

COMMITTEE B

FIRST MEETING

Wednesday, 20 May 2009, at 10:35

Chairman: Mr S. McKERNAN (New Zealand)

1. OPENING OF THE COMMITTEE: Item 13 of the Agenda

The CHAIRMAN welcomed participants and Dr Dahl-Regis, who, as Chair of the Programme, Budget and Administration Committee of the Executive Board, would report on several issues on the agenda dealt with on behalf of the Executive Board by that Committee at its tenth meeting (Geneva, 14 May 2009).

The CHAIRMAN informed the Committee that Mr U.S. Sutarjo (Indonesia) and Mr V. Jaksons (Latvia) had been nominated for the offices of Vice-Chairmen of Committee B, and Dr E.G. Allen Young (Jamaica) for the office of Rapporteur.

Decision: Committee B elected Mr U.S. Sutarjo (Indonesia) and Mr V. Jaksons (Latvia) as Vice-Chairmen, and Dr E.G. Allen Young (Jamaica) as Rapporteur.¹

2. ORGANIZATION OF WORK

The CHAIRMAN appealed to speakers to limit their statements to a maximum of three minutes. Document EB124/2009/REC/1, to which frequent reference would be made, contained the resolutions and decisions adopted by the Executive Board at its 124th session. He took it that the suggested working arrangements were acceptable to the Committee.

It was so agreed.

3. HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN: Item 14 of the Agenda (Documents A62/24, A62/24 Corr.1, A62/24 Add.1, A62/INF.DOC./1, A62/INF.DOC./2 and A62/INF.DOC./3)

The CHAIRMAN drew the Committee's attention to a draft resolution proposed by the delegations of Algeria, Bahrain, Bangladesh, Cuba, Egypt, Indonesia, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Mauritania, Morocco, Oman, Pakistan, Palestine, Qatar, Saudi Arabia,

¹ Decision WHA62(3).

South Africa, Syrian Arab Republic, Tunisia, United Arab Emirates, Venezuela (Bolivarian Republic of) and Yemen, which read:

The Sixty-second World Health Assembly,

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

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

Recalling resolution EB124.R4, adopted by the Executive Board at its 124th session, on the grave health situation caused by Israeli military operations in the occupied Palestinian territory, particularly in the occupied Gaza Strip;

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

Noting with deep concern the findings in the report of the Director-General on the specialized health mission to the Gaza Strip;²

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

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

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

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

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

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

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

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

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

1. DEMANDS that Israel, the occupying power:

- (1) lift immediately the closure in the occupied Palestinian territory, particularly the closure of the crossing points of the occupied Gaza Strip that are causing the serious shortage of medicines and medical supplies therein, and comply in this regard with the provisions of the Israeli Palestinian Agreement on Movement and Access of November 2005;
- (2) reverse its policies and measures that have led to the prevailing dire health conditions and severe food and fuel shortages in the Gaza Strip;
- (3) comply with the Advisory Opinion rendered on 9 July 2004 by the International Court of Justice on the wall which, inter alia, has grave implications on the accessibility

¹ Document A62/24.

² Document A62/24 Add.1.

- and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;
- (4) facilitate the access of Palestinian patients and medical staff to the Palestinian health institutions in occupied east Jerusalem and abroad;
 - (5) ensure unhindered and safe passage for Palestinian ambulances as well as respect and protection of medical personnel, in compliance with international humanitarian law;
 - (6) improve the living and medical conditions of Palestinian detainees, particularly children, women and patients;
 - (7) facilitate the transit and entry of medicine and medical equipment to the occupied Palestinian territory;
 - (8) shoulder its responsibility towards the humanitarian needs of the Palestinian people and their daily access to humanitarian aid, including food and medicine, in compliance with international humanitarian law;
 - (9) halt immediately all its practices, policies and plans, including its policy of closure, that seriously affect the health conditions of civilians under occupation;
 - (10) respect and facilitate the mandate and work of UNRWA and other international organizations, and ensure the free movement of their staff and aid provisions;
2. URGES Member States and intergovernmental and nongovernmental organizations:
 - (1) to help overcome the health crisis in the occupied Palestinian territory by providing assistance to the Palestinian people;
 - (2) to help meet the urgent health and humanitarian needs, as well as the important health-related needs for the medium and long term, identified in the report of the Director-General on the specialized health mission to the Gaza Strip;¹
 - (3) to help lift the restrictions and obstacles imposed on the Palestinian people in the occupied Palestinian territory;
 - (4) to remind Israel, the occupying power, to abide by the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War of 1949;
 - (5) to support and assist the Palestinian Ministry of Health in carrying out its duties, including running and financing public health services;
 - (6) to provide financial and technical support to the Palestinian public health and veterinary services;
 3. EXPRESSES its deep appreciation to the Director-General for the efforts to provide necessary assistance to the Palestinian people in the occupied Palestinian territory, including east Jerusalem, and to the Syrian population in the occupied Syrian Golan;
 4. REQUESTS the Director-General:
 - (1) to provide support to the Palestinian health and veterinary services including capacity building;
 - (2) to submit a fact-finding report on the health and economic situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;
 - (3) to support the establishment of medical facilities and provide health-related technical assistance for the Syrian population in the occupied Syrian Golan;
 - (4) to continue providing necessary technical assistance in order to meet the health needs of the Palestinian people, including the handicapped and injured;
 - (5) to provide also support to the Palestinian health and veterinary services in preparing for a potential pandemic of influenza A (H1N1);

¹ Document A62/24 Add.1.

- (6) to support the development of the health system in Palestine, including development of human resources;
- (7) to make available the detailed report prepared by the specialized health mission to the Gaza Strip;
- (8) to report on implementation of this resolution to the Sixty-third World Health Assembly.

The financial and administrative implications for the Secretariat were:

1. Resolution Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan		
Linkage to programme budget		
Strategic objective:	Organization-wide expected result:	
5. To reduce the health consequences of emergencies, disasters, crises and conflicts and minimize their social and economic impact.	5.3 Norms and standards developed, capacity built and technical support provided to Member States for assessing needs and for planning and implementing interventions during the transition and recovery phases of conflicts and disasters.	
(Briefly indicate the linkage with expected results, indicators, targets, baseline)		
If fully funded and implemented, the resolution is expected to have an impact on the targets for the second and third indicators for this expected result.		
3. Financial implications		
(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)		
US\$ 3 970 000 over the one-year period of the resolution, including staff, travel, training activities, technical assistance, health supplies, security and operational equipment.		
A substantial proportion of these resources have been raised as humanitarian voluntary contributions for addressing humanitarian health needs, implementing life-saving interventions, re-establishing the functionality of the disrupted health services and rolling out the Interagency Standing Committee health cluster.		
The breakdown of the estimated cost of operative paragraph 4 is as follows:		
Subparagraph (1)	US\$	100 000
Subparagraph (2)	US\$	70 000
Subparagraph (3)	US\$	50 000
Subparagraph (4)	US\$	200 000
Subparagraph (5)	US\$	500 000
Subparagraph (6)	US\$	3 000 000
Subparagraph (7)	US\$	50 000
Total	US\$	3 970 000
(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities)		
US\$ 3 970 000 (one year “life-cycle”).		
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009? Seventy-five per cent of US\$ 3 970 000 at headquarters, Regional and Jerusalem Office levels.		

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

Not applicable.

4. Administrative implications

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

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

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

It will be necessary to sustain beyond May 2009 the presence at country level of the national and international staff recruited to implement humanitarian health activities and interventions in the occupied Palestinian territory.

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

One year.

Mr BADR (Egypt), introducing the draft resolution, said that it reflected the deteriorating health situation of the Palestinian people resulting from continuing Israeli policies, in particular Israel's most recent aggression against the Gaza Strip in December 2008 and January 2009, in violation of international law and basic human rights. He expressed concern at the damage and destruction wrought by the conflict upon the physical infrastructure, including health facilities, and at the implications for the mental health of civilians, as described in the report of WHO's specialized health mission to the Gaza Strip.¹ His delegation had asked for further investigation into the unusual clinical presentations of some of the wounds seen, referred to in the report, as many nongovernmental organizations had indicated that banned weapons had been used. He commended the members of the mission, who had surmounted considerable obstacles in order to accomplish their task.

The draft resolution was a necessary step to help WHO to assume its mandated responsibility to provide basic health care to the Palestinian people and to avoid further deterioration in their health situation. The sponsors had sought to achieve consensus by consulting various groups of countries, including the European Union, in order to make clear Member States' determination to uphold the legitimate rights of the Palestinian people and to issue a message to Israel that the international community could not accept its behaviour. The draft resolution dealt purely with the medical and health situation of the Palestinian people under occupation and with health conditions arising from documented Israeli policies. Those matters fell within the purview of WHO. He called on Member States to approve the resolution by consensus. Its adoption would be a response to Israel's continued practices in the occupied territories and its violation of previous resolutions calling on it to respect international law and legislation and to assume its responsibility vis-à-vis the Palestinian people.

Mr ADAM (Israel) drew attention to the health situation in Sri Lanka, which the International Committee of the Red Cross had recently described as "an unimaginable human catastrophe". It had been a matter of the greatest urgency for the Executive Board, at its 124th session in January 2009, under the chairmanship of the member for Sri Lanka, to place the conflict in the Gaza Strip on the

¹ Document A62/24 Add.1.

agenda and adopt a resolution; however, there was no urgency now on the part of Sri Lanka or Egypt or any other Arab country to discuss the situation in Sri Lanka.

Ms MALLIKARATCHY (Sri Lanka), rising to a point of order, requested the Chairman to call on the delegate of Israel not to raise matters unrelated to the agenda item under consideration.

Mr ADAM (Israel) said that the Executive Board had adopted an unprecedented resolution calling for the withdrawal of armed forces from the Gaza Strip and it was inconceivable that a similar resolution could have been adopted on the situation in Sri Lanka. The United Nations General Assembly and the Security Council, not WHO, were the appropriate forums in which to conduct such a debate. Conflict had given rise to severe health conditions in other regions; the Health Assembly should discuss all of them, or none. It was wrong to single out one issue. The agendas of WHO, the Human Rights Council and other agencies had been hijacked.

Following several appeals by the CHAIRMAN to the delegate of Israel to keep to the subject under discussion, and after several points of order had been raised by Mr BADR (Egypt), Mr AL-ADOOFI (Yemen), Mr JAKHRANI (Pakistan) and Ms MALLIKARATCHY (Sri Lanka), the CHAIRMAN invited the Legal Counsel to clarify the applicable Rules of Procedure.

Mr BURCI (Legal Counsel) said that statements by Member States should focus on the agenda item under consideration. Several points of order had been raised in connection with the references by the delegate of Israel to the health situations in other countries and the Chairman had reminded the delegate several times to focus on the topic under discussion. The Chairman might wish to do so again. Clearly, if a delegate was speaking out of order, it was within the authority of the Chairman to call the delegate to order and, if necessary, terminate his or her statement. However, such a step should be taken with caution, since all delegates had the right to take the floor.

The CHAIRMAN again urged the delegate of Israel not to raise matters unrelated to the agenda item under consideration.

Mr ADAM (Israel) said that it was time to stop the annual politically motivated exercise of dealing with one health situation at the expense of many others. The need to improve the health situation of the Palestinian people was proper and valid, but WHO should show the same sensitivity to the needs of many other people.

Israel had nothing to hide. It could answer any questions regarding health matters on the ground. But those answers were irrelevant to the initiators of the agenda item. The Health Assembly was not the place to resolve a conflict of long standing.

He requested a roll-call vote, and called on the Committee to vote against the draft resolution, which had nothing to do with health conditions or the reality on the ground, but everything to do with politics. He believed that he already knew the outcome: Member States would vote not out of concern for the Organization and its burgeoning agenda, but rather on an irrelevant, political basis. He looked forward, for the sake of WHO and the United Nations, to an end to the whole annual exercise.

Dr SAID (Syrian Arab Republic) said that the Health Assembly annually heard descriptions of Israel's repressive practices as part of its expansionist and aggressive policy of occupation, in defiance of United Nations resolutions and international and humanitarian law. In the occupied Syrian Golan, for instance, the Syrian Arab inhabitants were denied access to health care, inasmuch as medical treatment was available only to those with Israeli identity papers or with health insurance that was prohibitively costly. The acute shortage of primary and specialized health-care facilities in Syrian Arab villages resulted from Israeli refusals to allow any health-related support. The Israeli authorities should be held fully accountable for that situation, and he called on the international community to exert pressure on Israel, as the occupying power, to comply with international humanitarian law and the Geneva Conventions in that regard.

As was noted in paragraph 25 of the fact-finding report,¹ the Secretariat had sought information on the health of the Arab population in the occupied Syrian Golan and on the feasibility of establishing clinics in that territory. His Government's views on that subject, submitted in March 2009, had been ignored; the report instead reflected the views of only one Member, which was unacceptable. Stranger still was the statement contained in paragraph 26 of the report that "the creation of a hospital within the occupied Syrian Golan is not deemed necessary in view of the small population size". The issuance of a corrigendum to the report² was positive but failed to fairly reflect the Syrian view that the establishment of a medical centre and hospital in the occupied Syrian Golan was urgently needed. He therefore wished to enter a reservation to that corrigendum and requested an explanation from the Secretariat as to how such an omission had occurred and who was responsible for it. All Members must be treated equally in the interests of maintaining the credibility and impartiality of the Organization. The Syrian views on the health situation in the occupied Syrian Arab Golan must therefore be included in the report.

Dr ABU MOGHLI (Palestine) said that the attempt by the Israeli delegate to dominate the proceedings exemplified the attitudes of his counterparts in other international forums, and was indicative of their attitudes towards the suffering of the Palestinian people. He expressed his gratitude to WHO and to humanitarian and other organizations and States that stood alongside the Palestinian people in order to relieve their suffering and provide support. It was 61 years since the *nakbah* (the Palestinian catastrophe), and the Palestinian people continued to endure oppression: the restrictions of the apartheid wall prevented secure and easy access to health services and exacerbated unemployment. For the past four years, the Gaza Strip had also been under an inhumane embargo that had hampered delivery of food and health supplies, as well as vital construction materials.

The report of the specialized health mission³ testified to the destruction wrought during the three-week Israeli assault and to the direct and indirect effects on health of such factors as non-functioning health clinics and damaged water and sewage networks. Regarding the catastrophic psychological effects, 80% of Palestinian children had experienced or witnessed traumatic incidents involving family members. Entire families had been decimated; nor had institutions flying the United Nations flag, including a school, been immune to attack. In short, the Israeli army had shown no mercy and no respect for the United Nations or its symbols, laws and customs.

With each day passing the Israeli embargo exacerbated the humanitarian tragedy. The international community must imperatively shoulder its responsibilities by protecting the Palestinian people until the two-State solution was implemented. In the interim, violations of health rights must be halted through the unimpeded delivery of medical assistance and supplies to the Palestinians in the Gaza Strip, reflecting the principles that were basic to the happiness, harmonious relations and security of all peoples articulated in WHO's Constitution. He expressed the hope that Members would vote in favour of the draft resolution. Health must be used as a bridge in resolving the Arab-Israeli conflict and granting the Palestinian people their rights with a view to the establishment of a comprehensive and lasting peace in the Middle East.

Mr STORELLA (United States of America) said that his country remained deeply concerned by the dire humanitarian situation facing innocent Palestinians in the Gaza Strip. Its commitment to providing support in that regard was in no way diminished by its opposition to the draft resolution. Neither progress towards peace nor improved health among Palestinians in the West Bank and the Gaza Strip could be achieved through the adoption of a one-sided political resolution, which would merely inflame tensions. The draft resolution also, regrettably, missed the opportunity to recognize the cooperation that could and did take place between Israelis and Palestinians.

¹ Document A62/24, Annex.

² Document A62/24 Corr.1.

³ Document A62/24 Add.1.

As was indicated by the report of the specialized health mission,¹ the humanitarian and health situation remained grave, as it did in many other regions of the world. The United States' commitment to supporting Gaza included donation of: US\$ 185 million to UNRWA in 2008; a further US\$ 99 million to UNRWA thus far in 2009, including US\$ 35 million for emergency support to the West Bank and the Gaza Strip, including health-care services; and US\$ 15.7 million to the International Committee of the Red Cross thus far in 2009 in support of critical repairs to the water and sanitation systems and health capacity-building in both the West Bank and the Gaza Strip. In addition, the United States continued advocacy with relevant governments and parties in the region in order to ease access restrictions for humanitarian workers and goods, particularly into and out of the Gaza Strip, which was vital to improving the overall health status of the Palestinian people. It supported WHO's technical role in contributing to global health, including as it related to the Palestinian people and their legitimate needs. It could not, however, support a draft resolution that was one-sided and politicized.

Professor HAQUE (Bangladesh) said that the contents of document A62/24 were a grim reminder of the critical health situation in the occupied Palestinian territory and of the persistent conflict and violence in the region. Statistics revealed that violence was a primary contributing factor to the rising death rate in that territory. He particularly condemned the fact that during the three-week destruction in the Gaza Strip almost one third of those killed had been children. The fragile health infrastructure had been too stretched to cope with the civilian casualties, which was a matter of grave concern.

The health landscape in the occupied territories was marked by, inter alia, chronic malnutrition, mental health problems and environmental health hazards, and exacerbated by a weakened health-care delivery system and an inadequate primary health care network. Restrictions on movement and administrative complications imposed by the occupation further constrained coordination between the dual health-care systems in the Gaza Strip and the West Bank. The Organization's continued engagement for health in those territories was vital and he welcomed operationalization of the "health cluster approach" in response to the humanitarian crisis that had unfolded in the Gaza Strip in January 2009. He also expressed appreciation for the role played by the Organization in leading the health component of the Consolidated Appeals Process for 2009 and looked forward to a positive international response to the enhanced health requirements. He called for more resources and expertise to be committed to achieving the health-related Millennium Development Goals, without which the situation in the occupied territories would remain static, and he reaffirmed strong support for the draft resolution.

Dr AL JOWDER (Bahrain) said that there was a mounting political, economic and social crisis in the Gaza Strip. As a result of the events of December 2008 and January 2009, the situation of Palestinians living there had deteriorated, as had the overall health system. The figures for deaths, many of them women and children, and wounded were confirmed by the reports of humanitarian organizations, some of whose own personnel had been killed. The Palestinian population in the Gaza Strip also lacked access to drinking-water and adequate health care, affecting women and mothers in particular. Some 40% of chronically ill Palestinians were unable to receive routine treatment.

That situation compounded the suffering caused in recent years by the Israeli blockade of the Gaza Strip, where mortality and morbidity were bound to increase. She therefore supported the draft resolution, which would enable the Palestinian people to overcome the effects of the blockade, and called on WHO to support their efforts and to work for the lifting of the blockade.

Dr AMMAR (Lebanon) said that all the documents before the Committee confirmed the worrying situation for the Palestinian people. The report of the specialized health mission¹ showed that Israel had indiscriminately attacked civilian and military targets, including hospitals; many civilians

¹ Document A62/24 Add.1.

and humanitarian workers had been killed or wounded. The economic and social situation that resulted from the blockade was preventing the Palestinian people from achieving the Millennium Development Goals; obstacles such as the ban on the imported construction materials prevented the rebuilding of many medical facilities and were hindering improvements in health conditions generally in the region.

As only the Syrian Government could evaluate the health needs of its citizens in the occupied Syrian Golan, he supported the statement by the delegate of the Syrian Arab Republic, as well as the draft resolution.

Dr RAZAVI (Islamic Republic of Iran) expressed appreciation for the report on the specialized health mission that showed the appalling health effects, suffering and casualties caused by Israel's three-week assault on the Gaza Strip. The report by the Secretariat¹ indicated the dire health and humanitarian situation of civilians resulting from the isolation, closure and siege of the Palestinian people, especially those living in the Gaza Strip. The two reports combined showed how close to 7000 people had been killed or wounded, including women and children. He drew attention to: the targeting of health and medical facilities, residential areas and civilians; the disabling of the local health-care system; the impeding of access for the wounded to health facilities outside the Gaza Strip; and the targeting of civilian infrastructure, such as electric power plants, roads and bridges, and drinking-water and sewage systems.

Most public health functions in the Gaza Strip were still suspended; hospitals were unable to provide secondary and tertiary care; lack of freedom of movement and insecurity impeded the delivery of medicines to hospitals; and food insecurity was widespread.

There were also reports of unusual clinical presentations that might be linked to the type of weapons used, lending credence to media reports about the use of phosphorus shells and bombs and ammunition containing depleted uranium. That issue should be kept under investigation by the United Nations system. Moreover, the Israeli army should be held accountable under international law for the harm caused to civilians.

The lingering health and humanitarian effects of the aggression, the siege conditions of the Gaza Strip and the resulting health needs of the Palestinian people called for further support by the international community, including WHO. His delegation therefore supported the draft resolution and believed that the report of the specialized health mission should be circulated.

Dr KUSRIASTUTI (Indonesia) associated herself with the statements made by the delegates of Egypt, the Syrian Arab Republic, Bahrain and the Islamic Republic of Iran on behalf of the sponsors of the draft resolution. She appreciated the action taken by the Director-General to implement resolution EB124.R4, including the sending of a specialized health mission to the occupied Palestinian territory, particularly the Gaza Strip. She also appreciated WHO's efforts to assist the Palestinian people in the occupied Palestinian territory and the Syrian population in the occupied Syrian Golan.

