EB113/2004/REC/2

WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

113TH SESSION

GENEVA, 19-23 JANUARY 2004

SUMMARY RECORDS

GENEVA
2004

EB113/2004/REC/2

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ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACHR – Advisory Committee on Health Research
ASEAN – Association of South-East Asian Nations
CEB – United Nations System Chief Executives Board for Coordination (formerly ACC)
CIOMS – Council for International Organizations of Medical Sciences
FAO – Food and Agriculture Organization of the United Nations
IAEA – International Atomic Energy Agency
IARC – International Agency for Research on Cancer
ICAO – International Civil Aviation Organization
IFAD – International Fund for Agricultural Development
ILO – International Labour Organization (Office)
IMF – International Monetary Fund
IMO – International Maritime Organization
ITU – International Telecommunication Union
OECD – Organisation for Economic Co-operation and Development
PAHO – Pan American Health Organization
UNAIDS – Joint United Nations Programme on HIV/AIDS
UNCTAD – United Nations Conference on Trade and Development
UNDCP – United Nations International Drug Control Programme
UNDP – United Nations Development Programme
UNEP – United Nations Environment Programme
UNESCO – United Nations Educational, Scientific and Cultural Organization
UNFPA – United Nations Population Fund
UNHCR – Office of the United Nations High Commissioner for Refugees
UNICEF – United Nations Children's Fund
UNIDO – United Nations Industrial Development Organization
UNRWA – United Nations Relief and Works Agency for Palestine Refugees in the Near East
WFP – World Food Programme
WIPO – World Intellectual Property Organization
WMO – World Meteorological Organization
WTO – World Trade Organization

PREFACE

The 113th session of the Executive Board was held at WHO headquarters, Geneva, from 19 to 23 January 2004. The proceedings are issued in two volumes. The present volume contains the summary records of the Board's discussions, list of participants and officers, and details regarding membership of commiteees and working groups. The resolutions and decisions and relevant annexes are published in document EB113/2004/REC/1.

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[1] As adopted by the Board at its first meeting (19 January 2004).

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[1] See document EB113/2004/REC/1, Annex 2 and Annex 3.

[2] See document EB113/1.

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Dra. M. BELLO DE KEMPER, Consejero, Misión Permanente, Ginebra
Srta. G.J. AQUINO, Consejero, Misión Permanente, Ginebra

FINLAND

Ms L. OLLILA, Ministerial Adviser, Ministry of Social Affairs and Health, Helsinki
Mr P. PUSKA, Director-General, National Public Health Institute of Finland, Helsinki
Ms A. VUORINEN, Minister Counsellor, Permanent Mission, Geneva
Ms K. HÄIKIÖ, Counsellor, Permanent Mission, Geneva
Mr M. JASKARI, Counsellor, Ministry for Foreign Affairs, Helsinki

GERMANY

Mr U. SCHOLTEN, Deputy Head of Department, Federal Ministry of Health, Berlin
Dr H. PEITSCH, Counsellor, Division of United Nations Specialized Agencies, Federal Foreign Office, Berlin
Dr I. VON VOSS, Counsellor, Permanent Mission, Geneva
Mrs B. BIDENBACH, Third Secretary, Permanent Mission, Geneva
Mr G. LINKE, Attaché, Permanent Mission, Geneva

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Sra. S. HOCHSTETTER SKINNER-KLÉE, Consejero, Misión Permanente, Ginebra

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M. E.L. JOSEPH, Ministre conseiller, Mission permanente, Genève

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Mr T. TÓTH, Ambassador, Permanent Representative, Geneva
Mr B. RÁTKAI, Third Secretary, Permanent Mission, Geneva

INDIA

Mr D. SAHA, Deputy Permanent Representative, Geneva
Mr B.P. SHARMA, Joint Secretary, Ministry of Health and Family Welfare, Government of India, New Delhi
Dr S.P. AGARWAL, Director-General of Health Services, Ministry of Health and Family Welfare, Government of India, New Delhi
Mr A.K. CHATTERJEE, First Secretary, Permanent Mission, Geneva

INDONESIA

Mr A.P. SARWONO, First Secretary, Permanent Mission, Geneva
Mr A.C. SUMIRAT, Third Secretary, Permanent Mission, Geneva

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Mr P. SEADAT, Counsellor, Permanent Mission, Geneva

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Ms S. MANGAN, First Secretary, Permanent Mission, Geneva
Ms M. AYLWARD, International Unit, Department of Health and Children, Dublin
Ms S. CULLEN, International Unit, Department of Health and Children, Dublin
Ms A. ATHANASOPOULOU, Second Secretary, Liaison Office of the General Secretariat of the Council of the European Union, Geneva

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Dr D. NIZAN KALUSKI, Director, Food and Nutrition Services, Ministry of Health, Jerusalem

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Mrs S. HERLIN, Adviser, Permanent Mission, Geneva

ITALY

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M. G. MAJORI, Directeur, Laboratoire de Parasitologie, Institut supérieur de la Santé, Rome
Mme N. QUINTAVALLE, Premier Conseiller, Mission permanente, Genève
Mlle L. PECORARO, Mission permanente, Genève
M. S. VARVA, Mission permanente, Genève

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Mr K. NAKAZAWA, Director, International Affairs Planning Office, International Affairs Division, Minister's Secretariat, Ministry of Health, Labour and Welfare, Tokyo
Dr Y. FUKUDA, Director, International Cooperation Office, International Affairs Division, Minister's Secretariat, Ministry of Health, Labour and Welfare, Tokyo
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Mr T. YAMAGUCHI, First Secretary, Permanent Mission, Geneva
Mr S. KOYAMA, Second Secretary, Permanent Mission, Geneva

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Mr H. AL HUSSEINI, Second Secretary, Permanent Mission, Geneva

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Mr P.R.O. OWADE, Deputy Permanent Representative, Geneva
Mrs L. NYAMBU, First Secretary, Permanent Mission, Geneva

LATVIA

Mrs G. VITOLA, Third Secretary, Permanent Mission, Geneva

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LESOTHO

Mrs M. PHEKO, Minister Counsellor, Permanent Mission, Geneva

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Dr A. ABUDAJAJA, Professor of Community Medicine, Tripoli
Dr S. AWENAT, Bureau populaire libyen, Berne
Dr S. ABUGHALIA, Bureau populaire libyen, Berne

LUXEMBOURG

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Dr D. HANSEN-KOENIG, Directeur de la Santé, Direction de la Santé, Luxembourg
Mme N. MAISCH ESTENNE, Premier Secrétaire, Mission permanente, Genève
M. M. GODEFROID, Premier Secrétaire, Mission permanente, Genève

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Mr R. SARSERO, Counsellor, Permanent Mission, Geneva
Mr J. BUSUTTIL, First Secretary, Permanent Mission, Geneva
Mr T. BONNICI, Second Secretary, Permanent Mission, Geneva

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Mr V. MUNGUR, First Secretary, Permanent Mission, Geneva
Ms N. PERTAUB, Second Secretary, Permanent Mission, Geneva

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Mr P.J. SCIARONE, Minister, Deputy Permanent Representative, Geneva
Mr L. VAN DER HEIDEN, Coordinator, Global Health Affairs, Ministry of Health, Welfare and Sport, The Hague
Mr P. VAN GROENEWEGEN, Policy Adviser, Ministry of Health, Welfare and Sport, The Hague
Ms E. VAN GINNEKEN, Policy Officer, United Nations Department, Ministry of Foreign Affairs, The Hague
Ms M.A.C.M. MIDDELHOFF, First Secretary, Permanent Mission, Geneva

NEW ZEALAND

Dr G. DURHAM, Deputy Director General – Sector Policy, Sector Policy Directorate, Ministry of Health, Wellington
Ms J. MACMILLAN, Counsellor, Permanent Mission, Geneva

NICARAGUA

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Sr. N. CRUZ TORUÑO, Primer Secretario, Misión Permanente, Ginebra
Sra. M.P. HERNÁNDEZ, Primer Secretario, Misión Permanente, Ginebra
Sra. P. CAMPBELL GONZÁLEZ, Primer Secretario, Misión Permanente, Ginebra

NORWAY

Mr S. RØREN, Deputy Director-General, Ministry of Health, Oslo
Ms E. RØINE, Adviser, Ministry of Health, Oslo
Ms M. TROMMALD, Director, Directorate for Health and Social Affairs, Oslo
Ms A. HAGA RIMESTAD, Director, Directorate for Health and Social Affairs, Oslo

Ms T. KONGSVIK, Counsellor, Permanent Mission, Geneva
Mr D. REKVE, Senior Adviser, Ministry of Social Affairs, Oslo

OMAN

Dr A. AL-KHAROUSSI, Director, Orthopaedic Unit, Khawla Hospital, Muscat
Mr A. AL-RIYAMI, Ambassador, Permanent Representative, Geneva
Mrs F. AL-GHAZALI, Counsellor, Permanent Mission, Geneva
Mr A. AL-QASSIMI, First Secretary, Permanent Mission, Geneva

PERU

Sr. J.L. SALINAS MONTES, Ministro, Representante Permanente Alterno, Ginebra
Srta. E. BERAÚN ESCUDERO, Segunda Secretaria, Misión Permanente, Ginebra

POLAND

Mr W. MASLOWSKI, Under-Secretary of State, Ministry of Health, Warsaw
Ms B. BITNER, Acting Director, European Integration and International Cooperation Department, Ministry of Health, Warsaw
Ms R. LEMIESZEWSKA, First Secretary, Permanent Mission, Geneva

PORTUGAL

M. J. PEREIRA MIGUEL, Directeur national de la Santé, Ministère de la Santé, Lisbonne
M. P. BÁRCIA, Conseiller, Mission permanente, Genève

ROMANIA

Mrs D. IORDACHE, First Secretary, Permanent Mission, Geneva

SAN MARINO

Mme F. BIGI, Ambassadeur, Représentant permanent, Genève
M. R. INNOCENTINI, Mission permanente, Genève

SLOVAKIA

Dr S. HLAVAČKA, Director-General for Health Care Strategy, Ministry of Health, Bratislava
Mrs Z. ČERVENÁ, Ministry of Health, Bratislava
Mrs J. BARTOSIEWICZOVÁ, Counsellor, Permanent Mission, Geneva

SOUTH AFRICA

Mrs P. LAMBERT, Special Adviser to the Minister of Health, Pretoria
Dr Y. PILLAY, Cluster Manager, Strategic Planning, Ministry of Health, Pretoria
Mr P.D. MONTWEDI, Counsellor, Chargé d'affaires, Permanent Mission, Geneva
Ms D. MAFUBELU, Counsellor (Health), Permanent Mission, Geneva

SWEDEN

Ms E. BORSIIN BONNIER, Ambassador, Permanent Mission, Geneva
Mr B. PETTERSSON, Deputy Director-General, National Institute of Public Health, Stockholm
Ms D. ALOPAEUS-STÅHL, Director, Ministry for Foreign Affairs, Stockholm
Ms P. STAVÅS, Counsellor, Permanent Mission, Geneva
Ms C. HALLE, Desk Officer, Ministry of Health and Social Affairs, Stockholm
Ms B. NORDSTRÖM, Desk Officer, Swedish International Development Cooperation Agency, Stockholm

SWITZERLAND

Dr G. SILBERSCHMIDT, Office fédéral de la Santé publique, Berne
Dr M. BERGER, Direction du Développement et de la Coopération, Département fédéral des Affaires étrangères, Mission permanente, Genève
Mme S. ZOBRIST, Office fédéral de la Santé publique, Berne
M. A. VON KESSEL, Office fédéral de la Santé publique, Berne
Mme A. OCHIENG PERNET, Office fédéral de la Santé publique, Berne
M. F. DEL PONTE, Département fédéral des Affaires étrangères, Berne
Mme B. SCHAER BOURBEAU, Deuxième Secrétaire, Mission permanente, Genève

SYRIAN ARAB REPUBLIC

Mr M.G. IBRAHIM, Attaché, Permanent Mission, Geneva

THAILAND

Professor PAKDEE POTHISIRI, Deputy Permanent Secretary, Ministry of Public Health, Nonthaburi
Dr SUWIT WIBULPOLPRASERT, Deputy Permanent Secretary, Ministry of Public Health, Nonthaburi
Dr VIROJ TANGCHAROENSATHIEN, Ministry of Public Health, Nonthaburi
Mr WITCHU VEJJAJIVA, First Secretary, Permanent Mission, Geneva

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M. H. LANDOULSI, Conseiller, Mission permanente, Genève

TURKEY

Mr H. ERGANI, Second Secretary, Permanent Mission, Geneva

VENEZUELA

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Sra. M. HERNÁNDEZ, Consejero, Misión Permanente, Ginebra
Sr. D. IBARRA, Tercer Secretario, Misión Permanente, Ginebra
Dra. K. GUZMÁN, Ministerio de la Salud y Asistencia Social, Caracas

YEMEN

Mr K. AL-MAKHETHI, Third Secretary, Permanent Mission, Geneva

ZAMBIA

Mr L. MTESA, Ambassador, Permanent Representative, Geneva
Mr A. ZULU, First Secretary, Permanent Mission, Geneva

ZIMBABWE

Mr C. CHIPAZIWA, Ambassador, Permanent Representative, Geneva
Mr B. MUGARISANWA, Counsellor, Permanent Mission, Geneva

OBSERVERS FOR A NON-MEMBER STATE

HOLY SEE

Mgr S.M. TOMASI, Observateur permanent, Genève
Mgr F. NWACHUKWU, Conseiller, Mission permanente, Genève
Mgr J.-M. MPENDAWATU, Conseil pontifical pour la Pastorale des Services de la Santé
Dr G. RIZZARDINI, Expert

REPRESENTATIVES OF THE UNITED NATIONS AND RELATED ORGANIZATIONS

United Nations

Mr A. SMITH SERRANO, External Relations and Inter-Agency Affairs Officer, Office of the Director-General, United Nations Office, Geneva
Mr J. LARRABURE, Executive Secretary, Joint Inspection Unit, Geneva
Ms L. OLDRING, Human Rights Officer, Office of the High Commissioner for Human Rights, Geneva
Mr L.-D. OUEDRAOGO, Vice-Chairman, Joint Inspection Unit, Geneva
Mr F.-J. HOMAN-HERIMBERG, Special Adviser to the Emergency Relief Coordinator, Office for the Coordination of Humanitarian Affairs, Geneva

Ms A. ABDELHADI, Office of the High Commissioner for Human Rights, Geneva
Mr I. GORITA, Inspector, Joint Inspection Unit, Geneva
Mr S. KUYAMA, Inspector, Joint Inspection Unit, Geneva

United Nations Environment Programme

Mr J.B. WILLIS, Director, UNEP Chemicals, Geneva
Mr S. MILAD, UNEP Chemicals, Geneva

United Nations Population Fund

Mrs S. CAGAR, Director, UNFPA Office in Geneva
Mr K.O. DANQUAH, External Relations Adviser
Dr V. FAUVEAU, Senior Adviser, Maternal Health, UNFPA Office in Geneva
Mr E. PALSTRA, Senior External Relations Officer, UNFPA Office in Geneva

World Food Programme

Mr D. BELGASMI, Director, World Food Programme Geneva Office
Mr C. JIBIDAR, Deputy Director, World Food Programme Geneva Office
Ms S. IZZI, Liaison Officer, World Food Programme Geneva Office

United Nations Relief and Works Agency for Palestine Refugees in the Near East

Dr F. MOUSA, Director of Health

Office of the United Nations High Commissioner for Refugees

Ms F. ABDALLA, Senior Nutritionist, Health and Community Development Section

UNAIDS

Dr P. PIOT, Executive Director
Ms K. CRAVERO, Deputy Executive Director
Ms M. FAHLEN, Director, Social Mobilization and Information Department
Mr M. SIDIBE, Director, Country and Regional Support Department
Mr P. DE LAY, Director, Office for Monitoring and Evaluation
Mr B. PLUMLEY, Director, Chief of the Executive Office
Ms C. HANKINS
Mr L. LOURES
Ms R. CHAHIL-GRAF
Mr E. HAARMAN
Ms J. GIRARD
Mr G. MITTERMANN
Mr J. FLEET
Mr R. GREENER
Mr C. ALMEDAL
Mr R. SALLA NTOUNGA
Ms L. ALYANAK
Mr B. WILLIAMS
Ms A. MENDOZA
Mr J. TYSZKO

The Global Fund to Fight AIDS, Tuberculosis and Malaria

Professor R.G.A. FEACHEM, Executive Director

SPECIALIZED AGENCIES

International Labour Organization

Mr A. BONILLA GARCIA, Social Protection Sector
Ms I. HERREL, Social Protection Sector

Food and Agriculture Organization of the United Nations

Mr T.N. MASUKU, Director, FAO Liaison Office, Geneva

Mr P. SHETTY, Chief, Nutrition, Planning, Assessment and Evaluation Service, Nutrition Division, Economic and Social Department
Mr J. SCHMIDHUBER

World Meteorological Organization

Dr B. NYENZI, Chief, World Climate Applications and CLIPS Division, World Climate Programme

World Intellectual Property Organization

Mme K.L. RATA, Conseillère principale, Bureau du Conseiller spécial

United Nations Industrial Development Organization

Mr A. DI LISCIA, Assistant Director-General and Director, UNIDO Office at Geneva
Mr B. CALZADILLA-SARMINETO, Senior Adviser, UNIDO Office at Geneva

International Atomic Energy Agency

Ms J. RISSANEN, External Relations Officer, IAEA Geneva Office

World Trade Organization

Mme J. WATAL, Conseillère, Division de la Propriété intellectuelle
Mme WU Ziaoping, Juriste, Division de la Propriété intellectuelle

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League of Arab States

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M. M.L. MOUAKI BENANI, Conseiller, Délégation permanente, Genève
Dr O. EL HAJJE, Délégation permanente, Genève

Office International des Epizooties

Dr J.-L. ANGOT, Chef, Service administratif et financier

African Union

Mrs S.A. KALINDE, Ambassador, Permanent Observer, Geneva
Mr V. WEGE NZOMWITA, Counsellor, Permanent Delegation, Geneva

Commonwealth Secretariat

Dr J. AMUZU, Chief Programme Officer, Social Transformation Programmes Division

European Commission

Mrs M.-A. CONINSX, Minister Counsellor, Permanent Delegation, Geneva
Mrs I. DE LA MATA, Directorate General for Health and Consumer Protection, Brussels
Mr J. PELEGRIN, Directorate General for Health and Consumer Protection, Luxembourg
Mr C. DUFOUR, Permanent Delegation, Geneva
Mr T. PIHA, Directorate General for Health and Consumer Protection, Brussels

International Organization for Migration

Dr D. GRONDIN, Director, Migration Health Services

Organization of the Islamic Conference

Mr B. BA, Ambassador, Permanent Observer, Geneva
Mr A.V. MOITABA, Deputy Permanent Observer, Geneva

REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS IN OFFICIAL RELATIONS WITH WHO

Aga Khan Foundation

Ms S. BANDALI

CMC – Churches' Action for Health

Ms A. LINDSAY
Ms A. STÜCKELBERGER
Dr E. RAM
Mr M. DOSANJH
Ms C. HÜRLIMANN

Commonwealth Association for Mental Handicap and Developmental Disabilities

Dr G. SUPRAMANIAM

Council for International Organizations of Medical Sciences

Dr J. IDÄNPÄÄN-HEIKKILÄ
Mr S. FLUSS
Dr J. VENULET

Council on Health Research for Development

Mrs S. DE HAAN

FDI World Dental Federation

Dr HEUNG-RYUL YOON
Dr J.T. BARNARD
Dr H. BENZIAN

Global Forum for Health Research

Mr S.A. MATLIN
Mr A. DE FRANCISCO

Industry Council for Development

Mr J. HOWLETT
Mr N. CHRISTIANSEN

Infact

Ms K. MULVEY

Inter-African Committee on Traditional Practices affecting the Health of Women and Children

Mrs B. RAS-WORK
Mrs B. VON DER WEID

Inter-American Association of Sanitary and Environmental Engineering

Mr O. SPERANDIO

International Alliance of Women

Mrs H. SACKSTEIN
Mrs M. PAL

International Association for Maternal and Neonatal Health

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International College of Surgeons

Professor P. HAHNLOSER
Dr R. DIETER
Professor Chun-Jean LEE
Mr M. DOWNHAM

International Confederation of Midwives

Mrs K. HERSCHDERFER
Mrs P. TEN HOOPE-BENDER
Ms R. BRAUEN
Ms J. BONNET

International Council for Control of Iodine Deficiency Disorders

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Mrs L. CARRIER-WALKER

International Council of Women

Mrs P. HERZOG

International Diabetes Federation

Mr N. RIGBY

International Federation of Business and Professional Women

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International Federation of Medical Students Associations

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International Federation of Pharmaceutical Manufacturers Associations

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Dr E. NOEHRENBERG
Mr B. AZAIS
Dr O. MORIN

International Federation of Surgical Colleges

Dr S.W.A. GUNN

International Hospital Federation

Professor P.-G. SVENSSON
Dr R. MASIRONI

International League against Epilepsy

Professor G. AVANZINI

International League of Dermatological Societies

Professor J.-H. SAURAT

International Organisation of Consumers Unions (Consumers International)

Ms A. ALLAIN
Ms N. EL RASSI
Ms M. LEHNERS
Dr L. LHOTSKA
Ms A. LINNECAR
Dr M. REA
Ms P. RUNDELL
Mrs V. DIPEOLU
Ms E. HOEN
Mr D. BERMAN
Ms R. COHEN
Ms S. GOMBE
Mr S. HEALY
Ms M. EWEN

International Pediatric Association

Dr J.G. SCHALLER

International Pharmaceutical Federation

Mr J. PARROT
Mr T. HOEK
Mrs S. TAINIO
Mr S. BELL
Ms J. CRUZ
Ms A. BOSMAN

International Planned Parenthood Federation

Dr F. TERKI

International Special Dietary Foods Industries

Dr A. BRONNER
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Ms J. KEITH
Mr D. HAWKINS
Ms C. DROTZ-JONASON
Mr THIEN LUONG VAN MY
Mr M. MIRANDA

Ms H. MOUCHLY WEISS
Ms K. BOLOGNESE

International Union against Cancer

Dr J. SEFFRIN
Mrs I. MORTARA

International Union against Sexually Transmitted Infections

Dr R. PATEL
Dr M. ANTAL

International Union of Nutritional Sciences

Dr N. RIGBY

International Women's Health Coalition

Mrs A. GERMAIN

La Leche League International

Ms G. LAVIOLLE
Ms H. KUONEN-GOETZ

March of Dimes Birth Defects Foundation

Dr M. KATZ

Medical Women's International Association

Dr C. BRETSCHER-DUTOIT
Dr S. CAPEK

Rotary International

Mr N.F. HACKETT

Soroptimist International

Ms I.S. NORDBACK
Ms J. GALLEY-SCHROPP

The International Association of Lions Clubs (Lions Club International)

Mr G.E. CANTAFIO

The Network: TUFH

Dr C. BOELEN
Dr P. KEKKI

Save the Children UK

Ms R. KEITH

World Association of Girl Guides and Girl Scouts

Ms J. VERKOOIJEN

World Association of Societies of Pathology and Laboratory Medicine

Dr U. MERTEN

World Federation for Medical Education

Dr H. KARLE
Dr J. NYSTRUP
Mr L. CHRISTENSEN

World Federation for Mental Health

Dr S. FLACHE
Mrs M. LACHENAL

World Federation of Hydrotherapy and Climatotherapy

Professor N.A. STOROZHENKO
Professor U. SOLIMENE
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World Federation of Neurology

Dr J.A. AARLI

World Federation of Nuclear Medicine and Biology

Dr WONSICK CHOE

World Federation of Public Health Associations

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Ms J. BELL DAVENPORT

World Heart Federation

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Ms D. GRIZEAU-CLEMENS

World Medical Association

Dr D. HUMAN
Dr Y. BLACHAR
Ms L. WAPNER
Ms E. VIAUD
Mr I. SHENKAR
Professor J. WILLIAMS

World Organization of Family Doctors

Dr I. HELLEMANN

World Organization of the Scout Movement

Mr A. ROMBOLI
Miss S. McELROY

World Self-Medication Industry

Dr D. WEBBER
Ms V. BOISARD

World Vision International

Dr M. AMAYUN

COMMITTEES AND WORKING GROUPS[1]

1. Programme Development Committee

Dr J. Boshell (Colombia), Dr M. Camara (Guinea), Dr M. Al-Jarallah (Kuwait, member *ex officio*), Dr H.N. Acharya (Nepal), Mr M.N. Khan (Pakistan), Dr M.M. Dayrit (Philippines), Professor Y.L. Shevchenko (Russian Federation)

Tenth meeting, 16 January 2004: Dr M.M. Dayrit (Philippines, Chairman), Dr J. Boshell (Colombia), Dr M. Camara (Guinea), Professor S.M. Furgal (Russian Federation, alternate to Professor Y.L. Shevchenko)

2. Administration, Budget and Finance Committee

Dr Yin Li (China), Dr C. Modeste-Curwen (Grenada, member *ex officio*), Dr J.C. Sá Nogueira (Guinea-Bissau), Mr D.Á. Gunnarsson (Iceland), Dr A.A. Yoosuf (Maldives), Dr A.B. Osman (Sudan), Dr W.R. Steiger (United States of America)

Twentieth meeting, 15 and 16 January 2004: Dr A.A. Yoosuf (Maldives, Chairman), Dr Yin Li (China), Dr J.C. Sá Nogueira (Guinea-Bissau), Mr D.Á. Gunnarsson (Iceland), Mr C.L. Jada (Sudan, alternate to Dr A.B. Osman), Mr D.E. Hohman (United States of America, alternate to Dr W.R. Steiger)

3. Audit Committee

Mr D.R. MacPhee (Canada, alternate to Dr I. Shugart), Dr Yin Li (China, member *ex officio*), Professor B. Fišer (Czech Republic), Professor M.N. El-Tayeb (Egypt, alternate to Dr M.A.A. Tag-El-Din), Dr J.-B. Ndong (Gabon), Mr M.A. Didi (Maldives, alternate to Dr A.A. Yoosuf), Dr Y.-J. Om (Republic of Korea)

Ninth meeting, 14 January 2004: Professor M.N. El-Tayeb (Egypt, alternate to Dr M.A.A. Tag-El-Din, Chairman), Mr D.R. MacPhee (Canada, alternate to Dr I. Shugart), Professor B. Fišer (Czech Republic), Dr J.-B. Ndong (Gabon), Mr M.A. Didi (Maldives, alternate to Dr A.A. Yoosuf), Dr Y.-J. Om (Republic of Korea)

4. Standing Committee on Nongovernmental Organizations

Dr F. Huerta Montalvo (Ecuador), Dr Z. Alemu (Eritrea), Professor Mya Oo (Myanmar), Dra. A.M. Pastor Julián (Spain), Dr A.B. Osman (Sudan)

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[1] Showing their current membership and listing the names of those members of the Executive Board who attended meetings held since the previous session of the Board.

Meeting of 20th January 2004: Dr Z. Alemu (Eritrea, Chairman), Dr F. Huerta Montalvo (Ecuador), Professor Mya Oo (Myanmar), Dra. P. Alonso Cuesta (Spain, alternate to Dra. A.M. Pastor Julián), Dr A.B. Osman (Sudan)

5. Ihsan Dogramaci Family Health Foundation Selection Panel

The Chairman of the Executive Board, the President of Bilkent University (Ankara) or his or her appointee, and a representative of the International Children's Centre (Ankara)

Meeting of 21 January 2004: Dr K. Afriyie (Ghana, Chairman), Dr Phyllis L. Erdogan (representative of the President of Bilkent University), Professor K. Yurdakok (representative of the International Children's Centre)

6. Sasakawa Health Prize Selection Panel

The Chairman of the Executive Board, a representative of the founder and Dr M.M. Dayrit (Philippines)

Meeting of 22 January 2004: Dr K. Afriyie (Ghana, Chairman), Professor K. Kiikuni (representative of the founder), Dr M.M. Dayrit (Philippines)

7. United Arab Emirates Health Foundation Selection Panel

The Chairman of the Executive Board, a representative of the founder and Dr Y.Y. Al-Mazrou (Saudi Arabia)

Meeting of 22 January 2004: Dr K. Afriyie (Ghana, Chairman), Mr N.K. Al Budoor (representative of the founder), Mr A.H. Al Humood (representative of the founder), Dr Y.Y. Al-Mazrou (Saudi Arabia)

SUMMARY RECORDS

FIRST MEETING

Monday, 19 January 2004, at 09:35

Chairman: Dr K. AFRIYIE (Ghana)

1. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA: Item 1 of the Provisional Agenda (Documents EB113/1 and EB113/1 Add.1)

The CHAIRMAN declared open the 113th session of the Executive Board and welcomed all participants.

Following past practice in dealing with mid-term vacancies for officers of the Board, he suggested that the new member for China be elected as a Vice-Chairman and the new member for France be elected as Rapporteur to complete the terms of office due to run until the 114th session of the Board.

It was so agreed.

The CHAIRMAN reminded the Board that it was meeting for the first time under the new Rules of Procedure, adopted at its 112th session.[1] Turning to the provisional agenda in document EB113/1 and the supplementary item referred to in document EB113/1 Add.1, which would be taken up under item 5, Financial matters, he proposed the deletion of item 5.2, Amendments to Financial Regulations and Financial Rules, since no amendment was being proposed at the current session. Under item 6.1, Human resources, there was no proposed amendment to the Staff Rules other than that in a draft resolution contained in document EB113/19, Report of the International Civil Service Commission.

The agenda, as amended, was adopted.[2]

Dr ZEPEDA BERMUDEZ (Brazil)[3] expressed concern that certain important and highly sensitive matters had been placed under item 8, Matters for information, scheduled for consideration on the last day of the session, by which time discussion on the "substantive" issues would have been completed and attendance was likely to have shrunk. Of particular importance were items 8.2, Reducing global measles mortality, 8.3, Severe acute respiratory syndrome (SARS), 8.5, Eradication of poliomyelitis, and 8.9, Intellectual property rights, innovation and public health: terms of reference for review group. Seconded by Dr HUERTA MONTALVO (Ecuador) and Dr GONZÁLEZ FERNÁNDEZ (Cuba), on behalf of the Latin American and Caribbean Group, he requested a readjustment in the timetable to enable those items to be considered on Wednesday, 21 January.

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[1] Resolution EB112.R1.

[2] See page ix.

[3] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Professor DAB (France) requested that item 8.10, Control of human African trypanosomiasis, be included under item 3, Technical and health matters, as France wished to submit a draft resolution on the subject.

Dr STEIGER (United States of America) questioned changes to an agenda that had been adopted. Furthermore, a change in the timetable involving the removal of an item from a section "for information" to one relating to substantive issues did not per se transform that matter into a substantive one.

Mr AITKEN (Director, Office of the Director-General) pointed out that the proposal concerned merely a change in the order of business and would not change the items into substantive ones. A revised timetable could be submitted to the Board the following day.

Mr TOPPING (Legal Counsel) said that France's proposal would require turning the item from one merely for information into a substantive item. Even though the agenda had been adopted, Rule 40 of the Rules of Procedure allowed for such a change, subject to a two-thirds majority of members present and voting.

The CHAIRMAN said that, in the absence of any objection, he took it that the proposal by France was agreed by consensus. He further took it that the Board agreed to the timetable as proposed, subject to adjustment in the light of the foregoing discussion and to any developments during the week.

It was so agreed.

The CHAIRMAN pointed out that in compliance with the amendments to Rule 7 of the Rules of Procedure, items 7.1 and 7.2, concerning appointments of Regional Directors, would be considered in an open meeting. Further also to the amended Rules of Procedure, he proposed that the reports of the awards Selection Panels be considered and recipients of the awards be determined in public session, under item 7.3, Reports of the Executive Board committees including awards. The reports of the Selection Panels would continue to be circulated as restricted documents to Board members. Should a member of the Board feel that consideration of the proposals in the reports should take place in a forum other than a public meeting, a proposal to change the nature of the meeting could be made and considered by the Board at the opening of the item.

In respect of item 7.4, Policy for relations with nongovernmental organizations, he proposed that any outstanding issues on the subject should be considered informally before being considered by the Board later in the week.

He took it that the Board agreed to his proposals on the organization of work.

It was so agreed.

The CHAIRMAN, drawing attention to the proposed meeting schedule, recalled the amended provisions of Rule 3 of the Rules of Procedure concerning participation in meetings by Member States not represented on the Board and Associate Members, and indicated the arrangements whereby such representatives and representatives of intergovernmental and nongovernmental organizations could indicate their wish to speak.

2. REPORT BY THE DIRECTOR-GENERAL: Item 2 of the Agenda (Document EB113/2)

The DIRECTOR-GENERAL outlined the activities of the Organization since he had taken office on 21 July 2003. As part of the recent celebrations of the twenty-fifth anniversary of the Declaration of Alma-Ata, 1978, he had visited Kazakhstan and Brazil. He had also joined his three predecessors as Director-General at a meeting in Geneva, which had provided the opportunity to review WHO's work and their many achievements. Although there had been changes in the world since 1978, the health of all peoples remained the guiding rationale for the Organization's activities. At the November 2003 meeting of WHO Representatives, and at the Board members' recent retreat, hosted by Ghana, there had been a sense that once again emphasis should be given to the vision of health for all. The Second Consultation on Macroeconomics and Health, held in October 2003, and the High Level Forum on Health, Nutrition and Population-Related MDGs (Geneva, 8 and 9 January 2004) had helped to clarify countries' needs and the options for meeting them.

WHO's work in the regions continued to evolve, and he paid tribute to the outgoing Regional Director for South-East Asia, Dr Uton Rafei, who was attending his last Board session.

WHO was refocusing its work to become more effective in helping communities respond to health crises. Over the past year the populations of some 50 countries had been placed at risk as a result of serious crises. Some of those events, such as the recent earthquake in the Islamic Republic of Iran, had called for a focused response to assist in meeting the health needs of the survivors and restoring essential services. Other crises arose from continuing conflict in which civilians, especially women and children, were more likely to suffer from unprevented and untreated illnesses than from bullets and bombs. Crises such as those caused by HIV/AIDS, tuberculosis and malaria, and the epidemic of arsenic poisoning in the Ganges delta developed more slowly but had a profound long-term impact. The devastation caused by all three kinds of crisis could be reduced by preventive measures and, where those failed, by well-prepared responses.

Rebuilding and strengthening health systems was the overall theme of *The world health report 2003*,[1] which reflected current changes in WHO as the Organization took up the challenges of the Millennium Development Goals. The next report, to be published in May 2004, would focus on HIV/AIDS.

The "3 by 5" initiative, launched at events in key locations on World AIDS Day, 1 December 2003, aimed to ensure antiretroviral therapy for HIV/AIDS for three million people by the end of 2005 and set milestones for progress. The technical means for mitigating and preventing the impact of HIV/AIDS were available, and the strategy was designed to mobilize the financial and human resources needed to make use of those means and reduce the current death toll. At the same time preventive measures and health service capacity would be enhanced. Since the launch, 31 countries had requested support for scaling up their national HIV/AIDS prevention and treatment programmes. Seven country planning missions had been completed and a further 13 would be completed by the end of February 2004. The first 20 country team leaders would be appointed shortly and would set up country teams to help deliver the initiative. WHO had also established the AIDS Medicines and Diagnostics Service to support countries in the purchasing and distribution of drugs and diagnostic materials, and had disseminated simplified antiretroviral treatment guidelines, which would facilitate the training of health care workers. The Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS and other international and national partners were playing a crucial role in those activities.

In order to complete global eradication of poliomyelitis, efforts were being intensified in the six remaining disease-endemic countries where a series of massive immunization campaigns would cover some 250 million children. In the meantime, vigilance in poliomyelitis-free regions was vital until transmission was finally broken everywhere.

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[1] *The world health report 2003: Shaping the future*. Geneva, World Health Organization, 2003.

The immunization activities in many countries had built up systems that could increasingly be used for other child health activities. Some 11.5 million children and more than 0.5 million mothers died every year from preventable causes, despite effective and affordable interventions. Concerted efforts were therefore needed to meet the commitment made by all countries in the Millennium Development Goals to reduce child and maternal mortality rates. The Board's agenda items on family and reproductive health would help outline the way forward, which would involve WHO in increasingly close partnerships with other parts of the United Nations system, in particular UNICEF and UNFPA.

Although suspected cases of severe acute respiratory syndrome (SARS) were currently being reported on a daily basis, only two had been confirmed at that time since the start of the year. WHO was working closely with national authorities in Asia on SARS and avian influenza surveillance and control activities. Continued global vigilance and quick concerted action as necessary would greatly reduce the danger of large outbreaks of such diseases. Such potential emergencies would in future be monitored by the strategic health information centre at WHO headquarters, which would be equipped with the latest communications technology, visual display systems and software to facilitate integrated crisis management; it was expected to be operational by May 2004.

Work on the revision of the 1971 International Health Regulations was making good progress. As globalization proceeded, countries became increasingly interdependent for their health and safety, emphasizing the need for closer cooperation, in particular in respect of food and water supplies and the prevention of biological, chemical and nuclear accidents. More was also needed in the area of prevention of road traffic accidents; "Road safety is no accident" would be the slogan for World Health Day in April 2004.

Global cooperation was also indispensable for the prevention of noncommunicable diseases. When properly informed and supported by sound policy, everyone could take three straightforward measures: they could avoid tobacco use, be physically active and have a healthy diet. Since its adoption in May 2003, 85 countries and the European Community had signed the WHO Framework Convention on Tobacco Control and five countries had ratified it. The Convention would come into force once it had been ratified by 40 countries and he urged countries that had not yet become signatories or parties to do so as soon as possible.

Questions of diet and physical activity had been of concern to some in the food industry and agriculture. However, unlike tobacco, food was a fundamental requirement for health. The proposed global strategy on diet, physical activity and health set out policy options for governments seeking to support good food and healthier living. Preventive measures for cardiovascular disease, diabetes, obesity, cancer and other chronic diseases had been neglected for too long. It was time to act decisively and in a spirit of positive interaction with all parties concerned, including the food industry and consumer groups as well as health services.

Many health systems had become weakened through instability, conflict and underfunding, resulting in reduced access and further exposure to disease, and perpetuating the cycle of poverty. The need to strengthen health systems was the most pressing reason for WHO's commitment to shifting resources to the country level and was reflected in the updated figures for the programme budget for 2004-2005, which showed an increase from 66% to 70% in the proportion of the budget allocated to countries and regions. It was hoped to increase the allocation to 75% for the 2006-2007 biennium.

