must pool their capacities in partnership with civil society and the private sector in order to meet one of the great humanitarian challenges of the day, namely the global fight against tuberculosis, especially multidrug-resistant and extensively drug-resistant tuberculosis.

Dr Yen-Jen SUNG (Observer, Chinese Taipei), speaking at the invitation of the CHAIRMAN, said that Chinese Taipei had developed an island-wide programme aimed at halving the incidence of tuberculosis in line with the Global Plan to Stop TB 2006–2015. Funding of US\$ 10 million a year had been allocated to DOTS and DOTS-Plus programmes. A consortium had been set up to expand involvement of the private sector and covered most multidrug-resistant cases; good early responses to treatment were being seen. Nevertheless, multidrug-resistant tuberculosis still accounted for around 1% of new tuberculosis cases each year. He welcomed the report on the ministerial meeting (document A62/20 Add.1) and the draft resolution. Chinese Taipei would be pleased to share its experience in preventing the global spread of multidrug-resistant and extensively drug-resistant tuberculosis through participation in future technical meetings organized by WHO and other international partners.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN, described the emergence of multidrug-resistant and extensively drug-resistant tuberculosis as a wake-up call for the strengthening of health systems. Emphasizing increased access to prevention, detection, treatment and care, his organization, in partnership with the pharmaceutical industry, national nurses' associations and ministries of health, had embarked on a global capacity-building project based on a "training of trainers" approach. It aimed to create a sustainable workforce that would train nurses and other health workers in high-burden countries.

Dr VON SCHLOEN ANGERER (MSF International), speaking at the invitation of the CHAIRMAN, said that progress towards universal access to treatment for multidrug-resistant

tuberculosis was falling far short of the targets of the Global Plan to Stop TB 2006–2015. A standard set of indicators must be developed to monitor progress with attention to people living with HIV/AIDS, migrants, prisoners and other vulnerable groups at risk because of stigmatization and discrimination. Affected communities and nongovernmental organizations needed to be involved in delivering treatment and monitoring progress in expanding treatment of multidrug-resistant tuberculosis. Sufficient first-line and second-line medicines were crucial together with strict quality standards to minimize the risk of resistance. Global targets could not be reached without better tools yet current spending on tuberculosis research came to less than a quarter of the annual requirement estimated by the Treatment Action Group, and no funding was available for the clinical trials needed to optimize treatment of multidrug-resistant tuberculosis. The Secretariat and Member States should encourage the use of alternative mechanisms of financing for making the available tools affordable by de-linking the cost of research and development from the price of the products.

Dr NAKATANI (Assistant Director-General) recognized the new challenges of tuberculosis, particularly in its multidrug-resistant and extensively drug-resistant forms. Even though the incidence of tuberculosis had been declining since 2004, the rate of decline was unsatisfactory, and the report had identified issues that needed to be addressed and action that should be taken by all Member States. High-level policy reinforcement or reform was required in all Member States, as well as commitment.

The specific concerns raised by delegates fell into three major areas. Regarding the interface between the Secretariat and Member States, and in response to the question from the delegate of Iraq, he said that WHO staff at headquarters and in the regional offices would make every effort to meet Member States' technical assistance needs. In response to the question by the delegate of Burundi about the work of WHO in Africa and in particular the Regional Office for Africa, he said that the Programme budget 2010–2011 allocated 37% of the resources related to HIV, tuberculosis and malaria to Africa. Normative functions such as monitoring indicators and new treatment guidelines would be addressed by staff at headquarters and the regional offices. Regarding research and development, WHO was working with research-oriented partners to find new ways to tackle the diseases. As to how WHO would work to address other issues, WHO was working with its partners, particularly the Stop TB Partnership and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) asked the Secretariat what the term "stringent regulatory authority standards" meant, noting that the web site referred to the Pharmaceutical Inspection Convention and Pharmaceutical Inspection Co-operation Scheme, of which only 33 countries were members.

Dr HOGERZEIL (Medicines Policy, Essential Drugs and Traditional Medicine) said that the term "stringent regulatory authority standards" was often used, especially in connection with the WHO Prequalification programme, and did not refer to specific regulators: sometimes the term was used in connection with the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use and sometimes in relation to the Pharmaceutical Inspection Co-operation Scheme.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) requested further clarification of the consequences of requiring stringent regulatory authority standards for first- and second-line medicines for tuberculosis treatment in regard to supply of such medicines.