She expressed deep concern at the deteriorating health conditions in the occupied territories, particularly the Gaza Strip, and urged the immediate lifting of the Israeli blockade and the opening of all border crossings to allow the access and free movement of humanitarian aid, medical and food aid and the passage of medical teams. Global efforts must ensure that people living in the occupied Palestinian territory and the occupied Syrian Golan were able to exercise their universal right of access to health.

Mr BAMBAS (Czech Republic), speaking on behalf of the European Union, welcomed the report of the specialized health mission.² The European Union was deeply concerned about the health and humanitarian situation in the occupied Palestinian territory, particularly the Gaza Strip, and it

¹ Documents A62/24 and A62/24 Corr.1.

² Document A62/24 Add.1.

called on all parties to meet the needs identified in the report. As the largest donor, it would continue to support WHO's health and humanitarian activities in support of the Palestinian people.

Dr AL KUWARI (Qatar) expressed strong support for the draft resolution, which addressed such issues as access to care and medicine, safety of health workers and citizens, and basic food and hygiene standards. The resolution was not political and its adoption would enable immediate action to be taken to mitigate the health consequences of the current situation and provide a basic health infrastructure.

Mr JAKHRANI (Pakistan) expressed deep concern at the health situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, where high levels of poverty and unemployment persisted. The occupied territories were on the brink of a humanitarian crisis. There was a grave public health problem owing to chronic malnutrition and associated micronutrient deficiencies, and more than 30% of the overall burden of disease among adults was caused by noncommunicable diseases. The Gaza Strip continued to be largely isolated from the outside world as a result of increasing levels of violence and the policy of external closure that had reduced access to secondary and tertiary health care, with fewer patients allowed access to treatment outside the Gaza Strip. The lack of spare parts and other medical supplies had further weakened the health-care delivery system.

The economic siege of the Gaza Strip had led to the degradation of health infrastructure and adversely affected the health sector. The recent shift in donors' funding policies had even affected essential primary health care programmes such as immunization and maternal and child care. In order to tackle the developing health emergency, WHO must expand the scope of its technical support, its support to UNRWA and use its influence with donors. The Organization must also send a strong message for an end to the practices of economic and political repression that continued to jeopardize access to and provision of preventive and curative health services to the population of the occupied territories.

He fully supported the draft resolution and urged the international community to support the Palestinian people and coordinate efforts to achieve a lasting peace.

Dr KESKINKILIÇ (Turkey) said that the international community should pay more attention to the situation in the occupied Palestinian territory. He emphasized the need to reconstruct the health infrastructure and ensure the availability of humanitarian support there. Adoption of the draft resolution should help to improve the living conditions of people in the region.

Ms MALLIKARATCHY (Sri Lanka) requested clarification as to how the Committee should proceed when Member States addressed issues not on the agenda. Such a clarification would focus the Committee's work and save time.

Her country remained concerned about health conditions in the occupied Palestinian territory. She requested that the Director-General provide further support in that regard and expressed support for the draft resolution.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) recalled that WHO defined health as physical, social and mental well-being, not just the absence of illness. The populations of the occupied territories were being denied such conditions and lacked not only health but also adequate health-care facilities and resources. Furthermore, their mental health was being affected by the constant attacks by Israel. He reiterated the inalienable right of the Palestinian people to establish an independent State and to enjoy the health they deserved. He fully supported the draft resolution.

Mr DELGADO HIGUERA (Bolivarian Republic of Venezuela) said that his country had recognized the Palestine Liberation Organization in 1998 and supported a two-State solution that would allow the Palestinian people to exercise their right of self-determination. It called for dialogue and cooperation in order to achieve the economic development of the region on the basis of a just and

lasting peace. The Health Assembly was an appropriate forum for addressing the alarming health situation in occupied and war-torn countries, including such issues as access to medicines, food shortages and the free movement of ambulances and medical and health personnel. He therefore supported the draft resolution and the statement made by the delegate of Egypt. Expressing solidarity with the Palestinian people, he announced that his Government and the Palestinian Authority had established formal diplomatic relations on 27 April 2009.

Dr SABATINELLI (Director of Health, UNRWA) said that, as the largest humanitarian operation in the occupied Palestinian territory, UNRWA provided primary and secondary health care to more than one million refugees in the Gaza Strip and about 800 000 in the West Bank. As a result of such interventions, health indicators for Palestinian refugees stood up well in comparison with those of host communities: infant mortality was 15 per 1000 live births in the West Bank and 25 per 1000 live births in the Gaza Strip.

He highlighted the difficulties experienced by UNRWA in delivering its services, including rises in food and medicine prices, the conflict and ongoing blockade, and the growing demand for support following cutbacks in public services. Restrictions on staff movement at checkpoints had become more unpredictable, limiting the Agency's ability to meet the needs of increasingly vulnerable communities. The closure policy also severely undermined refugees' access to health services: many pregnant women, children and patients with chronic diseases had been unable to reach health facilities and a 62% decrease compared with 2007 in admission of refugees to Jerusalem hospitals had been documented.

The combination of rapid population growth and the increase in demand and costs undermined UNRWA's capacity to mitigate the negative effects of food insecurity, unemployment, violence, social and institutional isolation. He appealed to the Health Assembly to exert every effort to ensure access to health care for Palestinian refugees and to ensure that the privileges, immunities and security of UNRWA personnel were guaranteed at all times.

The CHAIRMAN recalled the proposal to proceed to a roll-call vote.

At the invitation of the CHAIRMAN, Mr BURCI (Legal Counsel) explained the procedures for the roll-call vote. The Member States whose right to vote had been suspended by virtue of Article 7 of the Constitution, or which were not represented at the Health Assembly, and would therefore be unable to participate in the vote were: Argentina, Central African Republic, Comoros, Democratic Republic of the Congo, Dominica, Gambia, Guinea-Bissau, Niue, Palau, Solomon Islands, Somalia and Tajikistan.

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

The result of the vote was:

In favour: Afghanistan, Algeria, Andorra, Austria, Azerbaijan, Bahrain, Bangladesh, Belgium, Bhutan, Bosnia and Herzegovina, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, China, Congo, Costa Rica, Croatia, Cuba, Cyprus, Czech Republic, Denmark, Egypt, Estonia, Ethiopia, Finland, France, Gabon, Germany, Greece, Guatemala, Honduras, Hungary, Iceland, India, Indonesia, Iran (Islamic Republic of), Iraq, Ireland, Italy, Jamaica, Japan, Jordan, Kuwait, Latvia, Lebanon, Liberia, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Malaysia, Maldives, Malta, Mexico, Monaco, Morocco, Namibia, Netherlands, Nicaragua, Norway, Oman, Pakistan, Panama, Paraguay, Peru, Philippines, Portugal, Qatar, Republic of Korea, Romania, Russian Federation, Saudi Arabia, Senegal, Serbia, Slovakia, Slovenia, South Africa, Sri Lanka, Sudan, Sweden, Switzerland, Syrian Arab Republic, Thailand, Togo, Tunisia, Turkey, Uganda, Ukraine, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Venezuela (Bolivarian Republic of), Yemen.

Against: Australia, Canada, Israel, New Zealand, Papua New Guinea, United States of America.

Abstaining: Bahamas, Cook Islands, El Salvador, Samoa, Singapore.

Absent: Albania, Angola, Antigua and Barbuda, Armenia, Barbados, Belarus, Belize, Benin, Bolivia (Plurinational State of), Botswana, Burundi, Cambodia, Cameroon, Cape Verde, Chad, Chile, Colombia, Côte d'Ivoire, Democratic People's Republic of Korea, Djibouti, Dominican Republic, Ecuador, Equatorial Guinea, Eritrea, Fiji, Gambia, Georgia, Ghana, Grenada, Guinea, Guyana, Haiti, Kazakhstan, Kenya, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Lesotho, Madagascar, Malawi, Mali, Marshall Islands, Mauritania, Mauritius, Micronesia (Federated States of), Mongolia, Montenegro, Mozambique, Myanmar, Nauru, Nepal, Niger, Nigeria, Poland, Republic of Moldova, Rwanda, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, San Marino, Sao Tome and Principe, Seychelles, Sierra Leone, Spain, Suriname, Swaziland, The former Yugoslav Republic of Macedonia, Timor-Leste, Tonga, Trinidad and Tobago, Turkmenistan, Tuvalu, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Viet Nam, Zambia, Zimbabwe.

The draft resolution was therefore approved by 92 votes to 6, with 5 abstentions.¹

Mr BAMBAS (Czech Republic), speaking on behalf of the Member States of the European Union and in explanation of vote, said that the European Union remained concerned about the deteriorating health situation in the occupied Palestinian territory, including East Jerusalem. Although it had voted in favour of the resolution, it would have preferred to see a more balanced resolution, with a greater focus on the health issues affecting both Palestinian and Israeli people.

Mr THOM (Australia), speaking in explanation of vote, expressed concern for the health situation in the Palestinian territory, in particular following the recent conflict in the Gaza Strip. Australia had continued to provide financial aid to the Palestinian people, making significant commitments since January 2009, but had voted against the resolution as political issues should not be introduced in the Health Assembly. Lasting peace, based on a two-State solution, must be found.

Mr OLDHAM (Canada), speaking in explanation of vote, said that his Government remained concerned about the health situation of Palestinian people, in particular in the Gaza Strip; it therefore continued to provide aid through nongovernmental and multilateral organizations, and supported the Palestinian Authority in its efforts in that regard. It was to be hoped that progress would be made in compliance with the Israeli-Palestinian Agreement on Movement and Access. However, the resolution had been one-sided and focused on the actions of one country. His country had therefore voted against it.

Mr MACKAY (New Zealand), speaking in explanation of vote, echoed the concerns expressed in the resolution regarding the health crisis and rising levels of food insecurity, and said that the humanitarian crisis should be urgently addressed by Member States and intergovernmental and nongovernmental organizations in cooperation with Israel. The resolution was not confined to addressing humanitarian needs and raised political issues. His country had therefore voted against it.

Mr TAN York Chor (Singapore), speaking in explanation of vote, said that Singapore continued to support efforts to bring about a just and lasting peace in the region. It recognized the Palestinian right to a homeland and the need for a two-State solution and expressed concern regarding the difficult health situation in the region. His country had abstained in the vote because it did not believe that political elements should be included in Health Assembly resolutions.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as a resolution WHA62.2.

Mr BURCI (Legal Counsel), responding to a request to speak by the observer for Palestine, said that the debate on the agenda item had been closed. Sponsors of a draft resolution and observers were not permitted to take the floor after a vote had taken place.

The meeting rose at 12:55.

SECOND MEETING

Wednesday, 20 May 2009, at 14:45

Chairman: Mr S. McKERNAN (New Zealand)

1. PROGRAMME AND BUDGET MATTERS: Item 15 of the Agenda

Programme budget 2006–2007: performance assessment: Item 15.1 of the Agenda (Document A62/25)

Mr OLDHAM (Canada) confirmed that the extensive comments made by his delegation on the item under discussion during the tenth meeting of the Programme, Budget and Administration Committee of the Executive Board were reflected in the report of that Committee.

Dr JALLOW (Gambia), speaking on behalf of the 46 Member States of the African Region, welcomed the broad support that had been given to those States in line with WHO's country cooperation strategies. Of the expected results, 91% had been fully or partially achieved: significant progress over the 67% achieved in the previous biennium. That progress had been due to a range of country and organizational factors, including the political commitment of Member States in facilitating dialogue and motivating health workers; improved coordination of interventions; increased collaboration with the Secretariat at every level, which had ensured adequate strategic direction; and joint planning and networking, which had enhanced programme implementation.

She contrasted the implementation rate of 95.2% for the approved regular budget as of 31 December 2007 with the 78.6% rate for implementation of voluntary contributions over the same period. She expressed concern that in some instances implementation of the Programme budget had been hampered by late disbursement or a lack of voluntary funding, compelling the Regional Office to take emergency measures. Some countries had experienced difficulties in absorbing available funds because of a lack of human resources, thus limiting the scaling up of interventions. It was to be hoped that the Secretariat's internal changes, such as the Global Management System and the new programme budget structure with its shift from areas of work to strategic objectives, would improve administrative and financial processes and promote synergy among WHO's programmes and departments.

She looked forward to improved staffing profiles in country offices and further decentralization of programme implementation to intercountry support teams, in order to bring technical support closer to countries. United Nations reforms should lead to better harmonization among organizations of the United Nations system so as to further improve financial and technical support to countries in formulating their strategic plans, negotiating with donors and implementing interventions for which funding was available.

The Committee noted the report.

Implementation of Programme budget 2008–2009: interim report: Item 15.2 of the Agenda (Documents A62/26, A62/26 Corr.1 and A62/43)

The CHAIRMAN said that the item had been discussed the previous week by the Programme, Budget and Administration Committee.

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chair, Programme, Budget and Administration Committee, said that the report by the Secretariat on progress towards the technical

and financial targets of the Programme budget 2008–2009 as at 31 December 2008 provided greater detail than previous similar reports. About half the Organization-wide expected results appeared to be on track for technical implementation, whereas the other half were at risk of not being achieved; strategic objective 4, in particular, was “in trouble”. The Committee had expressed concern about the levels of funding and implementation of strategic objectives 4, 7, 8, 9 and 10. The Secretariat had explained that the problem was due mainly to the nature of voluntary contributions, on which more than 75% of WHO’s work depended, and steps were being taken to redress the situation. The Committee had asked for a comprehensive and concrete action plan for its next meeting and also a report on the options for facilitating the management and alignment of voluntary resources within results-based management.

Dr CAMPBELL-FORRESTER (Jamaica) said that the 10% reduction in base programmes in the Proposed programme budget 2010–2011 was acceptable, as it was projected that only 73.8% of the Programme budget 2008–2009 would be spent. She agreed with the amounts proposed for special programmes and outbreak and crisis response.

Nevertheless, underutilization of the amount earmarked for base programmes in 2008 and 2009 pointed to the need to strengthen the absorptive capacity of country programmes. As a pandemic of influenza A (H1N1) would affect the budget for outbreak and crisis response, the Health Assembly should empower the Director-General to adjust other budget lines if the need arose. She suggested that the financial summary table in the document should reflect the figures for the coming year in order to facilitate comparative analysis across regions.

Dr KÖKÉNY (Hungary) commended the greater detail provided in the interim report; however, in view of the predictable impact of the global financial crisis on income generation, WHO should make further efforts to reduce the differences in funding for strategic objectives and among its regional offices. A chronic lack of funding for areas such as maternal and child health or health systems would be unacceptable. The ongoing managerial reform should aim to decrease differences in funding between headquarters and the regions by improving capacity, staffing and expertise at regional level.

Dr JORGENSEN (Denmark) said that the interim report on implementation of the Programme budget 2008–2009 gave valuable information that should be taken into account when considering the Proposed programme budget 2010–2011, and he regretted that the two documents were to be considered separately.

The fact that only about half the 81 Organization-wide expected results were reportedly on track confirmed his country’s concerns about WHO’s implementation capacity, as expressed during previous budget debates. He would have appreciated some reflections on the matter in the report.

It was disquieting that all the Organization-wide expected results that were in difficulty related to strategic objective 4 concerning child, adolescent and maternal health, including sexual health. The total amount allocated to strategic objective 4 for the next biennium was still too small; special efforts and maximum support were therefore needed, especially when taking into account the lack of progress made towards achieving Millennium Development Goal 5.

He noted with concern the number of results “at risk” relating to strategic objectives 3, 6, 7, 8 and 9, and linked to noncommunicable diseases; furthermore, strategic objective 6, concerning health promotion and prevention, seemed to have a funding gap equal to its entire budget. Those areas were at risk as a result of insufficient funding, whereas other areas, such as the objectives with large partnerships involved in communicable diseases, were overfunded.

A special effort was needed to ensure sufficient funding for work on the goals related to noncommunicable diseases. The problem of uneven funding across the strategic objectives remained and his country would support the Director-General’s future endeavours to find solutions.

Mr AITKEN (Assistant Director-General) said that he shared the concerns of the previous speaker that results were not yet on track for certain strategic objectives. The Secretariat was working

with donors to augment funding in those areas. Flexibility of funding was the critical way forward to achieving the maximization of income.

Referring to the comment that performance of the budget for 2008 and the Proposed programme budget 2010–2011 were being discussed in separate meetings, he explained that the procedure had been adopted historically because the budget was treated as a technical item while performance was deemed to be non-technical. The Executive Board could consider combining discussion of the two items in the same committee when it compiled the provisional agenda for the next Health Assembly.

The Committee noted the report.

2. AUDIT AND OVERSIGHT MATTERS: Item 16 of the Agenda

Report of the Internal Auditor: Item 16 of the Agenda (Documents A62/27 and A62/45)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chair, Programme, Budget and Administration Committee, said that the Committee had reviewed the report of the Internal Auditor and had expressed satisfaction with the internal audit function. Members of the Committee had been concerned by the apparent lack of follow-up to a number of audits and evaluations and had urged the Secretariat to ensure the timely and effective implementation of the recommendations in the report. The Committee had noted that the annual report was a consolidated version but that individual reports could be consulted by its members.

Staged implementation of the Global Management System was proceeding and members of the Committee had been assured that the Internal Auditor would continue to review the process.

Ms BLACKWOOD (United States of America) said that the lack of response and follow-up to the Office of Internal Oversight Services' work and their recommendations was of particular concern to her country.

The CHAIRMAN noted that the delegate of the United States of America had raised her concerns in the Programme, Budget and Administration Committee at its tenth meeting.

The Committee noted the report.

3. FINANCIAL MATTERS: Item 17 of the Agenda

Unaudited interim financial report on the accounts of WHO for 2008: Item 17.1 of the Agenda (Documents A62/28, A62/28 Corr.1, A62/44, and A62/INF.DOC./4)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chair, Programme, Budget and Administration Committee, said that the Committee had noted the salient points of the unaudited interim financial report for the year 2008. The new format was a major step towards full compliance with the International Public Sector Accounting Standards planned for the financial period beginning 2010. Some one-off variances related to the recognition of income were primarily due to a change in the income-recognition policy that had come into effect in 2007. That change partially explained the large reported carry-forward at the beginning of 2008.

Total income for WHO's programme activities for 2008 was US\$ 1734.9 million; expenditure was US\$ 1735 million. Financial income of US\$ 34.8 million had been largely responsible for the final surplus of US\$ 34.7 million for the year. Despite difficult financial markets, the Secretariat had earned a modest return of US\$ 61.5 million in 2008. The positive returns and the preservation of

capital could be credited to close monitoring by the Investment Committee and the conservative investment policy. The Director-General had made plans to cut travel costs in response to the substantial increases expected by the end of 2009. The Organization needed US\$ 1000 million carry-forward to fund commitments for staff costs and programme activities. The higher total carried forward at 31 December 2008 had been due to an uneven distribution of the amounts carried forward and the earmarking of substantial funds for expenditure across several years.

The Committee had commented that expenses for research appeared to be higher at headquarters than at the regional offices. The Secretariat had explained that much of the expenditure for research was for two special programmes that were managed from headquarters, and the expenditures were recorded at the issuing office rather than in the country where the research was taking place.

The CHAIRMAN drew attention to the draft resolution contained in document A62/44.

The draft resolution was approved.¹

Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution: Item 17.3 of the Agenda (Documents A62/30 and A62/47)

Mr JEFFREYS (Comptroller) reported that, since the last meeting of the Programme, Budget and Administration Committee, payments had been received from Chad and Sudan, as a result of which those two Members were no longer concerned by Article 7 and should be deleted from the proposed resolution contained in document A62/47.

The CHAIRMAN invited the Committee to consider the draft resolution, amended in light of the additional information provided by the Comptroller.

The draft resolution, as amended, was approved.²

Interim report of the External Auditor: Item 17.2 of the Agenda (Documents A62/29 and A62/46)

Ms KUNDRA (representative of the External Auditor), presenting the interim results of the external audit of WHO for the financial period 2008–2009 on behalf of the External Auditor, said that audits had been conducted in the first year of the current financial period in the regional offices for Africa and the Western Pacific and in one country office in each of those regions.

The report also contained: an in-depth review of the Global Service Centre in Malaysia, which was responsible for processing administrative transactions for human resources, payroll, procurement and accounts payable; an audit of the Global Management System; and audits of several trust funds.

In the second year of the financial period, there would be an audit of the remaining regional offices and selected country offices and a detailed review of selected areas of WHO. An audit opinion would be expressed on the financial statements for the financial period 2008–2009. The interim report and the recommendations contained therein had been accepted by the Director-General, and assurances had been given that the necessary action would be taken. Changes to the Financial Regulations and Financial Rules in accordance with International Public Sector Accounting Standards included a shift to annual financial statements, introduction of full accrual accounting and a new method for recognizing fixed assets.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA62.3.

² Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA62.4.

She highlighted some of the report's main points relating to the Global Management System, which had begun operating on 1 July 2008 at headquarters, the Regional Office for the Western Pacific and country offices in that Region. Introduction to the remaining regions had been postponed until the system had stabilized. The complexity and scale of work on data conversion had been flagged as risk areas, as stated in a report to the Health Assembly the previous year. In regard to information technology security management, actions to address the risk areas had been flagged, including elaboration of a well-documented disaster recovery plan and the provision of further training.