Community participation was a highly effective means of strengthening health systems but required skilled management, reliable information systems and financial and political support. Adequately trained and supported personnel were the key to making health systems work for the people who needed them most; their provision formed a major component of all WHO programmes.

Dr KASSAMA (Gambia), speaking on behalf of the African Group, and supported by the CHAIRMAN, speaking in his capacity as the member for Ghana, congratulated Dr Lee on his appointment. The commitments he had made, at the Fifty-sixth World Health Assembly, to WHO programmes at country level, more focused operations in countries, an approach that was "closer to the ground" and closer cooperation with national health authorities regarding their priority health

goals, were welcome as were the pragmatism he had displayed, particularly at the retreat for members of the Executive Board in Accra, together with his intention to allocate more resources to the regions and to countries.

In Africa, poverty and its impact on health remained a major challenge. Africa bore the heaviest burden of communicable diseases and the incidence of noncommunicable diseases was rising. The African Group therefore supported the orientation of resolution WHA51.31 on regular budget allocations to regions and urged the continued shifting of resources to Africa. It also supported decentralization, which should continue to be implemented with adequate resources. Many challenges facing Africa required adequate human and financial resources. The Group welcomed the commitment to find solutions to the personnel crisis in many health systems. National health systems continued to lack adequate human resources. The African ministers of health looked forward to the Director-General's leadership in finding sustainable solutions to the problem of international migration of health workers within the context of resolutions WHA22.51 and WHA25.42.

WHO's efforts to combat HIV/AIDS were commendable. The ambitious "3 by 5" initiative would help to combat one of Africa's biggest killers, but questions regarding its funding (to ensure sustainability) and ethical issues arising from the selection of people for treatment needed to be answered. It should not divert attention from other diseases, especially malaria and tuberculosis. The Group was confident that WHO would provide guidelines on such issues. The "3 by 5" initiative should be a simple and accessible system, especially with regard to antiretroviral therapy; it should be quick to implement, but not at the cost of reduced quality. WHO should also give due regard to what worked in Africa, bearing in mind the successes achieved in Botswana, Senegal and Uganda. The initiative also needed to be backed up by capacity building, in order to ensure long-term sustainability, and strengthening of health systems. Countries with a low prevalence of HIV should not be forgotten. A good balance between treatment and prevention was essential.

The African Group was encouraged by the efforts to make essential medicines more affordable and accessible. It had great hopes of the Commission on Intellectual Property Rights, Innovation and Public Health soon to be established.

To enter into force, the WHO Framework Convention on Tobacco Control, so far signed by 86 countries and ratified by five, needed 35 more ratifications. The African Group trusted that the Director-General would continue to lead the fight against tobacco use.

The biggest challenge of all, however, was poverty. WHO's efforts to deal with that social evil were encouraging and should be pursued vigorously.

Mr AISTON (Canada) commended the Director-General's leadership since taking office, especially in the area of HIV/AIDS. His address had outlined a daunting series of challenges and an impressive list of achievements. HIV/AIDS raised questions of health, development and human rights, and Canada supported the "3 by 5" initiative. His Government had tabled legislation allowing Canadian producers of generic drugs to export cheaper versions of patented drugs to poor countries, and would amend intellectual property legislation in response to the WTO decision in that area. National responses to HIV/AIDS must address the full continuum of care, including prevention, support and treatment. Vaccine and microbicide research and development were particularly important given the current shortage of public- and private-sector funding for those activities.

Emerging and re-emerging communicable diseases, including SARS and influenza, demanded improved national and international preparedness against global disease threats. Revision of the International Health Regulations was a key element of such preparedness and substantial progress was expected at the intergovernmental working group meeting for that purpose scheduled for November 2004. The revised Regulations and national strategies for communicable disease control should be as comprehensive and effective as possible.

Noncommunicable diseases must not be forgotten and he supported the proposed WHO global strategy on diet, physical activity and health. WHO had played a valuable role in raising the profile of mental health internationally and should maintain the momentum achieved. Tobacco control should also remain a priority, with WHO continuing to assist countries in developing their capacity to

establish national control policies. Canada was working towards ratification of the Framework Convention at the earliest opportunity. WHO should continue to give importance to sexual and reproductive health, services for which, including those for young people, should be integral components of comprehensive health care plans. Adolescent pregnancies continued to account for a disproportionate share of maternal deaths and disabilities.

He welcomed the renewed emphasis on strengthening health systems, including human resources for health, in developing countries. Attainment of the health-related Millennium Development Goals and other targets, such as those of the "3 by 5" initiative, would not be possible unless the challenges and constraints facing health systems were tackled effectively.

He urged WHO to give greater attention to measuring and evaluating the progress achieved as a consequence of activities financed by the regular budget and extrabudgetary funds. The focus on results would allow Member States to assess properly the value for money secured in the course of the Organization's work.

Mr KHAN (Pakistan), expressing appreciation for the Director-General's commitment to reforming the working of WHO, commended the new focus on the control of communicable and noncommunicable diseases, with the former, including tuberculosis, malaria and HIV/AIDS, regarded as poverty-related diseases. Most noncommunicable diseases, on the other hand, were lifestyle-related, for which the most important tool available was public health education. The inclusion of an item on health promotion and healthy lifestyles in the agenda was therefore welcome. As the subject had generated much talk but little action in the past, the Board should urge the Fifty-seventh World Health Assembly to emphasize the promotion of healthy lifestyles. He also welcomed the inclusion of the item on road safety.

The report of the Commission on Macroeconomics and Health[1] had rightly urged countries to weigh the cost-effectiveness of the services being provided, and would help Member States to persuade those in charge of funding to invest more in health as a means of promoting economic development. However, WHO would need to provide technical support to introduce the concept of macroeconomics and health in most developing countries. Pakistan had recently increased its health budget by some 30% to 35%, the first increase of such a magnitude. As stressed in the report, resources needed to be mobilized for global health promotion. Developed countries must realize that diseases recognized no boundaries, and that it was in their interest to assist developing countries in controlling communicable and noncommunicable diseases. An unhealthy world could not aspire to development or even peace.

The Global Fund to Fight AIDS, Tuberculosis and Malaria had brought real hope to the victims of poverty-related diseases. The Fund would collect, manage and disburse funds to countries with scarce resources in addition to other forms of development assistance – the "3 by 5" initiative had also raised great hopes among people with HIV/AIDS in Africa, Asia, the Middle East and Latin America. The establishment of the Fund reflected the idea of the world as a global village and the interdependence of its inhabitants.

Many Member States, including Pakistan, had already introduced poverty-reduction programmes, seen as essential to overall development. Pakistan had allocated reasonable resources to its own programme.

The importance of sustainable development and of improving the performance of health systems had again been highlighted and new guidelines proposed should help Member States to introduce further reforms. A major weakness in developing countries was managerial capacity, whose improvement would have a tremendous impact on health systems. At the Fifty-sixth World Health Assembly, Pakistan had called for increased assistance to promote good governance, health

[1] *Macroeconomics and health: investing in health for economic development*. Geneva, World Health Organization, 2001.

economics, healthy lifestyles, networking in health care delivery systems, health systems research and information technology, all of which were grey areas in most developing countries.

Pakistan had almost succeeded in eradicating poliomyelitis with less than 100 cases reported in the past two years, and expected to complete eradication by the end of 2004. It thanked all its partners for their contributions to the eradication campaign.

With regard to SARS, the need for extreme caution during the winter months, in view of the possible resurgence of the virus, could not be overemphasized. Pakistan for its part had installed control systems at its airports.

The efforts of the international community to improve health and save lives would never be completely successful, however, without peace. That, and greater investment in the health and economic well-being of mothers, would help to stabilize communities, especially in developing countries in Africa and Asia.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), speaking on behalf of the European Union, the acceding states Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia and the candidate countries Bulgaria, Romania and Turkey, said that, when the European Union enlarged later in the year, it would represent a population of 450 million; enlargement should serve to enhance the already strong relationship between the European Union, the European Commission and WHO.

In the area of communicable diseases, the outbreak of SARS had reminded everybody of the vulnerability of national health systems. He commended the setting-up of a situation room at WHO with a view to strengthening the Global Outbreak Alert and Response Network. In that context, Member States of the European Community were pursuing several initiatives, including the establishment of a centre for disease prevention and control to enhance surveillance of and reaction to threats of communicable diseases. Since effective response to disease outbreaks depended on the availability of timely and accurate information, the revision of the International Health Regulations should be finalized as soon as possible.

In actively promoting the health-related Millennium Development Goals, Member States of the European Union recognized the importance of good health in achieving other internationally agreed development goals, particularly in the field of reproductive health, and welcomed the establishment of the High Level Forum on Health, Nutrition and Population-Related MDGs, and encouraged the Director-General to give it the highest priority. However, resources needed to be increased and national health systems strengthened to enable countries to meet the targets set. In that context, the European Union welcomed WHO's commitment to shifting resources to countries. Some countries of the European Region were experiencing unacceptably high rates of mortality and morbidity. More than 1.5 million people in the Region were living with HIV, and in some parts the HIV/AIDS epidemic and tuberculosis were spreading rapidly. European Union countries therefore emphasized the need to ensure, in accordance with resolution WHA51.31, a more equitable distribution of programme resources among the regions based on a transparent assessment of need.

WHO was to be commended for the draft global strategy on diet, physical activity and health and its associated consultative process. The Council of the European Union had developed conclusions on healthy lifestyles in association with WHO and other partners. Member States looked forward to future collaboration, particularly on cardiovascular health. With regard to the report on human organ and tissue transplantation (document EB113/14), European Union ministers would shortly be adopting a new directive on standards of quality and safety for tissues and cells. The European Union fully supported efforts to speed up ratification of the WHO Framework Convention on Tobacco Control, which had already been ratified by one of its acceding States.

The European Union looked forward to continuing its close partnership with WHO.

Dr STEIGER (United States of America), in welcoming the "3 by 5" initiative, which he had helped to coordinate with his President's own Emergency Plan for AIDS Relief, expressed appreciation of the Director-General's presence in associated events in Africa around World

AIDS Day. With regard to poliomyelitis, he commended the Director-General's organization of the recent high-level meeting of countries endemic for poliomyelitis and thanked the Ministry of Health of Pakistan for its commitment to completing poliomyelitis eradication. He urged other countries endemic for the disease to make similar efforts. As the largest public-sector donor to the eradication campaign, his country remained committed to meeting the end-2005 deadline for eradication.

He welcomed the Director-General's initiative to establish a situation room; his Government would make additional resources available to complete the task in the near future. The Organization's commitment to public health preparedness was one of its most important goals.

He requested an outline of the conclusions reached and the recommendations made by management consultants on WHO's transition to new leadership, which might assist the Board in its deliberations at the current session.

Dr PASTOR JULIÁN (Spain) congratulated the Director-General for successfully blending new initiatives into WHO's traditional programme of activities in support of public health. As a Member State of the European Union, Spain supported the views expressed by Sir Liam Donaldson and his emphasis on the importance of coordinating international action to avert or reduce the constant threat to public health of outbreaks of new diseases such as SARS. In that regard, she welcomed the Director-General's initiative in establishing the strategic health information centre.

She commended the "3 by 5" initiative, particularly those aspects that promoted international cooperation in the fight against HIV/AIDS. Spain, together with France, Italy and Luxembourg, was developing a technical cooperation initiative known as the ESTHER network for therapeutic solidarity in hospitals (*Ensemble pour une Solidarité thérapeutique hospitalière en Réseau*), which would aid the transfer of the necessary know-how and technology for the appropriate use of antiretroviral drugs. She welcomed the inclusion in the agenda of the item on human organ and tissue transplantation, since international cooperation in harmonizing the laws applying to organ and tissue transplantation was essential. She also welcomed WHO's objectives in the area of maternal and child health, emphasizing the need for education of women and women's access to health services.

Professor DAB (France) said that, with the threats to public health and the enormous challenges posed by increasing globalization, there had never been so great a need for a powerful and respected WHO. He commended the Director-General's pragmatism in choosing to tackle avoidable health problems, such as those resulting from road traffic accidents; his country had also decided to deal resolutely with that scourge and to strengthen efforts to reduce the dangers to health from all other types of violence.

He also welcomed the emphasis on health problems where the means were available to alleviate considerably the suffering of populations, such as the epidemic of obesity and, in particular HIV/AIDS and WHO's resumption of leadership in that area. The WHO Framework Convention on Tobacco Control was being considered by the French Parliament and it was hoped that final adoption would follow by the summer of 2004. The Director-General's efforts to curb epidemics were also worthy of praise, even though health security should not monopolize public health considerations. He was therefore satisfied that, under the leadership of the Director-General, WHO would demonstrate its usefulness, effectiveness and authority.

Dr AL-MAZROU (Saudi Arabia) reaffirmed his country's continued support for the plans proposed by the Director-General; their objectives should be achieved through cooperation with WHO's regional offices and Member States. He recalled the Director-General's commitment to divert a larger share of resources to regional offices and Member States, about which he awaited further information. He commended the "3 by 5" initiative, expressing the hope that such treatment activities would not mask the importance of prevention, which was needed by those same countries. The Director-General's report reaffirmed the importance of both communicable diseases and noncommunicable diseases at the international level.

Cooperation in providing support to disaster victims was a fertile area for international and regional cooperation. The Gulf Cooperation Council States had actively cooperated with WHO and other international organizations in assisting victims of the earthquake in the city of Bam in the Islamic Republic of Iran, and had provided financial assistance amounting to US$ 4 million for the reconstruction of the city. Saudi Arabia had provided urgent medical support, including a field hospital.

Professor FURGAL (Russian Federation) agreed with the evaluation of the difficulties facing health systems worldwide and with the priorities that the Director-General had proposed for WHO's future activities. He confirmed his country's readiness to participate actively in that work, which should be channelled in three strategic directions. First, the Millennium Development Goals, representing the basis of its day-to-day activities, had to be considered in the development of the programme budget and turned to practical account in the coordination of efforts to combat poverty in the name of health and to improve access to medical care.

Second, his country fully supported WHO's policy of concentrating efforts at the country level. Improving the health situation at that level was the key criterion in assessing the Organization's overall success. To achieve those improvements, continued work was necessary to find the optimum method of assigning roles, competencies and responsibilities at different levels within WHO. The European Region's experience of strategic two-year agreements with Member States, within a unified programme and budget, was instructive, showing adaptation of primary health care to contemporary conditions and available technologies. Given the continued relevance of the basic principles of primary health care expressed in the 1978 Declaration of Alma-Ata, he called upon the Organization to pay even greater attention to the activities of WHO collaborating centres and WHO experts, including the review of certain regulatory provisions. That area of coordination could be further improved through the implementation of recommendations formulated jointly by the directors of WHO collaborating centres in the Russian Federation, with the active participation of WHO headquarters and the Regional Office for Europe.

Third, he was convinced that the priorities defined in WHO's programme of activities were right. He supported the measures adopted by the Organization to strengthen the combat against tuberculosis, HIV/AIDS and malaria, and welcomed the positive results being achieved. The "3 by 5" initiative was ambitious but its goals were attainable; its implementation would usefully promote the formulation and implementation of national and regional programmes to combat HIV/AIDS, in particular, and would catalyse the strengthening of health systems as a whole. He agreed, however, with previous speakers that WHO should not relax its attention to the historical and traditional areas of programme activity, notably humanitarian efforts in crisis situations and the control of communicable diseases, particularly diseases for which vaccines existed, especially measles, rubella, hepatitis B and *Haemophilus influenzae* type b infection. That approach was proving successful in the eradication of poliomyelitis. WHO should analyse which of its activities had provided the richest experiences in historical terms. This would make it possible both to define historical solutions systematically and scientifically and to make projections of future trends in different programme areas. That approach would also be of interest to Member States.

Dr YIN Li (China) said that he was honoured to have been elected as a Vice-Chairman of the Executive Board. He had listened to the Director-General's report with enormous interest: since Dr Lee had taken office, remarkable progress had been made in responding to public health crises as well as in combating HIV/AIDS.

The Declaration of Alma-Ata had articulated the fundamental role of primary health care in achieving health for all. That philosophy had become widely accepted, contributing significantly to improvement in world health. He welcomed WHO's re-affirmation and support of the core principles of primary health care.

The United Nations General Assembly at its fifty-eighth session in September 2003 had demonstrated the global commitment to contain the HIV/AIDS pandemic. WHO's "3 by 5" initiative

had brought hope to all people living with the disease, and the Organization should play a wider role within the United Nations system in combating HIV/AIDS, notably by providing technical support to Member States. He looked forward to the timely publication of *The world health report 2004* which would provide further impetus in that regard.

United Nations General Assembly resolution 58/3 concerned the enhancement of global public health capacity building. Its main purpose was to improve the public health capacity of Member States so that they were better able to combat diseases such as HIV/AIDS and malaria and thus achieve a higher level of socioeconomic development. The resolution, which had been adopted unanimously, demonstrated the importance accorded to public health issues by the international community. WHO should play a leading role in its implementation.

Turning to the recent outbreak of SARS in Guangdong Province, he reported that three cases had been identified. Evidently, the disease was still a threat and China attached great importance to its control, providing timely treatment to the affected patients and placing their close contacts under quarantine. He emphasized that, thus far, no secondary cases had been detected and effective measures had been taken to prevent further spread of the disease. WHO and the international community had been informed of the outbreak as quickly as possible. China thanked WHO for its technical support.

Noting that some Board members had suggested revisions to the current agenda after it had been adopted, he pointed out that such incidents should not be deemed to set a precedent. In future, amendments should be made only before the adoption of the agenda.

Dr ACHARYA (Nepal) recalled that the discussions during the retreat for members of the Executive Board in Accra (November 2003) had included the country focus initiative. That initiative, together with an effective and continuous monitoring system, was urgently needed to support health care systems in South-East Asian countries, particularly in Nepal. It warranted serious attention, but had not been mentioned in the Director-General's report.

Nepal supported the "3 by 5" initiative launched in December 2003. While it would provide great relief, not all people with HIV/AIDS might be willing to undergo the continuous testing required if treatment were to be successful. In the meantime, WHO should not lose sight of the ultimate goal of developing a vaccine and conducting research on curative drugs. He asked what was being done in those directions.

Dr DAYRIT (Philippines) expressed appreciation for WHO's strong leadership, particularly in the areas of SARS, eradication of poliomyelitis, HIV/AIDS, tuberculosis and malaria. Working closely with the Regional Office for the Western Pacific and the country's WHO Representative, the Philippines had been able to keep its people well-informed on the measures taken to combat and to contain the re-emergence of SARS.

Although supporting the Director-General's commitment to increase the proportion of funds distributed to the regions and to Member countries, he pointed out that, during the previous five years, that Regional Office had contributed significantly to the reallocation of funds, perhaps to the detriment of its own operations.

He highlighted the continuing interest in health systems, as reform was badly needed to make operations more effective. He noted with satisfaction the inclusion in health systems performance of primary health care, reintegration of systems and health workforce issues.

Combining WHO's leadership with the necessary resources and efficient disbursement systems would sharpen the focus on health problems, and WHO should undertake meaningful evaluations at all levels in order to focus health initiatives better, to take new directions and to utilize resources cost-effectively and efficiently.

Dr TAG-EL-DIN (Egypt), expressing appreciation for the initiatives and the important topics addressed by the Director-General, said that revision of the International Health Regulations should take into account the capacities of and support for the developing countries as well as promoting international cooperation and coordination under the auspices of WHO. The rapid worldwide spread of

diseases attested to the importance of cooperation with WHO and the need for international coordination. The success of the "3 by 5" initiative to expand treatment to three million HIV/AIDS patients would demonstrate the will of the international community to eliminate suffering in countries that were unable to provide medication and care. It was to be hoped, therefore, that the initiative would increase the limited capacity of the Global Fund to Fight AIDS, Tuberculosis and Malaria. In view of the new health problems, diseases other than AIDS, such as tuberculosis, malaria and hepatitis, should not be forgotten, since they still posed a threat to millions of people worldwide.

With regard to poliomyelitis, the intense national campaigns in which WHO and other institutions had played a role had been extremely effective. Egypt's national campaigns had been tremendously successful; only one single case of poliomyelitis had been recorded in 2003. The attainment of the goal of eradicating poliomyelitis worldwide, likely in the very near future, with its associated international cooperation would show that many of the diseases threatening mankind could be overcome.

The WHO medicines strategy 2004-2007 and its relation to economic and social factors, globalization and the capacities of local health systems, and their ability to deliver both drugs and the necessary medicines, preventive materials and vaccines, were clearly linked to the subject of intellectual property rights. The 2001 Doha Declaration on the TRIPS Agreement and Public Health should be respected when applying, evaluating and interpreting the international trade agreement. There must be easy access to medical treatment in general and to medicines in particular for anyone, anywhere in the world, who needed such care and not only for those who could afford it. One of the noble objectives for which the Organization was striving was the ability to deliver drugs reasonably and affordably, while not relinquishing intellectual property rights. Compulsory licensing under the Agreement on Trade-Related Aspects of Intellectual Property Rights should be used to that end. At the same time, resolution WHA56.27 on intellectual property rights, innovation and public health was important; he looked forward to progress in the practice and implementation of that resolution. Given the scale of the problems to be confronted, both basic and additional resources should be devoted to major health problems.

He endorsed Pakistan's statement about the need for peace. He stressed the importance of the role of WHO, in conjunction with the international community, in mitigating difficult circumstances and curbing suffering caused by ill health among people in areas of conflict such as the Palestinian people in the occupied territories.

Mr GUNNARSSON (Iceland) said that health problems around the world required attention and investment on a scale that could not have been imagined 20 years previously. There was a discrepancy between the increasing burden of global disease and the attendant economic and social consequences of noncommunicable diseases on the one hand and the inadequate attention given to their prevention, particularly in developing countries, on the other. Noncommunicable diseases had a major impact on health economics as, once developed, they were both costly and difficult to treat.

He fully supported the "3 by 5" initiative. HIV/AIDS was the most difficult existing health problem and its defeat would require WHO's technical knowledge and political skills. He welcomed the Director-General's words on healthy lifestyles and on reproductive health: he looked forward to progress in both areas, which were of great importance to his country.

Dr BOSHELL (Colombia) said that he regretted having missed the retreat hosted by Ghana: he would have liked to comment further on the issue of human organ and tissue transplantation, further consideration of which had been supported at the 112th session of the Board.[1]

Congratulating the Director-General on his report and proposals, he supported the focus on sexual and reproductive health, as that was a fundamental and priority issue for his government. The draft strategy to accelerate progress towards the attainment of international goals and targets relating

[1] See document EB112/2003/REC/1, summary record of the second meeting.

to reproductive health[1] would be of crucial assistance to Colombia in encouraging multilateral cooperation to combat the increase in cases of HIV infection, teenage pregnancies and maternal mortality which aggravated the poverty of many women, particularly among populations displaced by violence. Colombia had been one of the first countries to adopt the measures recommended in the *World report on violence and health*[2] which showed clearly how violence could be diminished. He therefore requested the Director-General to continue to support the initiative strongly.

Dr AL-JARALLAH (Kuwait) thanked the Director-General and the Regional Director for the Eastern Mediterranean for having provided assistance to the Islamic Republic of Iran following the terrible earthquake in the city of Bam. Their rapid action had been appreciated also during the war to liberate the Republic of Iraq from the former regime; Kuwait had also played a role in providing prompt assistance and medical help to the towns in the south of the country. Drugs and testing equipment had been sent to Basrah within less than 24 hours of WHO reporting the possibility of an epidemic in that area. He also thanked WHO for the support given to the Palestinian people. He stressed the importance of improving health and of combating the major diseases which continued to threaten all countries. He supported Pakistan's observations that peace was the cornerstone of development and that the areas of violence and conflict were those also suffering from poverty, declining rates of development and, consequently, deteriorating health circumstances. If health services were to be improved, attention would have to be devoted to peace initiatives in those inflamed areas of the world.

Dr YOOSUF (Maldives) welcomed the introduction of the "3 by 5" initiative, but pleaded that the interests of countries with low prevalence of HIV/AIDS should not be neglected and that support should be given to strengthening prevention techniques and care for people with HIV/AIDS in those countries. In that respect, Canada's efforts to improve the availability of low-cost antiretroviral and generic drugs were much appreciated.

The establishment of the strategic health information centre was a good idea so long as Member countries were able to gain swift access to up-to-date information in times of crises, particularly where decisions related to international travel had to be made in a hurry. The recent Geneva Declaration for the Eradication of Poliomyelitis was a forceful reminder of the support that was still required if that crippling disease were to be eradicated as planned and on target.

Dr OSMAN (Sudan) agreed with the member for Pakistan that peace was an essential pillar of any successful health initiative. He therefore thanked the United States, in particular, for its initiatives that had contributed greatly to the re-establishment of peace in Sudan after 20 years of war. Sudan was receiving substantial help from both the international community and WHO, in particular the Regional Office for the Eastern Mediterranean, in devising strategies for delivering health care. His country might provide an inspiration to other war-torn countries and he called on WHO to promote peace as an essential prerequisite for health.

Mr SEADAT (Islamic Republic of Iran)[3] expressed his country's appreciation for WHO's timely and effective assistance following the recent earthquake in Bam. The Organization's continuing presence in the devastated region would be invaluable in ensuring that the present and future health needs there were tackled in a sustainable way.

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[1] Document EB113/15 Add.1.

[2] Krug EG et al. (eds). *World report on violence and health*. Geneva, World Health Organization, 2002.

[3] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Mr PEREIRA MIGUEL (Portugal)[1] endorsed the statement made on behalf of the European Union. Portugal greatly appreciated WHO's support and, in particular, had benefited from its collaboration with the Regional Office for Europe in developing its new national health strategy.

It had been an honour for his country to host the third intergovernmental preparatory meeting for the Fourth Ministerial Conference on Environment and Health to be held in Budapest in June 2004, which, it was to be hoped, would lead to the adoption of a declaration and a European action plan for children's health and environment. Portugal had also ratified the WHO Framework Convention on Tobacco Control.

Ms MAFUBELU (South Africa)[1] also endorsed the statement made on behalf of the African Group. It was to be hoped that the countries that the Group represented would continue to receive financial and other support. For their part, they would strive to ensure that the situation in their countries improved for the sake of future generations.

The DIRECTOR-GENERAL thanked the Board for its comments, noting that the praise given extended to all those involved. Responding to a question on the management consultants' report, he recalled that it had been supported by the Bill and Melinda Gates Foundation and had examined certain managerial aspects of WHO's work, in particular, decentralization, human resources and administrative practices. The report was useful in that it provided a fresh perspective on the Organization's work but was intended primarily as a reference work and its recommendations should not be regarded as binding; it would be made available to interested members of the Board.

The report on the Executive Board retreat would be discussed under item 7.6.

Several members had made valuable comments on numerous subjects which would be taken up later in the session. Responding to points that had been raised by many members, he said that the "3 by 5" initiative was designed to tackle the problem of HIV/AIDS in a comprehensive manner. If nothing were done, more than 27 million people in Africa and 50 million people worldwide would die because of HIV infection within 5 to 10 years. Furthermore, many countries were losing key workers, such as teachers and doctors, on a potentially disastrous scale. Whole generations were affected. Systems needed to be improved as well as those infected being treated. In Uganda, effective leadership, increased awareness and changes in behaviour had all contributed to a reduction in prevalence, as much as the provision of antiretroviral treatment. In Europe and North America, a combination of antiretroviral treatment and behavioural changes had changed HIV/AIDS from a fatal into a chronic disease. The "3 by 5" strategy had not been created in a vacuum but was designed to complement the actions of UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria, which currently amounted to about US$ 4000 million. The President of the United States of America had also pledged US$ 15 000 million over the next five years. The disease was spreading at an alarming rate and effective action must be taken. In his view, the economic and social effects of the pandemic had been underestimated.

WHO had been very active in dealing with the most recent cases of SARS and had sent teams to Guangdong and Taiwan, China. The international community should see SARS as an example of one among other possible emerging diseases and recognize the need for a system based on cooperation to deal with the potential problem. To that end, progress was being made in revising the International Health Regulations. The strategic health information centre had been established and would become fully operational in May 2004. The latter had greatly benefited from the financial support and technical expertise contributed by the United States of America.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Two members had drawn attention to the need to address the regular budget allocations to the African and European Regions; that subject would be discussed further by the Board. The extrabudgetary component currently exceeded the regular budget and the Organization needed to consider the allocation of the total budget.

The meeting rose at 12:45.

SECOND MEETING

Monday, 19 January 2004, at 14:10

Chairman: Dr K. AFRIYIE (Ghana)

TECHNICAL AND HEALTH MATTERS: Item 3 of the Agenda

Revision of the International Health Regulations: Item 3.1 of the Agenda (Resolution WHA56.28; Document EB113/3 Rev.1)

Dr OM (Republic of Korea) expressed appreciation of the progress made in the revision of the International Health Regulations. Recent public health emergencies, such as the outbreaks of severe acute respiratory syndrome (SARS) and avian influenza, had shown that communicable diseases could spread quickly because of the growth in tourism. WHO should strengthen its consultancy and technical assistance services to help Member States to reinforce their surveillance systems, and should intensify the joint efforts being made with its partners so that the new Regulations could be submitted to the 115th session of the Executive Board and later to the Fifty-eighth World Health Assembly.

Dr AL-MAZROU (Saudi Arabia) said that the revision of the International Health Regulations was of capital importance for various reasons. First, international travel was quick and easy. Second, new strains of viruses and previously unknown bacteria were appearing; there were currently no diagnostic tests or treatment for infection with them. Third, some countries failed to give prompt notification of outbreaks of such diseases, and consequently failed to deal with them. Saudi Arabia received pilgrims from many parts of the world every year, and therefore had a responsibility to ensure that all epidemics were handled with transparency, in order to protect its citizens and those of other countries from exposure to risks resulting from the transmission of pathogens outside its borders.

The definition of public health within the framework of the new Regulations had given rise to differing interpretations. At its fiftieth session, the WHO Regional Committee for the Eastern Mediterranean had recommended the following definition: "... the science and art of promoting, protecting and/or restoring the physical, mental and social well-being of people through prophylactic, diagnostic, therapeutic and rehabilitative measures applied to human beings and their environment". That definition should be considered by the intergovernmental working group on the revision of the International Health Regulations.

Professor DANG DUC TRACH (Viet Nam) said that, in view of the danger of the global spread of diseases such as SARS and avian influenza, the process for the revision of the International Health Regulations should be accelerated. He asked whether it might be possible to bring forward the dates for the meeting of the intergovernmental working group on the revision of the Regulations.

Dr YIN Li (China) agreed that the re-emergence of known communicable diseases and the emergence of new ones made revision of the International Health Regulations urgent. The global outbreak of SARS in 2003 had demonstrated that the current Regulations fell short of requirements, and they should be revised in an open and transparent process, with maximum participation by Member States. WHO should ensure broad participation in the intergovernmental working group by including observers as well. He endorsed the timetable proposed.

Dr AL-JARALLAH (Kuwait), noting that the current International Health Regulations were out of date, said that countries in the Eastern Mediterranean Region attached great importance to the revision process, and were therefore proposing a new definition of public health. It was to be hoped that the Board would consider that definition.

Mr AISTON (Canada) said that the International Health Regulations were a key component of Canada's approach to the management and containment of communicable diseases, and also central to the role and function of WHO. The approach proposed was good: while a case could be made for accelerating the process, revision required careful consideration and the timetable put forward was therefore probably realistic. Having been a participant in the negotiations on the WHO Framework Convention on Tobacco Control, he suggested that the process should be concluded in one or two negotiating sessions at most. Canada was preparing a domestic approach to the revision of the International Health Regulations and would keep WHO informed of developments.

Mr KHAN (Pakistan) said that the International Health Regulations were an important means of controlling the spread of communicable diseases across borders. There was an urgent need to ensure global health security at a time when the threat of infectious disease was re-emerging. New threats to health had to be taken into account, namely those arising from the deliberate use of agents for bioterrorism and from the substantial growth in international travel and trade, which provided greater opportunities for communicable diseases to evolve and spread.

Pakistan wished to participate in all committees and intergovernmental working groups established for the revision of the International Health Regulations, and to be kept informed and consulted on all technical issues relating to that revision. The arrangements made by WHO for the revision were satisfactory; involving all stakeholders was a step in the right direction.

He endorsed the definition of public health quoted by the member for Saudi Arabia, which was of great relevance in the context of intellectual property rights as applied in public health emergencies.

Professor FURGAL (Russian Federation) said that in general he supported the arrangements made for the revision of the International Health Regulations. The system for early reporting and notification of communicable diseases had been improved, as evidenced during the SARS epidemic. The proposed broad consultations should lead to a consensus among Member States and international organizations and provide a sustainable basis for successful implementation of the new Regulations, thus ensuring maximum protection against the spread of infectious diseases with the least possible impact on the movement of people and goods.

He shared, however, the concern expressed about the timetable for the consultations, which did not take sufficient account of the need for careful and detailed consideration of the issues by Member States before the regional consultations. More work also had to be done at country level, both to improve national surveillance systems and to ensure they were in line with the revised Regulations. Establishing links between surveillance systems was the only way of ensuring effective global action.

Dr MARTÍN MORENO (alternate to Dr Pastor Julián, Spain) said that his country was closely following the progress being made in the revision of the International Health Regulations, as international cooperation, joint development of strategies, collaborative research, and exchanges of experience were essential if global threats to health were to be overcome. Recent events such as the SARS epidemic and the outbreak of avian influenza had highlighted the limits of the current Regulations.

Spain welcomed initiatives such as the establishment of a European centre for disease prevention and control, and the advances made by WHO in coordinating alerts in different regions and countries. It endorsed the schedule proposed for revision of the Regulations, which should include intensified consultations at regional and global levels. The aim should be to provide Member States with a practical tool for responding effectively to global public health challenges.

Dr STEIGER (United States of America) said that the successful revision of the International Health Regulations was one of the most important tasks for the Director-General. In particular, the term "public health emergency of international concern" should be improved, and the Regulations should include a list of known communicable diseases with the potential to spread rapidly around the world and an algorithm for use by WHO in issuing alerts. He agreed with the member for the Russian Federation that the revision process would require extensive consultation. A mechanism should, therefore, be developed whereby Member States could provide input for the revised text before the regional consultations, and be able to see each other's textual comments in advance. Document EB113/3 Rev.1 did not explain how governments' comments and the outcome of the regional consultations would be incorporated into a second revised draft for consideration by the intergovernmental working group. That point was crucial because many governments had neither the funds nor the time for protracted negotiations.

Mr GUNNARSSON (Iceland) pointed out that the main aim of the revision process was to update the provisions adopted in 1969, which constituted the only legally binding set of regulations covering global alert and response to infectious diseases. Their purpose was, and would remain, to ensure maximum security against the international spread of disease with a minimum impact on world trade and travel. The SARS outbreak had highlighted the principal challenges to be met in revising the Regulations to ensure that they satisfied contemporary needs for surveillance and control of all public health emergencies of international concern, not only those involving cholera, plague and yellow fever. The process was clear and simple and it should therefore be possible, with good cooperation and coordination, to conclude it in a short space of time.

Dr CAMARA (Guinea) said that the International Health Regulations were extremely important. Their revision should be dealt with expeditiously and take account of the concerns of individual countries and of the nature of their health systems.

Dr SÁ NOGUEIRA (Guinea-Bissau), referring to paragraph 5 of the report, emphasized that all countries and institutions working in the field of public health should take part in the revision process. Not only would provision have to be made for implementation of the revised Regulations, but consideration would have to be given to national health structures, ensuring that these were adequate for the purpose. He endorsed the arrangements made for the meeting of the intergovernmental working group.

Ms WHELAN (Ireland),[1] speaking on behalf of the Member States of the European Union and of the acceding States (Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia), said that the emergence of SARS and avian influenza had served as a strong reminder of the ever-present threat of communicable diseases, and of the need for the effective protection of public health. The European Union looked forward to the early finalization of the International Health Regulations, and welcomed the availability of a revised draft to all Member States and interested parties. The importance of the revised Regulations was reflected in the urgency the Health Assembly attached to securing their adoption in 2005. A heavy onus had been placed on WHO to provide Member States with documentation in a timely manner, and the revised draft should be made available on the WHO web site for ease of reference before the negotiations later in the year.

The European Union supported the convening of the intergovernmental working group in November 2004 and would cooperate to ensure the success of its work. The negotiations would be complex, since the subject covered not only public health but also international trade, travel, border controls and global health security. Recognizing that the revised Regulations would affect not only individual Member States but the European Community as a whole, European Union health ministers

[1] Participating by virtue of Rule 3 of the Rules of the Procedure of the Executive Board.

had adopted a Council Decision mandating the European Commission to negotiate on behalf of the European Community the revision of the Regulations on matters within the Community's field of competence.

Timely and successful completion of the revision process would depend on a full and continuous flow of information, and the European Union was therefore anxious that all possible information was available to WHO Member States, the European Commission and all interested parties to ensure a successful outcome within the tight timeframe proposed.

Dr FUKUDA (Japan)[1] agreed that the SARS outbreak had underlined the importance of the revision of the Regulations, which should not be delayed. Countries should be given sufficient time for consultation, and national measures should be linked with the Regulations where necessary. Not only institutions dealing with infectious diseases but also other bodies concerned, such as trade ministries, should be informed about the new Regulations.

The revision process had technical and political dimensions. The political aspect should never be allowed to distort technical discussions, and should be minimized to the extent possible. Regional consultation was an effective means to achieve consensus, and in order to expedite the process, overall direction rather than detailed wording should be discussed at that level.

Mrs LAMBERT (South Africa)[1] supported the revision of the Regulations, which was long overdue. The Regulations should not specify particular diseases, but should provide a focus for all public health emergencies, including, but not limited to, communicable diseases. Her country looked forward to the regional consultations and the meeting of the intergovernmental working group, and she called on WHO to ensure the full participation of developing countries. The informal involvement of regional organizations such as the Southern African Development Community and the African Union should also be considered, because intercountry cooperation at regional level was essential. The additional resources that certain developing countries would require to ensure full implementation of the Regulations should also be taken into consideration.