Dr HOGERZEIL (Medicines Policy, Essential Drugs and Traditional Medicine) said that the term was very common in the context of international procurement and international supply provided by international bodies such as United Nations agencies, the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the international drug purchase facility UNITAID. Regulatory authority standards were used in such situations to select and to identify which products would be accepted. Since some medicines for certain diseases were not available according to such standards,

other standards could then be used based on risk assessment. However, Member States always had full authority over national procurement of goods, in accordance with their own standards.

The CHAIRMAN suggested that the Secretariat should prepare a revised version of the draft resolution to incorporate all of the amendments proposed and to be distributed later for the Committee's consideration.

**It was so agreed.**

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

## **2. SECOND REPORT OF COMMITTEE A: (Document A62/51)**

Ms AYDIN (Turkey), Rapporteur, read out the draft second report of Committee A.

**The report was adopted.<sup>1</sup>**

## **3. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (resumed)**

**Commission on Social Determinants of Health:** Item 12.5 of the Agenda (Documents EB124/2009/REC/1, resolution EB124.R6, and A62/9) (resumed)

Ms DAVIES (United Kingdom of Great Britain and Northern Ireland), reporting on the outcome of the informal consultations on the draft resolution considered earlier in the meeting, read out the following consolidated amendments. The final preambular paragraph should read: "Mindful of the important role of existing global governance mechanisms to support Member States in provision of basic services essential to health and the regulation of goods and services with a major impact on health, and the need for corporate responsibility", with a footnote to be inserted after the word "governance" giving a link to the defining text on the WHO web site. Subparagraph 2(4) should read: "to consider health equity in working towards the achievement of the core global development goals and to develop indicators to monitor progress, and to consider strengthening international collaboration in addressing the social determinants of health and in reducing health inequities". Subparagraph 3(1) should read: "to tackle the health inequities within and across countries through political commitment on the main principles of 'closing the gap in a generation' as a national concern, as is appropriate, and to coordinate and manage intersectoral action for health in order to mainstream health equity in all policies, where appropriate, by using health and health equity impact assessment tools". Subparagraph 3(3) should read: "to take into account health equity in all national policies that address the social determinants of health, and to consider developing and strengthening universal comprehensive social protection policies, including health promotion, disease prevention and health care, and promoting availability of and access to goods and services essential to health and well-being". Subparagraph 3(9) should read: "to develop, make use of, and if necessary, improve health information systems and research capacity in order to monitor and measure the health of national populations with disaggregated data such as age, gender, ethnicity, race, caste, occupation, education, income and employment (where national law and context permit) so that health inequities can be detected and the impact of policies on health equity measured". Subparagraph 4(3) should read: "to

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<sup>1</sup> See page 199.

make social determinants of health a guiding principle for the implementation of measures, including objective indicators for the monitoring of social determinants of health, across relevant areas of work and promote addressing the social determinants of health to reduce health inequities as an objective of all areas of the Organization's work, especially priority public health programmes". Subparagraph 4(4) should read: "to support the primary role of Member States in promoting access to basic services essential to health and the regulation, as appropriate, of goods and services with a major impact on health". Subparagraph 4(11) should read: "to convene a global event, with the assistance of Member States, before the Sixty-fifth World Health Assembly in order to discuss renewed plans for addressing the alarming trends of health inequities through addressing the social determinants of health". Subparagraph 4(12) should read: "to study and assess the performance of existing global governance mechanisms to address the social determinants of health and reduce health inequities".

Dr THAKSAPHON THAMARANGSI (Thailand) thanked all delegates for their constructive effort on the matter, particularly those of Sri Lanka, the United States of America, and the Czech Republic.

Dr VEGA MORALES (Chile), speaking on behalf of the Union of South American Nations, expressed agreement with all submissions except with respect to subparagraph 4(11) and recalled that the Union had specifically requested the inclusion therein of a clause requesting the Director-General to report to the Sixty-fifth World Health Assembly on the results of the global event.

Ms DAVIES (United Kingdom of Great Britain and Northern Ireland) observed that, since subparagraph 4(13) requested the Director-General to report on progress in implementing the resolution to the Sixty-fifth World Health Assembly through the Executive Board, such a clause was unnecessary in subparagraph 4(11).

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

**The meeting rose at 16:50.**

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA62.14.