She also highlighted a range of procedural areas covered by the report, including employment contracts, staff appraisal, procurement of services and goods, evaluation of vendors, and inventory records.

The implementation of significant recommendations would be noted in the final report on the current financial period. The External Auditor would continue to work towards bringing value to WHO and its stakeholders through the external audit process.

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chair, Programme, Budget and Administration Committee, said that the Committee, which had discussed item 17.2 at its meeting earlier in the week, had welcomed the External Auditor's informative and transparent interim report. That report had highlighted problem areas, including the introduction of the Global Management System and the functioning of the Global Service Centre, and had provided valuable information for managers. The Committee had appreciated the detailed information in the report and had taken note that the Secretariat had accepted all the External Auditor's findings and recommendations. At the next sessions of the Committee and the Executive Board the Secretariat would be submitting a detailed tracking report, which would cover implementation of the External Auditor's recommendations and systematic changes made or remedial measures taken by management.

Dr CHAUHAN (India), thanking the External Auditor for the interim report, said that the practice of interim reporting was useful as it kept the Health Assembly abreast of the audit procedure. He expressed satisfaction that audits had been conducted in the regional offices for Africa and the Western Pacific and in two country offices.

He welcomed the evaluation of the Global Management System; it was important that steps be taken to ensure the stability and efficiency of the System and the security of the information electronically stored therein. He appreciated the planned measures for disaster recovery and ensuring business continuity.

He looked forward to the submission of the External Auditor's final report to the Sixty-third World Health Assembly and encouraged the Secretariat's active cooperation with the auditors in support of a productive examination of systems and activities.

Ms BLACKWOOD (United States of America) said that the information relating to the Global Service Centre and to progress in the implementation of the Global Management System was particularly valuable, and she looked forward to further debate on those matters. She welcomed the fact that the External Auditor's findings would be followed up and would be the subject of reports.

The CHAIRMAN invited the Committee to note the interim report of the External Auditor contained in document A62/46.

The Committee noted the report.

Scale of assessments 2010–2011: Item 17.5 of the Agenda (Document A62/31)

Mr ALLO (France) said that the current Health Assembly had been invited by the Executive Board to adopt the latest United Nations scale of assessments, adopted by the General Assembly in December 2006, for application to Member States during the biennium 2010–2011. He wished to be certain that, at the next meeting of the Executive Board in January 2010, it would be invited to take a

decision with regard to application to Member States in 2011 of the updated United Nations scale that the General Assembly was expected to adopt in December 2009. Furthermore, he wondered why WHO could not apply the updated scale in 2010, since it would already have been adopted by the General Assembly in 2009.

Mr AITKEN (Assistant Director-General) said that the United Nations General Assembly would be reconsidering the scale of assessments for the following three years at the end of 2009. Nevertheless, WHO would not be altering its 2010 scale because invitations for payment would have been sent out a considerable time before that date. If it saw fit, in January 2010, the Executive Board could propose to the Sixty-third World Health Assembly that it approve changes in the scale of assessments, which would take effect in 2011.

The CHAIRMAN invited the Committee to consider the draft resolution contained in document A62/31.

The draft resolution was approved.¹

Amendments to the Financial Regulations and Financial Rules: Item 17.7 of the Agenda (Documents EB124/2009/REC/1, resolution EB124.R10, and A62/32)

The CHAIRMAN drew attention to the draft resolution recommended by the Executive Board in resolution EB124.R10.

The draft resolution was approved.²

4. STAFFING MATTERS: Item 18 of the Agenda

Human resources: annual report: Item 18.1 of the Agenda (Document A62/34)

The CHAIRMAN said that, if he heard no objections, he would take it that the Committee wished to note the report.

The Committee noted the report.

Report of the International Civil Service Commission: Item 18.2 of the Agenda (Document A62/35)

Mr OLDHAM (Canada) welcomed the useful research that had been done by the International Civil Service Commission, which also helped to keep WHO practices in line with those of other organizations of the United Nations system. In its report, the Commission had noted that there had been difficulties in attracting staff with the requisite skills and experience for nearly one quarter of the posts open for recruitment. That observation coincided with WHO's findings on technical implementation, that it was difficult to recruit skilled people for work on projects in the "at risk" category.

In the spirit of "One United Nations", it was to be hoped that WHO was actively working with other organizations, particularly at the field level, to tackle the common challenges of human resources recruitment and development. He wondered also whether working groups set up by the High-Level

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA62.5.

² Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA62.6.

Committee on Management of the United Nations System Chief Executives Board for Coordination were giving consideration to that matter.

Mr AITKEN (Assistant Director-General) replied that the Chief Executives Board's Human Resources Network, which comprised the heads of human resources of all organizations of the United Nations system, was considering the item.

The Committee noted the report.

Amendments to the Staff Regulations and Staff Rules: Item 18.3 of the Agenda (Documents EB124/2009/REC/1, resolutions EB124.R15 and EB124.R16, and A62/36)

The CHAIRMAN drew attention to the draft resolutions recommended by the Executive Board in resolutions EB124.R15 and EB124.R16.

The draft resolutions were approved.¹

Report of the United Nations Joint Staff Pension Board: Item 18.4 of the Agenda (Document A62/37)

Mr OLDHAM (Canada) commended the prudent approach to financial management of the United Nations Joint Staff Pension Board. However, he observed that the assumptions it made in paragraph 3 of its report had to be questioned in the light of recent economic developments. It would have been useful to have had an update on the amount of money currently available in the United Nations Joint Staff Pension Fund, which had apparently shrunk considerably. Perhaps an interim report based on the figures of December 2008 and the 56th session of the Pension Board could be submitted to the Executive Board in January 2010.

Mr AITKEN (Assistant Director-General) observed that the turmoil in the financial markets had occurred after the Pension Board's fifty-fifth session in July 2008. The Board had not met since, but the Fund's secretariat had posted an analysis of the current situation on the Fund's web site. According to that analysis, because the Fund's current income from serving staff members was still roughly equivalent to the amounts outgoing in pensions, the financial crisis had not had a major impact on the Fund's overall situation. Several additional paragraphs on the Fund's situation would be added to the relevant report to the Executive Board in January 2010.

The Committee noted the report.

Appointment of representatives to the WHO Staff Pension Committee: Item 18.5 of the Agenda (Document A62/38)

The CHAIRMAN, observing that the Health Assembly was invited to appoint one member and one alternate member to the WHO Staff Pension Committee in accordance with the rotational schedule explained in document A62/38, asked whether the Committee agreed to nominate Dr A.J. Mohammad (Oman) as a member and Dr H. Siem (Norway) as an alternate member for a three-year term ending in May 2012.

It was so decided.²

The meeting rose at 16:00.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolutions WHA62.7 and WHA62.8.

² Transmitted to the Health Assembly in the Committee's first report and adopted as decision WHA62(8).

THIRD MEETING

Thursday, 21 May 2009, at 10:15

Chairman: Mr S. McKERNAN (New Zealand)

1. ORGANIZATION OF WORK

The CHAIRMAN announced that, in accordance with a decision by the General Committee,¹ Committee B would take over from Committee A the consideration of agenda items 12.8 (Public health, innovation and intellectual property: global strategy and plan of action), 12.9 (Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis) and 12.10 (Progress reports on technical and health matters).

2. FIRST REPORT OF COMMITTEE B (Document A62/50)

Dr ALLEN YOUNG (Jamaica), Rapporteur, read out the draft first report of Committee B.

The report was adopted.²

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

Public health, innovation and intellectual property: global strategy and plan of action: Item 12.8 of the Agenda (Documents A62/16, A62/16 Add.1, A62/16 Add.2 and A62/16 Add.3)

The CHAIRMAN acknowledged the very significant amount of work that had been done in preparing the global strategy and plan of action, and recalled the Director-General's exhortation in plenary to complete the task. He also drew attention to a draft resolution on the item, proposed by the delegations of Canada, Chile, Islamic Republic of Iran, Japan, Libyan Arab Jamahiriya, Norway and Switzerland, and to its financial and administrative implications for the Secretariat, which read:

The Sixty-second World Health Assembly,
Recalling resolution WHA61.21 on the Global strategy and plan of action on public health, innovation and intellectual property, and noting the information provided by the Secretariat,³

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

² See page 201.

³ Documents A62/16, A62/16 Add.1, A62/16 Add.2 and A62/16 Add.3.

1. DECIDES
 - (1) to incorporate into the plan of action the additional agreed stakeholders as outlined in document A62/16 Add.3;
 - (2) to incorporate into the plan of action the updated time frames outlined in document A62/16 Add.1;
2. Accordingly ADOPTS the final plan of action in respect of specific actions, stakeholders and time frames;
3. NOTES the estimated funding needs related to the plan of action as outlined in document A62/16 Add.1;
4. ACCEPTS the proposed progress indicators as outlined in document A62/16 Add.2 as the basis for regular reporting to the Health Assembly on performance and overall progress made over a two-year reporting period.

1. Resolution Global strategy and plan of action on public health, innovation and intellectual property

2. Linkage to programme budget

Strategic objective:

1. To reduce the health, social and economic burden of communicable diseases.

2. To combat HIV/AIDS, tuberculosis and malaria.

10. To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.

11. To ensure improved access, quality and use of medical products and technologies.

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.

Organization-wide expected result:

1.5 New knowledge, intervention tools and strategies that meet priority needs for the prevention and control of communicable diseases developed and validated, with scientists from developing countries increasingly taking the lead in this research.

2.6 New knowledge, intervention tools and strategies developed and validated to meet priority needs for the prevention and control of HIV/AIDS, tuberculosis and malaria, with scientists from developing countries increasingly taking the lead in this research.

10.5 Better knowledge and evidence for health decision-making assured through consolidation and publication of existing evidence, facilitation of knowledge generation in priority areas, and global leadership in health research policy and coordination, including with regard to ethical conduct.

10.6 National health research for development of health systems strengthened in the context of regional and international research and engagement of civil society.

11.1 Formulation and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.

11.2 International norms, standards and guidelines for the quality, safety, efficacy and cost-effective use of medical products and technologies developed and their national and/or regional implementation advocated and supported.

12.3 Global health and development mechanisms established to provide more sustained and predictable technical and financial resources for health on the basis of a common health agenda which responds to the health needs and priorities of Member States.

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

The resolution builds on resolution WHA61.21 (Global strategy and plan of action on public health, innovation and intellectual property). The resolution is consistent with the above-mentioned strategic objectives and Organization-wide expected results of the Programme budget 2008–2009 and the Medium-term strategic plan 2008–2013.

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)**

WHO has the role of lead or co-lead stakeholder and implementing entity in almost half the 106 specific actions of the plan of action and is identified as stakeholder/implementing entity in a number of other specific actions. Based on the estimated funding needs outlined in document A62/16 Add.1, the financial and administrative implications of implementing the global strategy and plan of action by WHO (involving the relevant departments at headquarters and regional and country offices) over the envisaged seven-year period (2009–2015) is estimated at US\$ 350 million. It is further estimated that 40% of this amount can be subsumed within existing and future budgets).

(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)

Costs are estimated at US\$ 15 million.

(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009? US\$ 7 million.**(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)**

Financing will be sought from interested Member States, development partners, charitable foundations and other donors.

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

In the biennium 2008–2009, work will be largely performed at headquarters and in the regional offices.

(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)

In order to implement the global strategy, six additional staff in the professional category and four additional staff in the general service category will be required at headquarters. In addition, two additional staff in the professional category and one staff member in the general service category will be required in each regional office.

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

This report covers implementation of the plan of action in the biennium 2008–2009 and the following three bienniums. The final plan of action being considered by the Sixty-second World Health Assembly will define time frames for implementation of the global strategy over the full life-cycle. The global strategy requires a progress report to be submitted to the Health Assembly through the Executive Board every two years, and a comprehensive evaluation of the strategy to be undertaken after four years.

Dr VALLEJOS (representative of the Executive Board) said that the Executive Board had noted the report by the Secretariat at its 124th session,¹ welcoming the progress made regarding the immediate and medium-term actions requested in resolution WHA61.21, including preparation of the Quick Start Programme, the establishment of an expert working group and finalization of the outstanding components of the plan of action. The Board had appreciated the efforts devoted to determining the proposed time frames, estimated funding needs, and proposed progress indicators. The Board had looked forward to the outcome of both the Expert Working Group on research and

¹ Document EB124/2009/REC/2, summary record of the tenth meeting.

development financing and the informal consultations among Member States in the form of agreement on the open paragraphs on stakeholders in the plan of action.

Mr XABA (Swaziland), speaking on behalf of the 46 Member States of the African Region, commended the progress made. The finalized global strategy and plan of action would represent an enhanced and sustainable basis for research and development essential to the health needs of developing countries. Intellectual property was vital for access to essential medicines, affordable new health products and the funding of research and development. Reducing the incidence of communicable diseases in developing countries and redressing the growing burden of noncommunicable diseases were high priorities; as important were the effective means of tackling health-care needs, given the dependence of developing countries on innovative products designed principally for developed countries. Many treatments remained unavailable and unaffordable to those who needed them.

The interdependence of the international community had heightened global awareness of the potential consequences of failure to address poverty and sickness in developing countries. The Millennium Development Goals emphasized the importance of improved health for economic development. The challenge was to ensure access alongside innovation through mechanisms that corrected the deficiencies of current systems. Africa had been a key player in promoting a regional position and in negotiating the global strategy and plan of action.

He expressed support for the proposed progress indicators as a basis for reporting performance and progress. Implementation of the global strategy would require concerted stakeholder efforts and concrete initiatives at international, regional and national levels. Governments had the primary responsibility for initiating actions they had negotiated: implementation could wait no longer. He urged Members to consider the adoption of a draft resolution, currently in preparation, which was an African initiative for the delivery of products that would meet the needs of the people of the African continent.

Ms WISEMAN (Canada) said that her country was deeply committed to the intended outcomes of the global strategy and plan of action. The draft resolution, of which Canada was a sponsor, completed the current stage of work of an important tool for advancing health research and development on diseases that disproportionately affected developing countries. Canada looked forward to implementation and to the engagement of all partners and stakeholders.

Dr SADRIZADEH (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed appreciation for the Secretariat's commitment to the work of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property and in finalizing the plan of action. He further welcomed the development of the progress indicators and looked forward to positive results from, and periodic reports on, the implementation of the Quick Start Programme.

Resource mobilization was essential for taking that work forward, requiring effective leadership and higher priority within the Organization, as well as collaboration with other agencies, Member States and stakeholders. Of those important areas not covered by the Quick Start Programme, he emphasized element 5 of the global strategy, relating to the application and management of intellectual property to contribute to innovation and promote public health. Member States in the Region looked to the Secretariat for support in that work, which formed the heart of the global strategy and plan of action in so far as no other international agency addressed intellectual property from the health perspective. He requested updates on the Secretariat's efforts to build capacity in that crucial area. The regional offices should be strengthened in order to coordinate such work, in which his Region would continue to cooperate fully.

Dr CHAUHAN (India) said that his country had actively supported the establishment of the Intergovernmental Working Group, its deliberations and the spirit of compromise resulting in the adoption of resolution WHA61.21. The newly proposed programme indicators, however, were mostly

country specific and failed to address the international policies or trading conditions crucial to implementation of the global strategy and plan of action and to the effectiveness of measures undertaken. He therefore requested a review of those indicators, in consultation with all regions, in order to gauge the effectiveness of such measures at the international level in spurring research and development, enabling technology transfer, managing intellectual property and improving delivery and access.

The Organization should be a stakeholder for element 2.3(c), which related to improving cooperation, participation and coordination of health and biomedical research and development. WHO should be a lead stakeholder for element 5.3(a), which related to exploring and promoting incentive schemes for research and development on Type II and Type III diseases and on developing countries' specific research and development needs in relation to Type I diseases. In that regard he looked forward to innovative funding proposals. He also looked forward to the recommendations of the time-limited expert working group on current financing and coordination of research and development, which, together with prioritized national action plans, should promote achievement of the aims set forth in resolution WHA61.21.

Mr TRAMPOSCH (Czech Republic), speaking on behalf of the Member States of the European Union, expressed satisfaction with the process that had culminated in the adoption of the global strategy and plan of action – an important result. The European Union supported adoption of the draft resolution but requested additional information to meet concerns over the financial implications for stakeholders. It was nevertheless committed to full implementation of the global strategy and would work with the Secretariat to ensure its success.

Dr AL BURAIKY (United Arab Emirates) said that her country was a Middle-East pioneer in terms of protecting innovation, patents and intellectual property, particularly concerning medical products. It had introduced various principles and laws to that end and acceded to relevant international instruments such as the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). Protection was extended to traditional medicines and confidentiality of information concerning new compounds in products marketed by pharmaceutical companies. Medicinal products enjoyed the same intellectual property rights in the United Arab Emirates as in their country of origin until expiry of the patent. That policy also applied in regard to generics: information was obtained from such sources as Approved Drug Products with Therapeutic Equivalence Evaluations (the Orange Book), produced by the United States Food and Drug Administration. The same applied to research information concerning the safety and effectiveness of patented drugs. Such measures demonstrated her country's commitment to the protection of innovation and intellectual property in medicines.

Dr JARAMILLO NAVARRETE (Mexico) announced that the Mexican Senate had signed the Protocol amending the Agreement on Trade-Related Aspects of Intellectual Property Rights, making it possible for Mexico to use compulsory licences to produce patent-protected medicines in the event of a health emergency, for example if there was a shortage of antiviral medicines to tackle the epidemic of influenza A (H1N1).

In that connection, his delegation associated itself with the appeal by some Member States to eliminate the term "counterfeit medicines" from the Medium-term strategic plan 2008–2013. The Secretariat and health ministries must focus on guaranteeing access to medicines that met standards of quality, safety and bioavailability. The global strategy and plan of action fully reflected the actions developed by the Intergovernmental Working Group.

His Government had supported the development and marketing of interchangeable generic pharmaceutical products as part of its commitment to expanding access to cheaper medicines.

With regard to paragraph 10 of document A62/16, countries in the Region of the Americas suffered differing degrees of health inequality. The Secretariat should therefore consider establishing terms of reference for the definition of specific regional plans identifying which areas required intervention by regional committees.

He supported the draft resolution. Multilateralism must strike a balance between intellectual property rights and access to medicines. That would ensure that intellectual property worked for, rather than against, public health; that technology transfer and investment for the production of essential medicines were promoted; that the protection period for essential medicine patents was reduced; and that emphasis was placed on using the flexibilities provided by the TRIPS agreement.

Mr MSELEKU (South Africa) said that his country wished to sponsor the draft resolution. He welcomed the progress made in proposing time frames in the plan of action and the budgeting exercise for the plan's implementation. He supported the adoption of the action plan, including components on time frames and funding needs, and called on WHO to raise the necessary funds. The cost of implementing the global strategy at the regional and national levels should be largely determined by the magnitude of the disease burden, which disproportionately affected poor people in developing countries. Developing countries needed to support and improve technology transfer related to health innovation.

Dr CAMPBELL-FORRESTER (Jamaica) commended the progress made in launching the Quick Start Programme, as well as the establishment of a results-oriented and time-bound expert working group, in which the Caribbean region would be represented. In that context, Barbados and Bolivia (Plurinational State of) had worked on proposals to encourage essential health research in neglected diseases.

She supported the approach reflected in document A62/16 Add.1, particularly specific actions 1.2(e) and 1.3, and recommended that the sharing of the benefits of research and development in traditional medicine should be part of specific action 1.3(b) and that recognition of the source of traditional medicines should be added in order to protect intellectual property. With regard to specific action 2.4, specific regional and country plans were needed because of varying levels of economic development.

She said that she assumed that it was an oversight that WHO had been omitted from the list of stakeholders under specific action 2.3(c) in document A62/16 Add.3.

Mr COX (Barbados), speaking also on behalf of the delegations of Bangladesh, Bolivia (Plurinational State of) and Suriname, said that on 15 April 2009 their governments had submitted, inter alia, a proposal to the Expert Working Group calling for WHO to hold discussions on a biomedical research and development treaty, reflecting the consensus reached in specific action 2.3(c) in the annex to resolution WHA61.21 and containing possible elements for such a treaty and a schedule for taking the discussions forward. Only on 18 May had the Secretariat issued document A62/16 Add.3 containing proposals on the open paragraphs on stakeholders in the plan of action. He understood that only a limited number of countries had been invited to negotiate on the remaining bracketed text, leaving the majority of States with no real forum for engaging in negotiations before the convening of the Sixty-second World Health Assembly.

He noted with concern that WHO had been omitted as a stakeholder under specific action 2.3(c) and that the proposal he was putting forward would not have a forum for discussion once the expert working group completed its time-bound mandate. He therefore proposed the reinsertion of WHO as a stakeholder under specific action 2.3(c) and that the reference therein to "Interested governments" should be replaced by "Governments" in order to ensure consistency with the rest of the document. Otherwise, he requested the Secretariat to explain clearly what would be the consequences of the present Health Assembly removing WHO as a stakeholder under the specific action concerned. For instance, would WHO be able to convene meetings and conduct studies on topics such as identifying elements, models and objectives of a biomedical treaty and to consider alternative ways of providing sustainable funding for priority research and development?