Dr ANGOT (Office International des Epizooties), speaking at the invitation of the CHAIRMAN, said that his organization, which dealt with problems associated with communicable diseases, in particular zoonoses, and also with food safety in collaboration with the Codex Alimentarius Commission, was keen to participate in the revision process. Duplication should be avoided between the Regulations and the OIE International Health Standards that had been adopted by his organization's 166 Member States and recognized by WTO as reference standards for international trade.

Mr PELEGRIN (European Commission) welcomed the cooperation between the Commission and WHO, and in particular the shared commitment to the control of the spread of communicable diseases at the international level. Several important areas to be covered by the proposed new Regulations fell within the scope of existing Community legislation, and the European Commission had been authorized to negotiate on behalf of the European Community on those matters falling within the latter's field of competence. As a regional economic integration organization, the European Community intended to participate fully in the meeting of the intergovernmental working group and in the European regional meeting to be held in June 2004.

Final discussions were taking place for the adoption of a Community regulation establishing a European centre for disease prevention and control. The centre would substantially reinforce current measures for the control of communicable diseases in Europe, and would underpin the synergies between WHO and the European Community. It would also have an important role to play in the effective implementation and enforcement of the revised Regulations, and would help to strengthen

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

international cooperation against health threats, in particular under the auspices of WHO's Global Outbreak Alert and Response Network.

Dr ASAMOA-BAAH (Assistant Director-General) said that it was the Secretariat's understanding that, although members did not want the revision to be protracted, the process should provide for the meaningful participation of all stakeholders and adequate discussion at country level. Specific issues had been raised, such as the definition of public health and of a public health emergency of international concern, and the need to pay greater attention to national capacity building.

Mr AITKEN (Director, Office of the Director-General), responding to the questions raised, said that comments on the revised first draft, which it was hoped would be received shortly, would be consolidated before the regional consultations, posted on the web site and circulated in a document. After the regional consultations, a revised version of the text would be prepared indicating where the major differences lay. Countries would have an opportunity to comment on that revised text, and those comments would then be consolidated before the meeting of the intergovernmental working group.

Dr ASAMOA-BAAH (Assistant Director-General), outlining the situation with respect to SARS, said that there had been a few confirmed cases since the interruption of the human-to-human transmission of the SARS virus had been declared in July 2003: two had resulted from laboratory accidents in Singapore and in Taiwan, China, and the others had occurred in the Guangdong province of China. Although none of those cases had been fatal nor had there been amplification of transmission in health facilities, the outbreak had confirmed some of the predictions made the previous year; namely that in the influenza season there would be some confusion in distinguishing SARS from other respiratory illnesses, and that – given the large number of samples in laboratories, health facilities and research institutes – the risk of a laboratory accident was real. As SARS was a relatively new disease, the strategy was to keep levels of vigilance high, while intensifying work on laboratory safety, animal studies, vaccine development and research in order to attain a better understanding of the disease.

The five confirmed cases of avian influenza, some of which had been fatal, were of great concern to WHO: not only had several countries been affected by avian influenza and SARS simultaneously, but also the virus was highly pathogenic, and a global pandemic might be beginning. Beyond the usual global efforts undertaken to control the disease in birds and human beings, international action was being intensified to achieve a better understanding of the disease; to assess the risk to human health; to update and produce diagnostic tests; and to begin work on a candidate vaccine. A consultation would be held the following week to begin discussion on clinical trials. Furthermore, a letter would be sent to countries requesting them to step up their surveillance not only for suspected cases but also for any deaths from respiratory diseases of unknown origin.

Dr OMI (Regional Director for the Western Pacific) said that on 5 January 2004, WHO had been informed by the Government of Viet Nam that 12 people with a severe respiratory illness, associated with high levels of mortality, had been admitted to hospital in Hanoi. The Organization had promptly provided the Vietnamese health authorities with advice on diagnostic investigation. On 11 January, the presence of *Influenzavirus A* subtype H5N1 had been confirmed by an external influenza reference laboratory; five patients had so far been confirmed to have the virus and all had died. FAO and the Office International des Epizooties had been informed at the country and regional levels. WHO had subsequently received confirmation through FAO of suspected outbreaks of avian influenza in the south of Viet Nam. Two experts, including the Regional Adviser in Communicable Diseases, had already been despatched to Viet Nam to assist in investigating the epidemiology of human cases, and WHO veterinary experts had also recently arrived. Officials from WHO, FAO and the Vietnamese Ministry of Agriculture and Rural Development had already arrived in south Viet Nam, and a large team of WHO experts assembled by the Regional Office and headquarters was ready to be despatched. WHO had provided supplies and equipment, including personal protection

equipment, for those with occupational health risks. Guidelines for the protection of people involved in the slaughter of chickens had been drawn up, and other guidelines, including those for infection control in settings under surveillance, were in the final stages of preparation. A strategic framework had been established to link partner organizations, and WHO would continue to work with the Vietnamese health authorities and other Member States to enhance surveillance and preparedness.

The CHAIRMAN said that, in the absence of any objection, he took it that the Board agreed with the arrangements being made to convene the intergovernmental working group in the first half of November 2004.

It was so agreed.

HIV/AIDS: Item 3.2 of the Agenda (Resolution WHA56.30; Document EB113/4)

Dr CHOW (Assistant Director-General), introducing the report, said that after only two decades the annual death toll from HIV/AIDS currently stood at three million, and that without immediate, concerted and effective action communities, countries and societies would continue to be devastated. The strengthening of WHO country and regional offices lay at the core of action to support countries in mounting national responses. Recent advances in reducing pharmaceutical and diagnostic prices, and lessons derived from the experiences of countries such as Brazil, Kenya and Thailand, had shown that it was feasible to provide large-scale treatment for AIDS in developing countries and countries with economies in transition. WHO was committed to ensuring the success of the efforts of other major partners in combating HIV/AIDS, enabling those benefiting from the Global Fund to Fight AIDS, Tuberculosis and Malaria to implement their projects as soon as possible.

The strong support of countries and institutions such as the World Bank for the "3 by 5" initiative was appreciated. WHO would collaborate closely with UNAIDS and other bodies in the United Nations system to provide support to AIDS-stricken regions. Together, it should be possible to stem the tide of the devastating pandemic and provide the sustained development necessary for improving public health and health systems, with the additional aim of defeating tuberculosis and malaria, the annual death tolls of which equalled that of HIV/AIDS.

Dr SAMBA (Regional Director for Africa) said that the "3 by 5" initiative was the best news Africa had received for a long time, bringing hope after years of famine. However, the menu that the initiative represented needed to be turned into a meal as soon as possible, and fast delivery was essential. In Africa, which was the epicentre of the pandemic, the initiative faced several hurdles: promises of support had yet to be realized and the many partners in the fight against AIDS required coordination if targets were to be reached without delay. Moreover, the initiative relied on proactivity and pragmatism, qualities not often found among the bureaucrats who staffed organizations. Bureaucracy had to be minimized because the sick and suffering could not wait.

Dr FEACHEM (Executive Director, Global Fund to Fight AIDS, Tuberculosis and Malaria), congratulating the Director-General on his leadership in the fight against AIDS and, in particular, his launching of the "3 by 5" initiative, said that the Global Fund strongly supported that initiative in the belief that the world needed and was ready for a massive expansion of access to and the use of antiretroviral therapy. The Fund was working closely with WHO, UNAIDS and other partners to achieve the initiative's goals, and was one of the four major funders alongside the World Bank's Multicountry HIV/AIDS Program, the Emergency Plan for AIDS Relief proposed by the President of the United States of America, and individual countries which were contributing substantial amounts.

To maximize the usefulness of the Fund's contribution, programmes already approved by the Fund in the first three rounds had to be redesigned in order to allow more people to be treated. For the initiative to succeed it was essential to ensure that ambitious and high-quality proposals for wider antiretroviral treatment were submitted in round four; decisions on funding would be taken in

June 2004 and money would start to flow in September 2004. The Fund would work closely with WHO, UNAIDS and other partners to encourage countries to submit such proposals. It would likewise call on its donors to ensure that the Fund was financed to the level of at least US$ 1000 million for round four. To assist applicants, the Fund and WHO had commissioned a costing tool which would be available in early February on the Fund's web site; one feature would be a model completed application.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the report showed that, notwithstanding some pledges, the international community had not attained the objectives set for 2003 in the Declaration of Commitment on HIV/AIDS. The current level of resources devoted to AIDS was such that probably fewer than one million persons in the developing world would be able to obtain treatment by the end of 2005, in other words one sixth of those who actually required it; this, despite the fact that the Health Assembly in resolution WHA56.30 had recognized that access to antiretroviral treatment was vital to an effective health-sector response to HIV/AIDS. WHO, having pinpointed the impact of poverty and in an attempt to assist the most vulnerable, had set itself the target of providing effective antiretroviral treatment to three million persons in developing countries by 2005. In fact, a concerted effort should be made to reach the six million people actually requiring therapy. The Regional Director for Africa had been right to condemn the bureaucracy that prevented resources reaching the sick and needy quickly. Donors should be urged to cooperate with countries that were unable to devise the requisite projects, so that those countries would be able to ensure that resources reached the people in greatest need. The initiative should be a means of strengthening health systems, including preventive services, because prevention and health promotion should not be sacrificed for the sake of curative activities. An evaluation of the results of the "3 by 5" initiative in countries and regions should be presented to a future Health Assembly.

Dr KEBEDE (Ethiopia) commended the efforts of the Director-General in the demanding task of combating the HIV/AIDS pandemic. WHO's main role would be to provide advocacy and technical support, but the care and curative elements of the initiative would require direct funding. It was not clear whether the resources required would be additional to or part of the sums already pledged, or to the Global Fund, and he was therefore concerned about possible duplication of effort.

Mr AISTON (Canada) welcomed the substantial progress made by WHO and its partners in laying the groundwork for achieving the "3 by 5" target. The leadership of WHO had catalysed action in facilitating access to treatment. The initiative had supplied a valuable framework for stronger Canadian engagement in the global response. Canada would contribute up to Can$ 100 million over a five-year period to strengthen African-led programmes for the care, treatment and support of people with AIDS and the prevention of HIV infection. Initial contributions of up to Can$ 35 million would go to Mozambique and the United Republic of Tanzania. His country was also tabling legislative changes that would permit the export of Canadian-made generic versions of medicines patented in Canada. The Government was already working with governments of many developing countries with a view to supplying technical resources and assistance with strengthening health systems, surveillance, monitoring and facilitating an integrated, comprehensive response that did not promote treatment at the expense of the equally essential components of prevention and support.

The Organization should continue to strengthen collaboration at all levels with international agencies and national governments in order to implement the "3 by 5" strategy. It should ensure that human rights became a cross-cutting theme and that consistent attention was paid to gender equality; dealing with stigmatization and discrimination would become even more essential.

Canada commended the Organization's consistent attention to expanding access to antiretroviral treatment while retaining a focus on a comprehensive response embracing prevention and treatment. It was also vital to maintain the impetus of research into new means of prevention, including vaccines and microbicides, while sexual and reproductive health was an equally important subject in the battle against HIV/AIDS.

Dr KASSAMA (Gambia) said that his country endorsed the "3 by 5" initiative, which had been launched because of a lack of global access to antiretroviral treatment. He pointed out that only about 400 000 of the five to six million people in the developing world who needed such treatment, including only 100 000 (or 2%) in Africa, were receiving antiretroviral drugs. The aim of "3 by 5" was to improve that coverage by the end of 2005. For that reason his country and others warmly welcomed the initiative, which was designed to support, improve and complement existing programmes in countries within a framework of strong partnership. In Latin America and the Caribbean, partnership and coordination already existed and, as a result, coverage with antiretroviral drugs was somewhat higher than in Africa, where help was required to coordinate players and partners, especially in providing treatment and care. The effort would be more homogeneous and better coordinated if WHO took the lead in encouraging all players to work together, otherwise parallel systems could arise leading to confusion and reducing the impact of the initiative.

Dr CAMARA (Guinea), noting the devastating effect of AIDS globally, commented that sub-Saharan Africa was the poorest area of the planet, where people with HIV/AIDS could not pay for their treatment; millions of people had no access to antiretroviral drugs. He too noted that such treatment reached only a very small proportion of HIV-infected people in developing countries generally, and sub-Saharan Africa in particular. That situation jeopardized both action to alleviate poverty and the attainment of the Millennium Development Goals, especially the reduction of maternal, infant and child mortality. For that reason, a preventive strategy making treatment accessible to those needing it most was vital, and the "3 by 5" initiative was most welcome. Basic health structures had to be included in the fight against AIDS, malaria and tuberculosis, yet ethical problems remained. Advice from WHO on how a choice could be made among patients would be welcome. The sustainability of such a decision after 2005 was a further concern. He congratulated WHO on playing its rightful role in the battle against AIDS, and Canada for deciding to place generic medicines on the market and offer technical assistance to countries in need.

Mr GUNNARSSON (Iceland) said that the fight against HIV/AIDS must be intensified by preventing new infections as well as by treating people already infected, and the "3 by 5" target was therefore to be commended.

It was much easier to provide short-term drug therapy for tuberculosis than long-term drug treatment for HIV infection: resistance of HIV to drugs was already a substantial problem in developed countries, and was likely to be a huge problem in the developing world within a few years if delivery was inadequate. Drug delivery had to go hand in hand with a functioning health-care infrastructure and prevention had to be linked to treatment, since effective treatment would facilitate preventive measures. The "3 by 5" initiative was only the beginning, as every year three million people died from the disease and five million people became infected with HIV.

Mr KHAN (Pakistan) said that WHO's strategy was aimed at strengthening the Member States' ability to mobilize equipment and technical resources to combat the epidemics of HIV/AIDS and sexually transmitted infections and enhance individual and community efforts. There should be a special focus on young people, in order to reduce their risk, and to ensure that those affected recognized their infection status and had access to comprehensive and integrated care services. With reference to antiretroviral drugs, the word "treatment" was liable to cause confusion – although they served to enhance and prolong the life of patients, they were not in themselves a cure; preventive treatment required a focus on changes in lifestyles.

In countries such as Pakistan, where the prevalence of HIV/AIDS was low, it was especially important to raise awareness, notably through political advocacy. All countries should regard prevention as a key element, taking legislative and other measures to ensure the safety of blood transfusions and the use of disposable syringes. Political measures should include a focus on vulnerable groups, and women in particular should be warned about, and protected against, promiscuous men. The task was perhaps more difficult in Islamic countries, but television campaigns

could be effective, and freedom from HIV infection could be cited as an attribute in prospective bridegrooms. Accurate data were essential to effective policy formulation, and he agreed with the Regional Director for Africa that bureaucratic procedures should be curtailed.

Developing countries with the capacity to produce antiretroviral drugs should be given the opportunity to produce them locally, and the question of patents should be reviewed, since the true objective was the saving of lives, not economic benefit.

Dr DAYRIT (Philippines) noted with satisfaction that the "3 by 5" strategy was part of a comprehensive response, as indicated in the report. The prevalence of HIV infection in the Philippines, although relatively low, was growing, and with it the need for affordable antiretroviral treatment. The Philippines was keen to know how such drugs could be made more accessible. He appreciated the explanation of how the Global Fund could help countries to acquire resources for antiretroviral treatment, and would like to learn what other mechanisms could be tailored to meet the needs of countries such as his own.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) welcomed the report and endorsed the comments made on behalf of the European Union. He also welcomed the scaling-up of measures to make HIV treatment equitable and focused. His country would encourage greater priority to be given to women's access to treatment and, as a general principle, the recognition of reproductive and sexual rights as an essential element in any comprehensive response. He supported WHO's efforts to promote full integration of the "3 by 5" strategy with countries' own development plans. In that strategy, the work of WHO and UNAIDS should be complementary; WHO's normative role was especially important, whereas the mandate of UNAIDS was to coordinate the efforts of all partners, not simply those of the United Nations family, at country level.

In 2004, his Government would produce a new strategy on HIV/AIDS, embracing other countries and the international system. As a first step, in December 2003 it had issued a call for action, appealing to the international community to intensify its efforts. It welcomed the Director-General's leadership in combating HIV/AIDS, and supported all other efforts to that end, including those of UNAIDS and the Global Fund.

Professor DAB (France), noting that HIV/AIDS was an avoidable condition for which effective treatment was available, said that a situation in which only rich countries could offer their peoples effective preventive services and medicines was unacceptable, medically and socially – a view held by the European Union and, undoubtedly, by all Board members. France, currently the second largest contributor to the Global Fund, welcomed the "3 by 5" strategy, and supported its basic principles especially that of treatment free of charge, as the President of Senegal had recommended at the sixth Home and Community Care Conference for People Living with HIV/AIDS (Dakar, 9-12 December 2003).

One prerequisite for success would be the availability of competent health personnel. In 2001, France had adopted the ESTHER network for therapeutic solidarity in hospitals (*Ensemble pour une Solidarité thérapeutique hospitalière en Réseau*), linking European hospitals and health facilities with those in developing countries. Agreements had already been signed with Benin, Burkina Faso, Cambodia, Cameroon, Côte d'Ivoire, Gabon, Mali, Morocco, Senegal and Viet Nam. More than 1000 personnel had already benefited from training, and 35 agreements had been established between hospitals. The French Prime Minister was currently meeting people responsible for implementing ESTHER, whose facilities France was prepared to make available to WHO.

The target of the "3 by 5" strategy was ambitious but appropriate to the challenge. In order to attain it, the role of every institution, agency and entity must be made clear. In that regard, he sought clarification of the reference, in paragraph 6 of the report, to emergency country-response teams, including their financial and other arrangements, and likewise, that in paragraph 9 to patients with tuberculosis as the largest group of people eligible for antiretroviral treatment.

WHO should serve as a reference point for all health systems' efforts, and France would be tireless in its support of the collective efforts under the Director-General's leadership.

Dr YIN Li (China) commended the "3 by 5" strategy, which was of paramount importance to developing countries. Although antiretroviral drugs were vital for treatment, preventive measures such as the use of condoms should also be stressed and promoted. The Chinese authorities attached the highest importance to combating HIV/AIDS, which had recently spread rapidly in China: an epidemiological survey in 2003 had identified 840 000 cases of HIV infection, including 80 000 cases of AIDS.

As well as allocating more funds to combating HIV/AIDS, the Government had made five commitments. The first was to accord priority to treatment; steps were being taken to identify responsibilities, clarify targets and improve evaluation, supervision and monitoring. The second was to provide free treatment to economically disadvantaged patients in urban and rural areas, including screening, counselling and treatment in such priority areas as prevention of mother-to-child transmission of HIV; professional training would also be enhanced. The other three were: to improve regulations and raise awareness about hazardous behaviour and illegal acts such as prostitution and drug trafficking; to uphold the rights of people with HIV, combat discrimination and provide economic and other forms of support; and actively to promote international cooperation.

China, a densely populated country with regional imbalances in economic and cultural development, relied greatly on the support of the international community. In 2003, the Global Fund had actively assisted China in controlling HIV/AIDS. China was ready to participate in the "3 by 5" strategy, and would welcome the assistance of a WHO working group in identifying its problems. One such problem was the use of certain imported medicines whose patents had expired and which had such serious side-effects that roughly 20% of patients abandoned the treatment. Another was that, because of the country's cultural and social traditions, some infected people were reluctant to acknowledge their condition. The need for capacity building was a further difficulty; in that regard, WHO's proposed tuberculosis treatment model seemed a feasible solution.

If the target of reaching at least three million people in developing countries by 2005 was to be reached, 2004 was a crucial year, and speedy action by WHO would help greatly.

Dr ACHARYA (Nepal) said that his country was at high risk from an HIV/AIDS epidemic because of factors such as poverty, trafficking in people and illegal immigration, exacerbated by an unstable political situation; high rates of HIV infection were present in sex workers, their clients and injecting drug users. According to the national demographic and health survey conducted in 2001, only about 32% of women were aware of ways of protecting themselves against HIV infection. Sexually transmitted infections were common, and the number of HIV infections was growing rapidly. To respond better to the problem, national capacities and technical expertise needed to be greatly enhanced. It seemed that it was complicated to apply for assistance from the Global Fund; he requested the support of the Director-General in that regard.

Dr TAG-EL-DIN (Egypt) welcomed the "3 by 5" strategy as an important initiative, but wondered whether the priority was to finance the import of antiretroviral agents, to develop national capacities to manufacture them locally, or to support international drug producers in order to reduce prices. He also wondered whether any specific programmes had been or were being developed, on the basis of which additional financing could be monitored; how would the financing regulations be adjusted to take account of the nature of the initiative? WHO could also launch a similar initiative to control other lethal diseases, such as malaria and tuberculosis, which could be effectively treated. He asked about the position on other viral diseases with social, economic, psychological and health implications similar to those of HIV/AIDS. Modern drugs could be beneficial against, for example, hepatitis B and C – although in the latter case, long-term treatment including new drugs such as interferon could cost up to US$ 25 000 a year. He also asked whether other financing was available,

such as that proposed by the President of the United States of America, the Canadian initiative or the contributions of France and other countries to the Global Fund.

Dr STEIGER (United States of America) congratulated the Director-General on making the "3 by 5" initiative central to his tenure. The United States recognized WHO's leadership role in that area and would do everything it could to ensure the success of the initiative. With the implementation of his President's Emergency Plan for AIDS Relief, his country had become one of the primary funding sources for efforts to reach the targets set out by the Director-General. At least two million people would receive antiretroviral medication through new funding from the United States in 14 targeted countries over the next five years. In addition, more than 75 countries were already receiving bilateral assistance from the United States, which was intensifying its efforts to combat the spread of HIV.

He had noted the comments from members about coordination; his country was committed to working closely with WHO in order to ensure that all bilateral and multilateral donors maximized their impact and shared the burden in such a way as to achieve concrete and measurable results. All countries, donors, recipients and multilateral institutions had a common responsibility to move faster and more effectively. Potential donors might consider choosing nations that had not been part of a major initiative so far, for example, African countries that had severe problems but had not yet found a sponsor. His country was also committed to working closely with technical staff at WHO headquarters in order to reach the "3 by 5" target. It supported the promotion of in-country leadership, the creation of new public-private partnerships, the simplified and standardized tools for delivering therapy, the promotion of simplified regimens and the use of safe and effective therapy and diagnostics of high quality at the lowest possible cost.

There was evidence to suggest that fixed-dose combinations were an effective means of delivering therapy and fostering patient adherence. The United States had pledged to work with the pharmaceutical industry, both research-based and generic, WHO and other partners to make fixed-dose combination antiretroviral therapy safe and effective at the lowest possible cost. The research-based industry must work to ensure a sustainable supply of active ingredients and precursor chemicals for such drugs. The United States Department of Health and Human Services was undertaking an important initiative, in collaboration with WHO and the Southern African Development Community, on the safety, efficacy and quality of drugs for HIV/AIDS, tuberculosis and malaria and specifically for fixed-dose combination drugs. It would be cosponsoring a conference to be held in South Africa from 10 to 12 March 2004 with the goal of producing an international consensus document. This would set out principles to be taken into account by all parties when considering fixed-dose combination drug products for the three diseases; include definitions of terms and principles; and deal with such issues as bioequivalence, bioavailability, stability and clinical risk-benefit. A broad range of experts was expected to participate, and all Member States represented on the Board were encouraged to request information on the conference.

He recalled that the fourth round of applications for funding from the Global Fund was currently open and encouraged Member States that had not already done so to prepare applications.

Professor FURGAL (Russian Federation) said that it must be acknowledged, objectively and honestly, that the 20-year-old battle against HIV was being lost, despite the constant presence of HIV/AIDS on the world's political agenda and unprecedented decisions and actions at the widest range of levels. New approaches were clearly necessary, and the initiative would confront WHO, its partners and Member States with a noble but difficult task whose solution would require additional efforts and financial resources to underpin not only the delivery of therapy and medication but also the strengthening of national health care systems. Only through an equitable combination of preventive and treatment measures, with special emphasis on broad access of people living with HIV to antiretroviral therapy, could progress be made. His country therefore supported the "3 by 5" initiative, whose results would serve as an objective indicator of the world community's capacity to achieve the Millennium Development Goals by 2015.

Noting with satisfaction the growing role of WHO's expert and consultant network, he proposed that consideration should be given to the establishment of a special committee for achieving the "3 by 5" initiative; the creation of a specialized technical centre for support of that aspect of programme activity; and the strengthening of capacity in WHO's collaborating centres for biomedical, social, clinical and epidemiological work. WHO should likewise devote attention to subregional and interregional cooperation with countries and partners. The joint activities of the countries of the Commonwealth of Independent States, with the active participation of UNAIDS, together with similar approaches being taken by members of the Caribbean Community, were promising instruments of international cooperation which could be replicated in WHO's regional and global activities.

Dr MARTÍN MORENO (alternate to Dr Pastor Julián, Spain) said that he endorsed the statement that would be given on behalf of the European Union. Taking as read the gravity of the HIV/AIDS epidemic, the dramatic plight of many impoverished countries, the particular vulnerability of groups such as women and orphans, and the need for all countries to take appropriate action, he said that countries must cease to pay lip-service to an ideal and instead engage actively in the fight against HIV/AIDS, which was a problem common to all. He warned against enthusiastic endorsement of the "3 by 5" initiative becoming complacency or over-simplification; access to antiretroviral treatment could not be dissociated from other activities to combat HIV/AIDS. Carefully coordinated prevention, treatment, assistance and research activities were also needed; yet the value of the initiative lay in its capacity to bring together the various sectors involved in the struggle against HIV/AIDS. It was not enough simply to provide initial treatment by 2005: the initiative must be ensured continuity, integrity and sustainability.

There was thus a need for synergy among international organizations, governmental and nongovernmental organizations and industry itself. He emphasized the importance of the network for therapeutic solidarity in hospitals (ESTHER), through which France, Italy, Luxembourg and Spain were working together to facilitate technical training in integrated care for people living with HIV/AIDS and to provide technical and laboratory equipment to 22 countries in Africa and Latin America. The initiative demonstrated the importance of providing not only treatment but also know-how and technical support in order to ensure the quality of care and assistance. He agreed with other speakers that such initiatives must be closely linked with strategies for improving health care systems.

Dr BOSHELL (Colombia) said that the Colombian Minister for Social Welfare had recently communicated to the Director-General his Government's support for the "3 by 5" initiative, without prejudice to the need for prevention. Attaining the proposed target would require the commitment of all countries and their governments, and the contributions announced by Canada, France and the United States of America were thus praiseworthy and welcome. In addition, WHO's essential medicines programme should place its experience and strategies at the service of the "3 by 5" initiative to facilitate better provision of safe, effective and low-cost medication to affected people throughout the world.

Dr YOOSUF (Maldives), acknowledging donors' support, said that his country strongly endorsed the "3 by 5" initiative, but he reiterated the concerns already expressed about the need to ensure that similar targets were set and resources and efforts mobilized for the prevention of HIV. The South-East Asia Region, with about a quarter of the world's population, had the fastest-growing HIV epidemic. Unless adequate prevention measures were undertaken in that large population, the success of the "3 by 5" initiative would be short-lived, and the statistics on HIV in 10 years' time would be much more depressing than they currently were.

Dr NDONG (Gabon) said that, despite the support for the "3 by 5" initiative, which held out immense hope for the world, it had to be acknowledged that the road was strewn with obstacles. The keys to success in such an initiative had been identified; the need for high quality and competitive cost of antiretroviral drugs remained determining factors. He therefore asked for fuller information about

what measures were envisaged at different levels with regard to quality control of generic antiretroviral drugs.

The CHAIRMAN, speaking in his capacity as the member for Ghana, said that his country would do its best to achieve the objectives of the "3 by 5" initiative internally and externally, and that it was accordingly submitting a formal application to join the initiative. Its HIV seroprevalence rate was 3.6%, and currently only 2000 people out of a potential target group of 70 000 were receiving antiretroviral treatment. He cautioned that, although the initiative was welcome, HIV/AIDS interventions should not be overly "medicalized"; WHO ought to work with other agencies on integrated responses, ranging from the social and economic to the religious and moral. Massive medical intervention would increase awareness of seropositivity, and firm measures would have to be put in place to reduce stigmatization and discrimination in the workplace and elsewhere. As far as possible, interventions must be tailored to ensure that beneficiaries remained economically independent. Gender equity must be tackled, women must be empowered to negotiate safer sex, and legislation must be reviewed, as that was where the greatest impact could be achieved. Especially important was community action to change social mores, which in several African countries were the subject of taboos. The initiative must also cover the economic and social situation of orphans.

A combination of treatment and preventive measures, specifically in education and for behavioural change, could reduce HIV/AIDS to the level of a non-public health concern in the long term, but technical assistance was needed to develop country-specific models and enhance effective planning, so as to facilitate more accurate forecasting of the resources needed for such interventions. He expressed appreciation for the work of the Global Fund and the initiatives by Canada and the United States of America.

Mr KEENAN (Ireland),[1] speaking on behalf of the Member States of the European Union, the acceding States Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia, and the candidate countries Bulgaria, Romania and Turkey, strongly supported WHO's leadership role and the work it had undertaken on HIV/AIDS. The epidemic, with its devastating effect on individuals, families and the community and profound effect on the social and economic development of countries, was the biggest single obstacle to reducing poverty and attaining the development goals agreed by the international community at the Millennium Summit of the United Nations.

Prevention must continue to be the mainstay of the fight against HIV/AIDS. The balance between prevention, treatment, care and impact mitigation must be maintained. The comprehensive response to HIV/AIDS must continue to include reproductive and sexual health and rights. Leadership and debate were required at all levels and WHO had a key role to play in ensuring normative guidance and leadership on access to treatment for HIV/AIDS.

The European Union welcomed the "3 by 5" initiative as a key component of WHO's global health sector strategy for HIV/AIDS. The initiative provided a unique opportunity to mobilize and facilitate efforts to achieve the goal of providing effective antiretroviral treatment in a poverty-focused manner, equitably, and to those people who were most at risk. It had the potential to become an essential element of WHO's important mandate to fight HIV/AIDS, but it would succeed only if implemented as a solid building block in the strengthening of health systems in poor countries.

The European Union encouraged WHO to ensure that the HIV/AIDS strategic framework to bridge the global antiretroviral treatment gap was clearly aligned with the Millennium Development Goals and the United Nations General Assembly special session's Declaration of Commitment on HIV/AIDS. In addition, and equally important, it had to be aligned with national development plans and strategies and strengthened existing health systems. The "3 by 5" initiative could advocate a harmonized and coordinated approach to the delivery of HIV/AIDS treatment at country level. Its

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

implementation should take place within the framework of one national plan, one national AIDS council and one monitoring and evaluation mechanism.

Providing antiretroviral drugs in resource-limited contexts presented many challenges. Even though the "3 by 5" initiative primarily involved the health sector, some activities and risks went beyond health. The initiative must fit into a broader HIV/AIDS strategy and development response, including poverty reduction strategy paper frameworks, where they existed. There was little evidence that a disease-specific focus strengthened health systems. Many problems relating to policy and systems would need to be overcome, including ensuring high-level political commitment, clear policy guidelines, logistics, procurement, human resources and financial systems.

The European Union was encouraged by the emphasis on the balance between prevention, treatment and care in different contexts and, within the health sector, between the provision of antiretroviral treatment, other essential treatment and services specific to HIV, and non-HIV-specific services. That holistic approach must continue to inform the broader response to HIV/AIDS. The European Union welcomed the open and transparent approach that WHO had taken to developing partnerships and applauded the Organization for putting HIV/AIDS at the centre of its health care agenda. It would work with WHO, UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria in implementing a challenging, action-oriented plan.

Dr DOMINGUES GRANJEIRO (Brazil)[1] commended the Organization's excellent work in the area of HIV/AIDS. His country had made great efforts to increase the HIV diagnosis rate and distribute condoms in schools with the aim of reducing seropositivity among young people. Although more people were being treated, the unit cost of antiretroviral drugs was rising less rapidly than before, following the Government's negotiations with pharmaceutical laboratories. The Government aimed to reduce the rate of mother-to-child transmission of HIV to below 3%.

The "3 by 5" initiative had already produced programmes that could revolutionize the fight against AIDS in the developing world. The simplified treatment regimen, with fixed-dose combinations of antiretroviral drugs, was the best way to improve patient care and ensure a rapid, effective and ethically sound response. The initiative would require the participation of donor countries, developing country governments and other actors. He called on Member States to implement the resolutions calling for action to guarantee universal access to treatment. Brazil proposed to set up a network for the development and exchange of technology in the area of accessibility of medicines with China, India, the Russian Federation and South Africa; other countries were welcome to join. Brazil intended to support the "3 by 5" initiative by increasing the number of countries receiving technical assistance, training and drugs to 14 during 2004. For access to treatment, technical assistance from WHO would be essential; to that end, funding from Member States, the Global Fund and the World Bank would be required to maximize cooperation and technical assistance efforts in Latin America and the Caribbean. Brazil was currently developing a proposal for the management of cooperation activities within the regional horizontal technical cooperation group on HIV/AIDS: it covered the coordination of the various existing activities in the region, exchange of best practices and technical cooperation to meet identified needs.

Mr AGARWAL (India)[1] said that the launch of generic antiretroviral drugs by Indian pharmaceutical companies had brought down the price of those drugs throughout the world. Nevertheless, they were still too expensive for most patients. Indian manufacturers had the facilities to produce high-quality drugs, and proposed changes in legislation would allow them to export generic antiretroviral drugs to countries that did not have the necessary manufacturing capacity.

India's national AIDS prevention and control policy provided for free antiretroviral therapy for three groups: women registered under programmes to prevent mother-to-child transmission of HIV; young people under 15 years of age; and people with AIDS treated at government hospitals in six

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states with a high prevalence of HIV infection. That policy made improving access to antiretroviral therapy a national priority, and was thus consistent with the "3 by 5" strategy. Key challenges remained: strengthening the health care delivery system in order to ensure structured antiretroviral treatment; reducing the stigmatization and discrimination associated with HIV/AIDS in order to improve access to diagnosis and treatment; improving the affordability of antiretroviral drugs and their accessibility and acceptability in terms of per capita income and health expenditure; capacity strengthening, particularly in human resources and clinical facilities; effective monitoring of compliance with antiretroviral treatment in order to prevent the development of drug resistance, and continued prevention efforts alongside the strengthening of treatment and care.

Dr FUKUDA (Japan)[1] said that his country actively supported efforts to combat HIV/AIDS. The "3 by 5" initiative would not be easy to implement, but, having seen what had happened in Africa, his country recognized the potential threat to the countries of the Western Pacific Region. It therefore supported the initiative through both multilateral and bilateral channels, including a workshop that it had organized for the Member countries of ASEAN in December 2003.

With regard to the report, it was important to adopt different approaches in different contexts. Every region had a unique epidemiological situation and its own level of capacity, and should take advantage of the momentum generated by the "3 by 5" initiative to plan its own approach. WHO should help countries to establish ways of providing antiretroviral drugs and mechanisms to minimize the development of drug resistance. Partnerships would need to be built up with many stakeholders, including nongovernmental organizations and civil society. Health services must be strengthened, and the community empowered.

He reiterated the importance of prevention activities, which must be further intensified. He called on WHO to support countries with a significant burden of HIV/AIDS, and also those facing a potential threat from the disease, using the framework of UNAIDS and the Global Fund.

Dr BELLO DE KEMPER (Dominican Republic)[1] congratulated the Director-General on the "3 by 5" initiative, and thanked Canada, France and the United States of America for providing financial support; it was to be hoped that they would be joined by other countries. Referring to the beginning of paragraph 6, the end of paragraph 8 and paragraph 10 in the report, she expressed the hope that the "3 by 5" initiative would benefit most countries in all regions, especially when it came to strengthening their health systems to fight HIV/AIDS. Speaking as the representative of a region and a country gravely affected by AIDS, and endorsing the view that HIV/AIDS was everyone's problem, she said that she trusted that when the "3 by 5" initiative was evaluated the results would be found to be positive for the Region of the Americas.

Dr SUWIT WIBULPOLPRASERT (Thailand)[1] said that Thailand had been one of the first developing countries to support the "3 by 5" initiative. From 1 October 2003, the Government had undertaken to provide free antiretroviral treatment for everyone who needed it. By 2005, 210 000 patients, or 7% of the global target, would be receiving antiretroviral therapy. However, other considerations must also be borne in mind. Even though the Government's target for antiretroviral therapy in 2002 had been only 10 000 patients, only 70% of patients were still with the scheme by the end of the year, and only 60% of those had received 90% or more of the planned doses. That example showed the need to go beyond the "3 by 5" strategy and consider the sustainability of programmes and the potential positive effects for health system development.

One essential factor in the success of the "3 by 5" initiative would be political commitment. The US$ 5000 million raised by the Global Fund showed the strong commitment that existed at a global level. What was currently needed was more commitment at country level. The XV International AIDS Conference was to be held in his country in July 2004; it would include a leadership programme

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intended to increase political and other commitment. It was particularly important to foster political leadership in the affected countries: they would have to sustain their comprehensive approach to HIV/AIDS and scale up their own infrastructure and human resources. He welcomed the Director-General's decision to upgrade human resources management at headquarters, and expressed the hope that more resources would also be forthcoming.

He urged that the phrase "3 by 5" should become a slogan marking a comprehensive approach to the problem of HIV/AIDS, and not merely a "medicalization" of the issue, ignoring the social and other aspects of the problem.

Dr PIOT (Executive Director, UNAIDS) thanked Member States for their commitment to the "3 by 5" initiative, which UNAIDS fully supported, and the Director-General for his leadership in HIV/AIDS. The initiative would bring together all relevant actors and provide guidance on how best to allocate the increasing resources for HIV/AIDS. WHO was rightly concentrating on the treatment and care of people living with AIDS, since that was primarily the responsibility of health systems. The "3 by 5" initiative was part of an overall United Nations strategy, covering prevention of infection, treatment and alleviation of the impact of the disease. UNAIDS had worked on the initiative from the beginning, and the complementary roles of WHO, UNAIDS and the Global Fund were completely clear and harmonious. UNAIDS looked particularly at ways in which the United Nations system could: support countries in implementing the initiative, promote leadership and ownership by countries; stimulate community mobilization; tailor implementation to regional needs and opportunities; and integrate the initiative into the development agenda of individual countries – all of which were essential activities if the initiative were to be sustainable. Another important issue was to facilitate disbursement of funds. UNAIDS had held review meetings with the Global Fund and the World Bank to discuss specific problems in specific countries. The activities of organizations in the United Nations system added value to the implementation of the initiative.