## **TENTH MEETING**

**Friday, 22 May 2009, at 09:25**

**Chairman:** Dr F. MENESES GONZÁLEZ (Mexico)

### **1. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)**

**Primary health care, including health system strengthening:** Item 12.4 of the Agenda (Documents EB124/2009/REC/1, resolutions EB124.R8 and EB124.R9, and A62/8) (continued from the eighth meeting)

The CHAIRMAN said that there was a technical error in one paragraph of the resolution already approved by the Committee on “Primary health care, including health system strengthening” (resolution WHA62.12).

Ms DOLEA (Assistant Secretary) said that subparagraph 1(3) should read as follows: “to put people at the centre of health care by adopting, as appropriate, delivery models focused on the local and district levels that provide comprehensive primary health care services, including health promotion, disease prevention, curative care and palliative care, that are integrated and coordinated according to needs, while ensuring effective referral system”. The phrases “with other levels of care” and “to secondary and tertiary care” should be deleted.

### **2. DRAFT THIRD REPORT OF COMMITTEE A (Document A62/52)**

Ms AYDIN (Turkey), Rapporteur, read out the draft third report of Committee A.

Mr ALBUQUERQUE E SILVA (Brazil), supported by Ms THANTIDA WONGPRASONG (Thailand), drew attention to the draft resolution on agenda item 11 appended to the report and specifically to the phrase “endorses the amended Medium-term strategic plan 2008–2013”. Did the term “amended” cover the point raised by Brazil with regard to counterfeit medicines?

Dr ISLAM (Secretary) confirmed that the reference in the plan to counterfeit medicines had been amended as requested.

**The report was adopted.<sup>1</sup>**

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<sup>1</sup> See page 200.

### 3. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (resumed)

**Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis:** Item 12.9 of the Agenda (Documents A62/20 and A62/20 Add.1) (continued from the ninth meeting, section 1)

The CHAIRMAN drew attention to the revised version of the draft resolution that incorporated amendments proposed at the previous meeting and which read:

The Sixty-second World Health Assembly,

Having considered the reports on the prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis;<sup>1</sup>

Noting the progress made since 1991 towards achieving the international targets for 2005, the acceleration of efforts following the establishment of the Stop TB Partnership in response to resolution WHA51.13, and more recently following resolution WHA58.14 encouraging Member States to ensure availability of sufficient resources to achieve the internationally agreed goal relevant to tuberculosis contained in the United Nations Millennium Declaration by 2015;

Aware that the development of the Stop TB strategy as a holistic approach to tuberculosis prevention and control and represents a significant expansion in the scale and scope of tuberculosis-control activities as a part of strengthening health systems within the context of primary health care and addressing social determinants of health;

Noting that the Stop TB Partnership's Global Plan to Stop TB 2006–2015 sets out the activities oriented towards implementing the Stop TB strategy and achieving the international targets for tuberculosis control set by the Stop TB Partnership – in line with the target of the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration to “have halted by 2015 and begun to reverse the incidence of major diseases” – of halving tuberculosis prevalence and death rates by 2015 compared with 1990 levels;

Noting that the care and control of tuberculosis have progressed significantly during the past decade and the incidence of new cases is estimated to have fallen slightly each year since 2003;

Aware that a significant proportion – an estimated 37% of tuberculosis cases worldwide remain un-notified and receive either no treatment or inappropriate treatment;

**Recognizing that the rates of tuberculosis are disproportionately high in indigenous populations; [Canada]**

Recognizing that emergence and spread of multidrug-resistant and extensively, drug-resistant tuberculosis is facilitated by not detecting sufficient cases of tuberculosis and not treating them appropriately **by DOTS-based treatment [Japan] [United States of America]**

Concerned that the highest levels of multidrug-resistance reported in WHO's fourth global report on antituberculosis drug resistance<sup>2</sup> – an estimated half a million multidrug-resistant cases occurring globally, including 50 000 cases of extensively drug-resistant tuberculosis – pose a threat to global public health security;

**Recognizing that there is an urgent need to invest in research for development of new diagnostics, medicines and vaccines and in operational research to prevent and manage tuberculosis, including multidrug-resistant and extremely drug-resistant tuberculosis; [Canada] while ensuring affordability of these new products by de-linking cost of research and development from the prices of health products; [Thailand]**

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<sup>1</sup> Documents A62/20 and A62/20 Add.1.