Professor OLE KIYIAPI (Kenya) noted the concern expressed by some African Member States that had not been fully consulted during the informal consultation process. Serious efforts should be

put into the implementation of the global strategy and plan of action. While supporting the draft resolution, he proposed the insertion of a second preambular paragraph to read:

“Welcomes the report of the Director-General on the implementation of the African Network for Drugs and Diagnostics Innovation (ANDI), which supports and promotes African-led health product innovation for the discovery, development and delivery of drugs and diagnostics for neglected tropical diseases, and reiterates the need to fast-track activities to reach neglected people who are sick and suffering from neglected tropical diseases”.

He also proposed the insertion of a new operative paragraph, to read:

“REQUESTS the Director-General to significantly increase support towards greater efficiency and effectiveness in the implementation of the global strategy and plan of action on public health, innovation and intellectual property and prioritize concrete actions in the area of capacity building, and ensure that issues of access and benefit-sharing that affect local populations take front stage;”.

Dr CHEN Ningshan (China) acknowledged the important role of WHO in promoting research and development, building innovative capacity, improving access, ensuring sustainable financing and establishing monitoring systems. She looked forward to rapid implementation of the global strategy and plan of action for the benefit of developing countries and public health.

Her Government had recently promulgated the eleventh five-year plan for scientific and technical development in the health area and the outline for the innovative development of Chinese medicine, 2006–2020. It aimed to build and improve innovative capacity steadily by increasing government input and expanding international cooperation, with priority given to research and development.

WHO should strengthen coordination in health research work; mobilize more funds for major diseases that mainly affected developing countries; and establish a mechanism to support developing country innovation and sustainable financing. The Organization should support laboratories and collaborating centres in developing countries and the scaling up of transfer of technologies in order to enhance the research and innovation capabilities of developing countries.

Dr BERNADAS (Philippines) supported the global strategy and plan of action. His Government was committed to the formulation of a national plan of action. Despite resource constraints, it would seek a balance between establishing a research and development system and meeting basic needs of providing services and making cheaper, quality medicines accessible to its people. The formulation of a national action plan would depend on the forging of a strong partnership among all key stakeholders. The Government would pursue a legislative proposal that linked health promotion through research and development with fiscal incentives in order to harness innovative sources of funding. Private sector participation would be encouraged through research and development on Type II and Type III diseases; and specific Type I diseases linked to programmes for corporate social responsibility. It was crucial to involve private citizens and the corporate sector in the implementation of the global strategy and plan of action.

Mr DELGADO HIGUERA (Bolivarian Republic of Venezuela), speaking also on behalf of Argentina, Bolivia (Plurinational State of), Cuba, Ecuador and Nicaragua, expressed support for the global strategy and plan of action. With regard to document A62/16 Add.3, however, he found it unacceptable that informal consultations had been conducted in a manner that was neither transparent nor inclusive and that the document had not been duly discussed by all Member States. The omission of WHO as a stakeholder under specific action 2.3(c) must also be rectified.

The indicators proposed in document A62/16 Add.2 were essentially quantitative rather than qualitative. Indicators were needed that reflected the public health impact of the implementation of the global strategy and plan of action. The Member States concerned would therefore be unable to support

the draft resolution as currently formulated until the two documents in question had been properly debated by all the Member States.

Ms NAVARRO LLANOS (Plurinational State of Bolivia) said that it was extremely important that all WHO's discussions be conducted transparently and inclusively; further consultations should be held on those documents that had not been discussed multilaterally before the current Health Assembly. She also specified further discussions on qualitative indicators, and maintained that WHO should be reinstated as a stakeholder under specific action 2.3(c); furthermore, the word "Interested" before "governments" should be deleted.

Her country's new Constitution, adopted in January 2009, expressly prohibited the patenting of life, including microorganisms, and sought to provide strong protection for the traditional knowledge of Bolivia's 36 indigenous peoples. To that end, it used *sui generis* protection measures that were neither patents nor other forms of intellectual property, which it considered to be monopolistic and private in contrast to forms of collective protection. Accordingly, her Government would have reservations about any document adopted that ran counter to the new Constitution, particularly with regard to specific action 5.1(f) in document A62/16 Add.3.

Dr MADZORERA (Zimbabwe) said that Zimbabwe supported the draft resolution and wished to be included as a sponsor.

He commended the Secretariat's support for the establishment of the African Network for Drugs and Diagnostics Innovation, which would promote capacity building for research and development in Africa.

The global strategy and plan of action gave developing countries the opportunity to create a system of medical innovation and access to medicines and medical devices for those diseases that disproportionately affected their countries. The strategy would also support information sharing and capacity building in the management of intellectual property; early implementation would be vital.

Dr IDZWAN BIN MUSTAPHA (Malaysia) said that Malaysia had implemented several specific actions of the strategy: prioritizing research and development needs; promoting research and development; building and improving innovative capacity; and improving delivery and access. It would continue to support that initiative. Malaysia was concerned about the high estimated funding requirements for the global strategy; in the current global economic climate, innovative and sustainable financing mechanisms were needed to stimulate research and development. He expressed support for the draft resolution, together with the proposed progress indicators.

Dr TIPICHA POSAYANONDA (Thailand) commended the Secretariat's work on proposals for the time frames and funding estimates for the eight elements of the plan of action. She urged WHO and other relevant international partners to take a leading role for specific action 5.1(c).

With regard to the time frames proposed in document A62/16 Add.1, she recommended that specific action 1.1 be concluded by 2011, and that high priority be given to specific actions 5.1, 5.2 and 5.3, as the implementation of those actions was feasible. She asked the Secretariat to clarify the mobilization of funding for the eight elements and whether the plan of action, including the total resources requirement for 2008–2015, was to be integrated into the Medium-term strategic plan 2008–2013. Thailand wished to see increased resources allocated to diseases that disproportionately affected developing countries, from 3% to 12% of the US\$ 160 000 million currently spent globally each year on health research and development.

She supported the draft resolution but proposed that the word "updated" in subparagraph 1(2) be replaced by "proposed" and that a new paragraph 5 be inserted, to read: "REQUESTS the Director-General: (1) to conduct a major programme review of the global strategy and plan of action in 2014 on its achievement, remaining challenges and recommendations on the way forward to the Health Assembly in 2015 through the Executive Board".

The CHAIRMAN asked for the proposed amendment to be submitted in writing.

Dr HONG Jeong-ik (Republic of Korea) said that patients in many developing countries did not have sufficient access to essential, high-quality medicines at affordable prices. Cooperation should be improved between all countries with the private sector, in particular the pharmaceutical industry, playing a more active role. Intellectual property rights were vital to the pharmaceutical sector, promoting and rewarding innovation, but excessive protection could deny poor patients access to medicines. Accessibility of medicines depended on technology, economic development and international cooperation. His Government was ready to join the efforts of the international community in that field.

He urged the Secretariat to include that issue as an area for early implementation, in order to create a balance between intellectual property protection and access to medicines.

Mr TANAKA (Japan) emphasized that building structures for research and development of medicines against diseases that affected developing countries and improving access to medicines were crucial and should be dealt with by the international community. The global strategy and plan of action would be useful tools for fostering international cooperation in those fields.

Most research and development expenditure was covered by private funding; the Expert Working Group should discuss innovative financial mechanisms for procurement, such as advance market commitments for vaccines and the International Finance Facility, in order to encourage spending on research related to diseases that disproportionately affected developing countries. In order to recover the costs, the health sectors of developing countries must be willing to purchase medicines.

He suggested that the Secretariat should allocate substantial funding to research and development projects in developing countries and provide information regarding the effective and efficient use of funds.

Ms LUTTERODT (Ghana) supported the work of the African group on the global strategy and plan of action, as well as the long-term action to address the technology gap between new chemical compounds and old diseases. She suggested that WHO be included as a stakeholder for specific action 2.3(c). She emphasized that both qualitative and quantitative indicators should be used to measure progress.

With regard to access to medicines, she recognized the work of civil society organizations and recommended a regional approach to that issue in order to ensure value for money.

Mr HOHMAN (United States of America) said that the global strategy and plan of action contained many important provisions regarding public health, innovation and intellectual property rights. His country was not opposed to exploratory discussions on possible instruments and mechanisms for essential health and biomedical research and development, but those discussions could more appropriately be conducted by governments and civil society than by international organizations. He supported the draft resolution.

Mr TOBAR (Argentina) asked whether the funding for the global strategy and plan of action would be divided by country or by region, as that would have implications for the benefits of their implementation at both national and regional levels. Requesting information on the system for intermediate measurement of progress indicators, he expressed concern that the indicator for technology transfer did not seem to guarantee effective evaluation. He emphasized the value of the Intergovernmental Working Group's procedures, which enabled each country to carry out critical internal analysis of the issues under consideration.

Dr SILBERSCHMIDT (Switzerland) fully supported the draft resolution, which was the product of five years' work. However, his country could not support the proposed amendment to the list of stakeholders for specific action 2.3(c). He emphasized the importance of implementing the global strategy and plan of action at both national and international levels. Switzerland, for its part, had already initiated a national implementation process.

Mr McCARTHY (European Commission), referring to the implementation of the global strategy and concerns expressed by the European Parliament regarding poverty-related, tropical and neglected diseases and technology transfer in favour of developing countries, said that two Development Cooperation Instruments had been signed in 2008 between WHO and the European Commission. Those would help to identify research and development priorities and provide recommendations for further European Commission action in that field to contribute to the implementation of element 1 of the strategy. They would also promote greater access to knowledge and technology, develop capacity building for health innovation and promote coordination of technology transfers, thereby contributing to the implementation of element 4. Work in those areas would complement steps taken under the European Union Framework Programme for Research and Development in the area of health, as well as the Africa–European Union Strategic Partnership, which emphasized water and food security, and better health for Africa by strengthening local capacities.

Ms HASLEGRAVE (Global Forum for Health Research), speaking at the invitation of the CHAIRMAN, said that the implementation of the global strategy and plan of action would stimulate innovation of health products and technologies and enhance innovative capacities at the national level. Her organization had contributed to the elaboration of the plan and would collaborate with WHO on issues affecting its implementation. The plan of action focused on technological innovation; however, there was also a need to address social innovation, which would facilitate the development and delivery of effective, efficient and equitable health products and services. Issues relevant to the agenda item under discussion would be addressed at her organization's Forum, to be held in November 2009 in Havana, Cuba, on "Innovating for the Health of All".

Mr BALASUBRAMANIAM (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, expressed his organization's surprise that WHO had been removed from the list of stakeholders for specific action 2.3(c). Recent global health crises had highlighted the need for global norms in biomedical research and development, and, as the specialized organization of the United Nations system, WHO should participate in any such discussions. WHO should have an adequate mandate for the implementation and advancement of the global strategy and plan of action, which was a unique and important document.

Ms BLOEMEN (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, said that qualitative indicators should be developed to measure the health impact of innovation, ensuring a correct balance between intellectual property rights and public health. Furthermore, WHO should be included in the list of stakeholders for specific action 2.3(c), in order to ensure the success and legitimacy of a biomedical research and development treaty. As the process of developing the global strategy had not been inclusive, she urged Member States to take into account the concerns expressed in that regard.

Mr CHAN (International Pharmaceutical Federation) speaking at the invitation of the CHAIRMAN, said that the dearth of health-care professionals in many countries, which was often due to poor working environments, had a negative impact on both patient outcomes and research capacities and would affect the implementation of the global strategy and plan of action. The implementation of element 6 would benefit from targeted investment to strengthen the pharmaceutical sector. Unpublished research into development of the pharmaceutical workforce indicated persisting imbalances in many countries, particularly in sub-Saharan Africa. There was a need to improve training and institutional capacity building for education and research.

Dr RENGANATHAN (Public Health, Innovation and Intellectual Property), replying to the points raised, said that the progress indicators had been proposed on the basis of discussions within the Intergovernmental Working Group and at previous sessions of the Executive Board and Health Assembly. It had proved difficult to establish global qualitative indicators, although such indicators

had been established relating to the submission of reports under element 8 and in the four-year reporting cycle.

With regard to the Quick Start Programme, a report would be issued detailing progress made, and, although the global financial crisis had affected resources, the Programme was still moving forward. Concerning the mainstreaming of activities, the Secretariat was working across the Organization on various elements of the global strategy and plan of action, for example building on the activities of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases and on the work on the proposed WHO strategy on research for health and draft WHO medicines strategy 2008–2013. Progress made in intellectual property capacity building had been reported to WTO's TRIPS Council in October 2008. Work in that area was undertaken in conjunction with WTO and WIPO.

An ingredients approach had been used to estimate the funding required for the global strategy and plan of action, and document A62/16 Add.1 had provided an explanation as to how the figures had been reached. It would cost about US\$ 2000 million to establish a system for the development and implementation of the global strategy and plan of action, but the cost of undertaking the necessary research and development, innovation and technology transfer might be as high as US\$ 147 000 million, based on needs assessments.

Responding to a comment by the delegate of Thailand, he agreed that only about 3% of the US\$ 160 000 million per year spent globally on health research and development was currently allocated to neglected tropical diseases. It was hoped to increase that figure to 12% by 2015. Details of financial implications would be made available when a full workplan had been agreed; until then, all costs would be estimated.

Regarding the inclusion of the global strategy and plan of action in the Medium-term strategic plan, he referred the delegate of Thailand to strategic objective 11 of that plan.

The Secretariat was already working actively through the regional offices to ensure regional implementation of the strategy.

With regard to the Expert Working Group on research and development financing, which had been established in November 2008 and had held its first meeting in January 2009, he said that the meeting to be held in a few weeks' time would look at innovative financing and would review and subsequently decide upon proposals submitted by Member States and other stakeholders, as well as those submitted by experts.

Dr DAYRIT (Secretary) read out the proposed amendments to the draft resolution. The delegate of Kenya had proposed to add a preambular paragraph reading: "Welcomes the report of the Director-General on the implementation of the African Network for Drugs and Diagnostics Innovation (ANDI), which supports and promotes African-led health-product innovation for the discovery, development and delivery of drugs and diagnostics for neglected tropical diseases, and reiterates the need to fast-track activities to reach neglected people who are sick and suffering from neglected tropical diseases", and to add a new operative paragraph reading: "REQUESTS the Director-General to significantly increase support towards greater efficiency and effectiveness in the implementation of the global strategy and plan of action on public health, innovation and intellectual property and prioritize concrete actions in the area of capacity building, and ensure issues of access and benefit-sharing affecting local populations take front stage."

The delegate of Thailand had proposed replacing "updated" by "proposed" in paragraph 1(2), and had proposed a new operative paragraph, reading: "REQUESTS the Director-General to conduct a major programme review of the global strategy and plan of action in 2014 on its achievement, remaining challenges and recommendations on the way forward to the Health Assembly in 2015 through the Executive Board."

The CHAIRMAN asked whether the Committee wished to approve the draft resolution as amended.

Ms NAVARRO LLANOS (Plurinational State of Bolivia) said that some of the points raised by delegates had not been clarified. In particular she requested a more detailed explanation from the Secretariat of the consequences of not including WHO as a stakeholder in specific action 2.3(c).

The delegate of Barbados had expressed reservations, including those of her own country, about paragraphs 1(1) and 4 of the draft resolution, though without proposing specific amendments. Therefore, she proposed that the phrase “as amended to incorporate WHO as a stakeholder for action item 2.3(c)” should be added at the end of paragraph 1(1) and that paragraph 4 be replaced by the following text: “Considers the proposed progress indicators as outlined in document A62/16 Add.2 as a basis for the WHO Secretariat to facilitate further consultations among all Member States and other relevant stakeholders. WHO should present the revised progress indicators to the 126th session of the Executive Board in January 2010”. She further proposed that the word “Interested” be deleted in the “Stakeholders” column of specific action 2.3(c).

The dissatisfaction expressed by a number of delegations that felt that they had been excluded from the consultation process should be reflected in the document before the Committee, or set out in a Chairman’s statement or other paper.

Dr RENGANATHAN (Public Health, Innovation and Intellectual Property), in reply, said that the Secretariat could not prejudge the outcome of the work of the Expert Working Group. The proposal by Bangladesh, Barbados, Bolivia (Plurinational State of) and Suriname on specific action 2.3(c) would be forwarded, with many others, to the Expert Working Group for its consideration. The latter would then report to the Director-General who in turn would report to the Executive Board and subsequently the Health Assembly.

Mr TRAMPOSCH (Czech Republic), speaking on behalf of the Member States of the European Union, said that he had no objection to the amendment proposed by the delegate of Kenya to the preamble nor to the amendment proposed by the delegate of Thailand to paragraph 1(2).

Regarding the proposal by the delegate of Kenya for a new operative paragraph, he would prefer the proposed sentence to end with the words “capacity building”. Before commenting on the proposed new operative paragraph on the review of progress indicators, he would like to receive more information, for example on how the review mechanisms in the global strategy and plan of action related to existing review mechanisms.

He reminded the Committee that the stakeholders included in document A62/16 Add.3 had been agreed on by the Sixty-first World Health Assembly in May 2008, when consensus had almost been reached, and by the Executive Board at its 124th session in January 2009, when full consensus had been reached. The European Union could not, in the context of the draft resolution before the Committee, accept any modifications to a package that had been negotiated at great length and with broad representation.

Mr HOHMAN (United States of America) associated himself with the remarks made by the previous speaker.

Mr KAZI (Bangladesh) supported the amendments proposed by the delegate of the Plurinational State of Bolivia. As the Expert Working Group had not yet completed its work, he was strongly in favour of retaining WHO as a stakeholder in the process. The findings of that Group might have implications for the proposals jointly supported by his country, Barbados, Bolivia and Suriname.

Dr VIROJ TANGCHAROENSATHIEN (Thailand), responding to a point raised by the delegate of the Czech Republic, pointed out that specific action 8.1 largely concerned the monitoring of progress. The Health Assembly had not mandated action in that regard. He therefore wished to see a review of the global strategy and plan of action conducted, covering the achievement, remaining challenges and recommendations. No additional work would be involved; it should simply be a synthesis of findings from 2008 to 2015. The review should be conducted in 2014 and a report submitted for consideration by the Health Assembly in 2015.

Mr DELGADO HIGUERA (Bolivarian Republic of Venezuela) supported the statement made by the delegate of Bolivia. It was still not clear why WHO had not been included among the stakeholders in specific action 2.3(c). Its inclusion was of fundamental importance and should be reflected in the resolution. Qualitative as well as quantitative indicators were needed and that should be considered.

He suggested that a paper be prepared setting out the proposed amendments to the draft resolution and delegates' comments thereon, to assist the Committee in reaching agreement on a text.

The CHAIRMAN suggested that the Secretariat should prepare a paper containing all the proposed amendments to the draft resolution, for consideration by the Committee at its next meeting.

It was so agreed.

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

The meeting rose at 12:25.

FOURTH MEETING

Thursday, 21 May 2009, at 14:55

Chairman: Mr S. McKERNAN (New Zealand)

later: Dr U.S. SUTARJO (Indonesia)

1. ORGANIZATION OF WORK

The CHAIRMAN announced that agenda item 12.9, Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis, which had been transferred to the Committee for consideration, had been assigned back to Committee A.

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

Public health, innovation and intellectual property: global strategy and plan of action: Item 12.8 of the Agenda (Documents A62/16, A62/16 Add.1, A62/16 Add.2 and A62/16 Add.3) (continued from the third meeting, section 3)

The CHAIRMAN invited the Committee to consider the following draft resolution which incorporated amendments proposed at the previous meeting.

The Sixty-second World Health Assembly,
Recalling resolution WHA61.21 on the Global strategy and plan of action on public health, innovation and intellectual property, and noting the information provided by the Secretariat,¹

Welcoming the report by the Director-General on the implementation of the African Network for Drugs and Diagnostics Innovations (ANDI), which supports and promotes African led health product innovation for the discovery, development and delivery of drugs and diagnostics for neglected tropical diseases, and reiterates the need to fast-track activities to reach neglected people who are sick and suffering from neglected tropical diseases [Kenya];

1. DECIDES

- (1) to incorporate into the plan of action the additional agreed stakeholders as outlined in document A62/16 Add.3; **deleting "interested" before "governments" and incorporating WHO as stakeholder for action in item 2.3(c) [Bolivia];**
- (2) to incorporate into the plan of action the ~~updated~~ **proposed [Thailand]** time frames outlined in document A62/16 Add.1;

2. Accordingly ADOPTS the final plan of action in respect of specific actions, stakeholders and time frames;

¹ Documents A62/16, A62/16 Add.1, A62/16 Add.2 and A62/16 Add.3.