The "3 by 5" initiative and the global response to AIDS in general could only succeed through strong and broad alliances. UNAIDS was working with the Global Fund, the World Bank and funding countries, including the United Kingdom of Great Britain and Northern Ireland and the United States of America, to ensure national leadership and good coordination. That approach was vital in view of the growing number of national and international actors entering the field of HIV/AIDS; funding, while still not enough to meet the need, was increasing and must be put to the best possible use.

In most countries, the number of people requiring treatment far exceeded the resources available. Each country must decide for itself the difficult ethical question of who received treatment. The following week, UNAIDS and WHO would be hosting a meeting on the ethical aspects of access to care and treatment.

Further concerns included gender equity: the fact that as many women as men were currently living with HIV/AIDS must be reflected in access to care and treatment. Stigmatization and discrimination greatly hindered the implementation of both prevention and treatment programmes, not only violating the rights of affected people, but also posing operational problems. UNAIDS would continue its research in that area, maximizing the evidence base.

The United Nations system would have to learn to monitor and evaluate as it went along, because of the unprecedented expansion of activities, adapting guidance in order to avoid problems such as resistance to antiretroviral drugs and ensuring that plans devised in Geneva were feasible in the developing world.

For the first time, the world had the chance to stem the AIDS epidemic. There was momentum of leadership, evidence that prevention could work (despite some scepticism), and, perhaps the strongest asset, hope from the example of countries such as Botswana and Brazil, which had introduced treatment programmes some years before. Resources were growing: seven years before only US$ 200 million had been spent on AIDS programmes, whereas in 2003 the figure had been an estimated US$ 4700 million, the Global Fund had been established, and the Emergency Plan for HIV/AIDS Relief launched by the President of the United States of America. Irrespective of income, countries had committed funds. Even though in 2003 more people than ever before had been infected

with HIV and had died of AIDS, maintained momentum and innovative thinking should result in reduced morbidity and mortality.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that the mandate of his organization was to improve nursing practice, education, management and research and to strengthen the contribution of nurses to health systems at all levels. It applauded WHO for its "3 by 5" initiative and strategy, which was a sound vehicle for the overall strengthening of health systems. It would collaborate with WHO and others to mobilize millions of nurses in the fight against HIV/AIDS, but in addition the rest of society must be mobilized. Short-term gains must not be followed by long-term failure. The effective performance of health systems required the deployment of an adequate mix of human resources, including unemployed nurses, midwives and other health workers, and their full utilization.

The "3 by 5" strategy could not succeed if health care providers themselves were ill and dying of HIV/AIDS. Treating health care workers was a key to strengthening infrastructure and achieving the "3 by 5" objective. To that end, the Council, in partnership with industry, governments and member associations, would deliver antiretroviral therapy to HIV-positive nurses and other health workers. A project had already been launched in Zambia and would expand to other areas with high HIV prevalence among health workers. Caring for the carer was a cost-effective way of retaining health workers and a powerful incentive for them to remain in their countries. His organization called on WHO, governments and others to target health workers and give them access to antiretroviral therapy as a means of strengthening health systems' capacity.

Ms KEITH (The Save the Children Fund), speaking at the invitation of the CHAIRMAN and referring to paragraphs 5, 6 and 8 of the report, said that WHO should give technical guidance to donors to ensure that nongovernmental organizations and ministries of health began antiretroviral treatment only after certain minimum systems had been put into place. The availability of resources for antiretroviral therapy without a concurrent strengthening of the system could have a negative impact on the long-term management of the HIV pandemic. Although substantial resources were currently available for antiretroviral treatment, there were few or no resources for building the necessary infrastructure. Save the Children called on the G8 countries and WHO to increase dramatically the resources for strengthening health systems, especially as far as human resources and management infrastructure were concerned.

As far as paragraph 7 and the critical role of partners were concerned, her organization particularly offered its support in the following areas: strengthening health systems; outreach to those who were hard to reach; caring for orphans and vulnerable children. It also dealt with the issues raised by the "3 by 5" strategy pertaining specifically to child health and equity. It was encouraged by the strong focus on country technical support and the strengthening of health systems, and wished to be part of the initiative at that level.

Turning to paragraph 12 of the report, she welcomed the emphasis placed on prevention, care and treatment for those affected by HIV/AIDS. Much still needed to be done to reduce stigmatization, and the "3 by 5" targets and milestones should include indicators that focused on systems and people so ensuring that no vital area was missed.

Dr CHOW (Assistant Director-General) said that WHO sought to promote effective public health strategies related to HIV/AIDS, including prevention, treatment, palliative care, research and development, epidemiology and surveillance, monitoring and evaluation, health infrastructure (including education and training for health workers) and the building of partnerships, alliances and coalitions in civil society. He shared members' concern about the risks facing specific populations, such as women, who currently ran the same risk of being infected with HIV as did men. Another important issue was political leadership: the recognition that investment in the fight against AIDS and in public health systems benefited both the individual and the country's overall stability and security.

WHO must make it clear that keeping people with AIDS alive should be seen as an asset on a country's national balance-sheet, not as a liability.

Resource mobilization was essential; WHO would work with the Global Fund, the World Bank and bilateral donors such as the European Union, Canada and the United States of America, to mobilize both financial and technical resources.

In relation to the role of other agencies, WHO's work was "additive"; it complemented and strengthened many other activities. It was intended that that role would be maintained.

The framework for local drug production, established by recent WTO ministerial conferences, provided an excellent opportunity for international collaboration. WHO would help countries to establish their own drug production programmes. It also welcomed initiatives such as the French network (ESTHER), and would look for potential linkages.

Co-infections with HIV and other pathogens were often underestimated. Besides tuberculosis, sexually transmitted diseases were also a problem. Directly observed treatment, short-course for tuberculosis was an excellent entry point for the treatment of patients, since they were already used to a therapeutic regimen and could be given antiretroviral drugs in the same way.

WHO's core mandate was to advance public health; on that basis, countries, nongovernmental organizations and talented individuals could achieve change.

Dr KEBEDE (Ethiopia), thanking the Secretariat for its comments, urged the Director-General to coordinate efforts within the "3 by 5" initiative so as to avoid duplication of interventions. Further, capacity-building efforts should lead to the creation of institutions capable of providing enhanced treatment, care and support for people with HIV/AIDS, thereby putting the limited resources available to more effective use.

The Board noted the report.

The meeting rose at 18:00.

THIRD MEETING

Tuesday, 20 January 2004, at 09:05

Chairman: Dr K. AFRIYIE (Ghana)

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

Surveillance and control of *Mycobacterium ulcerans* disease (Buruli ulcer): Item 3.4 of the Agenda (Document EB113/40)

The CHAIRMAN, noting that the item had been placed on the agenda at the request of his country, drew attention to paragraph 18 of document EB113/40 containing a draft resolution, WHO's first on the subject, and which he urged the Board to support. Speaking in his capacity as the Board member for Ghana, he outlined why Buruli ulcer, a neglected disease, was a growing public health problem in several countries in West Africa and in tropical and subtropical countries in other regions, remaining underrecognized and underreported.

Dr LARIVIÈRE (alternate to Mr Aiston, Canada) said that, during the recent retreat for Board members in Accra (November 2003), compelling information had been presented about Buruli ulcer. Even though the epidemiological picture was incomplete, there was sufficient evidence of the socioeconomic burden of the disease to warrant increased attention. Society's frequently inappropriate reaction to the disease, due to inadequate information and poor clinical response, complicated the management of the disease. It was incumbent upon WHO and its Member States to show collective solidarity in investigating such neglected health problems. The Global Buruli Ulcer Initiative and the draft resolution deserved support. It would appear logical to include research on the disease within the mandate of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, which already had considerable expertise in the area of mycobacterial diseases and had the necessary infrastructure. He therefore suggested that the Special Programme's Scientific and Technical Advisory Committee, which would meet before the Fifty-seventh World Health Assembly, should be requested to consider the matter.

Dr CAMARA (Guinea) said that the report clearly showed that Buruli ulcer was an emerging disease but was neglected by health professionals and the community alike. In Guinea, despite inadequate information on prevalence, the disease had increased in recent years, with more than 400 cases reported in 2003, compared to three in 1993. Moreover 89% of cases had been detected only at an advanced stage, when the ulcer was already present. With WHO support, a national control programme had been established. He would have liked to see greater emphasis in the report on the lack of control measures (a vaccine to prevent the disease, therapeutic drugs and promotion of the use of protective clothing), the need to develop strategies to make treatment more affordable, and the need to raise awareness about the disease in order to ensure screening and earlier case detection. He urged the Board to support the Global Buruli Ulcer Initiative.

Dr SÁ NOGUEIRA (Guinea-Bissau), welcoming the report, said that Buruli ulcer was clearly an emerging public health problem associated with poor socioeconomic conditions, in particular in certain African countries, and represented an obstacle to the attainment of the Millennium Development Goals. He therefore supported the draft resolution and proposed that the resolution contained therein should be amended by the insertion of a new paragraph 2(3) to read "to intensify

community participation in the recognition of disease symptoms", in order to encourage early case detection and treatment.

Dr STEIGER (United States of America) welcomed the inclusion of the item on the agenda; neglected diseases such as Buruli ulcer deserved greater attention from WHO. He supported the Canadian proposal that efforts should be made to use the existing infrastructure in tackling the problem. For example, surveillance should be integrated into national and regional surveillance programmes. The United States was a committed partner in the Global Buruli Ulcer Initiative; the Department of Health and Human Services was currently analysing 2003 data on the extent and economic impact of the disease on individuals, households and countries, an activity that should help to raise awareness of the disease.

Dr MARTÍN MORENO (alternate to Dr Pastor Julián, Spain) said that, although Buruli ulcer was not recognized as a priority by many countries or the pharmaceutical industry, it was spreading rapidly and causing a considerable burden of disease in endemic countries. It resulted in loss of productivity and was an obstacle to socioeconomic development, as well as causing disability in individuals, often among vulnerable groups such as women and children under the age of 15 years. Despite the severity of the disease and the lack of available treatment, there was little investment in research since there was unlikely to be an economic return. International organizations and their Member States had a responsibility to take up the challenge of such neglected diseases. Spain was supporting the Global Buruli Ulcer Initiative on bilateral and multilateral bases and endorsed the priorities for action set out in the draft resolution.

Dr ASAMOA-BAAH (Assistant Director-General) said that, although Buruli ulcer was not usually fatal, it destroyed the lives of those affected, mainly poor people, causing considerable disfigurement and disability. He had taken note of the various suggestions made by Board members. It was a sad commentary that the disease, discovered some 50 years previously, remained a mystery and continued to be neglected. The draft resolution should serve to raise awareness of the condition and stimulate greater investment in research, and also provide a voice for all those, including many children, who suffered from the disease.

The resolution, as amended, was adopted.[1]

Health promotion and healthy lifestyles: Item 3.6 of the Agenda (Document EB113/7)

Mr GUNNARSSON (Iceland) commented that increasing importance had been attached to health promotion and healthy lifestyles as a consequence of the rise in the burden of noncommunicable diseases resulting from unhealthy diets, physical inactivity, tobacco use and the harmful use of alcohol in all Member States. Despite relevant discussions in recent Health Assemblies, for example, on diet, physical activity and health (leading to the adoption of resolution WHA55.23), violence (resolution WHA56.24) and the WHO Framework Convention on Tobacco Control (resolution WHA56.1), further action was needed to build healthy public policy, create supportive environments, strengthen community action, enhance personal skills and reorient health services, as indicated in the 1986 Ottawa Charter for Health Promotion. He therefore invited the Board to consider the draft resolution on health promotion and healthy lifestyles proposed by Canada, China, Czech Republic, Denmark, Iceland, Kazakhstan, Maldives, Norway, Republic of Korea, Russian Federation and Sweden, which read:

[1] Resolution EB113.R1.

The Executive Board,

Having considered the report on health promotion and healthy lifestyles,[1]

RECOMMENDS to the Fifty-seventh World Health Assembly the adoption of the following resolution:

The Fifty-seventh World Health Assembly,

Recalling resolutions WHA42.44 and WHA51.12 on health promotion, public information and education for health and the outcome of five global conferences on health promotion from Ottawa (1986), Adelaide, Australia (1988), Sundsvall, Sweden (1991), Jakarta (1997) and Mexico City (2000), and the Ministerial Statement for the promotion of health (2000);

Noting that *The world health report 2002*[2] addresses major risks to global health and highlights the role of behavioural factors, notably unhealthy diet, physical inactivity, tobacco consumption and the harmful use of alcohol as key risk factors for noncommunicable diseases which constitute a rapidly growing burden;

Recognizing that the need for health promotion strategies, models and methods is limited neither to a specific health issue nor to a specific set of behaviours, but applies to a variety of population groups, risk factors and diseases, and in various cultures and settings;

Recognizing the need for Member States to strengthen the policies, human and financial resources, and institutional capability for sustainable and effective health promotion that addresses the major determinants of health and their related risk factors, with a view to building national capacity, strengthening evidence-based approaches, developing innovative means of financing, and drawing up guidelines for implementation and evaluation;

Recalling the importance of primary health care and the five areas of action set out in the Ottawa Charter for Health Promotion,

1. URGES Member States:

(1) to strengthen existing capability at national and local levels for the planning and implementation of gender sensitive and culturally appropriate, comprehensive and multisectoral health-promotion policies and programmes, with particular attention to poor and marginalized groups;

(2) to give high priority to promoting healthy lifestyles among young people – boys and girls both in and out of school – including healthy and safe recreational opportunities;

(3) to include harmful use of alcohol in the list of lifestyle-related risk factors as stated in *The world health report 2002*, and to give attention to the prevention of alcohol-related harm and promotion of strategies to reduce the adverse physical, mental and social consequences of harmful use of alcohol, especially among young people and pregnant women, in the workplace, and when driving;

2. REQUESTS the Director-General:

(1) to give health promotion highest priority in order to support its development within the Organization as requested in resolution WHA51.12, with a view to supporting Member States more effectively and, in consultation with involved stakeholders, to addressing the major risk factors to health, including harmful use of alcohol and other major lifestyle-related factors;

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[1] Document EB113/7.

[2] *The world health report 2002: Reducing risks, promoting healthy life*. Geneva, World Health Organization, 2002.

(2) to continue to advocate an evidence-based approach to health promotion and to provide technical and other support to Member States in building their capacity for the implementation, monitoring, evaluation and dissemination of effective health promotion programmes at all levels;

(3) to provide support and guidance to Member States in relation to the challenges and opportunities stemming from the promotion of healthy lifestyles and the management of related risk factors, as outlined in *The world health report 2002*;

(4) to report on progress made in the promotion of healthy lifestyles to the Executive Board at its 115th session and to the Fifty-eighth World Health Assembly, including a report on the Organization's future work on alcohol consumption.

Mr AISTON (Canada) expressed support for the attention being given by WHO to health promotion and healthy lifestyles, and the Organization's recognition that some lifestyle questions were linked to socioeconomic status as well as other health determinants. He welcomed the reference in the report to elements that were crucial to Canadian initiatives, such as the integrated Pan-Canadian Healthy Living Strategy, including intersectoral collaboration, action on broader determinants of health, tackling health disparities, integrated approaches to chronic disease prevention and building and using the evidence base and, in particular, supporting disadvantaged populations, which were always the hardest to reach with such strategies. He welcomed the progress made in key areas and WHO's continuing efforts to enhance national health promotion capacity, address underlying health determinants and strengthen public health infrastructure. WHO should continue to give health promotion a high priority as it was essential for improving health status and reducing disparities. Canada was pleased to sponsor the draft resolution, which drew attention to areas where further work was needed. He looked forward, in particular, to the development, in cooperation with all interested parties, of WHO guidance on control of the harmful use of alcohol.

Mr KHAN (Pakistan) welcomed the strategies WHO was establishing for health promotion and healthy lifestyles, including the WHO Framework Convention on Tobacco Control, the proposed global strategy on diet, physical activity and health and the "Move for Health" initiative. Their implementation, however, required resources at country level that were hard to find in developing countries with other pressing health needs. Lack of evidence of the effectiveness of health promotion and health education programmes was a further barrier to the allocation of more resources. WHO should support Member States in undertaking activities to generate the necessary data, and the Board should recommend strong advocacy campaigns to mobilize additional funds. It was important to raise awareness that investment in health could help in the attainment of development goals, including poverty reduction.

Healthy lifestyles also depended, however, on peace of mind. Too many countries were experiencing conflict or its consequences, for example, bereavement or the movement of large numbers of refugees, as in Pakistan. The Fifty-seventh World Health Assembly must provide the impetus for establishing strong health-promotion and healthy-lifestyle programmes in all Member States.

Dr STEIGER (United States of America) said that his country viewed health promotion and protection as one of WHO's most important activities and an essential investment in and component of health and economic development. The President's HealthierUS Initiative, which encouraged people to take steps to improve their own health and prevent disease, challenged an array of national, state and community stakeholders to eliminate disparities, increase life expectancy and improve life quality. WHO's efforts in concert with other partners to ensure a sound peer-reviewed evidence base for health promotion practice were commendable. Actions to support and enhance health promotion, especially initiatives that empowered people and communities, were cost effective. Data reflecting the link between health promotion strategies and health outcomes, and the cost-effectiveness of such strategies,

were essential to help policy-makers to make difficult choices in allocating resources and framing health promotion as best public health practice, and to help individuals to make healthy choices in their own lives. He therefore seconded the call for better data. Health promotion strategies that were culturally and linguistically appropriate and were framed in partnership with stakeholders could be especially effective when targeting marginalized populations and those at risk.

Expressing support for the proposed draft resolution, he suggested that, for clarity, the text in paragraph 2(1) following the words "Member States" should read ", in consultation with involved stakeholders, to more effectively address the major risk factors to health ...".

Dr ACHARYA (Nepal) stressed the need for a multisectoral approach to health promotion, which was affected by many factors, including sociocultural and environmental variables. Nepal's health promotion strategy placed emphasis on information, education and communication, but an integral, participatory approach involving all stakeholders was still lacking. There was a particular need for health promotion in schools, local health care centres, in small rural communities and among marginalized groups. In a country with low literacy rates, audiovisual means were a top priority, and Nepal would like WHO to consider practical support in that area.

Dr AL-MAZROU (Saudi Arabia) said that health promotion and healthy lifestyles were decisive primary health care factors in a world beset by unhealthy practices. Education was crucial in tackling unhealthy diet, physical inactivity, tobacco use and alcohol abuse, major risk factors for noncommunicable diseases. The international community and WHO should step up their efforts to gather evidence of the effectiveness of health promotion strategies. He noted from document EB113/7 the substantial disparities among WHO regions regarding activities in support of the health promotion strategy.

In Saudi Arabia, several programmes had been launched in cities and schools, although more needed to be done to reach out to the wider population. His country was endeavouring to draw on international experience, participate in intercountry and interregional activities, examine the outcome of the Global Programme on Health Promotion Effectiveness and cooperate with the international network of institutions involved.

Dr YIN Li (China) stressed the importance China attached to health promotion. WHO should not only continue to provide technical assistance to countries but should carry out awareness and outreach programmes. Efforts should be made to promote the benefits of healthy lifestyles in the interests of the economy and welfare of countries, and WHO and Member States alike should invest more heavily in such action. He endorsed the comments made by previous speakers.

Professor KULZHANOV (Kazakhstan), expressing support for the draft resolution, observed that Kazakhstan had been implementing a healthy lifestyle programme for five years. Experience had shown how important it was to institute a legal basis for such programmes; the laws adopted in his country limiting the sale and advertising of alcohol and tobacco had yielded good and tangible results. More work was needed along those lines, especially among children and young people. He consequently suggested that paragraph 1(2) should be amended to include the words "children and" before "young people", and the word "school" be replaced by "all educational institutions".

Professor FURGAL (Russian Federation) commended WHO's successful action over the years in support of Member States' efforts to promote health and healthy lifestyles through national health programmes, a stronger legal framework and improved health services. Healthier lifestyles played a major role in improving health generally. Document EB113/7 referred to some of the shortcomings of, or gaps in, Member States' health promotion activities in the areas of policy, resources, infrastructure and reliable data on the effectiveness of health promotion measures, and he therefore supported WHO's plans to assess factors affecting health and enhance the potential of Member States to undertake comprehensive health promotion programmes, taking into account the specific national context.

Pending the Sixth Global Conference on Health Promotion, WHO's activities should focus on four major tasks: preparation and/or refinement of national policies and strategies for health promotion and healthy lifestyles, taking into account the situation in individual countries; sharing international experience of successful national and regional programmes and an assessment of their social and economic effectiveness; identifying sustainable sources of financing and improving social insurance arrangements; and providing support for information and health education.

Professor DANG DUC TRACH (Viet Nam), expressing support for the draft resolution, underscored the importance of health education in schools, from the primary level onwards, and hence the need to revise curricula by including practical information about healthy lifestyles, the dangers of alcohol, tobacco and other substance abuse and the importance of regular physical exercise.

Dr AL-JARALLAH (Kuwait) commended WHO's action in the important field of health promotion and healthy lifestyles. The Kuwaiti Ministry of Health, aware of the importance of that issue and of the lack of evidence and effective studies showing the impact of health promotion in health, economic and social terms in the developing countries, had established two prizes in that connection,[1] the first to be awarded by the Executive Board for research in health promotion in general and the second for the control of cancer, cardiovascular diseases, and diabetes in the Eastern Mediterranean Region, bearing in mind the importance of such studies for evidence-based medicine.

Dr DAYRIT (Philippines), commending WHO's leadership in promoting health and healthy lifestyles, said that the Philippines had been seeking to improve health promotion strategies by means, inter alia, of public awareness campaigns. Governmental health promotion activities were frequently hampered by such factors as advertising, fashion trends and even mistaken beliefs, all of which might perpetuate unhealthy behaviour. Experience in the Philippines had shown that, in addition to creating a favourable policy environment, other inputs were needed, such as the use of the media to launch campaigns, for instance, for the safe use of fireworks, to control dengue and to counteract hysteria over severe acute respiratory syndrome. The participation of local governments, which were the basic implementing units for many health policies and laws, was also useful, as was partnership with industry in promoting hygienic practices. More effective strategies and approaches were needed to evaluate the impact of health promotion activities and ensure that countries pursued successful activities.

Professor MYA OO (Myanmar) said that, since the adoption of the Ottawa Charter for Health Promotion in 1986, most developed countries had embarked on health promotion activities, and the developing countries, having studied their achievements and initiatives, were following suit. However, those countries bore a double burden – from the diseases of poverty and underdevelopment and those associated with progress. As lifestyles changed, risk factors increased, as did noncommunicable diseases, hence the need for improved dietary habits and education to improve hygiene and sanitation, combat tobacco use and alcohol abuse, and encourage physical activity. He endorsed the action outlined in the report and reiterated the developing countries' need for support in the form of human and technical resources to conduct health promotion and healthy lifestyle activities.

Dr MARTÍN MORENO (alternate to Dr Pastor Julián, Spain) stressed the importance of the concept of overall health, for the attainment of which WHO urged all Member States to provide good comprehensive health services, promote scientific research, including research into medicine and diagnostics and therapeutic technology, improve training for health professionals, and provide education in health issues. Health promotion and the encouragement of healthy lifestyles were essential to improving health. Unhealthy diets, the lack of physical activity, the abusive use of alcohol and tobacco use were causing serious health problems.

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[1] See summary record of the tenth meeting, section 5.

Certain unhealthy changes in dietary patterns had taken place in recent years. In developed countries, over-eating and unbalanced diets were directly linked to many preventable diseases such as type 2 diabetes, cardiovascular diseases, obesity and cancer, but it should be remembered that, in developing countries, the lack of food and the inability to keep food fit for consumption caused suffering, illness and death. Food safety therefore needed to be ensured before any further advances could be made, and WHO's efforts to achieve those goals were commendable. The Organization should promote health policies that would prevent diseases related to unbalanced diets and over-eating, but it also needed to respond to the problems of undernutrition and malnutrition in less favoured populations.

Investing in educational programmes on nutrition was not enough on its own: health promotion policies and programmes needed to involve all sectors of society; the food and advertising industries, in particular, needed to be involved in promoting healthy diets.

With regard to the draft resolution, which his country fully supported, he agreed with the member for Iceland on the importance of urging Member States to make explicit reference to the harmful or excessive use of alcohol. He also supported the amendment proposed by the member for the United States of America with a view to making the role of Member States in the initiative more explicit. Spain had recently launched two integrated projects – a national tobacco-control programme and a multisectoral plan dealing with poor nutrition, physical inactivity and obesity; because of their participatory and informatory approach, they were well received by the general public.

Dr HUERTA MONTALVO (Ecuador) said that, since the Lalonde Report of 1974 and the Ottawa Charter for Health Promotion, strategies for promoting health had been made an integral part of public health policies worldwide. However, not all countries had translated strategy into action, and he requested the Organization to continue to urge Member States to ratify the WHO Framework Convention on Tobacco Control. He also emphasized the continued need to promote equity and combat poverty: if those issues were not tackled in conjunction with health promotion, existing social tensions would increase.

Dr GONZÁLEZ FERNÁNDEZ (Cuba), acknowledging that the international conferences on health promotion had contributed to promoting health and healthy lifestyles worldwide, said that many countries still lacked policies, human and financial resources and the institutional capacity necessary to achieve such goals. He therefore urged WHO to continue to encourage those countries to develop health promotion policies for the benefit of their peoples.

Interpretations of health promotion strategies and practices, based as they were on different public health policies and competing or contradictory economic and health systems, and the types of action taken to promote health often varied and were sometimes contradictory. It was essential to take into account, in developing national health promotion strategies, core elements, such as the organization of health services and the social and physical environments, that were well defined and reflected the prevailing situation, and to consider the consequences of, for instance, globalization, development of communications, urbanization, and environmental and social changes. Formulating a health promotion strategy also required consideration of such factors as population trends, the environment, the position of women and children and the social security system. Such a strategy also needed to encourage leadership, participation, a sense of shared responsibility and awareness-building among people. Health as a universal value also encouraged social cohesion, to which the results of the activities involved in health promotion, such as the increased sense of participation, the development of personal skills and the creation of healthy environments, contributed significantly.

Dr YOOSUF (Maldives) said that successful health promotion depended on the promotion of effective and evidence-based tools and strategies, and important lessons could be learned from countries that were making good progress in that area. Despite the fact that health promotion programmes had been in place in many countries for many years, preventable diseases and illnesses continued to increase. Developing countries found that, once they had brought communicable diseases under control, they were faced with much more costly chronic diseases resulting from unhealthy

lifestyles. Some developed countries, however, succeeded in controlling morbidity from such diseases through effective health promotion and health legislation. For health promotion to be effective, partners were needed in areas other than health: health ministries needed to collaborate with other ministries, despite their pursuit of development policies that often resulted in a neglect of health considerations. He agreed with the member for Kazakhstan that a legal basis was needed for effective health promotion. Successful health promotion also depended on a strong political will. WHO had the necessary mandate and competence to achieve success in its policies on health promotion.

Dr MODESTE-CURWEN (Grenada) said that health promotion was one of the greatest investments that any country could make in health. She supported the draft resolution as amended by Kazakhstan. She particularly commended the inclusion in document EB113/7 of mental health promotion, which was neglected by many health agendas; in many regions such as hers, ability to manage mental health problems was lacking. School health programmes that were well structured and effectively delivered would undoubtedly result in significant lifestyle changes. In the Caribbean, and probably elsewhere, the media promoted alcohol, tobacco use and sedentariness; more health promotion was therefore needed via the media. In her region, PAHO had successfully begun that task but more needed to be done.

Mr SAWERS (Australia)[1] said that Australia supported the proposed draft resolution as amended by the members for the United States of America and Kazakhstan.

Australia would be hosting the 18th World Conference on Health Promotion and Health Education in Melbourne in April 2004, and, before that, co-hosting the meeting of WHO's Mega Country Health Promotion Network. The objectives of the two events were to explore critical challenges for health promotion, share evidence of effectiveness in promoting healthy lifestyles and build capacity to meet those challenges. Among the key topics were nutrition and physical activity, prevention of obesity, health of indigenous people, mental health, tobacco, healthy ageing, youth, HIV/AIDS and blood-borne diseases. In many of those areas, Australia was noted for its achievements and leadership in health promotion. It was expected that the two events would bring together the largest group of health promotion experts ever assembled.

Mr PEREIRA MIGUEL (Portugal)[1] expressed the commitment of his country's health authorities to implementing strategies targeting health determinants, especially through the promotion of healthy environments and lifestyles. His country's Minister of Health had recently approved a national programme for integrated action on health determinants linked mainly to lifestyles. That cross-sectoral programme aimed at curbing tobacco and alcohol consumption and promoting healthier diets and physical activity. He welcomed the technical support provided by WHO to ongoing projects such as the European Network for Health Promoting Schools and the Healthy Cities network, as well as to the creation of the necessary infrastructure to implement and evaluate the new national programme. Portugal fully supported the draft resolution proposed by Iceland and other countries and wished to be included as a sponsor.

Professor PAKDEE POTHISIRI (Thailand)[1] strongly supported the global movement towards health promotion, including the adoption of the WHO Framework Convention on Tobacco Control and WHO's work towards a global strategy on diet, physical activity and health. Thailand had enacted legislation to protect the health of non-smokers and to control tobacco use. As a result smoking prevalence had decreased from 30% to 20% in the past 20 years. The Ministry of Public Health had launched an annual exercise campaign by declaring a national exercise day in which, in 2003, more than eight million people had participated.

Thailand strongly supported the new financial mechanisms for health promotion. Its Health Foundation was financed by a 2% excise tax on tobacco and alcohol, which produced an annual

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

revenue of the equivalent of some US$ 60 million. The fund so created was used to support civil societies, the private sector and governmental agencies in their activities to promote the physical, mental, social and spiritual well-being of the Thai people. His country was hosting in 2005 the Sixth Global Conference on Health Promotion, which would be co-sponsored by the Ministry of Public Health, the Thai Health Foundation, WHO and other partners. The Thai Government had declared 2004 as "food safety year" in order to contribute to the better health not only of Thais but of people in other Member States, since Thailand was one of the world's main food exporters.

Health promotion was not only a means of preventing noncommunicable diseases, but a process whereby communities created and managed their own health policies in supportive environments through community actions, health systems and by developing personal skills to aid healthy living. Health promotion should be aimed at alleviating and preventing communicable and noncommunicable diseases. Thailand was ready to support WHO and work with all partners in that area, and supported the draft resolution as proposed by Iceland.

Ms HÄIKIÖ (Finland)[1] said that she greatly regretted the absence of Finland from the list of cosponsors of the draft resolution, particularly in view of the success of her colleague, Dr Puska, the Director-General of Finland's National Public Health Institute in promoting healthy lifestyles in a country whose inhabitants, particularly in North Karelia, had traditionally maintained a high-fat diet on account of the severe cold and harsh working conditions. Finland strongly supported the draft resolution and expressed the wish that Finland and Switzerland be included as sponsors.

Mr SEADAT (Islamic Republic of Iran)[1] commended WHO's leadership in the important area of health promotion. The World Summit on the Information Society (Geneva, 10-12 December 2003) had considered e-health and the best ways of using the enormous potential of information and communication technologies to promote health and encourage healthy lifestyles, especially in developing countries and among peoples living in remote areas. As the importance of e-health deserved greater recognition in the context of WHO's work, he urged the Organization to explore further the possibilities of using such tools for health promotion in developing countries.

Although it was necessary to create affordable infrastructures and strengthen national capabilities in health promotion, linguistic and cultural diversities needed to be taken fully into account. He supported the draft resolution.

Ms MAFUBELU (South Africa)[1] welcomed the report on health promotion and healthy lifestyles. Like other developing countries, South Africa had experienced an increase in diseases linked to lifestyle, such as hypertension, diabetes and obesity. It thus faced a double burden, as communicable diseases had also increased. Yet both types of diseases were preventable.

Critical areas requiring additional intervention included alcohol consumption, physical inactivity and poor nutrition; continued efforts were needed for tobacco control. In particular, she requested the Director-General to report on WHO's future work on alcohol consumption.

Mr GUNNARSSON (Iceland), confirming that Finland had been active in preparing the draft resolution and had indeed been one of its initial sponsors, apologized for the omission.

Dr KARAM (Lebanon),[1] noting the importance accorded to healthy lifestyles, queried how the relevant factors were to be assessed: should hygiene be deemed more important than diet or exercise, what type of diet was preferable and what level of alcohol consumption would be acceptable? It had already been established that tobacco was harmful at any level of intake. Should WHO's recommendations be addressed to governments, to the industries producing the items, or to the consumers? Should moderation and sobriety be recommended to consumers or, presupposing the existence of "good" and "evil" lifestyles, should they be allowed to make those choices by

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

themselves? If the targets of WHO's action were to be the consumers, then it was crucial to reach them in their early years, through school and educational programmes as lifelong habits were formed in youth.

Mrs HERZOG (International Council of Women), speaking at the invitation of the CHAIRMAN, said that health promotion strategies, models and methods were valid in the prevention of communicable and noncommunicable diseases, and acknowledged progress in various parts of the world. Young people, being naturally innovative, aware of their own needs and knowing what would be influential, should be involved in the planning and implementation of programmes and activities. They could be invited to submit action plans, through WHO, to the Sixth Global Conference on Health Promotion in 2005 with prizes awarded for the best plans. The attendant publicity might motivate additional young people and make health promotion more visible. Young leadership that would refuse alcohol, tobacco and drugs was essential for the future.

In the past, health promotion had involved diverse campaigns carrying negative messages that exhorted people not to smoke, consume alcohol or eat unhealthy foods. An integrated approach that took into account how attitudes might be changed and comprising positive statements might be more effective. Here again, young people, if consulted, might furnish helpful suggestions.

Dr BLACHAR (World Medical Association), speaking at the invitation of the CHAIRMAN, stressed the key role that medical practitioners and their professional associations could play in influencing health promotion and healthy lifestyles at the individual, national and global levels. Members of his Association, which represented more than seven million physicians, had adopted at its General Assembly statements on health promotion and on violence and health, and had covered health promotion and healthy lifestyles in its Declaration of Ottawa on the Rights of the Child to Health Care in 1998.

As problems affecting individuals had an impact on the health and resources of their community, the effectiveness of many programmes to enhance public health depended on the active involvement of medical practitioners and their professional associations in concert with public health agencies. Those practitioners were cognizant of personal and community illness patterns, and notified health authorities promptly of problems that might require further investigation and action; they and their professional associations had the skills, knowledge and competence that could be an asset to any health promotion intervention. There was also no substitute for an effective health education intervention in a one-on-one doctor-patient session.

He highlighted the importance of health-promoting hospitals and health care institutions. That initiative, which had been well supported by WHO in Europe, could be of benefit on a global scale and his Association was willing to cooperate closely with WHO to ensure that the experience and expertise of medical practitioners and their professional associations contributed effectively to further research, evidence gathering and implementation of agreed health promotion interventions.

Dr DANZON (Regional Director for Europe), referring to the intervention of the member for Iceland, affirmed the active role played by Finland and the other Nordic countries in giving impetus to health promotion in the European Region.

A strategy for integrating various aspects of health promotion with the global strategy for the prevention of noncommunicable diseases had been drawn up in collaboration with WHO headquarters in order to ensure a coherent approach and would be presented at the next meeting of the Regional Committee for Europe.

Dr LE GALÈS-CAMUS (Assistant Director-General) said that the report had articulated the clear mandate given by Member States on health promotion, in particular through the five international conferences, which had contributed to the development and guidance of practice globally. She had noted that speakers had underlined that health promotion contributed to the prevention of both communicable and noncommunicable diseases, and the report also mentioned the strengthening of national capacities in all regions.

The adoption of the WHO Framework Convention on Tobacco Control had been a major achievement: 86 Member States and the European Union had so far signed the Convention although, as fewer than 40 had ratified it, it had yet to enter into force.

Although the Organization would be willing to draft a report on its activities with regard to alcohol, she pointed out that work on alcohol-related topics had already been undertaken elsewhere. WHO's joint initiatives with the United Nations, the World Bank and other institutions, in particular those in the United States of America, in establishing health education in schools and for young people were in line with the view that closer attention should be paid to such target groups. She noted the concern that activities for vulnerable and poor populations should be further developed.

WHO would continue to provide technical support in the design, implementation and assessment of evidence-based health promotion, and she looked forward to forthcoming conferences, notably those to be hosted by Australia, as important opportunities for sharing the results of performance assessment and, so, contributing significantly to the evidence base. WHO would continue to work with all interested parties, paying keen attention to specific cultural requirements. Regional networks remained an essential means of disseminating information about experiences at country level, and would continue to be encouraged. She drew attention to the Sixth Global Conference on Health Promotion to be held in Thailand in 2005, which would undoubtedly prove to be another milestone in the field of health promotion.

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

The resolution, as amended, was adopted.[1]

Integrated prevention of noncommunicable diseases: Item 3.7 of the Agenda (Resolution WHA55.23; Documents EB113/36, EB113/44 and EB113/44 Add.1)

Dr LE GALÈS-CAMUS (Assistant Director-General), introducing the item, said that the draft global strategy represented a vital step in the prevention of noncommunicable diseases, enabling WHO to work more closely and effectively in that endeavour with Member States, in particular the developing countries.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) observed that the draft strategy advocated an integrated public health approach, bringing together the existing scientific data and evidence of the effects of poor diet, physical inactivity and tobacco consumption in causing noncommunicable diseases. Preventive measures should be based on the integrated control of the major risk factors described in the documents under discussion. Progress had been made, for example through the establishment of regional networks.

However, a report that mentioned diet as a means of achieving a high standard of public health but which ignored the existence of hunger was incomplete. Millions of people in developing countries suffered from malnutrition and were more likely to die prematurely than those who were overweight or sedentary. The adverse effects on health of protein-calorie malnutrition (for example, infantile blindness caused by vitamin A deficiency) made evident the need for a broader strategy. Given the scope of the problem and the fact that children, young people and women were its most numerous victims, he urged the Board to ensure that any such global strategy also highlighted the adverse effect of hunger and malnutrition on health.

Dr STEIGER (United States of America) highlighted the growing problem of obesity and overweight, among other noncommunicable diseases, in his country, where 15 million people were diabetic and a further 17 million were pre-diabetic. The epidemic was mainly caused by overeating and lack of exercise. Parents and communities needed to be educated, empowered and encouraged to

[1] Resolution EB113.R2.

make the right choices for their children and families to improve national health. The present administration in the United States had made encouraging healthy lifestyles a domestic priority and he commended the Government of the United Kingdom of Great Britain and Northern Ireland on its efforts in that direction. However, people should be empowered to take personal responsibility for their own lives. Rather than imposing solutions, governments could ensure that consumers had access to the best information to allow them to make healthy choices, through, for example, media campaigns and work in schools. Poor health had both physical and economic impacts. Employers recognized that poor health meant lower productivity and higher health insurance costs. Businesses must, therefore, do more to encourage healthy lifestyles.