<sup>2</sup> Document WHO/HTM/TB/2008.394.

Noting that less than 3% of the estimated total number of multidrug-resistant and extensively drug-resistant cases of tuberculosis receive treatment according to WHO recommended standards;

**Concerned that the disease transmission occurs mostly in communities where there is a lack of appropriate infection control; [Thailand]**

Concerned that the insufficient demand from countries for internationally quality-assured antituberculosis medicines resulting in an inadequate supply through the Green Light Committee mechanism has been a major bottleneck to treating multidrug-resistant and extensively drug-resistant tuberculosis and that quality-assured fixed-dose drug combinations, developed as a tool to prevent the emergence of resistance, are not widely used;

Aware that the delays in implementing the Global Plan to Stop TB 2006–2015 will result in increasing numbers of tuberculosis cases and deaths, including those due to multidrug-resistant and extensively multidrug-resistant tuberculosis and to the impact of HIV, and therefore in delays in achieving by 2015 the international targets for tuberculosis control and the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

Recalling resolution WHA60.19 on tuberculosis control in which the Health Assembly urged Member States to develop and implement long-term plans for tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis prevention and control in line with the Global Plan to Stop TB 2006–2015, within the overall health development plans, and resolution WHA58.33 on achieving universal coverage;

Welcoming the Beijing Call for Action on tuberculosis control and patient care given jointly by representatives of 27 Member States carrying a high burden of multidrug-resistant and extensively drug-resistant tuberculosis, civil society, the private sector and others to address the alarming threat of multidrug-resistant and extensively drug-resistant tuberculosis,<sup>1</sup>

1. URGES all Member States:

(1) to achieve universal access to diagnosis and treatment of multidrug-resistant and extensively drug-resistant tuberculosis as part of the transition to universal health coverage, thereby saving lives and protecting communities, by means of:

(a) developing a comprehensive framework for management and care of multidrug-resistant and extensively drug-resistant tuberculosis; **that including includes directly-observed treatment, community-based and patient-centred care, that and which [United States] identifies and addresses the needs of persons living with HIV, the poor and other vulnerable groups, such as prisoners, mineworkers, migrants, drug users, and alcohol dependants, [Thailand] as well as the underlying social determinants of tuberculosis and multidrug-resistant and extensively drug-resistant tuberculosis;**

**(abis) strengthening health information and surveillance systems to ensure detection and monitoring of the epidemiological profile of multidrug-resistant and extensively drug-resistant tuberculosis and monitor achievement in its prevention and control; [Sudan] [Thailand]**

(b) aiming to ensure the removal of financial barriers to allow all tuberculosis patients equitable access to tuberculosis care, that their rights are protected, and that they are treated with respect and dignity in accordance with the local legislation;

(c) making available sufficiently trained and motivated staff in order to enable diagnosis, treatment and care of tuberculosis including multidrug-resistant and

<sup>1</sup> Document A62/20 Add.1, Annex.

extensively drug-resistant tuberculosis, as an integral part of efforts to address the overall health workforce crisis;

(d) strengthening laboratory systems, through increasing capacity and adequate human resources, and accelerating access to faster and quality-assured diagnostic tests;

(e) engaging all relevant public and private health-care providers in managing tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis **and tuberculosis-HIV coinfection** according to national policies, and strengthening primary health care **in early detection, effective treatment and support to patients; networks for effective support to patients; [Czech Republic]**

(f) ensuring that national airborne infection-control policies are developed (as part of general infection prevention and control programmes) and implemented in every health-care facility and other high-risk settings and that there is sufficient awareness of tuberculosis infection control in the community;

(g) ensuring uninterrupted supply of first-, and second-line medicines for tuberculosis treatment, which meet **WHO prequalification or stringent [Canada] [United States of America]** regulatory authority standards, ~~or those of the WHO Prequalification programme [Canada]~~ and that quality-assured fixed-dose combination medicines are prioritized within a system that promotes treatment adherence;

(h) strengthening mechanisms to ensure that tuberculosis medicines are sold on prescription only and that they are prescribed and dispensed by accredited public and private providers;

(i) undertaking effective advocacy, communication and social mobilization, **avoiding stigmatization and discrimination, [Czech Republic]** and spreading community awareness about policies and plans for prevention and control of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis;