3. **NOTES** the estimated funding needs related to the plan of action as outlined in document A62/16 Add.1;

4. ~~**ACCEPTS NOTES [Bolivia]** the proposed progress indicators as outlined in document A62/16 Add.2 as the basis for regular reporting to the Health Assembly on performance and overall progress made over a two-year reporting period [Bolivia];~~

~~**OR**~~

4. **CONSIDERS** the proposed progress indicators as outlined in document A62/16 Add.2 as the basis for WHO secretariat to facilitate further consultations among all Member States and other relevant stakeholders. WHO should present these revised progress indicators to the 126th session of the Executive Board in January 2010 [Bolivia];

5. **REQUESTS** the Director-General to significantly increase support towards greater efficiency and effectiveness in the implementation of the global strategy and plan of action on public health, innovation and intellectual property and prioritize concrete actions in the area of capacity building, and ensure issues of access and benefit sharing affecting local populations take front stage [Kenya];

[Czech Republic proposed amendment to Kenya's proposal] deletion of:
and ensure issues of access and benefit sharing affecting local populations take front stage;

6. **REQUESTS** the Director-General to conduct a major programme review of the global strategy and plan of action in 2014 on its achievement, remaining challenges and recommendations on the way forward to the Assembly in 2015 through the Executive Board [Thailand].

Dr VIROJ TANGCHAROENSATHIEN (Thailand) invoked the Geneva spirit for the Committee's deliberations. He recalled that, before the adoption of resolution WHA61.21 in 2008, the Health Assembly had almost reached consensus on the plan of action: only 10 items relating to stakeholders remained to be resolved. Referring to the proposal by the delegate of Bolivia to delete "interested" before "governments" in specific action 2.3(c) through an amendment to paragraph 1(1) of the draft resolution, he said that the governments of all Member States appeared to be interested in the action concerned, and that the only outstanding issue concerned the position of WHO as a possible lead stakeholder. Referring to the proposal by the delegate of Bolivia for paragraph 4, he advised that the issues relating to progress indicators were technical and should be left to the Secretariat. The Health Assembly should follow the policy directions identified through the Intergovernmental Working Group process. The Health Assembly had approved specific actions by consensus. Paragraph 4 should remain unchanged. On the proposed amendments to paragraph 5, he had serious reservations about deleting the term "benefit sharing" and urged reconsideration. Regarding the "major programme review" called for in his delegation's proposal for a new paragraph 6, after informal consultations he would not insist on the inclusion of the word "major" since element 8 provided for monitoring and reporting. He urged Members to approve the draft resolution as time was running out for the adoption of a plan of action that covered the years 2008–2015.

Ms WISEMAN (Canada) accepted most of the proposed amendments. She suggested that, for the sake of clarity, the first part of the preambular paragraph proposed by the delegate of Kenya should be reworded to read: "Welcoming the report, A62/16, of the Director-General referring to the implementation of the African Network". Regarding the proposed revision of paragraph 4, she argued for retaining the reference to progress indicators as a basis for reporting. She recognized that the indicators might need refining and proposed the wording: "Accepts the proposed progress indicators as outlined in document A62/16, taking note of the need to periodically review and refine"; that should cover the concerns raised by the delegate of Bolivia. She supported the European Union's proposal that paragraph 5 should end with the words "capacity building" or "capacity building and access", in

order to meet the concerns of the delegate of Kenya. She welcomed the willingness of the delegate of Thailand to amend the reference in paragraph 6 to the need to conduct an overall review. Regarding paragraph 1(1), she said that the process of reaching agreement on the 10 remaining stakeholder items had been lengthy, and that she could not accept the proposed amendments.

Dr SILBERSCHMIDT (Switzerland) said that, since the creation of the Commission on Intellectual Property Rights, Innovation and Public Health in 2003, his country had strongly supported the establishment of the Intergovernmental Working Group, the fact-finding process and the negotiations. It was time to adopt the global strategy and plan of action and move on to implementation. It was necessary to maintain the consensus achieved at the previous Health Assembly.

He supported the proposal by the delegate of Kenya for a new preambular paragraph in the draft resolution, but could not accept any change to the wording of specific action 2.3(c) in the plan of action; the language was already a compromise. The commitment of WHO's resources to that issue could not be justified, and he was not willing to accept the inclusion of WHO as an active stakeholder.

He supported the amendment proposed by the delegate of Thailand to paragraph 1(2) and the language proposed by the delegate of Canada for paragraph 4, which took into account the concerns expressed by the delegates of Switzerland and Bolivia. He supported the proposal of the delegate of Kenya on paragraph 5, as amended by the delegates of Canada and the Czech Republic, and the replacement of "major programme review" by "overall programme review" in the new paragraph 6 proposed by the delegate of Thailand.

Ms NAVARRO LLANOS (Plurinational State of Bolivia) reiterated her proposal to delete the word "interested" before "governments" in specific action 2.3(c). She supported the amendment by the delegate of Canada to paragraph 4 regarding indicators. Members of the group headed by Venezuela that included Argentina, Ecuador, Nicaragua and her own country proposed adding the following sentence, after the amendment by the delegate of Canada, at the end of paragraph 4: "where the indicators are quantitative, the Secretariat shall provide complementary information on the implementation of the specific actions". The only remaining issue concerned whether WHO should be a stakeholder.

Professor OLE KIYIAPI (Kenya) said that he was willing to accept the suggestion by the delegate of Canada that "capacity building and access" should be included in the proposed wording for paragraph 5.

The CHAIRMAN suggested that the debate on the item should be adjourned in order to enable the parties to try to achieve consensus.

It was so agreed.

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

Progress reports on technical and health matters: Item 12.10 of the Agenda (Document A62/23)

A. Poliomyelitis: mechanism for management of potential risks to eradication (resolution WHA61.1)

Dr ALI PATE (Nigeria) recalled that in resolution WHA61.1 the Health Assembly had urged Nigeria to "reduce the risk of international spread of poliovirus by quickly stopping the outbreak in northern Nigeria through intensified eradication activities that ensure all children are vaccinated with oral poliomyelitis vaccine". His Government had implemented several supplemental immunization activities. The percentage of local government areas achieving 90% vaccination coverage had increased from 71% in July 2008 to 81% in March 2009. The estimated number of children left

unvaccinated had decreased by more than 100 000 between December 2008 and March 2009. In routine immunization, coverage with oral poliovirus vaccine had been 63% in the first quarter of 2009 compared with 47% in the same period of 2008. Certification-standard surveillance for acute flaccid paralysis had been maintained at national level in all but one State in 2008. More than 70% of local government areas had met the two main performance indicators for acute flaccid paralysis surveillance, and the enhanced quality of immunization activities had distinctly improved population immunity markers.

In regard to acute flaccid paralysis not due to poliovirus, the proportion of such cases in children aged 6 to 35 months who were reported not to have received a single dose of oral poliovirus vaccine had been 5% in the first quarter of 2009 compared with 15% in the same period of 2006. The proportion of cases in the same age group who were reported to have received at least three doses of oral poliovirus vaccine had increased from 62% in the first quarter of 2006 to 78% in the first quarter of 2009. The most dramatic improvement in population immunity had been registered in Kano, where for the first time the proportion of children never vaccinated had been reduced to less than 20%.

Progress in immunization had not been uniform in all states and local government areas. Transmission of wild poliovirus had continued because of the number of unimmunized children in particular areas. In response to those challenges, Nigeria would be conducting one nationwide campaign and three subnational campaigns in 2009. In addition, mop-up campaigns would be conducted in response to any confirmed case of poliomyelitis with disease onset after April 2009 in states where poliovirus was not endemic. Efforts to strengthen routine immunization would be intensified, with special priority given to local government areas with the lowest levels of population immunity.

In order to translate political commitment into improved programme performance, high-level intersectoral committees had been established at state and local government levels; that action had begun to yield dividends. All 36 states of the Federation would be encouraged to establish such committees. Nigeria was developing innovative approaches in programming, and accumulating skills and best practices. He was optimistic that such progress was changing the trajectory of the disease in Nigeria.

Dr MAHAMAT (Chad) emphasized the importance of the matter to the African Region. Since the launch of the Global Polio Eradication Initiative in 1988, all the countries in which poliomyelitis was endemic had made enormous efforts to eradicate the disease, with marked success. Unfortunately, that success could be compromised by short- and medium-term risks, represented by the persistent circulation worldwide of wild polioviruses and the absence of protection for countries free of such viruses. Long-term risks were represented by outbreaks due to circulating vaccine-derived polioviruses resulting from the continued use of oral poliomyelitis vaccine; cases of paralytic poliomyelitis associated with vaccination of immunodeficient individuals with oral poliovirus vaccine; excretion of vaccine-derived poliomyelitis among individuals with immunodeficiency disorders; and reintroduction of wild polioviruses or Sabin-strain derivatives originating in places where vaccine strains were kept.

Some risk factors were specific to the African Region and arose from various sources: inadequate means of reaching nomadic populations and other people in remote areas; lack of involvement of opinion leaders; weaknesses in the routine Expanded Immunization Programme; and people's resistance to vaccination coverage, owing to disinformation. Once they had eradicated poliomyelitis, the countries of the African Region would need to join forces with their partners to combat those risk factors.

Three elements were vital to stopping the circulation of wild polioviruses in the African Region: attaining and maintaining over time an oral poliovirus vaccine coverage rate of 80% or higher for children through systematic vaccination efforts; effectively reaching all children up to five years of age through the organization of high-quality supplementary vaccination campaigns; and reinforcing active monitoring of acute flaccid paralysis.

The countries of the African Region wished to reaffirm their commitment to the global eradication of poliomyelitis and urged other countries to join them in that effort.

Dr MOHAMMAD (Oman) said that, even though numerous strategies had been implemented and a significant amount of money spent for the purpose of eradicating poliomyelitis throughout the world, that goal had not been reached. There were only two ways to reduce the transmission of polioviruses between countries: to eradicate poliomyelitis from every country and to ensure that countries were in a position to stop transmission of poliovirus. He was confident that the four countries still endemic for poliomyelitis were capable of eradicating the virus, as 150 countries had already done so.

Dr SADRIZADEH (Islamic Republic of Iran) welcomed the details in the progress report on a mechanism for management of potential risks to eradication. He also welcomed the serious efforts being made by the four countries still endemic for poliomyelitis to interrupt their final chains of poliovirus transmission. He appreciated the information contained in the 2009 edition of *International Travel and Health* with regard to protection against importation of poliovirus, in particular the recommendations for immunization of residents travelling to and from areas where poliovirus was circulating. Implementation of those recommendations by all Member States should help to reduce further the international spread of the virus.

He expressed the hope that the countries still endemic for poliomyelitis, in particular Nigeria, which unfortunately had been at the origin of all new wild poliovirus exportations in the past 12 months, would take all necessary steps to reduce the risk of further international spread of poliovirus. Eradication efforts, despite being stepped up in 2008, could be thwarted if officials at state and district levels were not held fully accountable for the quality of poliovirus immunization campaigns in their areas over the next 12 months. In that connection, he suggested that the Sixty-third World Health Assembly consider the independent evaluation of the intensified eradication effort that had been requested by the Executive Board at its 124th session.

Ms TZIMAS (Germany) said that poliomyelitis eradication efforts contributed significantly to improving children's health and achieving the Millennium Development Goals. Her country had been committed for many years to fighting the disease, both bilaterally and multilaterally, and was grateful that eradication remained high on the Health Assembly's agenda. She commended the Secretariat's promotion and coordination of the Global Polio Eradication Initiative, to which Germany had contributed about US\$ 223 million, making it one of the most important bilateral partners in the eradication effort.

She estimated that funding commitments from various sources, including Germany, would amount to US\$ 630 million for poliomyelitis eradication, thereby reducing to about US\$ 200 million the funding gap predicted by the Secretariat for eradication by 2010. Convinced that global poliomyelitis eradication could be achieved through joint efforts, she called on all the governmental and nongovernmental bodies concerned to fill the funding gap, facilitate vaccination campaigns, and ensure that new vaccination programmes were implemented.

The final phase of the international campaign to eradicate poliomyelitis would involve strengthening health systems, developing and expanding surveillance systems and supporting countries as they faced their specific challenges. It was vital to ensure that no major setback occurred.

Dr Sutarjo took the Chair.

Dr HUSSAIN (Bahrain) fully supported the principles set out in resolution WHA61.1. Her country had been free of the disease since 1994. Surveillance of acute flaccid paralysis was efficient and formed part of a larger system of communicable disease surveillance. Regular, frequent visits by surveillance staff to doctors' offices and health facilities built links that helped to ensure weekly and zero reporting for poliomyelitis cases.

Bahrain's National Certification Committee was responsible for reviewing the work of the national expert group concerned with the identification of cases of acute flaccid paralysis; reviewing data submitted by the national poliomyelitis eradication programme; and making field visits to health facilities to verify the accuracy of the data. The Committee had been impressed by the eradication

programme's excellent overall performance. It had endorsed the Global Polio Eradication Initiative and had recommended that the Ministry of Health participate fully in future poliomyelitis eradication activities.

Dr SOPON IAMSIRITHAWORN (Thailand) appreciated the efforts made by local health workers and WHO poliomyelitis eradication team members, especially in security-compromised areas of countries where the disease was endemic.

The global epidemiological situation was worsening. In particular, urgent, concerted action was needed in Nigeria, where the continuing circulation of three poliovirus serotypes had increased the risk of sustainable local transmission and the potential of international spread of poliovirus – a problem exacerbated by the country's low rate of oral poliovirus vaccine coverage and the existence of cross-border populations.

Efforts to stop the transmission of poliovirus in endemic areas and prevent the reintroduction of poliomyelitis into poliomyelitis-free countries should be made a priority. Moreover, the international spread of wild poliovirus highlighted the need for every country to implement fully the International Health Regulations (2005) in order to ensure timely case reporting and rapid containment of poliomyelitis in areas not endemic for the disease. Cross-border outbreaks linked to the same source of infection were a public health emergency and warranted prompt and strenuous responses by national and international health agencies.

His country had not had a case of poliomyelitis in more than 10 years. It continued to pursue a policy of high vaccination coverage for children under 15 years of age. It was committed to the eradication of poliomyelitis worldwide.

Dr NAGAI (Japan) recalled that her country had made an enormous contribution to the combat against poliomyelitis. Japan joined other countries in expressing deep concern with regard to the continuing spread of poliovirus despite intensified efforts by WHO and the international community. The Global Polio Eradication Initiative Strategic Plan 2009–2013 contained the appropriate strategies, tools and tactics for achieving eradication. She emphasized the importance of the targeted use of seroprevalence surveys, which could establish definitively whether the current programme of oral poliovirus vaccination was effective. Eradication also required continued political engagement and she expected the Secretariat to encourage the full political commitment of those Member States in which the virus was endemic and still spreading.

Dr HUWEL (Iraq) said that the main factors in combating poliomyelitis were good hygiene, effective vaccines, seasonal vaccination campaigns and clean drinking-water. Despite all its difficulties, his country had not had a case of poliomyelitis since 2000. It was ensuring vaccination coverage, with increased doses of vaccine, of all children under the age of five years and carrying out epidemiological surveillance to monitor any potential spread of poliovirus.

Dr WU Jing (China) commended the progress report and the measures taken. China had actively responded to the call of the Health Assembly and had taken forceful measures to remain poliomyelitis-free. Poliomyelitis-free countries faced new challenges. The continued use of the oral poliovirus vaccine as routine immunization had created certain problems of international concern that should be resolved by the Advisory Committee on Poliomyelitis Eradication. The Secretariat could further define policies on the use of inactivated poliovirus vaccines, and support research into the use of single-antigen vaccines.

Professor RAHMAN (Bangladesh) said that Bangladesh had successfully implemented a poliomyelitis surveillance system that met the highest international standards. It had introduced awareness-raising activities including a National Immunization Day. As a result, there had been no case reported in Bangladesh between 2001 and 2005 and the country had been certified poliomyelitis-free since 2006. In 2006, however, 18 wild poliovirus cases had been reported in the eastern part of the country. A field investigation had revealed that those cases had been imported. Extensive

collaboration was vital in order to eradicate poliomyelitis. Eradication from the countries neighbouring Bangladesh would also mean that savings on poliomyelitis eradication campaigns could be invested in other priority areas.

He also recommended that inactivated poliovirus vaccine should be used to minimize the risk of vaccine-associated paralytic poliomyelitis among recipients.

Ms HENDRY (United Kingdom of Great Britain and Northern Ireland) commented that WHO needed to strengthen routine immunization activities as well as continuing supplementary activities and addressing the challenges where wider environmental factors appeared to undermine vaccine efficacy. The progress report raised four major concerns.

The increased spread of reinfection, particularly in western Africa, added to the global cost of eradication by diverting funds from front-line activities against other endemic illnesses. What were WHO's strategies for containment of poliomyelitis? What were the countries endemic for the disease doing, in particular what steps were being taken to reduce reinfection rates in those countries? She also asked what progress had been made with the external evaluation and when the findings thereof would be reported.

As mobilization of financial resources continued to lag behind requirements, she stressed the importance of multi-year pledges, such as that by the United Kingdom, which had pledged an assured funding stream for a five-year period.

Mr STENHAMMAR (Rotary International), speaking at the invitation of the CHAIRMAN, said that governments had enhanced their commitment to poliomyelitis eradication since the Sixty-first World Health Assembly, and that Afghanistan, India, Nigeria and Pakistan had made considerable efforts to step up the vaccination of children.

Recent outbreaks in western Africa and persistent transmission of virus in Angola, Chad and Sudan were causes for serious global concern and the response guidelines for outbreaks of poliomyelitis, as indicated in resolution WHA59.1, needed to be implemented fully and quickly in order to stop the outbreaks.

He welcomed the decision of the Executive Board and the Global Polio Eradication Initiative to conduct an independent review of the major barriers to stopping poliovirus transmission in all key countries in the coming months.

His organization was in the midst of its third public fund-raising campaign to aid the Global Polio Eradication Initiative, which faced a funding gap of US\$ 345 million for 2009–2010. It gratefully acknowledged all donors, and it looked to G8 countries to continue their support for poliomyelitis eradication at the forthcoming G8 summit in Italy. Failure to eradicate the disease was not an option as it would result in an estimated 10 million children being paralysed over the next 40 years, which would negate the world's US\$ 7 billion global investment in the Initiative.

Dr AYLWARD (Polio Eradication Initiative) said that 2008 had been a difficult year for the eradication programme. There had been outbreaks in all the countries endemic for poliomyelitis and renewed spread of virus from northern Nigeria. The Secretariat had found that routine immunization programmes had failed to reach and vaccinate children in sufficient numbers. Consequently, and as directed by WHO's governing bodies, the Global Polio Eradication Initiative and the Member States affected had used the lessons of the past 12 months to develop a new multi-year strategic plan which highlighted the new recommendations of immunization for travellers resident in areas affected by poliovirus and the need for a new strategy in terms of preventive campaigns across the importation belt which was regularly affected by exportations from both northern Nigeria and India. It also highlighted the work being done to develop a new vaccine which was expected to be in place by the third quarter of 2009.

The new strategic plan also laid out new steps and approaches in each of the endemic countries. The plan would be finalized after completion of the independent evaluation of the poliomyelitis eradication programme which had been called for by the Executive Board in January 2009. Since that time the Director-General had defined the terms of reference for the evaluation. She had established an

independent oversight committee and appointed international team leaders to work with national leaders in each of the remaining infected countries as part of the evaluation.

The final protocol would be completed in early July and should be available to the oversight bodies of the programme by November 2009. There had been profound changes in the nature of the eradication programme, regarding both the way in which it was managed and the attention given to the implementation of its strategies. He assured the Committee that the Initiative had emerged from a very challenging year on a much stronger footing in 2009.

B. Smallpox eradication: destruction of variola virus stocks (resolution WHA60.1)

Dr HUWEL (Iraq) said that studies and research had to be pursued with a view to assuring that smallpox did not re-emerge. That would require the existence of securely controlled stocks.

Dr SADRIZADEH (Islamic Republic of Iran) recalled resolution WHA55.15, in which the Health Assembly had authorized the further temporary retention of existing stocks of the variola virus. The considerable progress made during the past six years in the development of antiviral agents, safe vaccines and specific diagnostic tests showed that no further research requiring live variola virus was essential for those purposes. He urged the Health Assembly to end its temporary authorization of the retention of virus stocks for the purpose of sequencing, diagnostics and development of vaccines. The risks inherent in antiviral research outweighed the potential benefits.

He further stressed that the Health Assembly should under no circumstances approve the genetic engineering of variola virus or the distribution of variola virus DNA.

Mr MOREWANE (South Africa), speaking on behalf of the 46 Member States of the African Region, acknowledged the work of the Advisory Committee on Variola Virus Research. He nevertheless expressed concern about that Committee's report, which noted that all research projects in progress should be completed for the major review of variola virus research in 2010 with the possibility of an extension after the review had been finalized.

He urged the Director-General to ensure that no further research proposal would be accepted or considered and that the work of the Advisory Committee was in line with the resolutions adopted by the Health Assembly. The proposed review should focus on the destruction of variola virus stocks.

Dr SOPON IAMSIRITHAWORN (Thailand) commended the report and welcomed the information that the virus stocks were being held securely. He noted that 691 variola stocks were kept at the VECTOR Centre in the Russian Federation but the report did not provide information, in spite of the recent inspection, on the number of stocks kept in the Centers for Disease Control and Prevention in the United States of America. He looked forward to inclusion of that important information in the forthcoming report of the inspection team.