Good nutrition and a balanced diet coupled with physical activity were critically interrelated to countries' health. WHO needed to produce a strategy on diet, physical activity and health for the approval of the Fifty-seventh World Health Assembly. The proposed draft strategy represented a good first step, but, as the member for Cuba had noted, the current draft might not be as relevant to the needs of all countries as it could be. To be effective, the strategy must address all the complexities surrounding diet, nutrition and physical activity, as well as the role of the individual in health and dietary behavioural change. Therefore, countries should be allowed a further 30 to 45 days for detailed review in order to devise a stronger, more evidence-based version of the strategy for submission to the Health Assembly in May 2004. (In 2001, a similar approach had been followed for the draft global strategy on infant and young child feeding.) The strategy had to be grounded on science and public health evidence and to have evolved through a participatory and transparent process with public and private stakeholders if it were to be relevant across all countries and populations. WHO's role was to provide good evidence to Member States; the role of governments was to interpret and apply such evidence in the development of their national policies and programmes. Since individuals would have to adapt recommendations in the strategy to their own lives and change their behaviour accordingly, it had to be relevant and convincing.

The United States proposed the following amendments to the draft resolution:

the replacement of "occur in developing countries, mostly among people of working age" by "are from leading causes of adult death throughout the world and that in developing countries noncommunicable disease mortality is higher among adults under the age of 60 years than it is in the developed world" in preambular paragraph 3;

the insertion of a new preambular paragraph after preambular paragraph 6 to read "Recalling the renewed 'health for all strategy' that calls for a holistic global health policy based on the concepts of equity and solidarity, emphasizing the individual's, family's and the community's responsibility for health and promoting individual responsibility for health through the adoption of healthy lifestyles and other measures that protect populations from avoidable health risks";

the insertion of a new preambular paragraph to read "Recognizing that parents, families, legal guardians and other care-givers have the primary role and responsibility for the well-being of children";

the insertion of "and all concerned stakeholders and sectors" between "professions" and "in improving" in current preambular paragraph 7;

the replacement of "ENDORSES" by "SUPPORTS" and the insertion of "intent and concepts of the" between "the" and "global" in paragraph 1;

the insertion of a new paragraph 2(1) to read "to promote the healthy lifestyles that include balanced diet and physical activity and promote energy balance";

current paragraph 2(1) be changed to paragraph 2(2) and "develop, evaluate and" be inserted between "to" and "implement", "actions, including where appropriate, those recommended in" be inserted between "implement" and "the", and that "as appropriate to national circumstances as part of their overall policies and programmes on noncommunicable disease prevention and on health promotion, in order to ensure optimal health for all individuals and communities" be replaced by "to promote individual and community health through diet and physical activity and reduce the risks and incidence of noncommunicable disease";

the replacement of "mobilize" by "encourage mobilization of" between "to" and "all" in current paragraph 2(4);

the replacement of "to providing support to governments in implementing the strategy, and invites donors to provide adequate funding for the necessary measures" by "and invites public and private stakeholders, including the donor community, to explore ways to work together with governments in the promotion of healthier diets and physical activity to improve health outcomes" in paragraph 3;

the insertion of "science-based" between "to" and "action" in paragraph 4;

the replacement of "to ensure that the Organization at both global and regional levels provides support to Member States in implementing this strategy and in monitoring and evaluating implementation" by "to provide technical support at both global and regional levels to Member States when requested in implementing, as appropriate, aspects of this strategy" in paragraph 5(1);

the replacement of "specific" by "technical", the replacement of "advocacy" by "analyses", the replacement of "to ensure" by "so that", the insertion of "better" between "are" and "aware", the insertion of "cost benefit" between "the" and "contribution", the replacement of "unhealthy" by "healthy", the replacement of "inactivity" by "activity", the replacement of "to the" with "as they address their" in paragraph 5(2);

and the replacement of paragraph 5(4) by "to work with public and private stakeholders in the implementation of aspects of the strategy and the promotion of healthier diets and physical activity".

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) welcomed the report and observed that his comments were in line with the forthcoming statement by the European Union.

The world health report 2002[1] had rightly highlighted that the major noncommunicable diseases accounted for nearly 60% of all deaths worldwide. The principal risk factors were well established. WHO had already begun to tackle the global problem of tobacco use through its Framework Convention on Tobacco Control. It was gratifying that, through its draft global strategy on diet, physical activity and health, it was turning to face the other major behavioural risk factors for noncommunicable diseases.

The United Kingdom was preparing to tackle poor nutrition and physical inactivity. Its rates of obesity and overweight had tripled over the past 20 years. Not only a serious health threat worldwide, obesity and overweight also had serious health care consequences. Of particular concern was the rate of increase in those conditions among children and the attendant emergence of type 2 diabetes, a disease previously only seen in middle life. So far, no country had tackled the problem of obesity successfully, but the public worldwide expected robust responses. Improving diet and increasing physical activity involved work at national, international and local levels and the United Kingdom was currently engaged in developing national action plans. One of those focused on promoting consumption of fruit and vegetables and reducing salt intake. It was a venture in which all the stakeholders needed to participate: consumers, governments, industry, schools, sports bodies and the national health care system. In the case of salt, research in his country had shown that 75% of salt in the national diet came from processed and pre-prepared foods. Sugar and fat were next on the agenda.

WHO's proposed strategy adopted a broad approach calling for action from a range of sectors and merited submission to the Health Assembly in May 2004 in an adoptable form irrespective of the outcome of the Board's discussions, so that Member States could proceed with tackling those pressing problems.

Dr OM (Republic of Korea) expressed support for the proposal by the member for the United States of America to give Member States additional time for commenting on and proposing amendments to the draft strategy before its submission to the Health Assembly.

Dr DAYRIT (Philippines) said that his country shared the global concern regarding healthy diets, nutrition and the prevention of chronic diseases and commended WHO's leadership in that area.

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[1] *The world health report 2002. Reducing risks, promoting healthy life*. Geneva, World Health Organization, 2002.

The Philippines supported the draft resolution as amended and agreed with the need for further study of the draft strategy.

He drew attention to a technical issue raised in paragraph 19 of the draft strategy, which mentioned the need to "shift consumption away from saturated fats". There were in fact two types of saturated fats: medium-chain and long-chain fatty acids. The long-chain saturated fatty acids found in animal fat were associated with coronary artery disease. The Philippines, which did not have a high rate of coronary artery disease, had high consumption rates of coconuts and coconut oil, which contained a medium-chain saturated fatty acid. The indictment of saturated fats should have drawn the distinction between the two types. He therefore proposed the insertion of a qualifier so that the text would read "shift consumption away from animal saturated fats".

Mr KHAN (Pakistan) said that Pakistan, like many other developing countries, suffered from the "double burden" of disease, struggling with communicable and noncommunicable diseases. The four leading noncommunicable diseases (cardiovascular disease, cancer, common obstructive pulmonary disease and type 2 diabetes) were associated with preventable biological and behavioural risk factors. Prevention should focus on integrated control of those aspects. Pakistan was satisfied by WHO's work on the integrated prevention of noncommunicable diseases and supported the WHO Framework Convention on Tobacco Control and the draft global strategy on diet and physical activity.

He drew attention to the Report of the Joint WHO/FAO Expert Consultation on Diet, Nutrition and Chronic Diseases which had been launched in Rome in April 2003[1] and which he understood to be a new version of a technical report published in 1990,[2] which had been deemed unsuitable for use as a global policy. He asked whether the experts involved in the new report were the same as those in the previous one. He called for more transparency. The experts selected to produce the report should be from different nations and backgrounds so that the subsequent policy could be founded on science-based knowledge and evidence. He called for a special session to study the matter and formulate a policy on research. There was no scientific basis for recommending population nutrient goals. Indeed, even the Director-General of FAO had admitted that the 10% figure for sugars was arbitrary and not based on scientific evidence; that was an important matter that should be looked into. Some 2100 million people throughout the world were undernourished. Population nutrient intakes should focus on intake at the individual level and not on average intakes; huge disparities between rich and poor could be concealed by average consumption data. For example, sugar intake played a huge role in poor countries, which displayed enormous differences compared to countries like Switzerland or the United States. Rates of intake could be critical for poor countries in terms of their livelihood or intake of nutrients.

He concurred with many of the points raised by the member for the United States, especially the need for more time to consider the global strategy. It would be preferable to say "enough time" rather than "30 to 45 days". The member for the Philippines had mentioned the direct link in certain countries between diet and disease control. A study was needed on the direct impact of diet on disease. As had already been noted, there was no such thing as "good" food or "bad" food but only a good or a bad diet.

In the draft strategy the term "unhealthy diets" used in paragraph 4 was too ambiguous even when, in paragraph 19, the report recommended limiting energy intake from fats and sugars and increasing consumption of fruits and vegetables. He called for an evidence-based study on the damage caused to the health of communities by fast foods. The member for the United States of America had emphasized their great impact on obesity and other conditions. Although fast foods had been introduced into Pakistan only about five years previously, a direct link with obesity and cardiovascular diseases was already observable.

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[1] WHO Technical Report Series, No. 916, 2003.

[2] WHO Technical Report Series, No. 797, 1990.

Pakistan had created a tripartite model for prevention and control of noncommunicable diseases in which it cooperated with nongovernmental organizations through the WHO country office. The mechanism was working well.

Professor KULZHANOV (Kazakhstan) noted that he had several amendments to propose to the resolution, most of them based on his country's experience in its efforts to improve the national diet and overall health status of the population, which he would submit in writing. His Government had already adopted a law on the addition of salt for the improvement of flour. All the laws adopted to improve diet were based on scientific evidence. It intended to deal with problems of iodine and iron deficiency in the same way. He emphasized the important role for local authorities in such efforts. He supported the proposals made by the member for the United States of America, which emphasized the importance of enhancing the role of the family and parents in the development of children's health. Submitting the issue to the Health Assembly would encourage further improvements in the prevention of noncommunicable disease.

Professor FIŠER (Czech Republic), referring to paragraph 36(2) of the draft strategy, on price policies, said that tax policies were unlikely to encourage healthier food consumption, as they had no impact on eating habits. In the absence of evidence that tax policy did indeed influence eating habits, he proposed either the addition of a sentence "The impact of fiscal measures on healthier food consumption has not yet been evaluated" or the deletion of the words "healthy eating". In regard to paragraph 48, on international standards, he wondered whether there had been a change of practice in the Codex Alimentarius Commission and if the formulation had been agreed by all stakeholders, including "private companies".

He supported the amendments proposed by the member for the United States of America.

Mr AISTON (Canada) supported the comments of the member for the United Kingdom of Great Britain and Northern Ireland on the need for such a global strategy. Canada commended the text, the approach and recommended actions which were consonant with Canada's continued commitment to reduce the global health, human and economic burden resulting from largely preventable noncommunicable diseases. Implementation of the integrated approach among the different target groups would require a variety of mechanisms. The draft strategy itself rightly called for evidence-based approaches, which was an important aspect for its acceptance by those responsible for expenditure in governments. He thanked those who had developed the draft strategy and said that he looked forward to working with those who would deal with its implementation.

He reiterated the recommendation made at the Fifty-sixth World Health Assembly to secure the concrete commitment of each Member State to the development of a national plan of action consistent with the draft strategy. Canada had already implemented many of the recommended activities and would continue to do so.

References had been made to the need for evidence. Canada considered the draft strategy to be a product of evidence from several sources. The reference group of independent experts had included specialists from many areas and their varied experience had greatly illuminated the document. It was important for the draft strategy not to be prescriptive: it was a "menu" of best practices from which Member States could choose the elements best suited to their particular circumstances, and should be viewed as such.

Canada was able to support only some of the amendments proposed by the member for the United States of America. The Chairman might consider setting up a group to look at the amendments and engage in further negotiation. He welcomed the general sentiment that the draft strategy should be submitted to the Fifty-seventh World Health Assembly.

Dr ACHARYA (Nepal) informed the Board that two workshops in 2001 and 2002 had identified the major noncommunicable diseases in Nepal and their principal risk factors. The prevalence of each disease in Nepal, however, could not be quantified as the country lacked systematic information. The main source of data was the annual report published by the Department of Health

Services, which was derived from governmental hospitals and did not include the private sector. A further problem was the under-reporting or mis-reporting of events due to the poor accessibility of health care services as well as difficulties in establishing diagnoses, especially at district level. An information system for noncommunicable diseases within the general health information system was needed.

The most important approach was primary prevention in order to avert or limit epidemics, based on the identification of the major risk factors. Nepal needed that information in order to plan its action and monitor programme effectiveness. There was strong evidence that it was possible to prevent noncommunicable diseases and effect change through continuous actions aimed at individuals, families and the community as a whole so long as those actions were socially and culturally appropriate. People had to be persuaded that their current actions would produce worthwhile future benefits. However, disease prevention and other health promotion activities, especially in relation to dietary habits, physical activity and tobacco control, were seldom given priority by policy-makers. Nepal aimed to draw up strategies and a plan of action.

He supported the draft resolution but proposed that the words "civil society" be added in paragraph 2(4) after the words "private sector". The amendments proposed by the member for the United States of America needed careful consideration.

Dr HUERTA MONTALVO (Ecuador) said that the document emphasized some of the nutritional factors in certain noncommunicable diseases but omitted others related to malnutrition, due to micronutrient deficiencies, for example, and did not mention problems of quality or even the lack of food in Latin America and in Africa. Attention should be paid to diets that were harmful to health, but not only in regard to obesity. Hunger also needed to be taken into account as a contributory factor to noncommunicable diseases. Those chronic diseases needed a plan of action that was not just technical but which worked for equity and solidarity and sought new alliances between the public and private sectors, politics and economics, and scientific and cultural factors. He supported the request by the member for Cuba for a strategy that dealt with noncommunicable diseases resulting from hunger caused by a lack of solidarity and equity. Ecuador supported the draft resolution and the procedure suggested by the member for Canada.

The meeting rose at 12:30.

FOURTH MEETING

Tuesday, 20 January 2004, at 14:10

Chairman: Dr K. AFRIYIE (Ghana)

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

Integrated prevention of noncommunicable diseases: Item 3.7 of the Agenda (Documents EB113/36, EB113/44 and EB113/44 Add.1) (continued)

Dr TAG-EL-DIN (Egypt) emphasized the importance of the integrated prevention of noncommunicable diseases, to which, as developing countries progressed, their populations became increasingly prone. An additional burden was therefore placed on those countries' health systems that were still dealing with "traditional" diseases such as tuberculosis and malaria and their complications; although their danger was fully understood, the "modern" noncommunicable diseases, which were also potentially fatal, should be considered equally dangerous. Noncommunicable diseases required specific health care, early detection, close monitoring and lifelong drug treatment, and he therefore welcomed WHO's initiative to work with countries concerned to ensure prevention, monitoring and treatment.

Despite global campaigns and the adoption of the WHO Framework Convention on Tobacco Control, the use of tobacco remained an important issue, particularly for the developing countries. Furthermore, a healthy diet was closely related to the integrated prevention of noncommunicable diseases, and consumers should be made fully aware of the harmful effects of some types of diet for young and old alike. Communities should be motivated to encourage people to engage in more physical activity and lose weight, helping to reduce the incidence of the diseases and to control them in those already affected. Expressing support for proposed amendments to the draft resolution, he stressed that there was no one single cause of noncommunicable diseases; factors such as diet, lack of exercise and lifestyle were all contributory causes. Steps should be taken on the issue without delay.

Dr KASSAMA (Gambia) welcomed WHO's comprehensive approach in developing the draft global strategy on diet, physical activity and health, and the steps taken to ensure that public interest remained a priority. In order to avoid any conflicts of interest, particularly in the implementation of the strategy, he suggested that the words "while ensuring proper management of potential conflicts of interest." should be added at the end of paragraph 5(4) of the draft resolution contained in document EB113/44.

Professor FURGAL (Russian Federation) said that a comprehensive integrated approach for the prevention of noncommunicable diseases was constructive from both the scientific and the administrative point of view, and would prove particularly useful for countries where financial resources were scarce. WHO's consultations with Member States, United Nations specialized agencies and other stakeholders had been useful, and the draft global strategy would provide a solid basis for collective action for health care.

The Russian Federation welcomed the development of the WHO Mega Country Health Promotion Network linking the 11 most populous countries, including his own. His country was also participating in the countrywide integrated noncommunicable diseases intervention (CINDI) programme. Noncommunicable diseases would be discussed by the Regional Committee for Europe at

its forthcoming fifty-fourth session, attesting to the close cooperation on the subject that existed at the global and regional levels.

In the development of the global strategy, greater attention should be paid to international educational initiatives such as seminars, pilot projects and international post-graduate courses perhaps involving WHO collaborating centres. Furthermore, alcohol consumption, drug use and psychological and social factors should be listed among the risk factors of chronic noncommunicable diseases.

In view of the significance of the global strategy and the need for further consideration of experience obtained, the strategy should be discussed further and the draft resolution amended before being submitted to the Fifty-seventh World Health Assembly.

Dr AL-MAZROU (Saudi Arabia) said that diabetes was a major problem in Saudi Arabia: the prevalence in the adult population was 18%, and that figure would rise if the necessary preventive action was not taken. The number of obese children and adults was also increasing in a society where the problem had been unknown 40 years previously. Although attempts had been made to put into place measures to mitigate the effects of the problems, the process was long, and he therefore welcomed the draft global strategy. To further improve the strategy, more clearly defined mechanisms should be established to counter unhealthy diets. Measures similar to those taken to combat tobacco, such as restricting distribution and advertising, and imposing additional taxes for health promotion, might also be taken. Governments should also encourage adherence to traditional diets and caution should be exercised concerning potentially harmful low-calorie diets that lacked a scientific basis. The Board should have an opportunity to study the draft strategy and resolution in the light of the amendments proposed, several of which dealt with important points such as the role of individuals and the family in implementing the strategy.

Dr YIN Li (China) commended the consultations that had taken place on the draft strategy with Member States, international organizations, nongovernmental organizations and the food industry. In 2002, a survey of 250 000 people had been conducted with a view to assessing the impact of China's socioeconomic development in the 1990s and the relationship between nutrition, high blood pressure and diabetes. The results, which would be made public in the second half of the current year, appeared to indicate a close link between noncommunicable diseases, diet, physical activity and economic development. The establishment of the global strategy was very important for public health and to control noncommunicable diseases. Efforts should be made to revise the draft as quickly as possible with a view to its consideration by the Fifty-seventh World Health Assembly.

Professor DAB (France) said that, as many countries encountered difficulties in financing their health care systems, it was imperative for WHO to make every effort to facilitate the development of programmes so that a balance could be struck between the resources used for prevention and those for treatment of noncommunicable diseases. Dietary habits and levels of physical activity were complex issues. Individuals' behaviour and environmental influences were linked, and should be tackled together in the interests of success. Some large companies had marketing budgets that were bigger than certain Member States' health budgets, and an individual's behaviour could be socially determined by various extraneous factors.

The drafting of the strategy had been a complex task, particularly in view of the difficulties associated with the interpretation of data. The criticisms voiced had not been sufficiently compelling to justify delaying the strategy, and it was essential to begin implementation. A national plan for health nutrition had been launched in France in 2001; experience highlighted the importance of involving health authorities in order to ensure a coherent range of educational and preventive measures for the public at large and health professionals. Messages to consumers had to be consistent. It was not enough to call for personal responsibility when individuals were faced with a deluge of competing and often contradictory information.

France approved the draft strategy and emphasized the need to adapt it to local situations. Rather than delaying the implementation of the strategy, he proposed a new paragraph 5(2) in the draft resolution, to read: "to set up a permanent international scientific surveillance mechanism enabling

Member States to adapt their programmes in the light of the latest knowledge". Such a step would provide Member States with the best possible guarantee for implementing their activities in the light of the information available. He could accept some of the amendments proposed by the member for the United States of America provided that a working group ensured that the text retained its global nature, which was essential for effectiveness.

Dr BOSHELL (Colombia) wondered whether all the concerns expressed during the discussion could be covered in a single document. Further study was required to produce a more comprehensive document that pointed the way to a healthy, energetic and well-nourished lifestyle. He was in favour of postponing further work on the strategy until al' the comments made had been appropriately reflected.

Dr NDONG (Gabon) said that it was regrettable that the concept of personal or individual responsibility had been omitted from the section entitled "Responsibilities for action" in the draft global strategy set out in document EB113/44 Add.1. The choice of diet and whether to engage in physical activity were personal decisions. A new paragraph on personal responsibility might be added to the strategy itself, or the concept might be mentioned in the draft resolution, which his country supported.

Dr CAMARA (Guinea) said that noncommunicable diseases that had once been infrequent in developing countries had recently become genuine health problems there. Such diseases, which were difficult to control, normally necessitated public health approaches and costly, specific interventions that required advanced technology and highly skilled personnel. In contrast, the draft strategy proposed simple approaches which, if they were applied, would certainly help to reduce the morbidity and mortality related to those illnesses. The world was faced with huge problems, but resources were scant. Since the approaches outlined were not costly, his country supported the draft resolution as amended. Nevertheless, it also endorsed Cuba's suggestion that malnutrition should be viewed as a health problem affecting most developing countries.

Dr MARTÍN MORENO (alternate to Dr Pastor Julián, Spain) welcomed the draft global strategy and its linkage with the integrated prevention of noncommunicable diseases, which offered a way to avoid "paralysis through analysis". His country endorsed the statement that would shortly be made on behalf of the European Union. He would welcome the opportunity to consider in detail the amendments or additions to the document suggested by several members, and suggested the setting up of a working group as a means of expediting matters, since the strategy should not be held up. WHO should issue practical, flexible recommendations taking into account the diversity of contexts, although principles and continuity were vital.

His country was in favour of France's proposal to keep the scientific evidence under constant review, since modern lifestyles were resulting in new causes of death. Recent changes in diet had not followed the same pattern in all countries of the world or in all societies. While people in the most developed countries lived in opulence, ate too much and did not take enough exercise, societies in the developing countries suffered from a deficit of essential nutrients, which led to disease, suffering and death. That state of affairs should be borne in mind in the WHO strategy.

While scientific evidence and basic epidemiological research were necessary to elucidate the subject matter, clinical trials and random tests would not always be possible, so it would be imperative to strike a balance between boldness and caution. On the other hand, oversimplification and generalization could result in mistakes. Rather than trying to draw up a list of good and bad foods, it would be better to understand the importance of diet in terms of calorific intake, nutrients and expenditure of energy. For that reason, the WHO proposal to speak of diet and physical activity in the same breath was welcome. When foodstuffs were safe, they could usually be consumed in judicious amounts, but the main problem was inadequate diet.

Even in the most developed societies, messages regarding risks associated with overeating or dangerous foods needed to be couched in prudent language, to avoid the result of abnormal eating

patterns, such as anorexia or bulimia. Bodies like WHO should therefore do everything possible to ensure that any action taken was not counterproductive, especially among young or vulnerable sections of the population. On the other hand, for the global strategy to be successful, all sectors had to be involved. It would be necessary to invest in dietary education programmes and behavioural research and to mobilize the food industry, many parts of which were already willing to move in that direction. Health interests also had to be uppermost. The catering industry should be persuaded to plan and offer healthy meals and the media had to play their part in encouraging good eating habits.

Physical activity contributed to preventing disease, and the psychological and social benefits of adequate exercise should be publicized. As more than half the population led a sedentary lifestyle, his country supported an integrated programme promoting a healthy diet, combating eating disorders and encouraging physical activity.

The Mediterranean diet had traditionally been regarded as beneficial to health and the quality of life, as it offered a balanced and varied combination of fruit, vegetables, salads, cereals, nuts, fish and olive oil. Caloric intake should be in keeping with the amount of energy a person expended. It was a matter for concern that so many children spent long hours alone in front of the television or computer, not engaging in much physical activity and spending little time playing with their peers or other persons. The epidemic of obesity due to physical inactivity was the result of partly individual choice and partly the social environment. For that reason an integrated approach promoting physical activity, a healthy environment and a wholesome diet should be launched using all the means available.

His Government had participated actively with WHO, at headquarters and regional level, in revising the global strategy in order to adjust it to the needs of his country, for the strategy should be adapted to the requirements of societies and different groups. His country's plan covering obesity, diet and physical activity complemented other plans, including WHO's Health21, and was designed to combat heart disease, cancer and other diseases that took a heavy toll in Spain. It would focus on individual lifestyles and the social environment.

Dr MODESTE-CURWEN (Grenada) said that noncommunicable diseases contributed significantly to morbidity and mortality, and the economic burden on peoples. In the Caribbean, the incidence of those diseases was rising at an alarming rate, and effective action must be taken immediately to halt that trend. A healthy diet and exercise were essential for the prevention and control of many of them. Success in changing lifestyle would largely depend on the involvement of key stakeholders, each of whom must assume responsibility for the process. Securing the involvement of all required the provision of sound, evidence-based information. She said that she had received many questions about the scientific bases for the recommended quantities, the sources of the data and the reason why certain factors contributing to morbidity and mortality had been omitted. Those concerns were likely to increase by the time of the Fifty-seventh World Health Assembly if they were not tackled in a timely fashion. If the Organization wished to define the recommendations, it must be empowered to do so. In the interests of the success of the initiative, her Government supported the time extension recommended by the United States of America. While her country did not have the expertise to review the document in its entirety, she was sure that several other countries and entities could undertake that task.

Even though health ministries had been aware of the importance of a health diet and exercise for many years, it had unfortunately proved impossible to persuade populations to change lifestyles. A strategy such as that proposed by Cuba, which was relevant to the peoples of various countries and which would take account of their cultural background, was therefore vital to the effective implementation of a sustainable healthy lifestyle programme. Several countries had made progress in that respect; WHO might assist by coordinating access to that experience. In her country, a previous government many years earlier had initiated a programme called "Grow what you eat and eat what you grow". Although that programme had been most successful, it had been abandoned by subsequent governments. Her Government was attempting to revive it. Not only must health ministries offer advice about what to eat for a healthy diet, but ministries of agriculture and other international agencies also needed to work together to enhance access to those foods.

Mr GUNNARSSON (Iceland) said that the long-recognized, growing burden of noncommunicable diseases had been accurately described in *The world health report 2002*.[1] Oral health should have been included in the list of concerns, as it was closely associated with noncommunicable and communicable diseases. The leading causes of all those diseases were an unhealthy diet and lack of exercise. Noncommunicable diseases were causing a new situation in societies: middle-aged offspring were dying before their older parents. The draft strategy was most important, as it had been written after in-depth consultations with 80 nations. There was, however, a need for an open discussion because, although the text was fairly detailed, it did not specify any levels or margins for the various risk factors, such as different kinds of food. At the same time, it was essential that a broad understanding should be reached between the partners involved, such as the public health authorities and the food industry. He had personally held interesting discussions with representatives of the food industry in the Nordic and other European countries. While they did not agree with everything in the draft, they could live with the strategy as it stood, save for the section on taxation. His country endorsed the proposals made by Canada, France and the United Kingdom of Great Britain and Northern Ireland. If they were not enough to deal with the concerns voiced by the United States of America, his Government would support one further consultation before the next Health Assembly.

Dr OSMAN (Sudan) said that members' great interest in the fight against noncommunicable diseases was proof of its importance. Because dietary behaviour differed in developed and developing countries, the resolution was too general and it also lacked a scientific basis. His Government therefore welcomed the amendments put forward by the United States, although more time was needed to produce a clearer text to which all Member States could subscribe. A full two months needed to be set aside for consultations. Furthermore, the subject should be evaluated in time for the next Health Assembly.

Dr YOOSUF (Maldives) said that the well-prepared draft should be amended to highlight the role of the media, which could either promote good health or send out negative health messages. In households where both parents went out to work, they were tempted to cook fatty, salty fast food because they had neither the time nor the skills to prepare nutritious dishes. The educational policies of many countries placed too much emphasis on academic work and did not set enough time aside for physical activity. Moreover, there were few safe areas where children could play. Consequently their parents kept them indoors and allowed them to sit for hours in front of the television or computer. Municipal authorities should therefore make greater provision for safe recreation areas for children and young people. Furthermore, most people's long working hours made it difficult for them to find time for physical activity. A determined effort had to be made to ensure that all employees in the public and private sectors could take part in a healthy exercise programme. His country's Ministry of Health ran a daily half-hour voluntary exercise programme, in which the Minister himself participated. His Government recognized the importance of the topic and supported the proposal that a more detailed examination of the document should be undertaken before it was presented to the Health Assembly.

The CHAIRMAN, speaking in his capacity as the member for Ghana, said that most Ghanaians consumed large quantities of short-chain fatty acids in the form of palm and coconut oil, and the incidence of coronary and heart disease was not high; he therefore agreed with the comments by the member for the Philippines with regard to paragraph 19 of the draft global strategy. Publications in the western media during the 1980s had implied that tropical oils were noxious, whereas the opposite had proved to be the case, exemplifying that food science was not an exact science. For that reason, he agreed with the member for the United States of America on the need to seek further evidence. In general, Ghana supported the call for evidence-based strategies, while recognizing that enough

[1] *The world health report 2002: Reducing risks, promoting healthy life*. Geneva, World Health Organization, 2002.

evidence was already available to warrant action; for example, there was no doubt that consumption of fatty foods led to obesity. Ghana also was interested in the role of communities, families and individuals and their democratic right to make informed choices based on scientific evidence. He supported the United States' proposed amendments, which, inter alia, would draw a distinction between short-chain fatty acids of plant origin and long-chain fatty acids of animal origin.

Mr KEENAN (Ireland),[1] speaking on behalf of the Member States of the European Union, the acceding States Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia and the candidate countries, Bulgaria, Romania and Turkey, said that the European Union supported the draft global strategy as the culmination of much work between WHO and FAO experts. It would be a valuable resource to Member States and would greatly inform policy and actions to reduce risks of cardiovascular disease and certain types of cancer. It also drew attention to the need for concerted action to combat the growing incidence of diabetes and obesity.

Two of the three general objectives in the European Union's programme of Community action in the field of public health (2003-2008) were to improve health information and knowledge, and to promote health and prevent disease through addressing health determinants. The programme specifically referred to the potentially enormous dividends from eradication of smoking and the contribution to be achieved through eliminating or diminishing alcohol abuse, and improving diet and physical activity – aims consistent with those of the draft global strategy. In December 2003 the European Union Council of Ministers had adopted Council Conclusions entitled "Healthy lifestyles: education, information and communication". Work was also in hand to seek consensus among Member States of the Union on best practice in regard to population health strategies and those aimed at high-risk groups for the prevention of cardiovascular disease.

Community actions relating to tobacco control and food law were highly relevant to the integrated prevention approach set out in the draft global strategy, which would also link with the current European Union network on diet and physical activity and made common cause with the European Environment and Health Strategy. The latter would focus on children and culminate in an action plan for 2004-2010. The plan would be presented at the Fourth Ministerial Conference on Environment and Health (Budapest, June 2004), at which a children's environment and health action plan for Europe was due to be inaugurated.

Mr AGARWAL (India)[1] said that India, with some 30 million people affected by diabetes, welcomed WHO's leadership in preparing the draft strategy, which was a timely initiative. His delegation had some comments to make. First, the strategy should be culture-specific, taking into account the fact that in countries such as his own, diseases were linked not only to lifestyle but also to malnutrition. Secondly, any doubts about the scientific rigour of the Report of the Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases[2] should be dispelled with stronger evidence. Thirdly, it was not food, but diet, that should be deemed healthy or unhealthy. Fourthly, the use of taxation to promote healthy consumption of food might be a good idea in theory but could be difficult to apply in practice. Lastly, adoption of the global strategy could have implications for the food industry and consumer groups, which should therefore be included in consultations. Therefore, India supported the United States' proposals to find time for broader consultation.

Dr KARAM (Lebanon)[1] said that the draft global strategy represented a highly commendable approach. More important, however, was the question of its implementation, which required the involvement and support of all parties in order to be effective. Time spent in broader consultations, therefore, would not be time lost, and the comments of the member for the United States were relevant. The strategy must also take account of lifestyles and be realistic, recognizing, for example,

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[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[2] WHO Technical Report Series, No. 916, 2003.

that ideas about diet might simply reflect fads. Further consultation was needed, because the strategy, to be effective, must be implementable and based on sound scientific facts.

Ms SAHADUTKHAN (Mauritius)[1] said that her country could support the idea of a global strategy, provided that it was founded on the best scientific evidence. However, the strategy had been based on the Report of the Joint WHO/FAO Expert Consultation,[2] which had been widely criticized; Mauritius had itself voiced strong reservations on several issues. In particular, the proposal to limit the dietary intake of free sugars to less than 10% had no scientific foundation – there was no evidence that sugar was itself a direct cause of noncommunicable diseases; other factors such as heredity, lifestyles, occupation, and levels of stress and physical activity had not been considered in the report, which had merely set out population-wide nutrient goals but had given no upper limits for individuals. With regard to the recommendations on obesity, it should be noted that that was caused by an imbalance between calorie intake and energy expended, and was therefore a health education issue.

Mauritius, a small island developing country, was gravely concerned about the possible economic impact of the Report's recommendations. Sugar was not only recognized as the cheapest calorie source worldwide, but also made an important contribution to diet in many developing countries. For the reasons stated, the Report was too fundamentally flawed to serve as a basis for the global strategy. Her delegation therefore called for the deletion of all reference to it from the strategy to be submitted to the Health Assembly; it also found interesting the United States proposal concerning resolution WHA55.2 and agreed that more time was needed for study and consultation.

Dr DURHAM (New Zealand)[1] said that the "time bomb" of noncommunicable diseases had already exploded in New Zealand and other Pacific countries, whose health systems were struggling to cope with the increase in ailments such as renal failure. New Zealand, like many other countries, would be concerned if adoption of a global strategy was delayed beyond the Fifty-seventh World Health Assembly. It agreed that the draft strategy was evidence-based, although it endorsed comments on the evolving nature of the evidence. It supported the non-prescriptive approach to dealing with serious epidemics. A distinction must be drawn between a strategy that would be accepted and one that was acceptable. The present status quo, in which the world had failed miserably to control noncommunicable diseases, was unacceptable. In that respect, WHO could provide outstanding leadership.

She was somewhat confused by the various groups recommended in the draft resolution. She therefore welcomed the Canadian suggestion for a drafting committee, and urged WHO to seek a process to finalize the draft strategy for consideration at the Fifty-seventh World Health Assembly in such a way that, in addressing the concerns of some Member States, it did not generate concerns among others. A working group should include members and non-members alike, and its membership should be agreed on before the current meeting rose. An ongoing process was required in order to keep the strategy abreast of new evidence. New Zealand would be pleased to participate in that process.

Mrs LAMBERT (South Africa)[1] said that the proposed draft global strategy was particularly welcome for developing countries. South Africa's health system was already being stretched by the spread of communicable diseases, especially HIV/AIDS, tuberculosis and malaria. Although resources were being found with which to focus on preventable diseases of lifestyle, there had been an alarming rise in problems stemming from hypertension, diabetes and obesity, problems which had the potential to cripple the health system. Because such diseases were preventable, strong leadership, of the sort WHO could provide, was called for; in that connection, although tobacco was not a food, the WHO Framework Convention on Tobacco Control provided useful guidelines. As an example, control of advertising of unhealthy foods would be of enormous benefit in the developing countries. Although it was often said that governments could not alter people's attitudes, consumers needed accurate, clear

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[2] WHO Technical Report Series, No. 916, 2003.

and user-friendly information; governments should play a role in that regard. Likewise, although people might be expected to be responsible for their own behaviour, they also deserved adequate education and honest information; there again governments had a duty.

Her Government was currently promoting action plans to target sedentary lifestyles and excessive consumption of fats, sugars and salt as well as to deal with matters such as poverty, malnutrition and the need to fortify certain kinds of food.

The proposed strategy was evidence-based and, while being non-prescriptive, nevertheless offered a good mix of measures to promote ongoing work, nationally and internationally. Its scientific basis was sound: the Report of the Joint WHO/FAO Expert Consultation[1] was entirely in keeping with the regulations for study contained in basic WHO documents; it had been the subject of broad consultation and produced by internationally acclaimed experts. The comments of the member for France about the need to keep abreast of new evidence were cogent. Recognizing the need for consensus, however, she could agree to further consultations, on condition that the draft would be submitted to the Fifty-seventh World Health Assembly.

Dr BARBOSA DA SILVA, Jr (Brazil)[2] agreed that adoption of a global strategy was a high priority because of the burden that noncommunicable diseases placed on national capacities. The debate in the Board had shown the need for a larger measure of consensus; his delegation therefore supported the proposal to form a drafting group, with a view to achieving a text that could be submitted to the next Health Assembly.

Ms PORTOCARRERO (Venezuela)[2] supported the proposal to set up a group to consider the text of the proposed global strategy. In that connection, it was important to highlight the nutrient and micronutrient deficiencies which exacerbated chronic communicable and noncommunicable diseases, which were so widespread in developing countries.

Mr HOWLETT (Industry Council for Development), speaking at the invitation of the CHAIRMAN, said that his organization's only purpose was to work with WHO, FAO, other international health bodies and national governments towards the improvement of health; one result had been the formulation and dissemination of a training programme on food safety for health and nutrition professionals in South-East Asia and other parts of the world. It had also supported WHO's other efforts relating to noncommunicable diseases, a major cause of avoidable mortality that was growing to epidemic proportions throughout the world. It supported the WHO global strategy on diet, physical activity and health and was willing to collaborate in efforts to attack the problem of obesity and its related diseases.

Ms ALDERSON (World Heart Federation), speaking at the invitation of the CHAIRMAN, said that her organization was extremely concerned about worldwide obesity, unhealthy diets, physical inactivity and tobacco consumption, the main causes of major noncommunicable diseases. Unhealthy lifestyles, moreover, were being adopted at an ever earlier age; some 22 million children under the age of five were obese. An unhealthy childhood lifestyle was not just a matter of individual responsibility, however, but a health protection concern. Multilateral corrective strategies, together with supportive governmental policies, were essential for protection against the hazards associated with poor nutrition and physical inactivity. Her Federation urged the Board to recommend to the next Health Assembly the adoption of the draft global strategy on diet, physical activity and health. The Federation, through its member societies in more than 100 countries, would urge governments to adopt and implement effective policies to fight obesity, inter alia, through the development of physical activity and measures to make healthy food more readily available and more affordable. Adoption of the global

[1] WHO Technical Report Series, No. 916, 2003.