(j) **establishing national targets in order to accelerate access to treatment according to WHO guidelines, for multidrug-resistant and extremely drug-resistant tuberculosis patients; [Thailand]**

**(1bis) to enhance quality and coverage of DOTS in achieving 70% detection rate and 85% success rate of tuberculosis treatment, thereby preventing secondary multidrug-resistant tuberculosis; [Thailand]**

(2) to use all possible financing mechanisms in order to fulfil the commitments made in resolutions WHA58.14 and WHA60.19, including the commitment to ensure sustainable domestic and external financing, thereby filling the funding gaps identified in the Global Plan to Stop TB 2006–2015;

(3) to increase investment by countries and all partners substantially in operational research and research and development for new diagnostics, medicines and vaccines to prevent and manage tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis;

## 2. REQUESTS the Director-General:

(1) to provide technical support to Member States in order to develop and implement response plans, based on a comprehensive framework for management of care, for the prevention and control of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis;

(2) to provide support to Member States in developing and implementing strategies to engage all relevant public, voluntary, corporate and private health-care providers in the training for and scaling up of prevention and control of tuberculosis including multidrug-resistant and extensively drug-resistant tuberculosis **and all aspects of tuberculosis-HIV coinfection; [Czech Republic]**

- (3) to advise and support Member States to bring the standards of national drug regulatory agencies in line with international standards, thus enabling national pharmaceutical manufacturers to produce material of ~~sufficiently high assured~~ **[United States of America]** quality to be sold in the local and international markets;
- (4) to provide support to Member States for upgrading laboratory networks to be able to undertake diagnosis and monitoring of multidrug-resistant and extensively drug-resistant tuberculosis and facilitate systematic evaluations of newer and faster diagnostic technology;
- (5) to strengthen the Green Light Committee mechanism to help to expand access to concessionally-priced and quality-assured first- and second-line medicines, to encourage and assist the local pharmaceuticals in high-burden countries to get qualification within the Green Light Committee mechanism;
- (5bis) to explore and promote a range of incentive schemes of research and development, including the de-linkage of the cost of research and development from the price of medical products; [Thailand]**
- (6) to work with countries to develop country indicators and [Canada]** to support monitoring and evaluation of the implementation of the measures outlined in this resolution;
- (7) to report through the Executive Board to the Sixty-second~~third~~ and Sixty-third~~third~~ fifth [Canada] [Thailand]** World Health Assemblies on overall progress made.

Mr ABDOO (United States of America), supported by Dr SAKCHAI CHAIYAMAHAPURK (Thailand), suggested that the tenth preambular paragraph should be aligned with the wording of specific action 5.3(a) of WHO's Global strategy and plan of action on public health, innovation and intellectual property, and should thus read: "Exploring and, where appropriate, promoting a range of incentive schemes for research and development including addressing, where appropriate, the de-linkage of the costs of research and development and the price of health products".

Similarly, subparagraph 2(5)bis should be reworded to read: "to explore and, where appropriate, promote a range of incentive schemes for research and development including addressing, where appropriate, the de-linkage of the costs of research and development and the price of health products".

Mr SU Haijun (China) suggested that the first word of subparagraph 1(1)(g), "ensuring", should be replaced by "aiming to ensure".

Dr CAMPBELL-FORRESTER (Jamaica) suggested that, in the seventh preambular paragraph, the words "in indigenous populations" should be changed to "in high-risk populations, including indigenous populations".

Ms BLACK (Canada), speaking as the sponsor of the paragraph in question, said that she had no objection to the amendment proposed by Jamaica. With regard to subparagraph 1(1)(g), she proposed to clarify the word "stringent", which had been included at Canada's request, by rewording the paragraph as follows: "ensuring uninterrupted supply of first- and second-line medicines for tuberculosis treatment, which meet stringent international standards as defined by the WHO Prequalification programme or equivalent national standards and that quality-assured fixed-dose combination medicines of proven bioavailability are prioritized within a system that promotes treatment adherence".

Mr ABDOO (United States of America) supported the amendment proposed by Canada.

Mr SU Haijun (China) reiterated his wish to change "ensuring" to "aiming to ensure". He accepted the other amendments proposed by Canada.

Mr ABDOO (United States of America) said that he could agree to the Chinese proposal if subparagraph 1(1)(g) was further amended to read: “aiming to ensure uninterrupted supply of first- and second-line medicines for tuberculosis treatment and ensuring those medicines meet stringent international standards”.