Dr WU Jing (China) commended the Secretariat's work in monitoring variola virus stocks and reviewing the progress of the established research projects. He suggested that WHO's Advisory Committee on Variola Virus Research should further study the possibility of a cycle of related research projects and proposals and specifically identify the key research projects and set a time frame for them. That would accelerate the research process, and countries could reach global consensus within the time frame for the destruction of existing variola stocks to be set by the Sixty-fourth World Health Assembly in 2011 in line with resolution WHA60.1. Research must be carried out under the control and guidance of WHO's Advisory Committee, be transparent and easily reviewable, and result in regular progress reports to WHO. The Secretariat would then circulate the results to Member States in a timely manner, enabling the sharing of the results of the research on diagnosis, antiviral agents and vaccines.

Dr RYAN (Epidemic and Pandemic Alert and Response), replying to the point raised by the delegate of Iraq regarding the safety of stocks, said that on the instructions of the Executive Board and

the Health Assembly the processes for inspecting stocks had been thoroughly reviewed and new protocols had been developed and field-tested by the Centers for Disease Control and Prevention in the United States of America. Those would be further tested by the VECTOR Centre in the Russian Federation. Responding to the concerns expressed by the delegate of South Africa, he said that the Advisory Committee would report on research proposals before the review period for 2011. Research extending beyond that period and new protocols would not be accepted.

C. Malaria, including proposal for establishment of World Malaria Day (resolution WHA60.18)

Ms RAOUL (Congo), speaking on behalf of the Member States of the African Region, said that good but uneven progress had been made in malaria control, in particular with regard to the availability of insecticide-treated bednets, appropriate patient care, prevention for pregnant women, and indoor spraying with high-quality insecticides. She expressed gratitude for the commitment of governments and for the multilateral and bilateral initiatives launched by, for example, the African Union and regional economic communities, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the international drug purchase facility UNITAID and the World Bank. Africa, most seriously affected by malaria, had moved closer towards universal access and the attainment of the Millennium Development Goals. Those initiatives nevertheless had to be reinforced. In Africa only 23% of children under the age of five years slept under treated bednets; the use of artemisinin-based combination therapies remained limited; measures to prevent malaria in pregnant women covered on average less than 10% of the target population; and indoor spraying with insecticides such as DDT was not widespread.

The main obstacles to universal coverage were the shortcomings in health systems: in human resources; planning and management; supply and distribution of medicines; and information systems for surveillance, monitoring and evaluation. Adoption of intersectoral approaches would enable countries and their donors to forge closer links between malaria control and efforts towards poverty reduction and development. All should work towards improved health systems; universal access to cost-effective treatment; and strengthened surveillance, monitoring and evaluation.

The success of certain countries proved that it was possible in the medium term to eliminate malaria with sustained control measures and programmed transitions. However, in most countries success had been limited and sustained control efforts were required on the part of the governments and partners concerned.

She welcomed the introduction of World Malaria Day, which reflected universal recognition of the serious impact the disease had in many African countries and the commitment of the international community to fight it. Implementation of the measures needed to control malaria would require greater financial, human and technical resources. She called on WHO to continue advocating greater involvement by all stakeholders, including communities and the private sector.

Dr HUWEL (Iraq) said that Iraq had made great progress in controlling malaria, with the number of cases dropping from 100 000 in 1995 to six in 2008. Iraq's success in nearly eradicating malaria within its borders was due to effective surveillance, training of personnel, and intense spraying and fogging campaigns. It had drawn on WHO's technical support and the experience of other countries. Iraq marked World Malaria Day every year.

Dr SADRIZADEH (Islamic Republic of Iran) said that growing resistance to medicines and insecticides, two effective tools for malaria control, was one of the main obstacles to eliminating or even controlling the disease in countries where it was endemic. Furthermore, many of the diagnostic tests marketed and distributed for primary health care in developing countries were sold and used despite little or no evidence that they were effective, as they were not subject to regulatory approval and standards. Rapid, sensitive and affordable diagnostic tests were needed for developing countries.

In Africa in particular, health systems were unable to deliver measures to control malaria to all those who needed them. Community-based strategies could greatly enhance access, especially if the

communities were empowered to manage the process themselves. He emphasized community empowerment and ensuring universal access to long-lasting insecticide-treated bednets as key strategies for preventing and controlling malaria; WHO should enhance collaboration with UNICEF and other agencies to that end.

Countries with effective malaria-control programmes that had contained the disease should be encouraged to work towards complete eradication. WHO should provide technical and operational support to countries in the near-elimination phase and set up mechanisms for certification. The proposal to declare Africa Malaria Day, which was observed on 25 April, World Malaria Day, would ensure sustained advocacy worldwide.

Dr BART-PLANGE (Ghana) acknowledged the progress made on malaria control in countries in which the disease was endemic and thanked development partners. Ghana had joined the international community every year in observing Africa Malaria Day and was marking World Malaria Day. The 2009 events had focused on schools as well as the media and successfully promoted peer-to-peer education. Ghana's progress was measured in use of insecticide-treated bednets for children, household ownership of such nets and intermittent preventive treatment in pregnancy. The increase in the use of nets in particular had resulted in a drop in under-five mortality. Maternal health outcomes remained lower than expected, however.

He appealed for international support to enable countries to expand interventions on a sustained basis with a view to eliminating malaria. The research community should double its efforts to find alternative medicines for implementing intermittent preventive treatment in pregnancy, in view of growing plasmodial resistance to sulphadoxine-pyrimethamine.

Professor RAHMAN (Bangladesh) said that Bangladesh had marked both the first and second World Malaria Days, ideal platforms for encouraging awareness and sustained advocacy. People from all walks of life had taken part in rallies and other awareness-raising activities in parts of the country in which malaria was endemic. His Government remained fully committed to controlling the disease and achieving the Millennium Development Goals.

Mr SIMBAO (Zambia) called for greater support for the deployment and use of artemisinin-based combination therapy instead of monotherapy in the light of the latest signs of drug resistance to artemisinin. Resistance had also been noted in some countries to pyrethroids, the only insecticides used for long-lasting insecticide-treated bednets, but its full extent was not known. DDT should continue to be used in the African Region, as it was cost-effective and had a long residual effect. Countries needed increased monitoring and surveillance of resistance, and assistance to accelerate the implementation of interventions before resistance to medicines and insecticides thwarted the achievement of universal coverage and attainment of the Millennium Development Goals. Research to that end had to be prioritized.

He supported the establishment of World Malaria Day, which his country had already marked twice.

Dr NAKORN PREMSRI (Thailand), referring to paragraph 30 of the report, said that estimates of the disease burden of malaria based on the number of cases reported by national malaria control programmes failed to present the situation accurately: most cases occurred in developing countries, which tended to lack well-established reporting systems and usually underreported the number of cases. Strengthening of health information systems by all partners was crucial to the success of elimination programmes.

In addition, malaria was highly endemic in hilly and forested regions and in vulnerable groups such as hill-tribe communities, ethnic and religious minorities, and cross-border migrant workers. For those populations, suitable programmes should be designed that promoted adequate access to health facilities and malaria-control programmes.

Dr FIKRI (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, described the progress made in controlling malaria in the Region. Two countries had eradicated the disease. In countries where malaria was still endemic, cross-border information campaigns had been organized and insecticide-spraying had been instituted. Artemisinin-based combination therapy had been made available to 80% of cases. The obstacles met in the programme included inadequate supplies of artemisinin-based medicines and rapid diagnostic tests, and inefficient insecticides. The Region required additional technical assistance in order to eliminate malaria from its Member States.

Dr HONG Jeong-ik (Republic of Korea) expressed the willingness of his country to participate in both national and global projects initiated by WHO. He supported the establishment of World Malaria Day. He urged WHO to establish global and regional surveillance of all mosquito-borne diseases, which were becoming more prevalent due to global climate change.

Dr PYAKALYIA (Papua New Guinea) said that insecticide-treated bednets had been introduced in his country, but that that was the only intervention used. The country thus had no serious approach to vector control, and even effective coverage with bednets was a concern. He welcomed the proposal to convene a meeting of WHO's Expert Committee on Malaria and looked forward to recommendations on an integrated approach to vector control and the antimalarial medicines to be used.

Dr WU Jing (China) commended the report and welcomed the coordination of WHO's work on malaria control with that of other international organizations and global partners. Establishment of a Global Malaria Day would help governments and the international community to raise awareness about the means for malaria control. In his country, 26 April had been designated as Malaria Day, and activities had been implemented in collaboration with many government sectors, civil society and international organizations. China would be pleased to share its experience in malaria control and development of medicines. He looked forward to the rapid certification of Chinese-made artemisinin-based combination therapy so that it could be used in other countries.

Dr SPINACI (Global Malaria Programme) said that he had noted the concerns raised regarding progress in achieving the 2010 and 2015 targets for malaria control. He agreed that efforts should be made to improve surveillance and reporting of malaria and also the monitoring of resistance to artemisinin and pyrethroid insecticides, in order to replace their use with effective alternatives.

WHO was working with a number of institutions to improve existing diagnostic tests. WHO was coordinating with UNICEF, the World Bank and other agencies work to eliminate and control the disease among vulnerable groups by improving technical assistance. The Expert Committee on Malaria Control and Elimination would be convened and its report submitted to the Health Assembly in 2010.

D. Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (resolution WHA59.12)

Dr NAKORN PREMSRI (Thailand), commending their numerous contributions, asked multilateral institutional and international donors to maintain their support for the identified priorities. He asked the Secretariat to evaluate the effectiveness of the programmes that had been implemented, so that countries could more precisely allocate their limited resources.

Ms MOTSUMI (Botswana), speaking on behalf of the 46 Member States of the African Region, said that one way of ensuring coordination among partners of activities against HIV/AIDS was by applying the "three ones" principle, in which there was one national strategic framework for responding to HIV/AIDS, one monitoring and evaluation system and one national coordinating

agency. Several Member States had implemented that principle. Furthermore, in a number of countries the United Nations had formed joint teams on HIV/AIDS, which prepared a single plan for supporting national efforts that was based on a clearly defined division of labour. The plan simplified and harmonized the United Nations' input to the national response, avoiding duplication within the system and with partners. The plan emphasized capacity-building and provision of technical support, WHO providing leadership in aspects related to the health sector. Through the joint teams, the United Nations and international partners had supported resource mobilization for HIV/AIDS, by helping countries in drafting proposals and using the grants obtained. WHO had worked with UNAIDS and UNICEF to strengthen monitoring and evaluation systems and to harmonize reporting.

The remaining challenges in improving the coordination of activities against HIV/AIDS were to ensure equal commitment from all partners to implement the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, and to ensure that the "three ones" in different countries conformed to the same model. Greater understanding and better alignment of the division of labour were needed. The United Nations joint teams also faced problems stemming from lack of common administrative structures, segmented implementation of joint plans and the absence of a framework for monitoring and evaluation. WHO should continue to work with others to address those challenges and ensure better coordination of AIDS control activities.

Dr HUWEL (Iraq) said that the prevalence of HIV/AIDS in his country was very low. About three quarters of the cases were due to contaminated blood products. Medical and social care was offered to patients with AIDS, and about 70% of the 69 known cases were still alive. Surveillance for AIDS in his country was based on voluntary counselling and testing. Activities for prevention of infection with HIV had been incorporated into primary health care. He asked for assistance in ensuring that his country maintained its low prevalence of HIV infection.

Mr SU Haijun (China) welcomed the initiative to improve coordination of efforts for AIDS control. His country had already established such a coordination mechanism to ensure better use of the available resources. His Government was most concerned about transmission of HIV among men who had sex with men, and preventive measures were being promoted for such men, including use of condoms. Support was given to patients, and programmes were in place to raise public awareness and reduce discrimination.

Professor RAHMAN (Bangladesh) said that the prevalence of HIV/AIDS in his country was only 0.8% in the highest risk group. Nevertheless, as neighbouring countries had larger numbers of cases, his Government had established programmes that included targeted interventions; universal precautions against opportunistic infections; ensuring blood and injection safety; voluntary counselling and testing; diagnosis and treatment of sexually transmitted infections; surveillance of HIV infections and prevention of mother-to-child transmission of HIV. A unique feature of the HIV/AIDS programme in Bangladesh was the strong participation of the non-public sector in public-private collaboration. His Government also received funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria, including additional incentive grants for outstanding performance. The country still needed to strengthen its capacity for risk communication and means for reducing the transmission of HIV and other sexually transmitted infections. Monitoring of resistance to antimicrobial agents and surveillance of pregnant women for HIV infection were needed.

Dr SHEVYREVA (Russian Federation) said that, although many attempts had been made to coordinate activities against HIV/AIDS, particularly by UNAIDS, such coordination was still inadequate. Donors must consider the specific needs of countries for technical assistance. International organizations should thus avoid a unified approach and take into account the national priorities and the social and cultural particularities of each country in any attempt to ensure interagency coordination, including the mechanisms for financing projects. Regional initiatives were a useful means of addressing the problems of individual countries with regard to the spread of the epidemic.

Dr NAKATANI (Assistant Director-General) thanked speakers for their comments. Replying to the delegates of Botswana and the Russian Federation, he said that United Nations joint teams had been set up in 89 countries, and it was hoped to raise the number further. He agreed that it was important to evaluate the effectiveness of interventions, recalling that in 2008 revised guidelines had been issued for paediatric antiretroviral therapy, male circumcision and provider-initiated testing and counselling.

(For continuation of the discussion, see summary record of the fifth meeting, section 1.)

The meeting rose at 17:00.

FIFTH MEETING

Friday, 22 May 2009, at 09:30

Chairman: Mr S. McKERNAN (New Zealand)

later: Mr V. JAKSONS (Latvia)

later: Mr S. McKERNAN (New Zealand)

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

Public health, innovation and intellectual property rights: global strategy and plan of action:
Item 12.8 of the Agenda (Documents A62/16, A62/16 Add.1, A62/16 Add.2 and A62/16 Add.3)
(continued from the fourth meeting, section 2)

The CHAIRMAN invited the Committee to consider the revised draft resolution which reflected the results of informal consultations on amendments proposed at the previous meeting:

The Sixty-second World Health Assembly,

Recalling resolution WHA61.21 on the Global strategy and plan of action on public health, innovation and intellectual property, and noting the information provided by the Secretariat;¹

Welcoming the report A62/16 [Canada] by from the Director-General on the implementation of the African Network for Drugs and Diagnostics Innovations (ANDI), which supports and promotes African-led health product innovation for the discovery, development and delivery of drugs and diagnostics for neglected tropical diseases, and reiterates the need to fast-track activities to reach neglected people who are sick and suffering from neglected tropical diseases [Kenya],

1. DECIDES:

(1) to incorporate into the plan of action the additional agreed stakeholders as outlined in document A62/16 Add.3; **deleting “interested” before “governments” and incorporating WHO as stakeholder for action in item 2.3(c) [Bolivia];**

(2) to incorporate into the plan of action the ~~updated~~ **proposed [Thailand]** time frames outlined in document A62/16 Add.1;

2. Accordingly ADOPTS the final plan of action in respect of specific actions, stakeholders and time frames;

3. NOTES the estimated funding needs related to the plan of action as outlined in document A62/16 Add.1;

4. ACCEPTS **[Bolivia]** the proposed progress indicators as outlined in document A62/16, ~~Add.2 as the basis for regular reporting to the Health Assembly on performance and overall progress made over a two-year reporting period~~ taking note of the need to periodically review and refine **[Bolivia, Canada]. Where the indicators are quantitative, the Secretariat shall**

¹ Documents A62/16, A62/16 Add.1, A62/16 Add.2 and A62/16 Add.3.

provide complementary information on the implementation of the specific actions [Argentina];

OR

4. ~~CONSIDERS the proposed progress indicators as outlined in document A62.16 Add.2 as the basis for WHO Secretariat to facilitate further consultations among all Member States and other relevant stakeholders. WHO should present these revised progress indicators to the 126th session of the Executive Board in January 2010~~ [Bolivia];

5. REQUESTS the Director-General to significantly increase support towards greater efficiency and effectiveness in the implementation of the global strategy and plan of action on public health, innovation and intellectual property and prioritize concrete actions in the area of capacity building ~~ensure issues of and access and benefit sharing affecting local populations take front stage~~ [Kenya, Canada, EU];

[Czech Republic proposed amendment to Kenya's proposal] ~~deletion of: and ensure issues of access and benefit sharing affecting local populations take front stage;~~ [Kenya]

6. REQUESTS the Director-General to conduct ~~a major~~ an overall [Canada, Switzerland] programme review of the Global strategy and plan of action in 2014 on its achievement, remaining challenges and recommendations on the way forward to the Assembly in 2015 through the Executive Board [Thailand].

Ms NAVARRO LLANOS (Plurinational State of Bolivia) noted that, in responding to questions put by the delegate of Barbados in the discussion in the Committee's third meeting, the Secretariat had referred to the Expert Working Group on research and development financing set up under specific action 7.1(a) of the plan of action but not to the consequences of WHO not being listed as a stakeholder under specific action, 2.3(c). She asked the Legal Counsel to clarify the consequences of excluding WHO as a stakeholder. The delegations concerned assumed from the Secretariat's assurances that adoption of the draft resolution without WHO as a stakeholder would not prejudice their proposal to the Expert Working Group for WHO to hold discussions on a treaty on biomedical research and development. They also assumed that any government would be able to come back to the Executive Board or the Health Assembly with a proposal for future work on global norms for research and development, including a treaty, and that no decision taken at the current Health Assembly would prejudice such a proposal.

Mr BURCI (Legal Counsel) noted that the Expert Working Group had been established pursuant to paragraph 4(7) of resolution WHA61.21 and that any decision that the current Health Assembly might take would not affect that resolution. The Working Group's work was ongoing; it would meet in June 2009 and report to the Director-General, who would then report back to the Executive Board and the Health Assembly. All proposals submitted to the Working Group remained valid and might be taken up in a report to the Director-General and in the latter's subsequent reports to the governing bodies in 2010.

As to whether the exclusion of WHO as a stakeholder under specific action 2.3(c) would preclude Member States from raising the issue of a treaty on biomedical research and development before the Executive Board or the Health Assembly, all Member States had the right, under the Rules of Procedure of both governing bodies, to propose items for inclusion in their provisional agendas. Naturally, acceptance of such proposals was not automatic; it depended on several factors, such as their relevance to WHO's policy or consistency with previous Health Assembly decisions.

Ms VALLINI (Brazil), supported by Ms FASTAME (Argentina), suggested that the wording of the first two lines of paragraph 6 of the draft resolution, before the words "on its achievement", should be aligned with specific action 8.1(a) so as to read: "REQUESTS the Director-General to conduct an

overall programme to monitor performance and progress of the implementation of the global strategy and plan of action in 2014 ...”.

Dr SOMBIE (Burkina Faso) noted that in the French version of paragraph 4 of the draft resolution the words *indicateurs d'avancement* should be replaced by *indicateurs de progrès* or *indicateurs sur l'état d'avancement*.

Dr SILBERSCHMIDT (Switzerland) noted that specific action 8.1(a) referred to monitoring during the implementation phase, whereas the wording of paragraph 6 of the draft resolution, as proposed by the delegate of Thailand, concerned the final assessment of the global strategy and plan of action to be made in 2014.

Ms VALLINI (Brazil) maintained her proposal as there was also a need for periodic monitoring.

Dr GWENIGALE (Liberia) associated himself with the statement by the delegate of Switzerland. After years of debate on the issue, it was time to take a decision and he proposed that a vote should be taken if consensus could not be reached.

Dr BINAGWAHO (Rwanda) said that there was no reason why paragraph 6 should not provide for both periodic monitoring and a final evaluation.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) proposed the following compromise wording for paragraph 6: “REQUESTS the Director-General, in addition to continued monitoring, to conduct an overall programme review of the global strategy and plan of action ...”.

The CHAIRMAN said that, in the absence of any objections, he would take it that the Committee wished to approve the draft resolution as amended by the delegate of Thailand.

The draft resolution, as amended, was approved.¹

Ms NAVARRO LLANOS (Plurinational State of Bolivia), speaking also on behalf of Bangladesh, Barbados, Cuba, Ecuador, Nicaragua, Suriname and the Bolivarian Republic of Venezuela, welcomed the approval of the resolution but wished to state the position of several delegations that had been involved in the previous day's last-minute negotiations.

The Health Assembly stood at a crossroads. Resolution WHA61.21, adopting the Global strategy and plan of action, had marked a turning point, with Member States' recognition of the urgent need to address innovation and access. Specific action 2.3(c) was a central issue. The delegate of Barbados had mentioned during the Committee's third meeting that the Governments of Bangladesh, Barbados, Suriname and her country had proposed that WHO hold discussions on a treaty on biomedical research and development, on the basis of the consensus reflected in resolution WHA61.21. Exploratory discussions of global norms on research and development were crucial to fulfilling the promise of the global strategy not only to improve access to medicines but also to enhance sustainable, needs-driven medical innovation. A treaty on research and development would transform biomedical innovation by incorporating needs-driven research and development related to health and ensure sustainable financing mechanisms.

Excluding WHO as a stakeholder would undermine the faith of Member States in the competence of WHO to fulfil its public health mandate. The proposed treaty would have significant implications for global pharmaceutical research and development, and much time and effort might be lost if WHO, which was in a position to support the needs of developing countries, was not allowed to

¹ Transmitted to the Health Assembly in the Committee's second report, and adopted as resolution WHA62.16.

participate in bringing it to fruition. It was disappointing that such a situation had arisen, given the diligent efforts of all Member States, experts, intergovernmental organizations, civil society and the global health community involved in that process.