[2] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

strategy must be the first step towards a sustained long-term commitment by international agencies, governments, industry, nongovernmental organizations and civil society to address the problem.

Dr RIGBY (International Union of Nutritional Sciences), speaking at the invitation of the CHAIRMAN, as representative of the International Obesity Task Force, a scientific body that aimed to halt the rising epidemic of obesity, and on behalf of the International Diabetes Federation and the International Pediatric Association, said that his statement was also endorsed by the World Heart Federation. Those nongovernmental organizations represented not merely the scientific and medical community but also many members of civil society and worked with WHO to prevent noncommunicable diseases. He expressed their clear commitment to the proposals for a global strategy before the Board. His own organization was submitting to the Director-General a major report on the global challenge of childhood obesity.

The need for the strategy was urgent. A major epidemic of cardiovascular disease, type 2 diabetes, overweight and obesity was affecting both the developing and the developed world, fuelled by social factors that promoted inappropriate diet and inactivity. Children did not choose the environment in which they grew up, and were increasingly subject to high levels of obesity, unprecedented development of type 2 diabetes and cardiovascular risks. In the United States of America, one in three adolescents suffered from a combination of those risks known as the metabolic syndrome.

The draft global strategy was based on the Report of the Joint WHO/FAO Expert Consultation,[1] but that document was reinforced by a succession of others that provided evidence for action that could not be ignored. The Report had provided a rigorous assessment of the best available evidence and been subjected to peer review and to a more exhaustive public consultation process than any previous scientific study. Its careful scientific judgements had been reached impartially. The evidence supporting the role of excessive consumption of saturated fat, sugars and salt in the development of noncommunicable diseases was robust and indisputable. The benefits of promoting a healthier diet and, particularly of increasing the consumption of fruit and vegetables, were widely acknowledged.

The global strategy demanded the broad support of all WHO Member States and international agencies and must address other important determinants of health affected by trade, agriculture and economic environments. The Codex Alimentarius Commission should be encouraged to play an important role in those areas. The food and drink industry had an important role too, as it had far greater means at its disposal to provide solutions that would improve dietary health. It must be encouraged to rise to the challenge, seize significant new opportunities to optimize the nutritional quality of diets and honour the public commitments its leaders were already making to contribute to improving dietary health.

His organization would welcome stronger emphasis on the role of nongovernmental organizations in providing expertise and guidance in the further development of the strategy and in supporting its long-term implementation. Responsible bodies and research organizations could also support the international scientific surveillance mechanisms necessary to ensure that the strategy was sustained in an effective manner. He urged Board members to commend the resolution wholeheartedly to the next Health Assembly.

Ms RUNDALL (International Organisation of Consumers Unions (Consumers International)), speaking at the invitation of the CHAIRMAN and also on behalf of the International Baby Food Action Network and Health Action International, warmly supported the global strategy as an urgently needed attempt to address the epidemic of noncommunicable diseases. There was wide agreement in the scientific community about what constituted a healthy diet, and WHO's proposals, developed through extensive consultation, were clearly based on sound science. Only some members of the food industry questioned those findings. A firm stand must be taken against attempts to undermine, sideline or delay the global strategy. One of the countries with the highest obesity rates in the world had called

[1] WHO Technical Report Series, No. 916, 2003.

for a policy based in large part on individual responsibility, thus shifting responsibility away from industry. According to the Center for Science in the Public Interest, that policy had been tried in that very country and had failed. Was it right to export that failed strategy to the rest of the world?

Consumers had a right to expect their governments to develop effective policies and regulations to promote and protect public health. To that end, it was critically important to take up the Gambia's suggestion that WHO provide guidelines to protect its integrity and its policy-making process. A good example of such a mechanism had been seen with the negotiations on the WHO Framework Convention on Tobacco Control, in which tobacco companies were specifically excluded from policy setting. The global strategy on infant and young child feeding tackled the issues of conflict of interest by identifying an appropriate role for the food industry. Where was the evidence that involving commercial companies in policy setting was an effective strategy for protecting health?

Her organization was pleased that the global strategy mentioned the important role of breastfeeding and appropriate complementary feeding in preventing noncommunicable diseases throughout the entire life cycle. Those references must be retained and should be highlighted in the strategy and the proposed resolution. As nongovernmental organization networks working in the non-profit sector, the bodies for which she spoke offered support to WHO to develop the strategy for the benefit of citizens in all countries and believed that such collaboration should be mentioned in the report.

She raised concerns about over-emphasizing health and nutrition claims as agents for change; they could be used to project a healthy image for what were otherwise unhealthy products. Health claims were rarely seen on fresh fruits and vegetables. They were not appropriate on food for infants and young children. The food industry must reduce salt, fat and sugar contents of many foods, not hide those ingredients or pretend that they were not a problem. Neither was it acceptable to fortify foods of inherently poor nutritional quality. Issues such as sustainability and the impact of foods on national and family economies, healthy indigenous foods and traditional diets must also be considered.

She urged Board members to endorse the draft global strategy, without further weakening it and without further delay.

Ms MULVEY (Infact), speaking at the invitation of the CHAIRMAN, said that Infact, as a corporate accountability organization, welcomed the proposed global strategy and particularly applauded the emphasis on the provision of accurate information to consumers and the recognition that food advertising influenced food choices and dietary habits. To encourage Member States to curtail advertising of unhealthy food was consistent with the comprehensive ban on tobacco advertising, promotion and sponsorship in the WHO Framework Convention on Tobacco Control. Based on the precedent of that Convention, Infact was concerned about the failure to insulate the global strategy from potential conflicts of interest. Throughout the negotiation process for the Framework Convention, WHO had excluded tobacco corporations, their subsidiaries and affiliates on the grounds that their aims ran counter to those of the treaty. The final text had obligated parties to protect public health policies from the commercial and other vested interests of the tobacco industry. Those provisions had represented an important step forward in the global community's attitude to the deliberate production, distribution and marketing of a dangerous and deadly product. While WHO had made no distinction in the global strategy among the various "stakeholders", evidence was emerging that the food industry was aggressively attempting to water it down. The assertion that marketing of energy-dense food did not increase the risk of obesity was eerily reminiscent of the tobacco giants' insistence that tobacco marketing did not increase consumption. In both cases, the existence of multi-billion dollar corporate advertising budgets cast doubt on those claims. There was also a corporate connection: a single transnational owned the world's most profitable tobacco corporation and one of the largest food corporations.

WHO had commended certain voluntary initiatives by the food industry, but again, the lessons of the tobacco-control movement should be taken into account. Tobacco corporations had long sought to fend off regulation by putting forward voluntary marketing codes, but voluntary standards were non-binding, lacked independent oversight and had often proved ineffective in curbing the abusive practices they were nominally intended to address. The tobacco industry's supposed concessions even

reinforced its own promotional strategy. The tobacco industry had also stalled public health policies for decades, demanding more studies linking its product to death and disease while in the meantime tens of millions of people died. Where there was already evidence that certain products or practices could be harmful to health, the precautionary principle must apply, thereby shifting the burden of proof to those who sought to continue such products and practices.

Infact urged that the proposed global strategy be strengthened to acknowledge the potential conflicts of interest posed by food corporations and other private sector actors, and that implementation of its action plan be insulated from such conflicts.

Dr LE GALÈS-CAMUS (Assistant Director-General), responding to comments made, said that the global strategy had been elaborated as part of an overall approach to the prevention of noncommunicable diseases, which was why it focused on issues relating to inappropriate nutritional regimes and the lack of physical exercise. That focus, however, did not mean that the health problems of the impoverished and those suffering from hunger had been forgotten. WHO had done much work in that area and would continue to do so. The governing bodies had adopted recently several resolutions on malnutrition and the effect of micronutrient deficiencies on health. Resolution EB91.R8 had endorsed the Plan of Action for Nutrition, which had had the aim of eliminating famine and iodine and vitamin A deficiencies and reducing the prevalence of iron deficiency anaemia. Throughout the 1990s, several resolutions had reaffirmed the need to eliminate iodine deficiency and to promote universal salt iodization as a preventive measure. In 2002, resolution WHA55.25 had endorsed the global strategy for infant and young child feeding.

Thus, the global strategy before the Board was centred on prevention of noncommunicable diseases in view of their growing effect on world health. Mention had been made of the Report of the Joint FAO/WHO Expert Consultation;[1] science had evolved since the earlier report of a WHO Study Group on Diet, Nutrition and Prevention of Noncommunicable Diseases,[2] and it had therefore seemed timely to carry out a consultation with FAO. The experts who had participated in that consultation had been chosen according to the rules of the two organizations, namely recognition in their field of scientific competence, geographical representation and gender balance. Their draft report had been commented on extensively. The recommendations that formed the basis of the draft global strategy were coherent with those derived from a great many international and national expert studies, as well as with approaches being used by certain countries in building their nutritional strategies. Some countries had adopted still more restrictive recommendations.

As for the policy options proposed, the opportunity given to each Member State to take account of its own situation and political imperatives was the innovative aspect of the draft strategy. It should also be recalled that unusually extensive consultations had been held with Member States, as well as with other stakeholders, since the Health Assembly had expressed the wish that the strategy be elaborated on the basis of a multisectoral approach.

In view of the importance of the strategy, additional comments would be collected from Member States and further proposals made.

Mr AITKEN (Director, Office of the Director-General) said that, in order for the global strategy to be considered by the Health Assembly, the revised document would have to be sent to Member States by mid-March 2004. If a further round of comments was to take place, as a number of speakers had suggested, a deadline of 29 February 2004 could be set for their receipt from Member States. All the comments would be made public. The Director-General could then issue a revised draft strategy in good time for the Health Assembly.

As to the resolution currently before the Board, several changes had been proposed, and the Secretariat would incorporate them for consideration by a working group, following which a revised resolution could be submitted to the Board.

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[1] WHO Technical Report Series, No. 916, 2003.

[2] WHO Technical Report Series, No. 797, 1990.

The CHAIRMAN took it that the Board agreed to that approach.

It was so agreed.

Road safety and health: Item 3.9 of the Agenda (Document EB113/9)

The CHAIRMAN drew attention to the draft resolution contained in paragraph 13 of the report.

Professor DAB (France) said that road safety and health was as serious a problem for developed countries as for developing ones, and the report summed up the major public health arguments. He drew particular attention to the reference in paragraph 10 to the need to mobilize political will. One way to do so was to produce statistics on road accidents covering a decade rather than a year: in France, for example, 1 200 000 people had been injured and 100 000 killed on the roads in the past 10 years. Many victims were young people, who were disabled for the rest of their lives. That state of affairs had led the President of the Republic to speak out against road traffic injury, and the immediate consequence had been a drop in the figures on fatalities and injuries, even before a single additional police officer had been mobilized. In a single year, political commitment coupled with credible arguments in favour of prevention had enabled the rates of morbidity and mortality from road accidents to be reduced by 20%, the sharpest drop ever seen, making it the most cost-effective public health initiative ever undertaken. France was accordingly pleased to sponsor a world event in connection with World Health Day, to be held in Paris in the presence of the President of the Republic and at which the Director-General would be the guest of honour.

Paragraph 7 of the document dealt with an extremely important subject, the "systems approach" to the human, the vehicular and road infrastructural factors. Two additional factors deserved specific mention: medication – physicians and patients needed to be better informed about the effect of medication on driving ability – and psychoactive drugs: alcohol was rightly mentioned, but it was not the only substance that could modify behaviour.

The close link between road traffic accidents and public health was poorly understood because the responsibility often lay with transport ministers, not health ministers. However, public health approaches were extremely useful in mobilizing preventive action, also in sectors other than the health sector. That was why the resolution was so important, and his country supported it warmly.

Professor DANG DUC TRACH (Viet Nam) said that many factors were responsible for road accidents, including the rapid increase in the number of vehicles, particularly motor scooters, on the roads, the lack of pavements and pedestrian crossing places and the irresponsibility of some drivers. In order to deal with the problem of road accidents, committed and continuing cooperation from various sectors would be required. His Government had launched information and education campaigns, improved the performance of traffic police and encouraged the public to use public transport. Although the number of accidents was falling, more efforts were needed, and he called on WHO to help the countries concerned to strengthen their emergency and rehabilitation services for accident victims.

Professor FURGAL (Russian Federation) said that the problem of road traffic accidents was of great socioeconomic significance. In his country, more than 30% of all deaths from accidents occurred on the roads. The causes were not specifically health-related, although the health sector had to deal with the tragic consequences. Governments and social agencies must study the technical, legal and other causes of traffic accidents, and WHO should act in the area in which it could achieve the best results. WHO should clearly and convincingly demonstrate the adverse consequences of road traffic accidents for society and the importance of prevention, which would always be more cost-effective than treatment or rehabilitation, and should help Member States to strengthen the emergency services that treated victims of such accidents. It had already developed a strategy for road traffic injury prevention, which deserved a mention in the draft resolution. Preparations were under way for the

publication of a world report on the subject, which it was to be hoped would be published in all official languages.

He called on the Organization to develop criteria for action by health systems and recommendations to make the management of medical care for accident victims more effective. Within WHO's General Programme of Work, special guidelines should be prepared for social services managers at all levels on ways to reduce the negative effects of road traffic on health. He supported the draft resolution.

Dr AL-SAIF (alternate to Dr Al-Jarallah, Kuwait) said that all countries suffered traffic accidents, which had serious economic and social consequences and could ruin the lives of families. It was essential to regulate container lorries, which were often involved in such accidents, and other sectors besides the health sector would need to be involved in that effort.

He welcomed the decision to devote World Health Day 2004 to road safety, and supported the draft resolution before the Board.

Dr AL-MAZROU (Saudi Arabia) said that the report gave a good account of road traffic accidents from a health point of view, but did not discuss other aspects of the issue. Nor did the draft resolution give any clear recommendations for action by other sectors involved, such as research centres and ministries of transport.

The number of deaths and injuries on the roads in Saudi Arabia was still high: in 2002 there had been more than 16 000 accidents, 30 000 injuries and 4000 deaths. The Government needed to review the implementation of the national strategy, with the involvement of the various sectors concerned. World Health Day 2004 could provide an incentive for community activities: in his country, the Ministry of Health had organized public awareness campaigns, aimed particularly at schoolchildren and university students, who were more likely to be involved in road accidents. He supported the draft resolution.

Professor FIŠER (Czech Republic) said that about 1300 people died from road traffic accidents in his country each year, a high prevalence, but health ministries could not prevent such accidents by their own efforts. A useful concept in the promotion of road safety programmes was to quantify the losses caused by accidents through the use of the number of healthy years lost to injury. Spending on the treatment of certain diseases, such as cancer, had a much lower impact on disability-adjusted life-years lost than spending on road safety.

Dr TAG-EL-DIN (Egypt) said that road traffic accidents had obvious psychological, economic, health and social consequences, and young people between 18 and 30 years of age were the most affected. Under the auspices of WHO, all Member States could contribute to exchanges of expertise, experience and advice. World Health Day 2004 would provide a valuable opportunity for laying down principles, rules and directives on road safety for both private and public transport, covering such issues as the physical and mental abilities of drivers and the influence of drugs and alcohol. He supported the draft resolution.

Mr ASLAM KHAN (alternate to Mr Khan, Pakistan) said that the draft resolution should be more emphatic in its recommendations. It should call upon Member States, especially developing countries, to adopt and enforce legislation for the wearing of crash helmets by motorcyclists and pillion riders and the fitting and wearing of seat belts in vehicles. He suggested that a new subparagraph to that effect should be added after paragraph 5(4).

Dr MARTÍN MORENO (alternate to Dr Pastor Julián, Spain) congratulated WHO on its initiative. Road traffic accidents were a major public health problem in all Member States, leading to high rates of mortality, disability and morbidity and the loss of many potential years of life. Their many different causes made them difficult to tackle and prevent. A multidisciplinary and interinstitutional approach was needed, as reflected in the draft resolution. His Government had set up

an interministerial road safety committee, on which the Department of Health was represented, and intended to give more emphasis to the public health aspects of road traffic accidents, particularly as that was the theme of World Health Day 2004.

He agreed with previous speakers that the draft resolution should make reference to the role played in road traffic accidents by certain medicaments and psychoactive drugs. The effects of mobile telephone conversations and other distractions should also be mentioned.

Paragraph 4 of the draft resolution could also mention improving the attitude and behaviour of drivers, for example, aggressive driving, which affected not only accident risk but also cardiovascular health and the nervous system. Including that might provide useful guidance to other sectors. It was essential to reduce high-risk behaviour and to protect vulnerable groups such as children, elderly persons and the disabled. He supported the draft resolution.

Dr YIN Li (China) welcomed the forthcoming world report on road traffic injury prevention, which should be translated into all official languages. World Health Day activities around the theme of road safety would mobilize political will, raise public awareness, and provide a good opportunity for interdepartmental and interministerial cooperation. WHO should collect relevant experiences to assist developing countries. He supported the draft resolution.

Mr GUNNARSSON (Iceland), acknowledging the increasing burden of road traffic accidents, said that action by ministries of health alone could not prevent such accidents, which were due to human error, poor vehicle maintenance or faulty road infrastructure. Injuries and deaths from road traffic accidents were one of the most avoidable burdens on health and social systems. It was therefore appropriate that World Health Day in 2004 was to be devoted to road safety.

His country had created a central register of road traffic accidents, showing the cause of the accident and the people involved, from information provided by the police, insurance companies and hospitals. He too supported the draft resolution before the Board.

Ms VALDEZ (alternate to Dr Steiger, United States of America) said that, although road safety was often a matter of common sense, her country would encourage Member States to use science-based evidence when selecting interventions and implementing and evaluating relevant changes at local level. Neither the report before the Board nor the draft world report mentioned the individual responsibility of drivers and other road users. Many accidents were caused by irresponsible behaviour, and education, enforcement and skills training were important strategies for changing the behaviour of drivers and pedestrians alike. Education of both the public and policy-makers should be part of every effort to promote road safety. Governments should work closely with bus, taxi and other transport companies to ensure that vehicles were regularly inspected and maintained and drivers were properly trained. In many parts of the world, bus crashes attributable to reckless driving or poor maintenance of vehicles were responsible for many deaths every year. Future strategies should include elements such as improved road construction, higher vehicle-safety standards and behavioural change of road users. New laws and regulations were not always the answer: many countries had adequate traffic laws, but did not enforce them.

She noted with satisfaction that the draft resolution called for multisectoral collaboration. Her own country had found that collaboration between national, state and/or local government public health agencies, working with communities and other stakeholders, was critical to the effective implementation of interventions. She proposed some amendments. Two new preambular paragraphs should be inserted after the second preambular paragraph, to read:

> Recognizing the tremendous burden of global mortality resulting from road traffic crashes, 90% of which occur in low- and middle-income countries;
>
> Acknowledging that every user of the road must take the responsibility to travel safely and respect travel laws and regulations.

In paragraph 1, "injury surveillance and" should be added before "data collection", and "pre-hospital and" before "trauma care". In paragraph 3, a new subparagraph should be added, to read: "to establish

Government leadership in road safety, including designating a single agency or focal point for road safety." Three new subparagraphs should be added following paragraph 3(3), to read:

to take specific measures to prevent and control mortality and morbidity due to road traffic crashes and to evaluate the impact of such measures;

to enforce existing traffic laws and regulations and work with schools, employers and other organizations to promote education about road safety to drivers and pedestrians alike;

to use the forthcoming world report on traffic injury prevention as a tool to plan and implement appropriate road traffic injury prevention strategies.

Finally, a new subparagraph should be added after paragraph 4(3), to read: "to facilitate the adaptation of effective traffic injury prevention measures that can be applied in local communities."

Dr MODESTE-CURWEN (Grenada) acknowledged the importance of both the "systems approach" and multisectoral collaboration. In Grenada, a combination of political will, involvement of other ministries and agencies and, most importantly, adoption and enforcement of legislation (authorizing stiff fines as penalties) had accomplished what the Ministry of Health had been unable to do on its own in terms of advocacy and education.

Professor KULZHANOV (Kazakhstan) suggested that the preamble to the draft resolution should make specific reference to the role of ministries of transport before mentioning the multisectoral approach. Another important aspect was interregional and intercountry coordination: Kazakhstan, for example, had heavy flows of traffic transiting through the country, which created safety problems. Another, albeit less significant, factor in road safety was the import by developing countries of second-hand cars, which were often not up to standard and caused accidents.

He endorsed the suggestion of the member for the Russian Federation that WHO provide guidelines to social service managers. France was to be envied for the involvement of its Head of State, who had set an example that all Heads of State should follow. He supported the amendments proposed by the member for the United States of America and looked forward to seeing them in writing.

Dr YOOSUF (Maldives), commending the choice of road safety as the theme of World Health Day 2004, said that many road accidents were caused by reckless driving by young people and by overworked long-distance drivers. Poor road design and inadequate vehicle safety standards were contributory factors. Developing countries needed to adopt appropriate legislation and policies and create mechanisms to enforce them.

Health ministries were directly responsible only for pre-hospital and trauma care, which needed to be strengthened in most developing countries. However, other sectors also had an important role to play in road safety. One solution might be to tax vehicle manufacturers while increasing penalties for offenders, thus generating revenue for implementation of the necessary measures.

The CHAIRMAN, speaking in his capacity as the member for Ghana, expressed support for the draft resolution and for the amendments put forward by the member for the United States of America. His country ranked near the top worldwide in terms of road accidents, and second-hand vehicles were one of the single most important causes of fatalities. Another cause was the condition of the roads, most of which had been built in the 1960s for vehicles of a different tonnage, but following a period of economic depression were no longer up to standard. Existing regulations were often not enforced, and alcohol and drug use were contributory factors. His Government had embarked on a legislative and policy review, and had launched a mass media campaign to make the public, and especially drivers, more aware of their responsibilities.

He suggested that the resolution should recommend that health ministries be involved in the formulation of policy and in the creation of enforcement mechanisms.

Dr AL-KHAROUSSI (Oman)[1] said that the launch of the world report on road traffic injury prevention on World Health Day in April 2004 would clearly indicate the importance WHO attached to the issue. Oman strongly supported the draft resolution and suggested that it should also mention the importance of trauma registration with a view to the development of a data bank. He urged Board members to support the draft resolution on road safety and development put forward by Oman for discussion by the United Nations General Assembly at its fifty-ninth session.

Road accidents and their consequences were a major public health problem that, if not tackled early and decisively, would disproportionately, and disastrously undermine the progress of sustainable development.

Dr JEBAIL (Libyan Arab Jamahiriya)[1] welcomed the choice of road safety as the theme of World Health Day 2004. Measures taken in Libya included the establishment of a national accident-prevention committee whose members were drawn from all sectors concerned, namely health, justice, public safety and transport. Speed limits had been introduced both within and outside urban areas, wearing seat belts was compulsory and the use of mobile phones in cars was prohibited.

He suggested that paragraph 3(3) of the draft resolution should be replaced by "to facilitate close cooperation between relevant sectors in the different ministries and sectors".

Mr SEADAT (Islamic Republic of Iran)[1] commended the multisectoral approach advocated in the draft resolution. Although the health sector bore primary responsibility in the aftermath of road accidents, the role it could play in prevention by helping to formulate policy and set standards had not yet been fully recognized. He also commended the choice of road safety as the theme of World Health Day 2004, a step that would help national authorities to recognize the role of the health sector in preventing road accidents. He supported the draft resolution together with the amendments proposed.

Ms MAFUBELU (South Africa),[1] mentioning a common misconception that road safety concerned only developed countries, stressed its increasing importance for developing countries. Alcohol consumption exacerbated the dangers on roads, underscoring the need for WHO's planned work on the issue. In South Africa, the Ministry of Health was working with other relevant ministries to address the problem. Although the number of vehicle accidents during the festive season had fallen, the number of pedestrian casualties had risen, and the strategy therefore needed to include a focus on that category of road users.

She asked whether a mid-term review of the five-year WHO strategy for road traffic injury prevention, finalized in 2001, had been carried out, and if not, suggested that one be conducted.

She expressed support for the draft resolution.

Mr AGARWAL (India)[1] added his support for the draft resolution. In India, tens of thousands of people died because of road traffic accidents. To save those lives, not only did the roads need to be made safe for pedestrians, cyclists, motorcyclists and pillion riders, but trauma centres also had to be set up across the country, backed up by a good ambulance service with strong communication networks. Without such centres, it would be impossible to reduce the number of injuries and deaths caused by road traffic accidents. Legislation needed to be adopted on the compulsory use of helmets and seat belts, on upper speed limits and on driving while under the influence of alcohol, and needed to be strictly enforced. Measures had to be taken to prevent injuries and arrangements made for the immediate pre-hospital care of trauma victims, especially within the first hour after the accident. Road-safety awareness had to be promoted through campaigns and education, and the effectiveness of preventive strategies had to be constantly monitored. Although his Government had launched an ambitious scheme in that regard, it would have to mobilize additional resources, by measures which would include taxation of the automobile industry.

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[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

WHO should provide more funds to regions such as South-East Asia, where road crashes represented a heavy burden.

Mr MARTINEZ BUSTAMANTE (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, welcomed the draft resolution. Action taken by WHO should include promotion of implementation of existing international conventions on road safety and promotion of research designed to enhance surveillance, data management and evaluation. WHO should also encourage Member States to develop national strategies for road traffic injury prevention, and to create partnerships at the national, regional and global levels so as to ensure effective cooperation on road safety issues.

Despite the fact that road traffic injuries had an enormous impact in terms of mortality and morbidity and took a heavy social and economic toll, national and international funding for research into the problem remained limited. More research was urgently needed in order to enable effective and cost-effective strategies to be identified.

Mr DOWNHAM (International College of Surgeons), speaking at the invitation of the CHAIRMAN, noted the increasing burden of highway injuries on drivers, passengers and pedestrians worldwide and welcomed WHO's decision to tackle the issue of road safety and health. The provision of timely and capable health care at the scene of the accident and appropriate health care facilities called for high-level planning and organization. Providing such care remained a challenge internationally, especially in low-income countries and regions, and would require intensive and continuing review.

He highlighted some areas of concern where action needed to be taken, namely the great contribution of alcohol intake to the cause of accidents, and on the treatment outcomes of injured patients; the high number of automobile accidents involving wild animals; the risk of transmission of pathogens such as HIV and hepatitis viruses through direct blood contact at the scene of the accident and during subsequent care, treatment, operations and blood transfusions; and the financial toll on victims and third parties such as insurance companies.

The CHAIRMAN said that a revised draft resolution incorporating the proposed amendments would be issued.

(For adoption of the resolution, see summary record of the sixth meeting.)

The meeting rose at 18:00.

FIFTH MEETING

Wednesday, 21 January 2004, at 09:10

Chairman: Dr K. AFRIYIE (Ghana)

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

Family health in the context of the tenth anniversary of the International Year of the Family: Item 3.10 of the Agenda (Document EB113/45)

The CHAIRMAN drew attention to the draft resolution proposed by Australia, the Philippines, the Republic of Korea, the Russian Federation and the United States of America, which read:

> The Executive Board,
>
> Having considered the report on family health in the context of the tenth anniversary of the International Year of the Family,[1]
>
> RECOMMENDS to the Fifty-seventh World Health Assembly the adoption of the following resolution:
>
> > The Fifty-seventh World Health Assembly,
> >
> > Recognizing that parents, families, legal guardians, and other caregivers have the primary role and responsibility for the health and well-being of children;
> >
> > Recalling the shared commitment of the international community to preserve and protect human health and dignity;
> >
> > Further recognizing that cultural norms, socioeconomic conditions, and education are significant determinants of health;
> >
> > Stressing the importance of families and communities as the settings in which healthy behaviour is first established and where culture, values, and social norms are first moulded;
> >
> > Acknowledging that science is now revealing how strong and supportive families and social networks have a positive impact on health;
> >
> > Noting that changes in family structures, including particularly the increase in single-parent families, constitute additional challenges for the family;
> >
> > Noting that unhealthy behaviours occurring within the family and society, including child abuse, neglect, spousal and domestic violence, and neglect of older persons, especially those with disabilities, are of growing public health significance;
> >
> > Recalling the commitments, goals, and outcomes of United Nations conferences and summits that address family issues;
> >
> > Noting that the tenth anniversary of the International Year of the Family is being observed in 2004,

[1] Document EB113/45.

1. URGES Member States:

(1) to assess government policies with a view to strengthening the stability of the family;
(2) to ensure the availability of appropriate infrastructures to support parents, families, legal guardians and other caregivers, particularly older persons, to strengthen their capacity to provide care, nurturing and protection for children;
(3) to take measures to ensure that health policies, plans and programmes recognize the comprehensive health needs of families and their members;
(4) to strengthen the effective implementation of social, economic, and health promotion strategies for families to address existing health gaps and inequities, with a focus on vulnerable, marginalized and hard-to-reach populations;
(5) to establish and maintain information and surveillance systems to provide data, disaggregated by sex, socioeconomic conditions, ethnicity, and educational levels, to underpin the appropriate planning, implementation, monitoring and evaluation of evidence-based family-centred health interventions;
(6) to increase awareness of, and address, the public health challenges affecting the family, including the complexities surrounding child abuse, neglect, spousal and domestic violence, and neglect of older persons, especially those with disabilities;
(7) to develop or strengthen alliances and partnerships, including with nongovernmental organizations, community- and faith-based organizations, academia, the research community and relevant governmental agencies, to enhance and expand family-centred health policies and programmes;
(8) to strengthen national actions to ensure sufficient resources to fulfil the international commitments, goals and outcomes of relevant United Nations conferences and summits related to the family;

2. REQUESTS the Director-General:

(1) to take advantage of the tenth anniversary of the International Year of the Family (2004) to raise awareness of family health issues and to collaborate with Member States in increasing their efforts to support family-centred health policies;
(2) to provide support to Member States in the development of information and surveillance systems to provide data, disaggregated by sex, socioeconomic conditions, ethnicity, and educational levels, to underpin the appropriate planning, implementation, monitoring and evaluation of evidence-based family-centred health interventions;
(3) to support Member States in their efforts to fulfil their commitments to the goals and outcomes of relevant United Nations conferences and summits that address family issues, in collaboration with relevant partners and other stakeholders;
(4) to intensify efforts for mobilizing resources to support countries in developing comprehensive family-centred health policies, strategies, and programmes with special focus on vulnerable and hard-to-reach populations;
(5) to develop and support a strategy on family-centred health across the Organization and to ensure synergy between this strategy and other relevant strategies within the Organization;
(6) to work closely with the United Nations Department of Economic and Social Affairs on family-related issues by sharing experiences and findings;
(7) to report to the Fifty-eighth World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

Dr STEIGER (United States of America) said that his country had asked for inclusion of the item on the agenda because of the timeliness of the topic and the growing recognition of the family's role in protecting health. The subject was essential to WHO's technical cooperation activities; and the United States had held regional discussions at PAHO. Work on family health should cover all the factors that influenced behaviour and life choices, including healthy lifestyles for young people, abstinence and fidelity, the roles and responsibilities of parents and older family members, the critical role of fatherhood and the promotion of a healthy diet and physical activity. Implementation at country level should be ensured through effective evaluation. Member States' participation was critical for ensuring an integrated approach to the development of indicators and health risks surveillance systems.

He recalled that in 2002 the Health Assembly had asked for a report on the steps being taken by the Organization to pursue the International Plan of Action on Ageing 2002, adopted by the Second World Assembly on Ageing (Madrid, 2002), in which involvement of the family was prominent. When could such a report be expected?

Strengthening the family was a cornerstone of United States' national policy; every child deserved to live in a safe, permanent and caring family with loving parents. His country was pursuing that aim through its public health programmes, which included research on abstinence education, health promotion, links between a strong family and general welfare, and the role of the family in cognitive development.

The tenth anniversary of the International Year of the Family provided an opportunity to emphasize primary health care issues in support of the family together with the critical role of parents and families in the health of children and adolescents. The United States believed that the draft resolution could help to guide WHO's future action at the global level and reinforce collective efforts to strengthen the links between family, health and development. As informal consultations were being pursued among Member States with a view to achieving a consensus, however, he asked that formal consideration of the text be deferred.

Dr OM (Republic of Korea), speaking as a sponsor of the draft resolution, praised WHO for its introduction of new approaches for dealing with health challenges relating to child abuse, violence between spouses and the neglect of older people. During his country's economic and social development, drastic changes had occurred in the role and structure of the family. Comprehensive research and legislation were seeking to redefine the role of the family and deal with the new problems encountered. The draft resolution provided Member States with a benchmark for developing workable policies to enhance family health.

Dr AL-MAZROU (Saudi Arabia) said that improvements in family health, which was the cornerstone of a society's health, would therefore produce results at the population level too. However, the health sector's role was not confined to the provision of therapeutic services: it also included social, psychological, educational, preventive and rehabilitative interventions, and those delivered to the family in the home environment. Success depended on building strong links with various sectors of society and ensuring the positive involvement of all individuals. In cooperation with other international organizations, particularly UNICEF, WHO had implemented numerous child health programmes, involving the family and community. Although most countries had improved their child health indicators, adolescent health remained a primary concern; adolescents were particularly vulnerable to health and social risks owing to their natural energy, the temptations they faced and the limited influence of their families. More attention must be paid to that group to ensure a reduction of risk through better focused programmes.

Maternal care programmes had achieved significant successes, but a significant number of countries had so far been unable to meet the goals set by international conferences on the subject. He expressed support for the proposed draft resolution.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the report showed the need to strengthen activities in connection with the International Year of the Family to help families to fulfil their functions in society and in development. He affirmed that cultural standards, socioeconomic conditions and education had a decisive impact on the health of families. Health institutions had tended to focus on individuals at the risk of not paying sufficient attention to the family as a unit. Cuba had some 30 000 family doctors who considered the family as a dynamic unit, not as the sum of its individual members. He had some suggestions to make that had been considered in part by the 44th meeting of the Directing Council of PAHO/fifty-fifth session of the Regional Committee for the Americas. It was vital for Member States to set national priorities in order to strengthen the family's role in the promotion and protection of its own health and the capacity of the health system to respond to the needs of families. Public policies should give decision-making powers to the family and support legislation to protect family health. The design, implementation and evaluation of models, programmes and services connected with family health should be backed with social communication measures, and information provided to PAHO and WHO on national experiences in family health and in the improvement of information and surveillance systems for the preparation of indicators. He supported the request by the member for the United States of America for more time to discuss the draft resolution, although Cuba was in agreement with it in principle.

Dr DAYRIT (Philippines) highlighted the growing problem of migrant workers everywhere. Between two and five million Filipinos worked overseas, spending many months away from their families. He asked WHO to work closely with international organizations concerned with migrant workers to provide support for such workers and their families.

Professor KULZHANOV (Kazakhstan), commending the report, expressed support for the comments made by the members for the Republic of Korea and the United States of America. Kazakhstan proposed adding the following phrase at the end of paragraph 1(3) of the draft resolution: "and ensure that they receive the necessary medical care and essential medicines at the primary health care level".

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that the report covered important issues but did not provide a substantive basis for action. Further work and consultation were necessary to reflect progress called for in resolution WHA46.27 on collaboration within the United Nations system: International Year of the Family (1994). The United Kingdom was also concerned that the draft resolution included concepts and language on which no international consensus existed; nor did it reflect or refer to those issues on which consensus and agreement had been reached and to which the United Kingdom attached considerable importance. He therefore seconded the suggestion that more time should be allowed for further deliberation before the draft resolution was considered formally by the Board.

Professor DAB (France), observing that the full title of the French health ministry was the Ministry of Health, the Family and Disabled Persons, said that France welcomed WHO's efforts to show the links between family structure and the health of its members. There had been several stages in the growing awareness of that connection, including United Nations General Assembly resolution 48/04, which referred to the international conferences in Cairo (1994), Beijing (1995) and New York (2000), and resolution WHA56.21. He concurred on the value of further deliberation on the draft resolution, which was necessary for several reasons apart from those advanced by the member for the United Kingdom of Great Britain and Northern Ireland (with which he fully agreed). Any draft resolution should refer to both the health of adolescents and unwanted pregnancies. The current text was sometimes too specific. For example, paragraph 1(5) on information and surveillance systems was too detailed. Age was not mentioned among the variables although ethnicity, which French law prohibited as a criterion, was; it would be regrettable for the resolution to recommend action that contravened national legislation.

France welcomed the draft resolution, and was ready to help to make it more specific, with clearer priorities. The concept of family was evolving; the notion of family stability warranted further definition as it varied from country to country and should reflect social and cultural differences. WHO should not be too prescriptive in this area.

Dr YIN Li (China) said that family health was the cornerstone of the public health system. He therefore supported both the draft resolution and the observations made by the member for France.

Dr MARTÍN MORENO (alternate to Dr Pastor Julián, Spain) praised the report's sensitive consideration of the public health, health-care and socioeconomic problems that affected the family as well as the well-being and health of communities. Spain supported the actions proposed in the report, particularly the development of future health policies. He concurred with other speakers that the concept of the family had changed over the previous 20 years. Indeed, the nuclear family composed of mother, father and children clearly needed support, but it was important to recognize the frequency of new forms of family groups, such as single-parent families and individuals who were not related by blood to the child. Those groupings resulted from socioeconomic changes or from problems associated with the entry of women into the labour market, high morbidity and mortality rates among the most vulnerable groups, poverty, or development. For the individual, the effects of such problems were similar: isolation, marginalization and, in many parts of the world, neglect of their social, educational, health and economic needs.

The family needed to be seen in a wider context. He emphasized the need to meet the social and health challenges caused by migration, and the educational and health requirements of families or individuals who were isolated from their own sociocultural environments. New tools were also needed to improve the living conditions of families and to adapt health services to new cultural modes and living styles. Gender-equality policies had to be devised that were more in tune with new forms of family groupings. Such policies should be strengthened in relation to programmes that targeted the most economically disadvantaged and vulnerable, and marginalized minority groups.