Mr SU Haijun (China) could not agree to that suggestion. He insisted on retaining the amendments proposed by Canada.

Mr MONTIEL (Bolivarian Republic of Venezuela) considered that the first word of subparagraph 1(1)(g) should remain as “ensuring”.

The CHAIRMAN requested the delegations of Canada, China, Thailand, the United States of America and the Bolivarian Republic of Venezuela to work together to devise a consensus text.

**The meeting was suspended at 09:45 and resumed at 10:55.**

The CHAIRMAN asked the Secretary to read out the proposed amendments and the consensus text discussed by the interested delegations.

Ms VESTAL (Assistant Secretary) read out the consensus text of subparagraph 1(1)(g), which read as follows: “ensuring an uninterrupted supply of first- and second-line medicines for tuberculosis treatment, which meet WHO prequalification standards or [comparable/assured] national standards, and that quality-assured fixed-dose combination medicines of proven bioavailability are [prioritized/encouraged] within a system that promotes treatment adherence”.

With the amendment proposed by Jamaica, the seventh preambular paragraph would read “Recognizing that the rates of tuberculosis are disproportionately high in high-risk populations, including indigenous populations”. In the tenth preambular paragraph, the United States had proposed to delete the last phrase, beginning with the words “while ensuring affordability”, and to substitute the following: “exploring and, where appropriate, promoting a range of incentive schemes for research and development including addressing, where appropriate, the de-linkage of the costs of research and development and the price of health products”. The United States had proposed similar wording to replace the text of subparagraph 2(5)bis, which would accordingly read: “to explore and, where appropriate, promote a range of incentive schemes for research and development including addressing, where appropriate, the de-linkage of the costs of research and development and the price of health products”.

The CHAIRMAN requested delegates to express their preferences regarding the bracketed terms in the consensus text: “[comparable/assured]” and “[prioritized/encouraged]”.

Dr REN Minghui (China), Dr KUSRIASTUTI (Indonesia) and Dr SAKCHAI CHAIYAMAHAPURK (Thailand) expressed a preference for the word “assured”.

Mr ABDOO (United States of America) preferred “comparable”.

Dr ASLANYAN (Canada) and Mr VOLF (Czech Republic) said that the text should retain “comparable” and “prioritized”.

Dr CHAUHAN (India), Mrs OYWER (Kenya), Ms AYE (Myanmar), Dr GBADAMOSI (Nigeria) and Mr JAYATHILAKA (Sri Lanka) expressed a preference for “assured” and “encouraged”.

Dr MASKEY (Nepal) explained that Nepal preferred “assured” because it made the national authorities responsible for applying national standards. In the second pair of terms, either “prioritized” or “encouraged” would be acceptable.

Dr SUGIURA (Japan) supported the United States’ position. High-quality medicines were essential for treating multidrug-resistant tuberculosis.

Ms CEESAY (Gambia) said that, although she had not been in the room when the interested delegations had returned, she understood that consensus had been reached on the words “assured” and “encouraged”. She expressed concern that the Committee was spending so much time on what was essentially a semantic problem.

The CHAIRMAN said that the text as a whole appeared to reflect a consensus except in the case of certain words. He urged delegates to agree on one of the two proposals presented so that the resolution, which was important for all countries, could be approved.

Mr XABA (Swaziland) asked why the interested delegations had been unable to agree.

Dr CHAUHAN (India) said that in subparagraph 1(1)(g) it had initially been proposed to insert the word “stringent” before “regulatory authority standards”. It had then been proposed to replace “stringent” with “equivalent”, but that term had been rejected as too exacting. Canada had then suggested “comparable”, but some delegations had disagreed because that term sought to link national standards to WHO prequalification standards. So, as a compromise, the word “assured” had been chosen because it was felt that national authorities would try to assure quality for their own populations. With regard to “prioritized” and “encouraged”, experts at the meeting of ministers from countries with high burdens of multidrug-resistant and extensively drug-resistant tuberculosis (Beijing, 1–3 April 2009) had agreed that it would be easier to ensure compliance with the treatment regimen if co-blistered packs were used rather than fixed-dose combination medicines, which could, however, be encouraged.

Mr WATERBERG (Suriname) said that, if no compromise could be reached, it would be best to take a vote. He was confident that the minority would go along with whatever the majority decided.