Nevertheless, given the Legal Counsel's assurances that the resolution would not prejudice future consideration of a treaty on biomedical research and development by the Executive Board and the Health Assembly, the delegations concerned had joined the consensus and trusted that the finalization of the plan of action would result in the transformation of biomedical innovation, ensuring genuine access to medicines for all.

The CHAIRMAN, referring to the concern expressed by a number of delegations that they had not been involved in the informal consultations leading up to the finalization of the draft resolution and the remaining elements of the plan of action, said that all Member States should reflect on the perception that the consultation process had not been sufficiently inclusive and transparent. Informal discussions and consultations were valuable means of making progress, but it would be useful to consider how best language arrived at through those means could be brought back to the Health Assembly, so that the process was as inclusive and transparent as possible.

Progress reports on technical and health matters: Item 12.10 of the Agenda (Document A62/23) (continued from the fourth meeting, section 2)

E. Prevention and control of sexually transmitted infections (resolution WHA59.19)

Dr JALLOW (Gambia), speaking on behalf of the 46 Member States of the African Region, recognized that sexually transmitted infections were a leading cause of morbidity and mortality in the Region, even though their prevalence was not fully known. Increased support was needed, particularly in the areas of human resource development and health information management regarding such infections, in order to obtain a clearer picture of the situation. Given the low levels of condom use, preventive measures such as the introduction of education about sexually transmitted infections in school curricula and intensified operational research into prevention and control of such infections were vital. She commended the Secretariat's work on an action plan for the implementation of the global strategy for the prevention and control of sexually transmitted infections. That strategy should be put into effect by all Member States. She commended also the introduction of the human papillomavirus vaccine and the expansion of cervical screening, but recommended a thorough assessment of the vaccine, including its cost-effectiveness.

Financial, material and human resources should be made available on the basis of needs assessments and situational analyses, particularly for developing countries and countries where sexually transmitted infections were a cause of stigmatization and discrimination.

Ms MAFUBELU (Assistant Director-General) said that the Secretariat would work with Member States on the implementation of the action plan. She agreed that the cost-effectiveness of the human papillomavirus vaccine needed to be assessed. That should be done on a country-by-country basis and should be seen as one component of a comprehensive approach to the management of cervical cancer.

Mr Jaksons took the Chair.

F. Strengthening of health information systems (resolution WHA60.27)

Dr ZHOU Jun (China) supported the Secretariat's programmes and activities on strengthening health information systems. The Ministry of Health was currently working on a health information framework and building up surveillance systems. In order to improve cost-effectiveness, the Secretariat might provide support to Member States on a case-by-case basis, in the light of their information-gathering capability.

Mr MOURBAS (Indonesia) said that a health information system was vital to a country like Indonesia, which comprised more than 17 000 islands. A national Intranet system covering 33 provinces and 347 districts had been developed, and would soon be extended to the whole country. Improvements to the death registry were required, for which purpose he requested further WHO assistance.

Dr GEBREMEDHIN (Eritrea), speaking on behalf of the 46 Member States of the African Region, said that an evidence-based allocation of the scarce available resources was essential, in order to ensure the use of accurate and current data for major policy decisions within WHO. The Member States in the Region had been working to establish health information systems as an integral part of their overall health systems. Some of the achievements and challenges faced had not been reflected in the progress report. The achievements included the strengthening of health information systems (in accordance with Regional Committee resolution AFR/RC54/R3); completion of health information system assessments by 18 Member States, with emphasis on the assessment of the data platform for health indicators relating to the Millennium Development Goals; the organization of training workshops to identify better information-generation methods and to present and disseminate the methods used to estimate maternal mortality for 2005; and improvement of management at district level following an initial assessment of resources and service availability in areas such as HIV, tuberculosis and maternal and child health. The challenges included increasing the capacity of health workers and developing an information culture to collect accurate health information; accelerating the implementation of the coding system of the International Statistical Classification of Diseases and Related Health Problems (tenth revision) in regional and national hospitals; increasing coverage of birth and death registration; linking the strengthening of health information systems to policies and programmes related to building statistical capacity; and avoiding duplication of effort due to vertical data collection by donors or nongovernmental organizations. He emphasized the African Member States' commitment to the strengthening of health information systems.

Dr HASHIM (Malaysia) said that Malaysia's efforts with regard to health information management centred on collaboration between the Ministry of Health, other public sector agencies and private entities. In order to fulfil the goals of increased availability, quality and use of accurate data, improvements had been made to the framework of the Health Metrics Network, technical and financial support had been mobilized, and access to and use of data by local, regional and global constituencies had been expanded.

Dr PHUSIT PRAKONGSAI (Thailand) noted that the Secretariat and country reports pointed to an increase in collaboration between the health ministries and national statistics offices in many countries. However, despite the efforts deployed by Member States, the Secretariat would be required to play an active, supporting role on the issue.

Dr EVANS (Assistant Director-General) said that for island States, such as Indonesia, the use of information and communication technologies, an area known as e-health, was valuable. He noted and endorsed the important achievements and challenges reported from the African Region, and said that the Secretariat had been working on those issues with the Regional Office for Africa, Member States and the Health Metrics Network.

G. Working towards universal coverage of maternal, newborn and child health interventions (resolution WHA58.31)

Mr ADAM (Israel) noted that pneumonia was the leading cause of death for children under the age of five years, despite the availability of effective, easy and inexpensive treatment. About two million children in that age group died each year, most in Africa and south-east Asia. Events such as World Malaria Day were useful for raising awareness, and he therefore supported efforts by nongovernmental organizations to establish a world day on pneumonia. He proposed that pneumonia

should be included as a separate item in the agenda for the next session of the Executive Board. Vaccination against pneumonia would shortly be introduced as part of the free immunization services for all children up to one year of age in Israel.

Mr KYEREMEH (Ghana) concurred that pneumonia was a frequent cause of death in children aged under five years; it was also commonly a factor in mortality attributed to malaria. He therefore supported the introduction of pneumonia vaccination, as advocated by the delegate of Israel.

Dr CHARNCHAI PINMUANG-NGAM (Thailand) welcomed the progress report, which clearly identified the challenges faced in the area of universal access to maternal, newborn and child health services. Millennium Development Goals 4 and 5 had already been reached in his country, but Thailand needed to improve access to sexual and reproductive health services (particularly for young people), which was affected by demand and external factors. According to UNICEF,¹ the rate of child marriage in Thailand was 20%. That state of affairs, together with ignorance about ways of preventing unplanned pregnancy, resulted in high rates of teenage pregnancy. There were also social barriers to the use of family planning services by young people.

He welcomed WHO's efforts to increase access to maternal and child health services, but noted that a different, more cost-effective approach was needed to promote demand for such services among young people. Many countries had achieved universal access to health care, including sexual and reproductive health. However, social factors preventing access to those services should also be addressed.

Professor SHRESTHA (Nepal) said that exclusive breastfeeding for the first six months after birth could substantially reduce neonatal mortality and lower maternal mortality rates by preventing postpartum haemorrhage. He welcomed the fact that the report included exclusive breastfeeding initiated within one hour of birth and its continuation for six months thereafter as key indicators of intervention coverage for reproductive, maternal, newborn and child health. The Health Assembly should urge all Member States to adopt those indicators as national benchmarks for monitoring achievement of Millennium Development Goal 4. He further called for stricter monitoring of the observance and enforcement of the International Code of Marketing of Breast-milk Substitutes, so as to ensure that alternatives to breastfeeding were not promoted in violation of that Code.

Dr HASHIM (Malaysia) said his country continued to invest in intersectoral action to strengthen primary health care, which had led to the achievement of all the Millennium Development Goal targets related to maternal and child health, including nutrition. Updated guidelines for continual training in primary health-care facilities had been issued for all maternal and child health services, which would continue to be provided free of charge. Monitoring of progress continued to be strengthened through the introduction of electronic systems. Malaysia fully supported the Secretariat's efforts towards achieving universal access to reproductive, maternal, newborn and child health care, and looked forward to sharing experiences in the framework of global partnerships.

Professor RAHMAN (Bangladesh) said that reproductive health care in Bangladesh was provided both at health-care facilities and in homes. The leading causes of maternal mortality were haemorrhage, abortion, injury, eclampsia, sepsis and obstructed labour, with maternal malnutrition an underlying cause in many cases. Nutrition supplementation programmes were being implemented for pregnant and lactating women. The number of obstetricians, anaesthetists and skilled birth attendants had increased.

Local community health clinics were being promoted by health policy-makers as a model for the further development of all public health facilities. Based on the principle of community ownership,

¹ UNICEF, *The State of the World's Children 2008: child survival*. New York: United Nations Children's Fund, 2008.

such one-stop clinics, each serving some 6000 inhabitants, would provide comprehensive curative and preventive health care. He urged the international community to consider using that successful model as a means of ensuring enhanced access to maternal, neonatal and child health care.

Dr ZHOU Jun (China) said that China, in accordance with the provisions of resolution WHA58.31, had strengthened its maternal and child health-care delivery system, in particular in rural areas. A network of improved town and village clinics was taking shape. Maternal and child health care had been incorporated in national public health service schemes, and the 2009–2011 health reform plan proposed that the basic public health service should cover both urban and rural areas. China also aimed to deliver maternal and child health care for the migrant population. Of the four million babies born with defects every year, 85% were in developing countries. As birth defects and genetic disorders continued to be leading causes of mortality, he encouraged the Secretariat to increase its efforts to promote prevention and intervention in that area.

Dr TSHOMO (Bhutan) supported the Secretariat's endeavour to evaluate the effectiveness of approaches to increasing access to services, but felt that stronger language should have been used in paragraph 73 of the progress report. Member States should take responsibility for providing a free basic health service. Despite its difficult terrain and scattered population, Bhutan had succeeded in improving a number of key health indicators over the past two decades, as a result of the introduction of a single, free health-care system, supported by international agencies, with no duplication by the private sector. Thus, infant mortality, maternal and under-five mortality and contraceptive prevalence rates, antenatal attendance and the number of births attended by skilled health professionals had all shown improvement, and universal child immunization had been achieved. She urged all Member States to guarantee the provision of free immunization, family planning and antenatal services.

Dr MBEWE (Zambia) said that his country had been making progress, albeit slowly because of a lack of resources, in reducing maternal, neonatal and child mortality. Noting that the least progress had been made on maternal health, he supported calls for more financial and human resources in that area. Financial resources were crucial for procuring equipment for emergency obstetric and neonatal care, strengthening systems of referral from the community to health facilities and rehabilitating infrastructure. With respect to human resources, Zambia had increased the intake of nurses and introduced a health-worker retention scheme and a programme to train midwives directly from school. Yet human resources were increasing only slowly and Zambia needed support in tackling the problem.

Ms BRIDGES (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN and also on behalf of the International Council of Nurses, welcomed the Director-General's commitment to the reallocation of resources to women's health issues, particularly in Africa. However, she expressed concern at the persistence of high rates of maternal, neonatal and child morbidity and mortality, especially in developing countries, given the availability of cost-effective interventions. The reduction of those rates depended on universal access to and use of effective maternal, reproductive and child health services. She called on the Secretariat, Member States and other interested parties to accelerate their efforts to achieve universal coverage and to strengthen the education and regulation of nurses and midwives.

Dr GUPTA (Corporate Accountability International), speaking at the invitation of the CHAIRMAN, said that only about 48 million out of the 135 million children born annually benefited from early and exclusive breastfeeding, notwithstanding solid evidence that the lives of millions of neonates and infants could be saved by that practice. Many women were forced to replace breastfeeding with use of infant formula powders because of a lack of facilities, support and information, which was the result of increasing corporate interference in infant nutrition and of baby milk corporations convincing parents that their products were better than breast milk.

The International Baby Food Action Network Asia had initiated a campaign in support of breastfeeding in February 2009, and an international petition had been submitted to the President of

the World Health Assembly the previous day, calling on all world leaders to stop corporate interference in infant nutrition. Resolution WHA54.18, on transparency in tobacco control, and Article 5.3 of the WHO Framework Convention on Tobacco Control gave clear guidance on interference and conflict of interest. Similar action was warranted on infant nutrition. He therefore urged the Health Assembly to adopt a resolution in 2010, calling specifically for an action plan on infant and young child feeding and breastfeeding, within maternal, neonatal and child health action plans, which would be designed to put an end to all promotion of baby foods aimed at children under two years of age, with a clear timeline for implementation, perhaps by 2015.

Ms MAFUBELU (Assistant Director-General), replying to the points raised, said that the Secretariat would work with Member States to meet the challenges and needs identified by speakers and to build on the successes achieved so far. She agreed that pneumonia was a leading cause of mortality in children aged under five years and had noted the proposals for a declaration, a special day, a separate agenda item or a resolution on that topic. The Secretariat would seek the guidance of Member States on how to proceed. WHO was working on a global action plan on pneumonia, to include prevention, promotion and treatment.

WHO promoted exclusive breastfeeding for the first six months after birth followed by continued breastfeeding and appropriate complementary feeding for up to two years and beyond. Exclusive breastfeeding had been included in *The world health statistics* as an indicator, as had pneumonia.

Agreeing that stronger measures were needed to prevent birth defects, she observed that the topic was on the provisional agenda of the 125th session of the Executive Board.

Regarding the Millennium Development Goals, she noted that WHO, UNICEF, UNFPA and the World Bank had stepped up their support for the improvement of reproductive, maternal, neonatal and child health coverage in seven action areas, including one dealing with the urgent need for skilled health workers, especially midwives. The Secretariat would continue to work with Member States to help them to achieve all the health-related Millennium Development Goals, especially Goals 4 and 5.

H. Strategy for integrating gender analysis and actions into the work of WHO (resolution WHA60.25)

Dr MBEWE (Zambia), speaking on behalf of the 46 Member States of the African Region, welcomed the progress that had been made in implementing WHO's gender strategy. Since the adoption of resolution WHA60.25, the Secretariat had made important strides towards analysing and addressing gender equality as one of the key social determinants of health. Through its efforts, a women's health strategy for the African Region had been developed and disseminated. A health profile for women had been drawn up in 16 African countries, highlighting the linkages between women's social and economic status, their health status and the status of their families and communities. Some Member States in the African Region had designed and/or revised national policies on gender, and health policy documents requiring the inclusion of a gender perspective had been identified. They included disease-specific policies on HIV and AIDS, tuberculosis and malaria; maternal, neonatal and child health; and health information systems. Gender-mainstreaming programmes were contained in national health strategic plans and annual action plans in several African countries, including separate budgeting lines for the implementation of gender activities.

Notwithstanding the progress made, the major challenge facing most African Member States was a lack of financial support, skills and capacity to integrate fully global strategies on gender mainstreaming into national policies and strategic plans at country level. Mechanisms and health systems were not adequate to implement the gender strategy effectively. There was a misunderstanding of gender issues at community level and a persistence of sociocultural barriers to women's empowerment in the African Region. The high rate of illiteracy, the general lack of knowledge on women's rights, and the increasing incidence of gender-based violence had exacerbated the situation. Human resources were inadequate to implement the strategy. Poor collaboration between national health authorities and other bodies involved in gender and human rights issues at country

level, for example United Nations agencies, governmental bodies and nongovernmental organizations, was a further problem.

He called for concerted efforts and a multisectoral approach to the implementation of gender programmes at country level, including strategies against gender-based violence; heightened awareness; and increased allocation of resources for gender equality, women's empowerment and maternal health. It would then be possible to reduce household and national poverty, and thereby improve health outcomes. He urged the Secretariat to expedite implementation of the strategy at country level and called on the countries themselves to report annually on progress made towards implementation. The Secretariat should scale up capacity-building activities at country level in the areas of policy formulation and integration of gender into all health programmes, action plans, budgets and research.

Ms THANTIDA WONGPRASONG (Thailand), commending the progress made towards implementing the strategy, proposed that, under the first strategic direction, the training course on gender-based violence should not be limited to emergency situations but should deal with gender-based violence in general. Violence against women had a considerable impact on their physical and mental health; it also had serious implications for children, potentially creating a vicious cycle of violence in the next generation. Training was therefore very important.

It was important to bring gender into the mainstream of the Secretariat's management in order to ensure that gender equality and equity were incorporated into the Organization's work and that WHO staff members at all levels were aware of the importance and sensitivity of the issue. Emphasis should be placed on building WHO staff capacity at all levels for implementing the strategy. Computer-based classes for all WHO staff should be complementary, but not the sole or main training course, since the issue was sensitive and required more interactive learning.

Dr ZHOU Jun (China) described some of the measures adopted by China under the strategy. Two capacity-building sessions had been organized in 2007 and 2008 to provide training in women's rights and gender analysis. With regard to programme planning, women's reproductive health had been a focus of attention, for example through the provision of screening for uterine and breast cancer. China's statistical services had carried out a systematic analysis of gender specificity as an independent indicator. Activities to counter violence against women had also been strengthened. Pilot regions had been selected where violence against women was being investigated and special care services were provided for female victims of violence, especially pregnant women.

Dr SULAIK (Philippines) strongly supported the strategy. His country had undertaken several activities to implement the first strategic direction, for example conducting orientation and training courses on gender and development for national, subnational and local health staff, and designing a training programme on gender-responsive and rights-based integrated reproductive health service delivery for health providers. The full implementation of those measures and their continuation, however, needed further support.

The second strategic direction – bringing gender into the mainstream of management – was being promoted by a national mandate requiring 5% of the budget of government agencies to be allocated to gender and development activities and projects. An intersectoral technical working group had formulated national harmonized gender and development guidelines which would serve as a tool for sector groups, including health, in ensuring that gender was taken into consideration in the planning, management, implementation, monitoring and evaluation of development projects. His Government affirmed its commitment to and support for the strategy.

Ms MAFUBELU (Assistant Director-General) commended countries' actions towards implementing the strategy, which had led to significant achievements, and she encouraged them to continue with WHO support. The Secretariat would work with countries towards finding solutions to the challenges encountered in the implementation of some aspects of the strategy. The comments on the various strategic directions of the strategy would be taken into account.

I. Rational use of medicines (resolution WHA60.16)

Dr SADRIZADEH (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the topic was crucial from the public health point of view. The irrational use of medicines was tragic. Developing countries spent, on average, up to 40% of their recurrent budget on medicines, more than half of which, according to WHO's estimates, was wasted owing to improper prescription or use. It followed that no more than 25% of people in developing countries had access to medicines from which they benefited. Yet the irrational use of medicines was not even considered important enough as a public health issue to be tackled seriously at national level. All efforts to improve access to medicines were wasted if medicines were not used properly; indeed they could even be counterproductive and cause severe harm. Pharmacovigilance in many developing countries was weak, so that the actual extent of the harm caused by the irrational use of medicines was not known.

The Member States in the Region had all supported the adoption of resolution WHA60.16, while stressing the importance of allocating matching resources for its implementation. They welcomed the development of an implementation strategy but were disappointed that no provision had yet been made for the US\$ 30 million needed over a period of five years. Notwithstanding substantial international concern at the lack of access to medicines, the use of medicines was not high enough on the political agenda; concerted efforts by Member States and international partners alike were needed in order to change that.

He noted with satisfaction that the Secretariat had continued its exploratory and analytical work in the area and had taken part in two international conferences on improving the use of medicines. Those conferences had collated robust evidence, in terms of understanding the problems and of effective interventions. Most importantly, the evidence showed that ad hoc and piecemeal efforts to promote rational use of medicines did not work. What was needed was strong national commitment, coordination and resource allocation to translate what was known on the subject into action. That was an investment worth making because of the potential for huge savings and better health outcomes. He therefore strongly supported the creation of national programmes on rational use of medicines and the establishment of multidisciplinary national committees of experts who could provide collective support to national initiatives. Ensuring rational use of medicines was a complex issue because it involved changing human behaviour.

He urged the Secretariat to accelerate its work, emphasizing the importance of resources of all kinds and the need for national commitment and leadership. Resource mobilization efforts for the effective implementation of the resolution should be redoubled.

Mr VINEET (India) said that the rational use of medicines was vital in a world that was increasingly dependent on medication. With regard to proposals for activities in which the Secretariat might consider offering support to Member States, he endorsed the statement of the previous speaker.

Dr ZHOU Jun (China) said that a priority area of his Government's current health reform was the establishment of a national essential medicines system, which would be fully operational by the end of 2009. The system would be of major significance in promoting the rational use of medicines. With reference to resolution WHA60.20 on better medicines for children, he expressed the hope that the model formulary for children's medicines would soon be published.

Dr PHUSIT PRAKONGSAI (Thailand) requested further details of the Secretariat's work in the countries where it was piloting its strategy for supporting the implementation of national programmes to promote the rational use of medicines, in addition to information on the global steering committee responsible for guiding that process. WHO's activities, however, appeared to focus more on the rational use of specific groups of medicines than on redesigning the systems or mechanisms that were perhaps the root cause of irrational medicines use, a problem that demanded adequately resourced health authorities and appropriate legislation. Such a redesign would maximize the use of stakeholder capacities in promoting the rational use of medicines.