Often, insufficient resources were provided to protect the health of the elderly, despite their growing numbers in society generally. The health of children, particularly orphans or other vulnerable children that had suffered from family or societal violence, had to be protected. Governments and health administrations recognized that measures designed to protect and promote the health of families, whatever the sex, age or origin of the individual family members or the relationships between them, should be carried out in a spirit of respect for cultural values, gender equality and beliefs. For family health policies and programmes to be effective, coordination between different government departments was essential. His Government planned to create a coordination committee, which would be responsible for preparing, overseeing and following up the activities undertaken in connection with the tenth anniversary of the International Year of the Family. Spain's main objective was to improve the living conditions and well-being of families, placing particular emphasis on children's and adolescents' development and reproductive health by means of a health promotion and protection strategy and policies promoting equality between men and women.

He endorsed the draft resolution and the comments of previous speakers. He proposed several additional themes that the report could have emphasized. Cooperation with the media could promote healthy family lifestyles. Information systems were necessary that were sensitive to population change and movement and that could be useful in decision-making and the formulation of new policies regarding the family. High-quality maternal and child-care services provided by health professionals and qualified staff should also be extended to provide coverage for all pregnancies and births. Measures designed to prevent sexually transmitted diseases, particularly HIV/AIDS, and the protective use of barrier methods in high-risk sexual relations should be promoted. The prevention and control of addictions was also essential.

He emphasized men's responsibility in reproductive and family health. New legislation was needed to protect the family from domestic violence and programmes should be implemented to encourage men to adopt responsible behaviour in the family context. The recommendations adopted

by the Health Assembly on violence and health in resolution WHA56.24 had served to support his country's policies on that issue, and he congratulated the Director-General for the excellent *World report on violence and health.*[1]

He emphasized the need for flexibility in implementing family health policies in view of the new forms of cohabitation and family structures that were emerging. Such policies should respect diversity, sexual equality and human rights. WHO should continue its efforts to promote family health policies.

Mr GUNNARSSON (Iceland) said that it was essential that WHO continued to coordinate activities and encourage research and discussion on family-related issues. He would, however, have preferred the report to have dealt with families in a broader context, and wanted to make several changes to the draft resolution. He therefore endorsed the proposal that the Board should be given more time to discuss the text of the draft resolution.

Mr AISTON (Canada), endorsing the comments of the members for France, Iceland and the United Kingdom of Great Britain and Northern Ireland, supported the proposal of the member for the United States of America that the Board should redraft the resolution.

Professor FURGAL (Russian Federation) said that he welcomed the inclusion on the Board's agenda of an item on family health. It was an opportunity to take stock of the work already carried out and to define future areas of work. The family was the basic social institution of any society; it provided the environment in which society's greatest wealth was formed, namely, the human personality, and determined an individual's physical and mental health as well as attitudes to health. The formulation and strengthening of national legislation on family affairs was a major goal of the International Year of the Family. Such legislation should not only take into account the relations between family members. It should also establish standards defining relationships between the state and the family by means of appropriate implementation mechanisms, as such legislation was the only means to increase the influence, role and responsibility of families for the health of their own members, particularly children and adolescents.

He supported the call for informal consultations on the text of the draft resolution at the current session.

Dr HUERTA MONTALVO (Ecuador) said that Ecuador supported the family-centred approach to health policies, and that the definition of the family should be as broad as possible and not be limited to the nuclear family. He agreed that the family needed to be strengthened. He echoed previous comments on the divisive effect of migration. Family health policies needed to address the causes of migration. The opportunity presented by the tenth anniversary of the International Year of the Family should lead to adoption of measures to protect the family against the harmful effects of migration.

Dr YOOSUF (Maldives), noting the multifaceted nature of family health, said that the phenomenon of working parents, which reflected issues of gender equality, had major consequences for families; with both parents often working long hours, children grew up with childminders. He agreed with previous speakers that the migration of workers posed significant problems for their families, but migration also opened a market for commercial sex. The movement of workers within a country without their families similarly contributed to the break-up of the family. In developing countries, job opportunities existed only in large cities, attracting workers who left their children behind. Governments should ensure that family-friendly employment mechanisms existed. He supported the draft resolution.

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[1] Krug EG et al., eds. *World report on violence and health*. Geneva, World Health Organization, 2002.

Dr BOSHELL (Colombia) said that, although he supported the draft resolution on family health, he shared the concerns raised by several members relating to the concept of the family and the scope of its definition. The incorporation of his country's Ministry of Health into a new ministry, called the Ministry of Social Protection, demonstrated the importance that Colombia attached to protecting the health of the family. In view of the importance of the draft resolution, he echoed the request that the Board should be given more time to reconsider the text in order to broaden its scope.

The CHAIRMAN said that informal discussions would be held.

Dr PILLAY (South Africa),[1] saying that his country also recognized the importance of the family in strengthening all aspects of health of its individual members, agreed with comments on the need to review the draft resolution. He asked that particular attention should be given to a definition of the term "family"; that was particularly important in view of the emergence of single-parent families and child-headed households (which were becoming increasingly prevalent in Africa, including his country, as a result of deaths caused by HIV/AIDS). He said that he wished to participate in the informal consultations on the draft resolution.

Dr JEBAIL (Libyan Arab Jamahiriya)[1] said that, although family-health programmes had been implemented in many countries, and despite the efforts of WHO and UNICEF in the field of family health, major problems persisted within the family: child abuse, sexual exploitation of children, domestic violence, neglect of the elderly, poverty, economic migration, malnutrition, the difficulties of adolescence, and single-parent families resulting from divorce or the death of a parent. He proposed that, to enable those problems to be examined in depth, Member States and experts should draft working papers that would be used in the preparation of an integrated document for submission to the Fifty-seventh World Health Assembly. He called for sufficient time to draft a resolution that befitted the importance of the family.

Mrs PHUMAPHI (Assistant Director-General) thanked Board members for emphasizing the importance of family health. The United Nations International Conference on Population and Development, the United Nations Fourth World Conference on Women and the various resolutions adopted by the Health Assembly relating to the International Year of the Family had marked a commitment by the international community to safeguard and promote family health. She recalled that the Health Assembly had adopted the strategy on child and adolescent health.

She agreed that family health covered a broad area, encompassing the period before pregnancy, pregnancy, infancy, childhood, adolescence and ageing, as well as issues such as migrant workforces, epidemics such as HIV/AIDS and malaria, the increasing incidence of violence, and sexual health. It was the responsibility of the family to make sure that the health of each member of the family was protected. The vulnerability of neonates represented a particular challenge to families. The highest rate of infant mortality occurred within the first 28 days of a child's life. That period was therefore described as the "golden month" and could be compared with the first hour following a road accident, which the Board's discussions on road safety and health had touched upon, within which time it was vital that pre-hospital care was provided for trauma victims.

She appreciated that the draft resolution required further discussion and amendment.

Mr AITKEN (Director, Office of the Director-General) said that it was the intention that the International Plan of Action formulated at the Second World Assembly on Ageing (Madrid, 2002) would be reviewed at the Executive Board and the Health Assembly in 2005.

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[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The CHAIRMAN took it that discussion on the item would be resumed following conclusion of informal discussions.

It was so agreed.

(See summary record of the tenth meeting, section 2, for adoption of the resolution.)

Reproductive health: Item 3.11 of the Agenda (Resolution WHA55.19; Documents EB113/15 and EB113/15 Add.1)

The CHAIRMAN drew attention to the draft strategy on accelerating progress towards the attainment of international development goals and targets relating to reproductive health contained in document EB113/15 Add.1, to the report by the Secretariat on that subject in document EB113/15 and to the draft resolution submitted by Canada, Denmark, Finland, France, Ghana, the Netherlands, South Africa, Sweden and the United Kingdom of Great Britain and Northern Ireland which read as follows:

The Executive Board,

Having reviewed and considered the draft strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health,[1]

RECOMMENDS to the Fifty-seventh World Health Assembly the adoption of the following resolution:

The Fifty-seventh World Health Assembly,

Having considered the draft strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health;

Reaffirming the Programme of Action of the International Conference on Population and Development (Cairo, 1994) and key actions for the further implementation of the Programme of Action of the International Conference on Population and Development adopted by the twenty-first special session of the United Nations General Assembly in July 1999;

Reaffirming further the Beijing Platform for Action (Beijing, 1995) and the further actions and initiatives to implement the Beijing Declaration and the Platform for Action adopted at the twenty-third special session of the United Nations General Assembly in June 2000;

Reaffirming also the development goals of the Millennium Declaration adopted by the United Nations General Assembly at its fifty-fifth session in September 2000;[2]

Recognizing that attainment of the Millennium Development Goals and targets and other international goals and targets require, as a priority, strong investment and political commitment in reproductive and sexual health;

Recalling that resolution WHA55.19 requested the Director-General, inter alia, to develop a strategy for accelerating progress towards attainment of international development goals and targets related to reproductive health,

1. ENDORSES the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health;

[1] Document EB113/15 Add.1.

[2] United Nations General Assembly resolution 55/2.

2. URGES Member States, as a matter or urgency:

(1) to adopt and implement the strategy as part of national efforts to achieve the United Nations Millennium Development Goals;

(2) to make reproductive and sexual health an integral part of national planning and budgeting;

(3) to strengthen capacity of their health systems to achieve universal access to sexual and reproductive health care, with particular attention to maternal and neonatal health in those countries where related mortality and morbidity are highest;

(4) to monitor implementation of the strategy to ensure that it benefits the poor and other marginalized groups, and that it strengthens reproductive and sexual health services at all levels;

(5) to ensure that all aspects of reproductive and sexual health including, inter alia, maternal and neonatal health, are included within national monitoring and reporting of progress towards attainment of the development goals of the United Nations Millennium Declaration;

3. REQUESTS the Director-General:

(1) to provide support to Member States, on request, in implementing the strategy and evaluating its impact and effectiveness;

(2) to devote sufficient organizational priority, commitment and resources to supporting effective promotion and implementation of the reproductive health strategy and the necessary actions it highlights;

(3) to give particular attention to maternal and neonatal health in WHO's first progress report on reproductive and sexual health in 2005, as part of its contribution to the Secretary-General's report to the United Nations General Assembly on progress towards attainment of the development goals of the United Nations Millennium Declaration.

(4) to provide regular (at least biennial) progress reports on implementation of the strategy to the Health Assembly.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), introducing the draft resolution on behalf of its sponsors, said that it was the United Kingdom's conviction that, without progress in reproductive health, the Millennium Development Goals would not be attained. He was therefore pleased to support WHO's reproductive health strategy. It was also highly appropriate to be addressing reproductive and sexual health in the year of the tenth anniversary of the International Conference on Population and Development (Cairo, 1994).

The draft strategy, which had been the subject of extensive consultation, provided a strong, evidence-based foundation for action. Its guiding principle and five core aspects established valuable standards of expectation for good reproductive health services. It provided a clear sense of what needed to be done, recognized the diversity of country situations and the importance of country-led action, and underlined the importance of working in partnership, collectively and coherently. The Organization would need to devote sufficient resources to reproductive health and ensure that all relevant departments and initiatives contributed appropriately to implementation.

The United Kingdom strongly supported the draft strategy and wanted to see it go forward for consideration by the Fifty-seventh World Health Assembly, with a clear indication from the Board of the importance it attached to WHO's giving priority to work in reproductive health.

Dr BOSHELL (Colombia), speaking on behalf of the Group of Latin American and Caribbean countries, commended the draft strategy. It identified barriers to progress in health experienced by most of the world's population and proposed practical and reliable measures and solutions. It set out with clarity the way forward in respect of safe motherhood, improved access to maternal and child

health care, strengthened prevention of sexually transmitted diseases and decreased domestic and sexual violence. There were marked similarities between the text and national policies in countries in the Group in regard to sexual and reproductive health and, in particular, those adopted by Colombia. He reaffirmed his country's commitment to human rights and to the programmes agreed at the International Conference on Population and Development and the United Nations Fourth World Conference on Women (Beijing, 1995).

The Group supported forwarding the strategy, as drafted, to the Health Assembly.

Mr AISTON (Canada) considered the draft strategy to be of the utmost importance, adding that it accurately depicted the current situation in respect of reproductive health and of the world as those present might wish it to be. It fully supported the consensus reached at the International Conference on Population and Development, and subsequent forums, which committed Member States to ensuring universal access to high-quality reproductive care and services. Those agreements, and the more recent United Nations Millennium Declaration, reflected governments' collective recognition of the importance of reproductive and sexual health and the right to achieve development, poverty reduction and population health goals.

The draft strategy correctly described the global context and challenges faced, and mapped out clearly where action needed to be taken to accelerate progress. In particular, Canada supported the focus in the draft strategy on strengthening health systems' capacity, and the need to ensure that reproductive and sexual health became an integral component of national health sector plans and poverty reduction strategies. Equally important was the role identified for WHO to continue its work in supporting evidence-based research, norms and standards to advance reproductive and sexual health.

The draft strategy provided an overarching guide for action in key areas, but it did not attempt to dictate all the components of reproductive health care and services that needed to be implemented. Those aspects had already been well articulated in the programmes agreed at the conferences in Cairo and Beijing, and underpinned the actions to be taken in the draft strategy.

In implementing the draft strategy WHO should place particular emphasis on strengthening collaboration with United Nations' agencies and other partners; it should also tighten its internal coordination to ensure both policy coherence and the effective and efficient use of resources. WHO's reports on the strategy should clearly outline the actions taken to make reproductive health an organizational priority.

Canada supported both the draft strategy as an important contribution to attaining international development goals and targets and the draft resolution.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the excellent report drew on the experiences and lessons learned by countries in implementing their own strategies. Although the draft strategy was comprehensive, greater emphasis should be placed on families and on schools, as it was there that an awareness of how to use reproductive health services and to live a more fulfilling life could be fostered. Other sectors of society had to be engaged as they too could make an important contribution. The draft should emphasize primary health care, as had been outlined in the programmes and plans of action of the International Conference on Population and Development and the United Nations Fourth World Conference on Women. A comprehensive and rational approach to the issues was required, with a focus on gender and taking into account the entire sexual and reproductive life cycle of both men and women. An integrated and qualitative focus should be preferred to the purely quantitative. He expressed full support for the statement made on behalf of the Group of Latin American and Caribbean countries. His country supported the draft strategy and the draft resolution.

Dr YIN Li (China) endorsed the draft strategy. Three of the eight Millennium Development Goals were closely related to reproductive health, namely: a reduction in the maternal mortality ratio and the under-five mortality rate and the reversal of the spread of HIV. The need to strengthen health systems' capacity in reproductive health was a prerequisite for many countries in attaining the health-

related Millennium Development Goals. He expressed concern that the efforts of WHO and its partners to fulfil the reproductive health goals set out in Cairo and Beijing had diminished in recent years and he called for renewed cooperation in those areas. China wished to be included as a sponsor of the draft resolution.

Dr KEBEDE (Ethiopia) said that successful reproductive health services could only be attained through the provision of comprehensive and high-quality care within the setting of an equitable and accessible health delivery system. The draft strategy contained many innovative suggestions, but the desired mobilization of political will could not be achieved unless appropriate mechanisms for a sustainable reproductive health service and the appropriate means to finance it were defined. The only effective way to assure sustainability within the sphere of national politics was to centre and institutionalize the issue in order to convince governments to adopt reproductive health as a priority. It would thus have a greater chance of being reflected in general policies and development strategies and carried forward by all members of governments. His country wished to be included as a sponsor of the draft resolution.

Dr TAG-EL-DIN (Egypt) requested that Egypt be added as a sponsor of the draft resolution, whose substance he endorsed given its firm basis in international mandates for action. Swift attainment of the Millennium Development Goals was essential. Reproductive health was an important part of national development in terms of both planning and funding. Egypt had been pursuing those goals for several years: reproductive, maternal and child health were all vital aspects of its national strategies, and work in those areas had resulted in major improvements. There had been a decline in mortality during pregnancy and childbirth, as well as reductions in infant mortality between the first month and first year of life and in mortality among children under three years of age. Access to services, the quality of delivery of such services countrywide to all groups without exception and the coverage of deprived areas were key elements of those strategies.

He urged the full backing of members, and expressed the hope that due emphasis would be placed on the fact that abortion, as mentioned in paragraph 17 of the Annex to document EB113/15 Add.1, applied only to those exceptional cases where it was necessary for pressing health or medical reasons.

Dr ACHARYA (Nepal) said that, although much had been achieved in Nepal in respect of reproductive health, much still remained to be done. The maternal mortality ratio in Nepal was one of the highest in the world: 539 per 100 000 live births. One fifth of all deaths among women of reproductive age was due to pregnancy-related causes: mainly postpartum haemorrhage, obstructed labour, eclampsia, sepsis and complications of abortion. Girls were married very young and the fertility rate was high. In addition, the coverage of maternity care services was also low. Antenatal care coverage, consisting of one check up, was only 48% and institutional delivery was only 12%. Most maternal deaths occurred at home as more than 86% of women delivered their children at home, of which 50% of births were attended only by friends and relatives. Nepal's national safe motherhood programme recognized the need to address urgently the lack of skilled birth attendants for all pregnant women in the country. The development and implementation of an effective, innovative human resource strategy for safe motherhood to ensure skilled attendance for delivery at home or in a nearby institution, linked to an effective referral system, was critical for saving the lives of pregnant women in Nepal. The situation in the country had been further exacerbated by Maoist insurgents who destroyed vehicles carrying vaccines and medicines and threatened health workers. The draft strategy was therefore of great importance to Nepal, which fully supported the actions it proposed.

Professor DANG DUC TRACH (Viet Nam) expressed appreciation for the quality of the draft strategy and approved the draft resolution.

The role that midwives could play in reproductive health in developing countries such as Viet Nam was extremely important. Most women of child-bearing age and pregnant women,

particularly those living in the countryside, felt more confident and at ease consulting a midwife rather than a doctor. Until recently, midwifery training had focused mainly on obstetrics. However, in some Vietnamese provinces, midwives were also being trained to perform the social role of counsellor and educator, an initiative that had contributed to the strategy to accelerate achievement of reproductive health goals in those provinces.

Mr ASLAM KHAN (alternate to Mr Khan, Pakistan) said that document EB113/15 Add.1 provided a comprehensive picture of the global situation as regards reproductive health, as well as the challenges presented and the interventions needed to improve reproductive health worldwide. However, to establish supportive legislative and regulatory frameworks, countries needed to collaborate and share their experiences within their respective WHO regions. Development partners should also work together to devise uniform strategic guidelines and avoid duplication of activities. Although the draft strategy on reproductive health was, generally speaking, acceptable, paragraph 32 was incompatible with the religious and cultural values of many countries and he requested its deletion.

Mr GUNNARSSON (Iceland) said that Iceland wished to be added to the list of sponsors of the draft resolution. Even though its maternal death rate of 0% was almost due largely to the attendance of skilled professionals at every birth, it had to contend with other problems, such as sexually transmitted diseases and violence against women and children. The draft strategy, which was in line with the United Nations Millennium Development Goals, covered extremely important reproductive health issues and would be helpful to all Member States. Iceland fully supported both the draft strategy and the draft resolution.

Professor FURGAL (Russian Federation) said that the draft strategy, which had been prepared on the basis of broad regional consultations, presented a well ordered and realistic set of measures. He supported its main provisions and recommendations, including the proposed key areas of activity at country level and WHO's commitment to provide support to Member States in selecting alternative ways to deal with national problems. In the draft resolution, he doubted whether the expression "reproductive and sexual health" used in a single context accurately reflected the title of the draft strategy or the draft resolution. A uniform technical description of the issues covered in the documents should be used instead.

Mr BRUNET (alternate to Professor Dab, France) observed that the draft strategy had evolved through a long consultation process and provided a satisfactory response to the needs of Member States. Certain aspects were particularly important to France: prevention of violence against women, the right of adolescents to good information and health services, and unwanted pregnancies – a pressing problem for adolescents in many countries. France had recently introduced some innovative measures to tackle unwanted pregnancy that included facilitating access to emergency contraception. Although the report also referred to the genital mutilation of children and adolescents, greater emphasis needed to be placed on the consequences of female genital mutilation in relation to the ability of women to carry pregnancy to term safely and without any untoward incident due to that early mutilation. France wished to be a sponsor of the draft resolution and preferred it to remain unchanged. He endorsed the comments of the member for Canada to the effect that WHO should play a key role in the intersectoral work of implementing the strategy.

Dr STEIGER (United States of America) said that the United States was fully committed to seven of the goals contained in both the draft strategy and the draft resolution: reducing maternal and infant mortality; providing greater access to obstetric care; reducing domestic violence; providing voluntary family planning; the need for trained, skilled birth attendants and midwives; equality between men and women and empowerment of women; and reducing sexually transmitted diseases. On all of those aspects the United States urged further work by WHO.

The United States nevertheless had reservations on several issues in the draft resolution and would be obliged to disassociate itself from those aspects of the draft strategy should the governing bodies endorse it as it stood. He acknowledged that the draft was underpinned by internationally agreed human rights instruments and global consensus declarations, but WHO should recognize that States had assumed different obligations under international human rights law. The numerous references to "reproductive and sexual health services" were unacceptable as the phrase was often interpreted in international forums to include abortion and abortion services, and the significant focus on unsafe abortions seemed to imply that safe abortions were always acceptable. While recognizing the humanitarian need to provide care to women who suffered adverse health consequences after an abortion, the United States objected to the suggestion in paragraph 37 that urgent action could include providing abortion services at the primary health care level and, in paragraph 40, that attention to violence against women could be tackled by providing abortion. The United States continued to believe that, as a matter of principle, United Nations organizations should not promote abortion, especially in States where it was illegal. As in earlier drafts, there was still inadequate recognition of the rights and responsibilities of parents, legal guardians or other caregivers, which had been central to the 1990 World Summit for Children. The text should also be less prescriptive and the language reflect its non-binding nature by recommending rather than indicating that some actions were necessary; such decisions should be made by Member States themselves. In the introduction to the draft strategy, it was stated that resolution WHA55.19, which the United States had endorsed and which called for the strategy to be drawn up, reaffirmed the outcomes of the International Conference on Population and Development and the United Nations Fourth World Conference on Women. In fact, that resolution only recalled and recognized those conferences, an inconsistency that should be rectified in the final draft.

Informal consultations on the draft resolution should continue. For that purpose, and based on resolution WHA55.19, which reflected the consensus language, he proposed the replacement of "reaffirming" by "recalling and recognizing" in the second, third and fourth preambular paragraphs, the replacement of "Millennium Development Goals" by "Development Goals of the United Nations Millennium Declaration" in the fifth preambular paragraph and in paragraphs 2(1), 2(5) and 3(3); the insertion of "health, including" between "make" and "reproductive" in paragraph 2(2); the replacement of "services" with "care" in paragraph 2(4), and the deletion of "necessary" in paragraph 3(2). The United States' approval of the draft resolution was contingent on a satisfactory conclusion of informal discussions on the draft resolution on family health and the mutual recognition of sensitivities.

Dr AL-MAZROU (Saudi Arabia), welcoming the draft strategy, said that its antenatal, perinatal, postnatal and child care aspects were of particular importance to his country. If sufficient attention were paid to those areas, which included other aspects such as family planning, considerable benefits would ensue in the provision of more focused and comprehensive reproductive health services; other services could then be made available at the point of attendance. The establishment and strengthening of health systems were prerequisites for improved reproductive health and should be given priority. Paragraph 32 contained language that was inappropriate in certain countries, including his own, and should be removed to ensure consensus. He also endorsed the reservations made by the United States and expressed the hope that they would be given due consideration when the draft strategy was being revised before its submission to the Health Assembly.

The 2003 external assessment of the Special Programme on Research, Development and Research Training in Human Reproduction for the period 1990-2002 had emphasized the programme's success in carrying out health research, publishing its findings and strengthening research capabilities in several countries. WHO should be justly proud of its achievements.

Dr MODESTE-CURWEN (Grenada) supported the draft resolution on reproductive health. She applauded the emphasis placed on maternal and newborn health, and the request to the Director-General to give particular attention to maternal and neonatal health in WHO's first progress report on

reproductive and sexual health in 2005. Nevertheless, it was a matter of concern that current data trends of maternal and newborn indicators had shown no significant overall or global progress in maternal and newborn health over the past decade. The global inequities that led to morbidity and mortality during pregnancy and childbirth, as a result of conditions that were preventable or treatable, were also matters of concern.

Recalling the specific targets set out in the Millennium Development Goals, namely, to reduce the maternal mortality ratio by three-quarters and the under-five mortality rate by two thirds between 1990 and 2015, she called on WHO to include maternal and neonatal health on the agenda of the 115th session of the Executive Board.

Dr KASSAMA (Gambia) said that Gambia would like to be included on the list of sponsors of the draft resolution. Since the International Conference on Population and Development (Cairo, 1994) and the United Nations Fourth World Conference on Women (Beijing, 1995), the importance of reproductive health had been widely recognized, as evidenced by the support expressed during the current session of the Board. He highlighted the role of family planning services as set out in the draft strategy, in particular the need to make condoms available to adolescents. As there would be a better chance of achieving the Millennium Development Goals if the strategy were broadened still further, he proposed that the words "and all concerned parties" should be inserted after the words "Member States" in paragraph 3(1) of the draft resolution.

Dr CAMARA (Guinea) expressed support for the draft resolution and the draft strategy. Given conditions prevailing in the developing countries, with high infant mortality rates, poor access to basic services, the lack of qualified personnel including midwives and the consequent lack of skilled assistance during childbirth, reproductive health warranted strong action, and the strategy would be a useful tool in attaining the Millennium Development Goals. Concerns remained, however, about the inequities in access to basic social and health services, which failed to target the most disadvantaged groups.

Dr DAYRIT (Philippines), welcoming the draft strategy and the draft resolution, said that his Government recognized the need for vigorous action, in line with the Programme of Action adopted in Cairo in 1994 and the Plan of Action adopted in Beijing in 1995, while at the same time acknowledging that there were certain sensitivities, notably religious ones, that must be taken into account, particularly in regard to the issues of abortion and emergency contraception. Reproductive health policy in the Philippines rested on four main pillars: respect for life, responsible parenthood, birth spacing and informed choice based on religious beliefs and cultural practices. Information was provided on both artificial and natural methods of family planning. He associated himself with the comments of the member for the United States of America and also with those of the member for Pakistan concerning the wording of paragraph 32 of the draft strategy, in particular the reference to emergency contraception.

Dr ALONSO CUESTA (alternate to Dr Pastor Julián, Spain) said that the content and goals of the draft strategy would contribute to the attainment of the Millennium Development Goals and commendably addressed not only the health priorities but also the wider context of gender equality, poverty eradication and human rights. Spain's own health strategy for the period 2004-2007 laid particular emphasis on maternal and child health, one of its priorities being to provide accessible maternal and child health services responsive to the evolving social and cultural context. Spain supported the proposals to implement policies based on the recognition of parents' responsibility for planning their families, their right to have the information and the means to do so, and the right to enjoy optimum reproductive and sexual health.

Spain supported the draft resolution but considered that the draft strategy needed reviewing. A working group might usefully be set up to revise certain of its aspects, for example, on the question of abortion services: her Government was in favour of providing reproductive health services of high

quality throughout a woman's life. The question of self-medication should also be addressed. Furthermore, specific action should be taken for the benefit of two particularly vulnerable groups – immigrants, having due regard for their culture and ensuring that they were properly informed and had access to quality health services, and adolescents, with due provision for specific information and sex education. Of particular importance in that regard was action to prevent unwanted pregnancies and to stress the role of the family in providing relevant information. For both groups, further steps should be taken to provide more information on the prevention of sexually transmitted infections.

Dr AL-JARALLAH (Kuwait), noting the importance of reproductive health and welcoming the preparation of the draft strategy, endorsed the statements made by the members for Pakistan, Saudi Arabia and the Philippines regarding paragraph 32 of the draft strategy, which should be deleted. He also supported the statement of the member for Egypt on the restriction of abortion to cases of medical necessity.

Dr BOSHELL (Colombia), speaking on behalf of the Group of Latin American and Caribbean countries, said that the adoption of the draft resolution was of the utmost importance to those countries in support of their policies, and expressed concern about possible delay in transmitting the resolution and the draft strategy to the Health Assembly. If the working group proposed by Spain were to meet immediately, it would in all probability be able to iron out differences before the end of the Board's session.

Another matter of concern related to the comments of the member for the United States of America and the interpretation of the term "reproductive and sexual health services" to mean abortion services. Comparing the situation to road traffic injuries, he pointed out that, while prevention was obviously better than cure, where abortions were carried out – and the fact was that they were – proper emergency services should be there to treat the consequences. The fact that such services existed did not mean that abortion was being encouraged.

Colombia wished to be added to the list of sponsors of the draft resolution.

Mr AGARWAL (India),[1] commending the draft strategy, outlined some of the innovative actions taken in India in the field of reproductive health, including the national maternity benefit scheme, public-private partnership for free antenatal and postnatal care, and training for birth attendants. The specific targets set by India's tenth Five-Year Plan for reducing maternal and infant mortality rates in line with the Millennium Development Goals would require a significant upgrading of institutional capacity and substantial resources.

A global alliance in the field of reproductive health, along the lines of the other global alliances pioneered by WHO, would go a long way towards making the programme a success.

Ms MIDDELHOFF (Netherlands),[1] speaking also on behalf of Belgium, Denmark, Finland, Luxembourg, Sweden and Switzerland, applauded WHO for developing the draft strategy on reproductive health and for engaging in an open and comprehensive consultative process with Member States and other stakeholders. The draft strategy provided an important framework for the implementation of the Programme of Action adopted in Cairo, the Plan of Action adopted in Beijing and the Millennium Development Goals. She would nevertheless have welcomed an even stronger strategy with more emphasis on human rights, including sexual and reproductive rights, issues related to men, investment in sexual and reproductive health of adolescents, access to contraceptive services, and maternal mortality related to unsafe abortions. The strategy did, however, reflect the different concerns and views of Member States. Further consultations would not necessarily add to the quality of the strategy and she urged adoption of the draft resolution and a consensus on forwarding the draft strategy to the Health Assembly for consideration.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Mr BÁRCIA (Portugal)[1] said that, while he was sensitive to the arguments put forward concerning different practices in the field of reproductive health, he considered the draft resolution to be reasonably balanced and expressed his country's wish to be included among the sponsors.

Mr SEADAT (Islamic Republic of Iran)[1] agreed that reproductive health was an important development-related issue. While expressing support for the draft strategy, he fully shared the views expressed by the member for Egypt that abortion should be carried out only in exceptional cases where the health of the mother or child was in danger and in proper clinical conditions; that was his understanding of the concept of safe abortion. He also shared some of the concerns of the member for Pakistan about the content of paragraph 32; he suggested deleting the wording in parentheses and amending the last sentence to make it less prescriptive, with a reference to the need to take into account national circumstances.

Professor PAKDEE POTHISIRI (Thailand)[1] noted with concern the slow progress towards achieving the goals of the International Conference on Population and Development and the Millennium Development Goals in the field of reproductive and sexual health. Thailand fully supported human rights as a guiding principle in accelerating progress towards those goals but, under that heading, suggested that "pro-poor" and "gender-sensitive" health programmes should be advocated in order to improve access by poor people, marginalized groups and women to health services, including reproductive and sexual health care. Thailand fully supported the five actions proposed in the strategy but recommended adding "and financial resources" to the heading "Mobilize political will" preceding paragraphs 55 and 56.

He proposed two amendments to the draft resolution: to insert a new subparagraph in paragraph 2 to read "to mobilize political will and financial resources and create a supportive legislative and regulatory framework in order to achieve the goals of the International Conference on Population and Development and the United Nations Millennium Development Goals"; and to insert the words "goals of the International Conference on Population and Development and the" before "United Nations Millennium Development Goals" in paragraph 2(1).

He requested WHO to make every effort to help improve and strengthen national information systems for measuring achievements in reproductive health, as currently available information on maternal and infant mortality rates was still inadequate.

Ms MAFUBELU (South Africa)[1] welcomed the draft strategy and fully supported the provision of comprehensive reproductive health services, including family planning and abortion services. Some issues needed to be highlighted. The needs in developing countries were often exacerbated by lack of information and inadequate health sector resources. Moreover, social and cultural factors must be taken into account to ensure that services were acceptable. The involvement of men was crucial in promoting reproductive and sexual health, and the provision of information to men should be a distinct initiative. In male-dominated societies, the omission of men's involvement had impeded the implementation of reproductive health programmes. The migration of skilled health workers from developing countries to developed countries caused serious concern and was affecting the provision of services and leading to a drop in the standards of training. WHO should support countries in generating baseline data and establishing monitoring and evaluation systems, which were often lacking. There was a need to develop instruments that respected and improved women's health. For example, maternal deaths should be notifiable, and deaths in institutions and children's deaths should be investigated. Given the large number of AIDS-related maternal deaths, the management of HIV/AIDS should be integrated in the strategy. As one of the sponsors, South Africa urged the Board to support the draft resolution.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Mrs IORDACHE (Romania)[1] expressed appreciation for the efforts made by WHO, in particular in respect of poor and disadvantaged populations. After years in which contraception and abortion were banned and which were associated with high rates of maternal mortality, Romania was implementing a dynamic national reproductive health programme in line with the Programme of Action of the International Conference on Population and Development. Maternal mortality had decreased substantially, mainly as a result of fewer abortion-related deaths, from 149 deaths per 100 000 live births in 1989 to nine in 2002. In 2003, the Ministry of Health had formulated a national strategy for sexual and reproductive health based on the WHO European regional strategy. She therefore welcomed the draft strategy. Romania's experience had shown that implementation of the Programme of Action adopted in Cairo was indispensable to the attainment of the Millennium Development Goals. Her country was willing to share its experience and to disseminate best practices in the European Region.

Ms CAGAR (UNFPA), speaking at the invitation of the CHAIRMAN, said that UNFPA welcomed the draft strategy, which should be considered by the Health Assembly. It was fully compatible with the Programme of Action adopted at the 1994 International Conference on Population and Development, which had been reaffirmed at the twenty-first special session of the United Nations General Assembly in 1999. There should be an integrated approach to the provision of reproductive health care, while ensuring that each country emphasized priorities appropriate to its own circumstances. The Millennium Development Goals had been based on the goals and targets established by global conferences held during the 1990s, including the International Conference on Population and Development. The draft strategy was well designed to accelerate progress towards the specific goal, set in Cairo, of universal access to reproductive health services by 2015. Attainment of that goal was essential if the targets of the Millennium Development Goals, especially those related to poverty, child and maternal mortality, HIV/AIDS and gender equity, were to be met on time. At the Fifth Asia and Pacific Population Conference held in Bangladesh in December 2002, the United Nations Secretary-General had warned that the Millennium Development Goals, in particular the eradication of extreme poverty and hunger, could not be achieved if questions of population and reproductive health were not squarely addressed, which meant stronger efforts to promote women's rights and greater investment in education and health, including reproductive health and family planning.

UNFPA endorsed the five core aspects of reproductive and sexual health set out in paragraph 35 of the draft strategy. As indicated in paragraph 36, essential obstetric care should be given due attention within maternal health services, ensuring attendance at birth by skilled health personnel and comprehensive emergency obstetric care to manage complications. Such an approach necessitated referral systems that included appropriate lines of communication and transport of patients. Family planning services played a major role in reducing maternal deaths and childbirth injuries by preventing unintended pregnancies. Family planning was a success story, with massive increases in contraceptive use in developing countries over the past three decades. Exemplifying the value of an integrated approach to reproductive health within an overall policy of strengthening health systems, reproductive health services also provided opportunities to provide HIV prevention and treatment services to women, thereby contributing to the "3 by 5" initiative.

She welcomed the attention given in the draft strategy to the human rights dimensions of reproductive and sexual health and to adolescents, gender disparities, gender-based violence and the need for priority to be given to poor and underserved populations.

UNFPA looked forward to continued collaboration with WHO on activities to improve reproductive health and ensure the reproductive rights of women and men across the world.

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[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Ms SPRY (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that her organization had worked intensively in the area of reproductive health for more than 10 years, giving particular attention to the impact of HIV/AIDS and to projects for young people. Increased access by young people to reproductive health information and services was vital for the attainment of the Millennium Development Goals. The many barriers that prevented young people from taking control of their reproductive health included lack of education, poverty, stigmatization and peer pressure. Information and services must be therefore youth-friendly, with skilled health professionals and significant commitment on the part of those who commissioned and managed health care training and reproductive health services. Her organization welcomed the progress towards improved and equitable access to reproductive health services and was proud to collaborate with WHO for the benefit of young people.

Ms KEITH (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, endorsed the draft strategy. Referring to paragraph 42, relating to actions, she said that the strategy would benefit from research on which reproductive health programmes were and were not funded at country level, and the reasons why. Such an analysis would need to cover country and external donor and nongovernmental organization initiatives as well as those funded by health ministries. Increased political commitment to the adequate financing of health systems strengthening in respect of safe motherhood and other reproductive health services was needed if Millennium Development Goal 5 was to be attained. Her organization, together with the Grow Up Free from Poverty Coalition, had recently completed a report entitled *80 million lives* which demonstrated the need to assess the impact of the "investment in health" approach on the likely attainment of Millennium Development Goals 4 and 5; 80 million was the number of lives that could be saved if those goals were met. The report called for a return to primary health care principles and a social model of health, while ensuring greater financial input and accountability on the part of national and international institutions. Problems remained in relation to indicators. For example, many donors supported training of traditional birth attendants as a means of reaching targets for skilled birth attendants. Advocacy and technical support were needed to ensure that donor programmes followed best practices in relation to safe motherhood and used realistic indicators.

Referring to paragraph 43, she endorsed the need to strengthen health systems capacity. All aspects of such systems must be adequately coordinated and linked, in particular cost of services, cost recovery and other aspects of inpatient care. Experience in some countries, for example Sri Lanka, had shown that abolition of cost-recovery mechanisms had had a favourable impact on maternal mortality. Referring to paragraph 45(1), she supported WHO's call for reproductive and sexual health to be central to planning and strategy development processes such as Poverty Reduction Strategy Papers, which they currently were not. Referring to paragraph 45(2), she requested clarification of the comment made by the Executive Director of the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria during the Board's consideration of item 3.2 of the agenda that programmes currently being funded would need to be re-engineered to meet the "3 by 5" goals. What impact would that have on access to resources already committed to the strengthening of adolescent-friendly health services, an area in which her organization was collaborating with WHO? She also requested that mechanisms to support effective nongovernmental organization and civil society initiatives be included in the development of the health-sector reforms and sector-wide approaches referred to in paragraph 45(3). Referring to paragraph 47, she suggested that development of training and supervision strategies might be added to the recommended actions, since many new approaches would need to be added to initial and in-service training curricula of health workers and to ensure effective management of health information.