The CHAIRMAN suggested that the Committee should try to reach agreement on the terms to be used in subparagraph 1(1)(g) before the other proposed amendments were considered.

Ms BLACK (Canada) said that her delegation had proposed the term “comparable” because it was less stringent than “equivalent” and offered more flexibility to Member States that were not in a position to adopt national standards equivalent to the WHO Prequalification programme. Although she would be reluctant to change the word “comparable”, she could, in a spirit of compromise, accept the preference of some Member States for “encouraged” over “prioritized”.

Dr REN Minghui (China) said that, although his delegation was flexible with regard to the use of “encourage” or “prioritize”, it would not accept the term “comparable”.

Dr THAKSAPHON THAMARANGSI (Thailand), supported by Dr CHAUHAN (India), still preferred the word “assured”. The word “comparable” could prevent access by patients to tuberculosis medicines.

Mr ABDON (United States of America) said that the issue was access to products that would actually help to treat tuberculosis, prevent additional drug resistance and halt the further spread of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis. Stringent regulatory standards were needed to avoid worsening what was already a global problem. He preferred the word

“comparable” because it recognized that not all Member States could meet the WHO prequalification standards currently, but that a comparable standard should be applied to ensure the safety, efficacy and quality of the medicines.

Dr REN Minghui (China) acknowledged the concerns of the delegates of Canada and the United States; he believed, however, that most Member States were more concerned about ensuring the quality of medicines for multidrug-resistant tuberculosis. He proposed that wording from the Beijing Call for Action on Tuberculosis Control and Patient Care, i.e. “strict regulatory authority standards”, should be inserted following “which meet WHO prequalification standards or”.

Mr ABDOO (United States of America), supported by Ms BLACK (Canada), Professor ADITAMA (Indonesia) and Dr SAKCHAI CHAIYAMAHAPURK (Thailand), said that he could accept the Chinese proposal.

Dr CHAUHAN (India) said that it was his understanding that Canada preferred the word “encouraged” in the last line of subparagraph 1(1)(g). It was also the word that he preferred.

Mr ABDOO (United States of America) said that he did not agree to the use of the word “encouraged”. In a spirit of compromise, he had agreed to amend the first part of the paragraph, going beyond the instructions received from his capital to do so. He urged the delegate of India, in a similar spirit, to accept the word “prioritized” in the last line of the paragraph.

Ms BLACK (Canada) said that her proposal to accept the word “encouraged” had been based on the desire to reach a compromise within the language of the draft resolution. However, in order to strengthen the draft, she would prefer to retain “prioritized”.

Dr CHAUHAN (India) said that, in consideration of the previous two statements, he accepted the word “prioritized”. He nonetheless reiterated the views of his country’s experts regarding compliance and co-blistered packs.

Further discussion took place among Ms BLACK (Canada), Mr VOLF (Czech Republic), Dr GBADAMOSI (Nigeria) and Mr ABDOO (United States of America) in order to ensure that the revised text reflected accurately the agreed positions.

Ms CEESAY (Gambia) agreed with the proposed amendments.

At the CHAIRMAN’s request, Ms VESTAL (Assistant Secretary) read out amended subparagraph 1(1)(g), which read: “ensuring uninterrupted supply of first- and second-line medicines for tuberculosis treatment, which meet WHO prequalification standards or strict national regulatory authority standards, and that quality-assured fixed-dose combination medicines of proven bioavailability are prioritized within a system that promotes treatment adherence”.

The CHAIRMAN said that, in the absence of any objections, he would take it that the Committee wished to approve the draft resolution.

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

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<sup>1</sup> Transmitted to the Health Assembly in the Committee’s fifth report and adopted as resolution WHA62.15.



**4. DRAFT FOURTH REPORT OF COMMITTEE A (Document A62/53)**

Ms AYDIN (Turkey), Rapporteur, read out the draft fourth report of Committee A.

**The report was adopted.<sup>1</sup>**

**5. CLOSURE**

The CHAIRMAN, speaking as the delegate of Mexico, expressed gratitude to the Director-General and all Member States for the support shown to his country during the recent outbreak of influenza A (H1N1). Although there was still much to learn, the lessons of the previous few weeks would stand the international community in good stead in responding to and containing future epidemics and in pursuing the wider agenda of promoting public health.

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

**The meeting rose at 11:45.**

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<sup>1</sup> See page 200.