He urged the Secretariat to explore strategies aimed at increasing the use of professional pharmacies by public health-care systems. His country's research findings in that regard showed an impressive input from such pharmacies and were therefore promising. Another important mechanism for synergizing stakeholder capacity was Thailand's programme on the smart use of antibiotics, which not only focused on providers in hospitals but also incorporated pharmacies and consumers in an increasingly successful package. He reiterated his appreciation of the Secretariat's promotion of the rational use of medicines but called for more attention to be devoted to exploring means of mitigating the problems associated with their irrational use.

Dr MOKOBOCHO-MOHLAKOANA (Lesotho), speaking on behalf of the 46 Member States of the African Region, said that, with the Secretariat's support and guidance, many African countries had developed and/or updated their national essential medicines lists and standard treatment guidelines, established drug therapeutic committees and strengthened human capacities in the area of prescribing and dispensing medicines. However, their resource constraints meant that progress was hampered by the lack of laboratory capacity and appropriately trained human resources, recourse to alternative treatment options and uneven development and implementation of regulations. A further challenge was resistance to medications caused by the increasing prevalence of multidrug-resistant tuberculosis and complicated opportunistic infections related to HIV.

It was incumbent on Member States to implement WHO's recommendations for the protection of their citizens against the irrational use of medicines, focusing on education and the regulation of irrational dispensing and sale. The Secretariat should mobilize resources for, and provide various forms of technical support to, initiatives launched by Member States in the Region.

Dr GAMARRA (Paraguay) said that experience with the complex problems associated with such issues as quality control, appropriate management in the interest of optimizing resources, good pharmaceutical practices and the conduct of prescribers, dispensers and users of medicine had led Paraguay to formulate a participatory, interinstitutional and intersectoral national plan designed to promote a cultural change and better use of financial resources. It was vital to continue implementing the resolution so that all peoples benefited.

Mr CHAN (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that his organization's mission was to improve access to and the value of appropriate medicine use worldwide. Noting the quest for resources to begin implementation of the approved strategy for the rational use of medicines, he requested further information on the composition of the global steering committee and its plan of action. He cited sources for the considerable evidence showing that inappropriate use of medicine was a persistently widespread problem in developing countries and those with economies in transition. Moreover, little improvement had been reported in the area of prescribing and patient care practices. He therefore urged Member States to strengthen support and investment for the establishment of national programmes involving pharmacists in order to promote the rational use of medicines through coordinated implementation of sustainable interventions and in-built systems that allowed progress to be evaluated. National policies should also include capacity building for pharmacists, who played a central role in many areas, including health promotion, ethical access to information for patients and pharmaceutical care. His organization urged the allocation of more resources to improving the rational use of medicines worldwide.

Ms LUTTERODT (Ghana) said that the challenges of drug resistance were no longer merely institutional, but had public dimensions with global consequences, requiring innovative public health approaches based on global actions and sustainable partnerships. WHO should: take the lead in working with other global institutions already active in that area; work with countries that demonstrated best practice in evidence-based policy decision-making in order to obtain value for money, especially in selecting medicines within the supply chain; and take the lead on governance and organization in the supply and management of essential medicines.

Dr BHUTTO (Pakistan) said that the irrational use of medicines was a widespread tragedy in both the public and the private sector in developed and developing countries alike that needed urgent attention. Its undesirable consequences included poor patient outcomes, adverse reactions and increased antimicrobial resistance.

Dr HOGERZEIL (Essential Medicines and Pharmaceutical Policies) said that specific note had been taken of the statements made by the delegates of India, the Islamic Republic of Iran and Lesotho. Efforts would be made to raise the profile of rational use of medicines, place it higher on the international health agenda and mobilize additional resources. In response to the delegate of China, he said that the electronic and hard-copy versions of the model formulary for children's medicines, which was in preparation, should be available in early and mid-2010, respectively. Responding to the concerns expressed by the delegate of Thailand, he said that the Secretariat would continue to do its utmost to implement a systems approach to rational use of medicines rather than a disease-related approach, focusing on the primary health care component of health systems, with particular emphasis on patient-centred care.

Mr McKernan resumed the Chair.

J. Better medicines for children (resolution WHA60.20)

Dr SILLANAUKKEE (Finland) said that the lack of appropriate medicines for children was a global problem affecting all countries, which would make it difficult to achieve some of the child-related Millennium Development Goals. Although the problem had to some extent been recognized in recent years, the lack of a global perspective meant that no global development plan was envisaged. Continued implementation of resolution WHA60.20 was therefore to be welcomed.

Dr ABHE GNANGORAN (Côte d'Ivoire), speaking on behalf of the 46 Member States of the African Region, said that better medicines for children were essential for Africa, where millions of children died annually from curable and preventable diseases. Reasons included treatment difficulties that were partially linked to medicines in so far as paediatric dosage formulations were either incompatible with the existing forms or simply unavailable. Quality control was also inadequate. Pursuant to resolution WHA60.20, however, initiatives were under way to find solutions and reduce neonatal, infant and child mortality rates. A current survey of medicine prices in 15 Member States in the Region, for example, was expected to provide information on the availability of and access to essential paediatric medicines.

She called on the Secretariat and other health partners to provide more financial and technical support for combating endemic diseases such as malaria. Pharmaceutical companies also had a role to play in promoting research and development, which would facilitate the full implementation of resolution WHA60.20 and strategies for the rational use of paediatric medicines. Such an approach would substantially reduce the risk of child morbidity and mortality, particularly among children under the age of five years.

Ms HELA (South Africa) said that developing countries continued to use medicines that were old but nevertheless safe, effective and affordable. Unfortunately, however, commercial preparations were regularly discontinued on account of small market size and profit margins, as in the case of zinc preparations, which were on South Africa's essential medicines list. Adult doses therefore had to be manipulated, which was a highly unsatisfactory practice in that dosages and safety could be compromised. The use of off-label paediatric medicines also posed challenges at the primary health-care level, where nurses were the backbone of service delivery but sometimes lacked the competence or confidence to use such medicines. She therefore called for the strengthening of global advocacy to support the continued identification and production of such essential medicines.

Professor WANICHA CHUENKONGKAEW (Thailand) said that better medicines for children were vital and should be a top priority on the health-care agenda. The results of a recent survey to identify appropriate medicine dosage and strength for children had shown that her country needed to improve practices. Research was being conducted on an appropriate formulary for children, but difficulties remained with regard to drug authority licensing. The Secretariat should closely monitor the progress of the international regulatory working group set up to review existing standards for regulation of medicines for children. In addition, it should carry out a more proactive “Make Medicines Child Size” campaign. She urged the Director-General to allocate more resources, from assessed or non-earmarked voluntary contributions, to ensure the successful implementation of WHO’s activities connected to the rational use of medicines, especially medicines for children.

Dr HASHIM (Malaysia) said that his country’s medicines control authority had imposed stringent requirements to ensure that medicines for children were safe, effective and of good quality and that children’s needs were being met through the use of appropriate dosages, formulations and strengths. Malaysia had begun monitoring medicine prices and had set up a database of prices disaggregated by method of procurement. In addition, a policy concerning the prescription of generic medicines had been instituted to foster competitive pricing.

In response to the pharmaceutical industry’s growing use of the media, including the Internet, to promote children’s medicines, his Government had adopted a strict regulatory and licensing scheme that ensured that such promotional materials were in line with existing regulations and guidelines.

Continuous monitoring of developments in the field of paediatric medicine was one of Malaysia’s priorities and, in that connection, his country was trying to ensure that its regulatory practices were in line with international practices guaranteeing better use of medicines for children.

Dr HOGERZEIL (Essential Medicines and Pharmaceutical Policies) said that the Secretariat would be taking the measures requested and also making use of the specific examples mentioned to strengthen the better medicines for children programme.

K. Health technologies (resolution WHA60.29)

Dr MESELE (Ethiopia), speaking on behalf of the 46 Member States of the African Region, said that health technologies enhanced the quality, safety and effectiveness of health-care delivery. High-quality and affordable health technologies could, in particular, contribute to the achievement of the Millennium Development Goals. Access to reliable and cost-effective health technologies must be supported by policies and guidelines and, in resolution WHA60.29, the Health Assembly had urged Member States to take appropriate action in that regard.

While health technologies underpinned universal public health care, efforts to introduce and maintain such technologies in Africa were often beset with difficulties. For example, information and communication technology had become a vital support system for health technology and could potentially play an important role in improving access to health care in rural areas. Yet, Africa was faced with shortages and rapid turnover among medical engineers and information technology specialists. Another challenge was ensuring the standardization, safety and quality of health technologies, especially medical devices. Future progress reports should consider such critical issues.

Health technologies were increasingly available in Africa as a result of local and international efforts. It was important to finalize the revision of WHO’s guidelines for health-care equipment donations and the preparation of guidelines on procurement mentioned in the report. Their implementation would minimize the burden on countries arising from inappropriate equipment and associated maintenance services. Attention also needed to be paid to appropriate and affordable diagnostics and technology transfer, which were central to countries’ efforts to tackle priority problems in a sustainable manner. Technology transfer should also be supported by training and technical support to ensure that the transfer was properly made and to make health services more efficient.

As technology was constantly changing, it was vital to establish a regular review mechanism in order to prevent inappropriate investments in unnecessary or suboptimal health technologies. Another major challenge was the protection of intellectual property rights on essential health technologies, which often made sustainable use impossible. WHO, in conjunction with WIPO, should strive to ensure greater access to such technologies by encouraging their classification as public goods.

Dr SULAIK (Philippines) outlined the various measures taken by his Government's Department of Health in the field of health technology, including bringing its national standards for medical electric equipment and other medical devices into line with international standards; adopting ISO 13485, which defined good manufacturing practices for medical devices; engaging in dialogue with regulatory agencies in other countries and with representatives of the medical device industry; and inviting representatives of professional organizations, the academic community, and testing laboratories to sit on technical committees.

Mr MOURBAS (Indonesia) said that rapid developments in health-care technology, if not properly regulated, could lead to more costly and less efficient health care. His country had been conducting health technology assessments since 2002. The assessment consisted of analysing the safety and efficiency of health technology. Some 70% of the resulting recommendations had already been implemented in the form of guidelines and manuals, and recommendations on procurement of medical equipment would be issued in the future. Full implementation of the recommendations would improve the country's health-care system.

Dr HASHIM (Malaysia) commended WHO's contribution to ensuring the safety, effectiveness and cost-effectiveness of health technologies, in particular medical devices. His Government's Health Technology Assessment Section, which used an evidence-based approach, had been designated as a WHO Collaborating Centre for Evidence-Based Health Care Practice until 2012. Malaysia was currently developing a regulatory system to ensure the quality, safety and effectiveness of medical devices, as recommended by the Global Harmonization Task Force and WHO. It supported the Secretariat's efforts to provide support to Member States regarding health technologies.

Dr PHUSIT PRAKONGSAI (Thailand) said that health technologies had become a priority in the light of increasing health-care costs and the global financial crisis. He endorsed the use of health technology assessments to identify countries' needs and optimize the use of technologies. He urged the Secretariat to provide support to Member States in building their capacities for technology assessment since such assessments helped authorities in making policy decisions on the use of health resources. His country's Health Intervention and Technology Assessment Programme had worked on various issues including the criteria for national medication lists, guidelines for economic evaluation of health technology and selection of cost-effective health interventions under health insurance schemes. As a developing country with limited resources, Thailand had difficulty evaluating the quality of remanufactured devices. The Secretariat should encourage debate and establish assessment guidelines for that particular type of medical device.

Dr BHUTTO (Pakistan) said that she appreciated the support provided by the Secretariat to Member States in the prioritization, selection and use of health technology, in particular medical devices, and its efforts to disseminate evidence-based guidance on health technology.

Dr ETIENNE (Assistant Director-General) said that the Secretariat recognized that the availability and appropriate and safe use of health technologies and medical devices were critical to the expansion of coverage and to clinical, preventive, rehabilitation and promotion efforts. She assured the delegate of Thailand that the Secretariat was in the process of updating and developing guidelines and tools with regard to remanufactured equipment. The Secretariat pledged to continue working with Member States, United Nations organizations, donor agencies, industry, professional organizations and patient groups to provide the best possible technical guidance and support.

L. Multilingualism (resolution WHA61.12)

Dr NZEYIMANA (Rwanda), speaking on behalf of the 46 Member States of the African Region, highlighted the challenges Africa faced in implementing the plan of action on multilingualism. The African Region had thousands of vernacular languages, some of which spanned national boundaries. Ways had to be found of disseminating health messages to speakers of those languages, especially where languages were not written. To meet the growing demand for health information, WHO's support was needed in translating documents into the most commonly used local languages. That meant that language services had to be properly staffed and equipped.

Turning to the specific questions of meetings and documentation, he said that most of the official meetings organized by the Regional Office for Africa were provided with interpretation into English, French and Portuguese, the three working languages of the Region, and that progress was to be commended. Nevertheless, documentation was not always available in those three languages. He urged headquarters to support the efforts of the Regional Office in Africa to ensure that its official documents were ready on time and available in the three working languages.

Mr FILLON (Monaco), supported by Ms GRATWOHL EGG (Switzerland), emphasized the importance of multilingualism. Some difficulties had been experienced with the interpretation services provided in Committee A. Such difficulties could easily be avoided and the Secretariat must remain vigilant in that regard.

Dr EVANS (Assistant Director-General) said that he had taken note of the points raised by delegates, in particular the comments by the delegates of Monaco and Switzerland. The Secretariat would do its best to ensure that future meetings of the governing bodies were provided with the appropriate interpretation services.

The CHAIRMAN said that, if he heard no objections, he would take it that the Committee wished to note the progress reports contained in document A62/23.

The Committee noted the reports.

2. SECOND REPORT OF COMMITTEE B

Dr YOUNG (Rapporteur) read out the draft second report of Committee B.

The report was adopted.¹

3. CLOSURE

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

The meeting rose at 12:10.

¹ See page 202.

PART II
REPORTS OF COMMITTEES

The text of resolutions and decisions recommended in committee reports and subsequently adopted without change by the Health Assembly (except where indicated by a footnote) has been replaced by the serial number (in square brackets) under which they appear in document WHA62/2009/REC/1. The verbatim records of plenary meetings at which these reports were approved are reproduced in document WHA62/2009/REC/2.

COMMITTEE ON CREDENTIALS

Report¹

[A62/42 – 20 May 2009]

The Committee on Credentials met on 19 May 2009. Delegates of the following Member States were present: Andorra; Belize; Brunei Darussalam; Cape Verde; Greece; Lao People's Democratic Republic; Mozambique; Oman; Venezuela (Bolivarian Republic of).

The Committee elected the following officers: Mr J. M. Casals Alis (Andorra) – Chairman, and Mr I.A.S. de Carvalho (Cape Verde) – Vice-Chairman.

The Committee examined the credentials delivered to the Director-General in accordance with Rule 22 of the Rules of Procedure of the World Health Assembly. It noted that the Secretariat had found these credentials to be in conformity with the Rules of Procedure.

The credentials of the delegates of the Member States shown at the end of this report were found to be in conformity with the Rules of Procedure as constituting formal credentials; the Committee therefore proposes that the Health Assembly should recognize their validity.

The Committee examined notifications from the Member States listed at the end of this paragraph, which, while indicating the names of the delegates concerned, could not be considered as constituting formal credentials in accordance with the provisions of the Rules of Procedure. The Committee therefore recommends to the Health Assembly that the delegates of these Member States be provisionally seated with all rights in the Assembly pending the arrival of their formal credentials: Albania; Belarus; Colombia; Kiribati; Kyrgyzstan; Luxembourg; Malawi.

The delegate of Greece stated that, although Greece did not oppose the consensus in the Committee on Credentials, it would like to reiterate its well-known position that the use of the name "Republic of Macedonia" by The former Yugoslav Republic of Macedonia fully disregards United Nations Security Council resolutions 817 (1993) and 845 (1993).

States whose credentials it was recommended should be recognized as valid (see fourth paragraph above)

Afghanistan; Algeria; Andorra; Angola; Antigua and Barbuda; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belgium; Belize; Benin; Bhutan; Bolivia (Plurinational State of); Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam;

¹ Approved by the Health Assembly at its fifth plenary meeting. Formal credentials of Albania and Kyrgyzstan were examined by the President and accepted by the Health Assembly at its sixth plenary meeting.

Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; Canada; Cape Verde; Central African Republic; Chad; Chile; China; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kuwait; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Lithuania; Madagascar; Malaysia; Maldives; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Mexico; Micronesia (Federated States of); Monaco; Mongolia; Montenegro; Morocco; Mozambique; Myanmar; Namibia; Nauru; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Serbia; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; Spain; Sri Lanka; Sudan; Suriname; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Thailand; The former Yugoslav Republic of Macedonia; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Vanuatu; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe.

GENERAL COMMITTEE

Report¹

[A62/49 – 21 May 2009]

At its meeting on 20 May 2009, the General Committee, in accordance with Rule 100 of the Rules of Procedure of the World Health Assembly, drew up the following list of 12 Members, in the English alphabetical order, to be transmitted to the Health Assembly for the purpose of the election of 12 Members to be entitled to designate a person to serve on the Executive Board: Brunei Darussalam, Burundi, Canada, Chile, Estonia, France, Germany, India, Japan, Serbia, Somalia, Syrian Arab Republic.

In the General Committee's opinion these 12 Members would provide, if elected, a balanced distribution on the Board as a whole.

¹ Approved by the Health Assembly at its seventh plenary meeting.

COMMITTEE A**First report¹**

[A62/48 – 20 May 2009]

Committee A held its third meeting on 19 May 2009 under the chairmanship of Dr F. Meneses González (Mexico).

It was decided to recommend to the Sixty-second World Health Assembly the adoption of one resolution relating to the following agenda item:

12. Technical and health matters

12.3 Prevention of avoidable blindness and visual impairment [WHA62.1].

Second report²

[A62/51 – 21 May 2009]

Committee A held its eighth meeting on 21 May 2009 under the chairmanship of Dr F. Meneses González (Mexico).

It was decided to recommend to the Sixty-second World Health Assembly the adoption of two resolutions relating to the following agenda items:

11. Medium-term strategic plan, including Proposed programme budget 2010–2011

Appropriation resolution for the financial period 2010–2011 [WHA62.9]

12. Technical and health matters

12.1 Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits [WHA62.10].

¹ Approved by the Health Assembly at its sixth plenary meeting.

² Approved by the Health Assembly at its eighth plenary meeting.

Third report¹

[A62/52 – 22 May 2009]

Committee A held its ninth meeting on 21 May 2009 under the chairmanship of Dr F. Meneses González (Mexico).

It was decided to recommend to the Sixty-second World Health Assembly the adoption of four resolutions relating to the following agenda items:

11. Medium-term strategic plan, including Proposed programme budget 2010–2011

Medium-term strategic plan 2008–2013, including Proposed programme budget 2010–2011 [WHA62.11].

12. Technical and health matters

12.4 Primary health care, including health system strengthening [WHA62.12]

Traditional medicine [WHA62.13]

12.5 Commission on Social Determinants of Health

Reducing health inequities through action on the social determinants of health [WHA62.14]

Fourth report²

[A62/53 – 22 May 2009]

Committee A held its tenth meeting on 22 May 2009 under the chairmanship of Dr F. Meneses González (Mexico).

It was decided to recommend to the Sixty-second World Health Assembly the adoption of one resolution relating to the following agenda item:

12.9 Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis²

¹ Approved by the Health Assembly at its eighth plenary meeting.

² Amendments to the draft resolution contained in document A62/53 were introduced by the Health Assembly at its eighth plenary meeting; the resolution was adopted as resolution WHA62.15.

COMMITTEE B**First report¹**

[A62/50 – 21 May 2009]

Committee B held its first and second meetings on 20 May 2009 under the chairmanship of Mr S. McKernan (New Zealand).

It was decided to recommend to the Sixty-second World Health Assembly the adoption of seven resolutions and one decision relating to the following agenda items:

- 14. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan [WHA62.2]
- 17. Financial matters
 - 17.1 Unaudited interim financial report on the accounts of WHO for 2008 [WHA62.3]
 - 17.3 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution [WHA62.4]
 - 17.5 Scale of assessments 2010–2011 [WHA62.5]
 - 17.7 Amendments to the Financial Regulations and Financial Rules [WHA62.6]
- 18. Staffing matters
 - 18.3 Amendments to Staff Regulations and Staff Rules
 - Amendments to Staff Regulations [WHA62.7]
 - Salaries of staff in ungraded posts and of the Director-General [WHA62.8]
 - 18.5 Appointment of representatives to the WHO Staff Pension Committee
 - United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee [WHA62(8)].

¹ Approved by the Health Assembly at its seventh plenary meeting.

Second report¹

[A62/54 – 22 May 2009]

Committee B held its third meeting on 21 May 2009 under the chairmanship of Mr S. McKernan (New Zealand), its fourth meeting on 21 May 2009 under the chairmanship of Mr McKernan and Dr U.S. Sutarjo (Indonesia), and its fifth meeting on 22 May 2009 under the chairmanship of Mr McKernan and Mr V. Jaksons (Latvia).

It was decided to recommend to the Sixty-second World Health Assembly the adoption of one resolution relating to the following agenda item:

12. Technical and health matters

12.8 Public health, innovation and intellectual property: global strategy and plan of action

Global strategy and plan of action on public health, innovation and intellectual property [WHA62.16].

¹ Approved by the Health Assembly at its eighth plenary meeting.