Mrs PHUMAPHI (Assistant Director-General), thanking Board members and other speakers for their support for the draft strategy and their suggestions, noted the general recognition that reproductive health was pivotal to the health of the global community. It was also an important determinant of quality of life, affecting the health and economic development of individuals, families,

communities and ultimately countries, especially in the developing world. Of the 210 million pregnancies each year, some 80 million were unwanted for various reasons, including economic problems, cultural factors and the fact that the mothers were too young. Reproductive health was covered directly by three of the Millennium Development Goals, a clear statement by the global community that reproductive health must be a priority for resource allocation and mobilization, as well as for planning. Speakers had acknowledged the need for special emphasis on adolescent reproductive health programmes. Children must be given the chance to grow and to reproduce only when their bodies were ready and once they had become socially responsible.

Clearly, WHO could not interfere with the legislative framework of any Member State, since legislation was a matter for the populations and governments of countries. WHO took the position, however, that it should develop strategies, programmes and guidelines on abortion services for Member States whose legislation provided for such services, including termination when the mother's life was in danger, so as to ensure that such services were safe. Any reference to abortion in the draft strategy was made within that context, and it was for Member States themselves to determine their approach to the matter.

Emphasis on reproductive health could make a big difference to progress towards the Millennium Development Goals, which was currently behind schedule.

The CHAIRMAN suggested that further consideration of the draft resolution should be postponed pending informal consultations.

It was so agreed.

(For continuation of the discussion and adoption of the resolution, see summary record of the tenth meeting, section 2.)

The meeting rose at 12:20.

SIXTH MEETING

Wednesday, 21 January 2004, at 14:10

Chairman: Dr K. AFRIYIE (Ghana)

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

Road safety and health: Item 3.9 of the Agenda (continued from the fourth meeting)

The CHAIRMAN invited the Board to consider the draft resolution on road safety and health, as amended at the fourth meeting, which read:

> The Executive Board,
> Having considered the report on road safety and health,[1]
>
> RECOMMENDS to the Fifty-seventh World Health Assembly the adoption of the following resolution:
>
> > The Fifty-seventh World Health Assembly,
> > Recalling resolution WHA27.59 (1974), which noted that road traffic accidents caused extensive and serious public health problems, that coordinated international efforts were required, and that WHO should provide leadership to Member States;
> > Welcoming United Nations General Assembly resolution 58/9 on the global road safety crisis;
> > Recognizing the tremendous global burden of mortality resulting from road traffic crashes, 90% of which occur in low- and middle-income countries;
> > Acknowledging that every road user must take the responsibility to travel safely and respect traffic laws and regulations;
> > Recognizing that road traffic injuries constitute a major but neglected public health problem that has significant consequences in terms of mortality and morbidity, and considerable social and economic costs, and that in the absence of urgent action this problem was expected to worsen;
> > Further recognizing that a multisectoral approach is required successfully to address this problem, and that evidence-based interventions exist for reducing the impact of road traffic injuries;
> > Noting the large number of activities on the occasion of World Health Day, 2004, in particular, the launch of the first world report on traffic injury prevention,
> >
> > 1. CONSIDERS that the public health sector should actively participate in programmes for the prevention of road traffic injury through injury surveillance and data collection, research on risk factors of road traffic injuries, implementation and evaluation of interventions for decreasing road traffic injuries, provision of prehospital and trauma care and mental-health support for traffic-injury victims, and advocacy for prevention of road traffic injuries;

[1] Document EB113/9.

2. URGES Member States, particularly those which bear a large proportion of the burden of road traffic injuries, to mobilize their public-health sectors by appointing focal points for prevention and mitigation of the adverse consequences of road crashes who would coordinate the public-health response in terms of epidemiology, prevention and advocacy, and liaise with other sectors;

3. RECOMMENDS Member States:

(1) to assess the national situation concerning the burden of road traffic injury, and to assure that the resources available are commensurate with the extent of the problem;

(2) if they have not yet done so, to prepare and implement a national strategy on prevention of road traffic injury and appropriate action plans;

(3) to establish government leadership in road safety, including designating a single agency or focal point for road safety;

(4) to facilitate multisectoral collaboration between different ministries and sectors, including private transportation companies;

(5) to take specific measures to prevent and control mortality and morbidity due to road traffic crashes, and to evaluate the impact of such measures;

(6) to enforce existing traffic laws and regulations, and to work with schools, employers and other organizations to promote road safety education to drivers and pedestrians alike;

(7) to use the forthcoming world report on traffic injury prevention as a tool to plan and implement appropriate strategies for prevention of road traffic injury;

(8) to ensure that ministries of health are involved in the framing of policy on the prevention of road traffic injuries;

4. REQUESTS the Director-General:

(1) to collaborate with Member States in establishing science-based public health policies and programmes for implementation of measures to prevent road traffic injuries and mitigate their consequences;

(2) to encourage research to support evidence-based approaches for prevention of road traffic injuries and mitigation of their consequences;

(3) to facilitate the adaptation of effective measures to prevent traffic injury that can be applied in local communities;

(4) to provide technical support for strengthening systems of prehospital and trauma care for victims of road traffic crashes;

(5) to collaborate with Member States, organizations of the United Nations system, and nongovernmental organizations in order to develop capacity for injury prevention;

(6) to maintain and strengthen efforts to raise awareness of the magnitude and prevention of road traffic injuries;

(7) to recommend to Member States, especially developing countries, to legislate and strictly enforce wearing of crash helmets by motorcyclists and pillion riders, and to make mandatory both provision of seat belts by automobile manufacturers and wearing of seat belts by drivers.

The resolution, as amended, was adopted.[1]

[1] Resolution EB113.R3.

Quality and safety of medicines, including of blood products: Item 3.12 of the Agenda (Document EB113/10)

- **WHO medicines strategy** (Document EB113/10 Add.1)

Dr LEPAKHIN (Assistant Director-General), introducing the reports, said that WHO's pre-qualification scheme for antiretroviral drugs had to date assessed 265 products at various manufacturing sites and pre-qualified more than 90 of them. Its scope had recently been expanded to include antimalarial and antituberculosis drugs.

Increased commitment to regulatory controls was needed urgently, both internationally and nationally; halting the expansion of unregulated commercial activity was an immediate priority. It was essential that regulatory oversight mechanisms received sufficient resources, since inadequate support would render them ineffective.

The WHO medicines strategy for 2004-2007 had been developed after extensive consultations with staff from various programmes and key development partners. The four main policy objectives remained unchanged; however, after the Fifty-sixth World Health Assembly, traditional medicine formed a separate component. The challenges remained the same, but the strategy was more focused on countries' needs; priority was given to solving the problem of unaffordable drug prices in low-income countries and resource-poor settings, in order to ensure that all patients had equitable access to essential medicines.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean) said that in its collaboration with Member States his office considered quality and safety of medicines as an integral component of national drug policy. Collaborative programme activities in that field focused on developing properly functioning quality assurance systems and establishing independent, efficient and accountable drug regulatory authorities. Of special interest to the Eastern Mediterranean had been the efforts of WHO to ensure the quality of medicines procured by countries in emergency situations, such as Afghanistan and Iraq. The pharmacovigilance system was essential to ensure the quality and safety of medicines during their shelf lives and throughout the drug supply chain.

The Regional Office also gave particular attention to assuring the quality and safety of blood products and other biologicals. National blood banks should comply with criteria for good manufacturing practice and follow standard operating procedures for the quality and safety of plasma products. The Regional Office had issued two publications, on blood transfusion[1] and plasma fractionation programmes[2]. Special attention was paid to the quality and safety of biologicals, in particular vaccines produced locally. Thus, national plans for the setting up of an independent national regulatory authority for biologicals had been drawn up for three producing countries, Egypt, the Islamic Republic of Iran, and Pakistan. There was an urgent need to build national expertise on the quality and safety of medicine, particularly in view of the rapid increase in the production and availability of biotechnology-derived medicines. Although the efforts of institutions other than WHO – notably the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use – were appreciated, WHO must remain the international standard-setting body for medicines, biologicals and other health commodities. In applying the WHO medicines strategy, the Region involved all partners (including professional associations and academic institutions) and promoted community-oriented pharmacy education. In support of the regional initiative of self-sufficiency in the production of essential medicines and biologicals, particularly vaccines, a memorandum of understanding had been signed by the vaccine-producing countries, Indonesia, the Islamic Republic of Iran and Pakistan, to strengthen technology

[1] *Blood transfusion: a basic text.* Alexandria, Egypt, WHO Regional Office for the Eastern Mediterranean, 1994.

[2] *Plasma fractionation programmes for developing countries: technical aspects and infrastructural requirements.* Alexandria, Egypt, WHO Regional Office for the Eastern Mediterranean, 1997.

transfer and interregional collaboration. The main current challenge was to ensure access and affordability of essential medicines for all, particularly new medicines that were essential for the control of both communicable and noncommunicable diseases; and to promote national use of drugs and compliance with ethical criteria for drug promotion. A regional drug programme based on traditional medicine had been introduced, and countries were being given support in formulating national policies in that regard.

Dr ALONSO CUESTA (alternate to Dr Pastor Julián, Spain) said that her country considered it of crucial importance to promote regulatory systems for medicines and to set up bodies responsible for coordinating national policies and strategies in that field. She invited Board members to attend the Eleventh International Conference of Drug Regulatory Authorities to be held in Madrid in February, which would provide an opportunity for discussion and input for revision of document EB113/10 before its submission to the forthcoming Health Assembly.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that, although the Health Assembly had adopted numerous resolutions on the quality, safety and efficacy of medicines, blood products, vaccines and other biological products, much still remained to be done. The lack of an efficient or even any regulatory system in some countries, as mentioned in document EB113/10, was a matter of concern. While Cuba, which had created a national regulatory authority, could endorse the strategy set out in paragraphs 13 and 14 of that document, that strategy should be supplemented by action to make Member States aware of the need to set up a regulatory system; to continue the pre-qualification process for vaccines and antiretroviral drugs; and to pursue efforts to improve access to medicines for the people who needed them most. He suggested that, after the conference in Spain, it would be advisable to present the Health Assembly with a report on progress on the subject.

Professor FURGAL (Russian Federation) agreed that, when considering the safety and quality of medicines, emphasis should be placed on services responsible for standard-setting and regulation of the various stages in the life cycle of medicines. His country was radically reforming its regulations on the subject; WHO's efforts to determine criteria and methods for testing the quality of medicines, and its technical support for national regulatory services, were playing an important role. One difficulty encountered when trying to ensure the safety and quality of medicines was the selection of appropriate international standards: many experts in his country considered it essential to follow WHO's universal standards, notably the rules on Good Clinical Practice. He requested advice from WHO on how to achieve closer harmonization with those rules. The Organization should step up work on developing both methods to detect counterfeit medicines and measures to prevent their production and distribution. Member States needed more support from WHO in studying the secondary effects of drug therapy. There was also need to develop internationally recognized guidelines for the licensing of pharmaceuticals and their wholesale and retail distribution, and to define the role of nongovernmental and religious organizations in the provision of medicines and in humanitarian programmes.

Mr ASLAM KHAN (alternate to Mr Khan, Pakistan) said that, because technological developments, increased international trade and the opening of borders had greatly increased the circulation of medicines, the lack of an effective international regulatory mechanism gave cause for considerable concern. The absence of appropriate regulatory oversight in some countries meant that some products on the market did not comply with quality specifications. In some cases the labels made unverified claims and the products could trigger adverse reactions. Unless medicinal products derived from blood and plasma were subject to control, they could transmit pathogens. Access to an ever-expanding array of vaccines required more effective regulation of exports and imports in order to ensure safety and efficacy.

His country had a well-established regulatory system, which complied with WHO regulations for the protection of the public from fraudulent practices. A national control authority for biologicals had been set up, which was responsible for the postmarketing surveillance of all vaccines and serums

manufactured in, or imported into, Pakistan. A national control laboratory had been established to assess the quality, efficacy and safety of all registered vaccines. He called on WHO to foster international collaboration in forums such as the International Conference of Drug Regulatory Authorities since the recommendations made at such forums might form the basis of future action.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) welcomed the continued focus on the WHO medicines strategy and the increased emphasis on access to drugs to combat HIV infection, tuberculosis, malaria and other high-priority diseases. WHO's efforts to be responsive to countries' needs would be more effective if they were linked to country-led analysis. There should also be a stronger link between policy on research and development for new medicines and access to existing medicines.

He endorsed the view that regulation was important, but there was a difference between sharing good practice among existing regulators and establishing new regulatory mechanisms. It was extremely difficult to establish new mechanisms in a situation where they had not emerged spontaneously.

It was important to connect the strategy with the wider issue of patient safety, since 25% of all medical errors worldwide were due to the administration of the wrong medication. Little was said in the report about professional and patient education, both of which were essential to high-quality care and risk reduction. One problem encountered in securing blood safety when a new transmissible agent was identified was how to find a rapidly available diagnostic test and it would be valuable if some mechanism could be introduced to speed up the development of new diagnostic tests once a new hazard had been identified.

The "3 by 5" initiative would lead to many drugs becoming available in a large number of countries, and efforts should be made to ensure that effective quality assurance was built into that programme at all levels in order to avoid counterfeiting and to make sure that the right drugs of the right quality went to those who needed them.

Dr STEIGER (United States of America), endorsing the views of the three previous speakers, said that the "3 by 5" initiative was a critical component of the strategy that needed more attention. His Government undertook to make every effort to develop and enhance drug regulatory mechanisms in countries with which it would be collaborating as part of his President's Emergency Plan for AIDS Relief, and WHO's advice would be crucial. His country was also concerned about counterfeit drugs; they were a problem there despite the existence of a strong regulatory regime. He reiterated concern that WHO might be overstepping its mandate in addressing issues of trade, intellectual property and pricing.

Dr AL-SAIF (alternate to Dr Al-Jarallah, Kuwait) said that WHO had achieved substantial success with regard to the quality and safety of medicines, including blood products. He suggested that it should devote more attention to the reliability of traditional medicines, given that their use had become widespread. He shared the view that countries should continue to report all counterfeit and substandard medicines, and that WHO should help in establishing mechanisms for quality control.

Mr BRUNET (alternate to Professor Dab, France) said that his Government associated itself with all initiatives taken by WHO to promote strong regulation guaranteeing high-quality, safe medicines. Responsibility in that sphere nevertheless lay primarily with national authorities, and covered assessment, pharmacovigilance, and the inspection of companies; it also included the essential assistance provided by WHO to countries that did not have the resources to exercise such responsibilities themselves. In that connection, France was prepared to give such countries any assistance needed in setting up the requisite mechanisms. He welcomed the progress made in that area, since new regulations currently being discussed in the European Union would enable the European Agency for the Evaluation of Medicinal Products, at WHO's request, to provide scientific opinions on medicines appearing on the market, even outside Europe.

High-quality, safe medicines had to be made accessible to the people who needed them, but that was far from the case to date: the flexibility introduced by the agreements at the WTO ministerial conference in Doha was a step forward in that connection. He agreed that action on pricing and intellectual property rights was not strictly within WHO's mandate, but if discussion of those issues was to be well-informed, WHO would need to provide information on their impact. The Organization could not be excluded from such discussions, and should continue to participate in them.

Professor MYA OO (Myanmar) also endorsed the four main objectives of the WHO medicines strategy. Unfortunately many developing countries could not afford high-quality drugs, without which it was impossible to reduce morbidity and mortality. If health was a human right, it should not be seen as a commodity subject to supply and demand. Developing countries needed drugs to combat malaria and tuberculosis, but transnational corporations spent only 1% of their research and development budgets on such drugs. In addition, without some flexibility in international agreements, such countries would not be able to operate compulsory licensing.

When prices were too high, people in poor countries often turned to traditional medicines. WHO should therefore promote traditional medicines, using its strong negotiating status at WTO to help developing countries to gain access to quality drugs. It should likewise help them to improve their regulatory mechanisms and laboratories.

Dr TAG-EL-DIN (Egypt) fully endorsed the four main objectives of the WHO medicines strategy. Special consideration had to be given to the supply and subsidizing of essential medicines for certain diseases. In addition to tuberculosis, malaria and AIDS, millions of people suffered and died from other equally serious diseases, and the question was whether essential medicines should be supplied for them as well. The WHO list of essential medicines was therefore widely welcomed. One third of the global population, and more than half the population in some of the lowest-income countries in Africa and Asia, had no regular access to essential medicines. Similarly, antiretroviral agents were available to only 300 000 of the five to six million people currently in need of treatment.

International standards for the quality control of drugs could prevent access to cheap but effective medicines, with the result that poor countries had no access to medicines of any kind. However, some limits had to be set, and the use of drugs that were adulterated or unsafe was unacceptable on ethical and health grounds. His Government therefore supported the efforts of the Regional Office for the Eastern Mediterranean to coordinate an effective network of intercountry cooperation to strengthen the quality and safety of medicines and blood products.

Dr YOOSUF (Maldives) said that many small countries depended heavily on imported drugs because they did not have the capacity to produce drugs themselves and because their regulatory mechanisms were weak. In addition, exporting countries, although they had the capacity to produce good-quality drugs, often did not regulate them with the necessary stringency. He therefore supported the proposal made by the member for the United Kingdom that WHO should facilitate the development of better drug regulatory mechanisms on the basis of the experience of countries with efficiently functioning systems. WHO should also extend the pre-qualification scheme to include medicines for chronic noncommunicable diseases, which accounted for a large percentage of health expenditure.

Dr DAYRIT (Philippines) said that in his country the cost of medicines accounted for 60% of health expenditure. With regard to accessibility, quality and safety of medicines, a number of initiatives had been taken: for instance, local industry had been encouraged to promote good manufacturing practices; measures had been drawn up to combat the use of counterfeit drugs; and collaboration had been sought with the medical profession in matters such as rational prescription. In addition, medicines were imported in order to keep down market prices.

Document EB113/10 Add.1 did not address the crucial issue of prices – a serious problem in the Philippines, where medicines could cost up to 10 times more than in neighbouring countries such as

Thailand. Since the public sector clearly could not provide all medicines free of charge, price reduction was a key element of any strategy aimed at improved access to medicines, and with this in mind the Philippine authorities were working with local and international pharmaceutical companies. People would be willing to pay for medicines if prices were affordable. More dialogue between WHO and Member States would help greatly to promote better access to essential medicines.

The CHAIRMAN, speaking in his capacity as the member for Ghana, said that in his country the issue of quality and safety of medicines was highly important. One matter of concern was public perception: recent problems with a poliomyelitis vaccine had led to widespread rumours that it had the potential to cause infertility, cancer and other clinical conditions, even though such risks were known to be very remote. In that way, government expenditure of more than US$ 1 million had been wasted by setbacks fuelled by unwarranted adverse publicity. Perhaps WHO could help countries such as his own to restore public trust in the efficacy, quality and safety of drugs, especially vaccines.

Dr ZEPEDA BERMUDEZ (Brazil)[1] said that his delegation appreciated the inclusion of the item on the agenda, as it was of great importance for the policies of developing countries. He welcomed the bolder approach to such sensitive matters as lack of access to medicines, the excessively high price of new products, the need to strengthen regulatory bodies, and irrational prescribing and dispensing. He was glad to note the implementation of a system to monitor progress in countries, and that the impact of globalization and trade agreements, notably those led by WTO, as well as guidelines to enable countries to implement policies giving public health priority over commercial interests, was given particular attention. It was gratifying that some areas hitherto considered taboo were being dealt with as a matter of course.

He supported requests that the subject of intellectual property rights, innovation and public health be included on the agenda of the Fifty-seventh World Health Assembly.

Dr PILLAY (South Africa)[1] welcomed the report and congratulated the Director-General on his leadership in launching the traditional medicines strategy, implementation of which should be accelerated. South Africa appreciated WHO's continued support in the development and implementation of its medicines policies. It was continuing to seek innovative ways to improve access to essential medicines, and would appreciate information about progress on fixed-dose combination treatment, especially for the treatment of HIV/AIDS, tuberculosis and malaria.

Professor PAKDEE POTHISIRI (Thailand)[1] said that his country welcomed WHO's efforts in carrying out a pre-qualification scheme for priority medicines, particularly antiretroviral and other drugs for the treatment of HIV/AIDS, tuberculosis and malaria, the three diseases that were of priority concern to many countries, as well as being one of the targets of the Millennium Development Goals. Thailand proposed that WHO should adopt a more proactive approach to the scheme in countries with the potential to produce generic versions of such drugs, providing technical support and cooperating with producers. It should set a target for the number and distribution of pre-qualified generic producers in every region, based on economy of scale, consumption level, competitiveness and sustainability. Proactive involvement was essential to ensure the availability of good-quality essential medicines at an affordable price, in keeping with the "3 by 5" initiative and the Millennium Development Goals, and his delegation requested the Director-General to take suitable measures as a matter of high priority.

Dr BALE (International Federation of Pharmaceutical Manufacturers' Associations), speaking at the invitation of the CHAIRMAN, said that drug quality was a vital public health and safety issue for all countries, involving measurement of drug utilization as well as controls against substandard and

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

counterfeit medicines. The pharmaceutical industry supported the work of the WHO Oslo Collaborating Centre for Drug Statistics Methodology and urged WHO to continue focusing its efforts on the development of statistics relating to long-term consumption of drugs that met international quality standards. It was important to adhere to the Anatomical Therapeutic Chemical/Defined Daily Dose (ATC/DDD) guidelines, notably those on cost control measures.

The use of substandard and counterfeit drugs had led to increased resistance to current treatments for malaria and tuberculosis, causing hundreds of thousands of otherwise preventable deaths. Counterfeits could account for up to 50% of medicines in some African markets and up to 20% of consumption in Latin America and Asia. Generic versions of drugs such as amoxicillin and paracetamol were also widely counterfeited in developing countries. A recent WHO study of antimalarial drugs in seven African countries had revealed that 100% of samples in some countries had failed key quality tests. Such studies were vitally important in showing the gravity of the problem and motivating measures at national level to combat counterfeit and substandard drugs. Product diversion through parallel trade likewise increased opportunities for substandard and counterfeit drugs to enter the market place by avoiding official distribution channels.

A joint working group involving WHO, his Federation and other organizations was working to improve awareness of the growing problem of counterfeit drugs. The pharmaceutical industry was committed to working together with WHO, national governments and other responsible partners to fight against that growing menace to public health, which disproportionately affected poor and disadvantaged populations.

Dr LEPAKHIN (Assistant Director-General) acknowledged the Board's expressions of appreciation. Not all comments and proposals made could be answered at the current meeting, but he assured members that they would be studied carefully and given a response.

The proposal by the member for Spain, supported by the member for Cuba, that quality and safety of medicines should feature on the agenda of the Health Assembly could certainly be arranged if the Board so decided. He noted that virtually all speakers had supported the call for efforts to strengthen national regulatory authorities; that was indeed a core activity of WHO, which in past years had supported some 120 countries. Members had also stressed the need for work to improve and ensure drug quality, including the use of pre-qualification for product assessment and quality assurance. If funds permitted, WHO would be pleased to pursue that line, particularly since it had ample experience of international expert cooperation in that field, involving many inspectors from countries in all regions.

With regard to the proposal by the member for the United Kingdom, he said that WHO had an essential drugs and medicine policy department and also an essential health technology department, which would be ready to establish a fast-track methodology for diagnostic kits and other approaches for dealing with the appearance of new pathogens. WHO was aware of its responsibility with regard to the growing problem of counterfeit drugs, but he pointed out that national governments and other agencies shared that responsibility. The pre-qualification scheme was an additional and powerful tool in the campaign against substandard and counterfeit drugs.

The original purpose of the current agenda item had been to draw attention to drug quality and safety, but it had later been expanded to include the wider issue of medicines strategy. The member for the United States of America had observed that the issue of pricing was somewhat beyond the scope of WHO; however, the Organization had become involved pursuant to resolution WHA54.11 which requested the Director-General to explore the feasibility of implementing systems for voluntary monitoring and reporting of global drug prices. While he appreciated the concern expressed on that issue, he stressed the consensual approach that was being taken: the work was being done in complete transparency; all matters were being openly discussed; and two eminent United States scientists had been invited to participate.

Dr STEIGER (United States of America) said that he did not in fact consider the issue to be outside WHO's mandate. Rather, he considered that any work done must be carried out carefully *within* that mandate.

The CHAIRMAN took it that the Executive Board wished to take note of the reports contained in documents EB113/10 and EB113/10 Add.1.

It was so agreed.

Health systems, including primary health care: Item 3.13 of the Agenda (Documents EB113/11 and EB113/11 Add.1)

Dr EVANS (Assistant Director-General) said that, pursuant to resolution WHA56.6, over the past four months, a number of events relating to the twenty-fifth anniversary of the Declaration of Alma-Ata had been held in South Africa, Kazakhstan, Spain and Brazil, and elsewhere. The quarter-century milestone provided an opportunity to reflect on the past and look to the future. A recent editorial in the *British Medical Journal* had noted that shaping the future depended on strengthening health systems and that the core principles of primary health care remained as relevant in 2003 as they had been in 1978. Those core principles were universal access to care and coverage on the basis of need, commitment to health equity, community participation and intersectoral collaboration. The Board was dealing with a range of critical opportunities to improve health, each priority programme having set ambitious targets for performance and indicating how they might best be achieved, but each priority programme could not create its own health system.

Two critical questions arose. First, would health systems constrain or facilitate priority programmes? In the case of the Global Alliance for Vaccines and Immunization, for instance, a recent report had identified a set of broad health system issues that immunization programmes were not able to address on their own. Secondly, would priority programmes erode health systems or strengthen them? Those questions had also to be considered in the context of development and of overall frameworks for development and health policy. For example, could more favourable fiscal frameworks be developed to facilitate the expansion of health programmes? Rigorously enforced ceilings existed that were often at odds with the need to expand health programmes. Could human resources be managed so as to ensure that critical thresholds in staffing, beyond which delivery of life-saving interventions became difficult if not impossible, were preserved?

WHO was tackling those questions, through such institutions as the European Observatory on Health Care Systems and the Observatory of Human Resources in Health Sector Reforms, in the Region of the Americas. A health metrics network was to be launched in 2004, aimed at strengthening in-country health information systems, and the Organization was working on costing tools, sustainable financing and the mobilization of human resources for the "3 by 5" initiative. However, more needed to be done, and quickly. Over the 25 years since Alma-Ata, values and principles, ambitious targets, billion-dollar funds and an impressive arsenal of cost-effective interventions had been "road-tested". The time had come to ensure that health systems were strong enough to realize that potential.

Dr ROSES PERIAGO (Regional Director for the Americas) noted that many speakers on previous items had called attention to the overburdening of health systems and the critical role of those systems in ensuring effective public health responses. The assessment of health sector reform undertaken over the past decade showed that the guiding principles followed had been efficiency, quality, patient safety, financing and private sector participation, whereas the overarching health-for-all values of equity and social justice, appropriate technology, strengthening of public health infrastructure and community participation had been somewhat neglected.

The twenty-fifth anniversary of the Declaration of Alma-Ata had been an excellent opportunity to recommit to principles for ensuring universal access, reducing social exclusion and enhancing public health responses. Member States in the Region of the Americas had participated in round tables

during the fifty-fifth session of the Regional Committee for the Americas and had approved a series of activities. Critical changes that had emerged in past decades had been identified for consideration during the preparation of a regional declaration for 2004. Those changes included the demographic and epidemiological situation, specifically ageing and urbanization, violence, chronic diseases and HIV/AIDS; prodigious technological expansion, and its impact on health care; the development of new strategies and interventions that affected the links between health and human security, human rights, social protection and human development; decentralization; and the participation of civil society. What at the time of Alma-Ata had been an aspiration had since become a reality.

If health outcomes were to be improved and the health-related Millennium Development Goals attained, health systems' development and strengthening must be given specific consideration when specific health risks and diseases were being addressed.

Dr HUERTA MONTALVO (Ecuador), speaking on behalf of the Latin American and Caribbean Group, said that in the absence of an agreed definition of a health system, WHO would not be able to make progress towards the fulfilment of its mandates, notably equity in health. The objectives outlined in the Declaration of Alma-Ata and in the Ottawa Charter for Health Promotion could be achieved only through the construction of solid national health systems in which health ministries provided strong central leadership and guidance without excessive control, and facilitated discourse on the whole system, not just its parts. Regarding document EB113/11, he supported the sections relating to health financing, the health workforce and health information and research.

As the Director-General had stated, without solid health systems, aspirations for primary health care provision could not be realized; for that reason, the forthcoming Health Assembly should consider adopting a resolution aimed at promoting the building of health systems and reiterating the proposals in *The world health report 2000*[1] for improving health systems' performance. Success in that area had still not been achieved in most countries of his region, and WHO's support in that effort should therefore be strengthened.

Dr KAMAL (Canada) said that his country was pleased to note the renewed emphasis on the critical importance of strengthening health systems in developing countries. There was growing recognition that without effectively addressing the challenges and constraints faced by health care systems in such countries, it would be impossible to achieve the health-related Millennium Development Goals or other goals set by WHO, including the "3 by 5" initiative. Canada supported WHO's position that for a health system to perform well, sufficient financial resources and a well-trained human resource base were needed; it welcomed the Organization's efforts to prepare health ministries for political and budgeting exercises which would secure the resource base they needed to operate effective, responsive health systems. It also welcomed the relevant findings of the Commission on Macroeconomics and Health.

Gender inequality continued to pervade many health systems, and additional efforts were needed to recognize and address that problem. Two issues must be tackled: how to make the overall health care system more gender sensitive and equity oriented, and how to empower women, particularly the poor and disadvantaged, so that they could effectively articulate their needs and demand better services.

Since 2003 had been the anniversary of the Declaration of Alma-Ata, which had enabled WHO to make primary health care the cornerstone of its strategy for the provision of health services at community level, Canada was particularly pleased at the renewed emphasis. It also appreciated WHO's efforts to strengthen health information and research in order to overcome the poor correlation between supply, demand and use of information.

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[1] *The world health report 2000: Health systems: improving performance*. Geneva, World Health Organization, 2000.

Professor FIŠER (Czech Republic) drew attention to the principles for improving health financing set out in paragraphs 9 and 10 of document EB113/11. Political forces in many countries, his own included, were emphasizing the role of the market economy in health systems, and were promoting deregulation and competition among health providers and private health insurance companies while discouraging governmental intervention. Hence it was important to disseminate evidence in support of policies for achieving health-for-all goals.

Dr OM (Republic of Korea) urged WHO to pay more attention to the issue of social health insurance. Many countries were running health insurance systems that occupied the largest share of national health expenditure, but little effort had been made so far to enhance cooperation in that field. WHO was already working to frame health financing policies that were appropriate to the circumstances of each Member State, but additional work should be done to investigate how, and in what circumstances, health insurance could help to overcome financial barriers preventing citizens international bodies on social health insurance in order to explore opportunities for further cooperation, including the convening of a world conference on social health insurance and health financing.

Professor FURGAL (Russian Federation) said that his country fully supported the conclusions and recommendations in document EB113/11, and agreed that health systems were a key instrument for improving health and quality of life in Member States on the basis of the primary health care concept. That was a crucial issue for most countries in the European Region, which in the past decade had been undergoing a traumatic transitional period involving the reform of health systems as structural components of national social welfare institutions.

Overall reductions in expenditure on health, due to a general economic downturn and shrinking budgetary allocations in the social sphere, were becoming a serious problem for State health care systems. Governments faced the task of not only selecting strategic areas on which to expend limited resources, but also designing models for systems that had to be rebuilt from the ground up. WHO should continue to support Member States by recommending scientifically sound approaches to the construction of effective and stable health systems. The Russian Federation endorsed one of the main arguments in document EB113/11 Add.1, namely that health could be improved through the coherent application of updated principles of primary health care. He accordingly called on WHO to formulate recommendations for improving primary health care on the basis of differences in the way national health systems were organized and with emphasis on the responsibility of governments to improve the health of the population.

Dr YIN Li (China) welcomed the revitalization of primary health care and supported the new principles proposed. In 1990, his Government had launched a national programme to achieve primary health care targets by the year 2000. Primary health care included basic medical care, medical insurance, health education, reduction of infant and maternal mortality rates, provision of safe drinking-water, food safety, immunization and reduction of communicable diseases. By 2000, 95% of the areas covered had achieved the targets.

In June 2002, a new primary health care plan up to the year 2010 had been launched, focusing on rural areas. A new cooperative scheme whereby financial resources would be mobilized from central government, local government and the farmers themselves had been introduced, which would provide funding for new primary health care services in rural areas. His Government was ready to work with WHO to help achieve primary health care throughout the world.

Dr AL-MAZROU (Saudi Arabia) said that the reports provided evidence of the need to return to the discussion of health systems on the basis of the primary health care initiative. They covered essential points that all States should take into consideration, namely: the need to regard health as a national resource essential to social and economic development and not as a burden on such

development; the important role of health in the social cohesion of local communities; the importance of ongoing assessment and monitoring of the progress of primary health care services and the extent to which primary health care workers put into practice the concept and strategies entailed; the importance of devoting considerable attention to developing and strengthening community participation in the process of drawing up health policy frameworks; and determining the best way of building health systems that could promote health and deliver the health care needed by all groups in society. It was encouraging to see that WHO was once again firmly supporting the principles of primary health care, and was working to ensure that regional offices and Member States did likewise.

Ms GIBB (alternate to Dr Steiger, United States of America) said that her country saw primary health care as a critical component of national health systems. It remained committed to building stronger health systems and promoting primary health, particularly through the development of in-country capacity and the production of the data and evidence needed to inform future health policy. Her President's Millennium Challenge Account aimed to fight poverty through stronger assistance to nations committed to open markets, good government reforms and investment in people through health and education.

A major challenge for WHO and countries was to attain broad international support and vetting in terms of the dimensions of health being measured and the data sources and methods used for such measurement. Investments in primary care and health systems needed to be made wisely and carefully, in full and transparent consultation with Member States.

In response to Ecuador's call for a resolution on the subject, she suggested that the Organization should first identify the human and financial resources needed for some of the proposed recommendations. Some existing resolutions already adequately covered the issue of primary health care.

Dr ACHARYA (Nepal) said that the Global Strategy for Health for All by the Year 2000 remained as relevant as it had been 25 years earlier. If its goals were to be achieved, an effective and responsive health delivery system would be required, with adequate financing and an efficient health workforce. In Nepal, the Government had begun to hand over peripheral health institutions, including primary health centres, to local management committees, which then provided essential health care services for the people. However, a monitoring authority made up of governmental and nongovernmental agencies and external development partners was required to supervise their activities at central, regional and district levels. WHO country offices could coordinate the activities of other stakeholders in developing such a mechanism.

Mr GUNNARSSON (Iceland) said that two earlier resolutions (EB109.R10 and WHA56.25) could serve as a basis for country-level work on the strengthening of health systems. The excellent documents before the Board referred to *The world health report 2003*[1] and the principles of the Declaration of Alma-Ata. Iceland agreed with the five key elements of a health system based on primary health care set out in paragraph 6 of document EB113/11, particularly the Alma-Ata principles: equity, universal access, community participation and intersectoral approaches. Countries must be concerned about health outcomes and define indicators to measure the performance of health systems. The connection must be established between health principles, activities and auditing of outcomes.

The health systems unit at the Regional Office for Europe provided a valuable example. The Regional Director had established an advisory group on health systems, with members from all over the Region, to develop a vision for the programme. Members of its expert panel implemented programme activities in the countries of the Region. While the programme had been in place for only a short time, it was promising and might provide guidance for other regions.

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[1] *The world health report 2003. Shaping the future*. Geneva, World Health Organization, 2003.

Dr ALONSO CUESTA (alternate to Dr Pastor Julián, Spain) said that her country strongly advocated the strengthening of universal, equitable and accessible health systems. The Global Meeting on Primary Health Care (Madrid, October 2003) had created a new framework for primary health care. It had concluded that no vertical health-care programmes could be established unless health systems were strengthened, particularly in the area of primary health care. It had added a number of principles to those laid down in Alma-Ata: for instance, the principle that health was an instrument of social cohesion and that national governments should increase their role in the strengthening of health services. Patients and their families should be active participants in the system, thus promoting not only "health for all" but also "health with all". The meeting had noted that countries that based their health systems on primary health care got better results. Countries should set up a monitoring system to determine whether their equity and coverage goals had been achieved. The health care systems of the future should be integrated, ensure continuity of care, and avoid gaps between the various levels of health care, including the social and welfare aspects.

Drawing up a policy did not automatically ensure that it would be implemented: tools must be established to evaluate the implementation process and its outcomes. There were currently many forms of basic health care, ranging from those in countries where primary care employed multidisciplinary teams and offered access to specialist services, through others where patients went directly to a specialist, to those where community members were trained to provide health care. It would be necessary to identify and evaluate those models and obtain more information about coverage, quality and health outcomes. To that end, it was necessary to develop information systems and in parallel research on health systems performance.

Professor KULZHANOV (Kazakhstan) said that the International Conference on Primary Health Care, held in Almaty (formerly Alma-Ata) in October 2003, had commemorated the twenty-fifth anniversary of the original Alma-Ata conference and discussed the major problems currently facing primary health care, including prioritization and distribution of resources. Although primary health care was a priority in every country, the resources allocated to it were often not commensurate with its importance. The meeting had also discussed the relationship between primary health care and public health. Many factors were beyond the control of the primary health care system, but depended on the efficient functioning of the public health services – nutrition and clean water, for example. Other topics discussed had included risk factors and intersectoral cooperation. The meeting had called on governments to restrict the advertising of products that had adverse effects on health. The meeting had also called on WHO and other international organizations to help countries to develop effective, objective and measurable performance indicators for primary health care. WHO should support research in countries intended to reform both primary health care and health care generally.

The proceedings of that Conference would be published in February 2004 in three languages. He had already provided the Secretariat with an advance copy in English.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) welcomed WHO's renewed interest in strengthening health systems, particularly primary health care. WHO needed to think about the kind of health systems required to meet the United Nations Millennium Development Goals, including the competence to manage chronic diseases. If the goals of the "3 by 5" strategy were to be met, universal access to effective pro-poor health services would be required in both the private and public sectors. He welcomed WHO's leadership and the launch of the High Level Forum on Health, Nutrition and Population-Related MDGs, which would help to create a consensus for building effective health services, maintaining progress and attracting additional resources and donor effort.

His own country had recently given a more central role to primary health services. First, 75% of health expenditure would be devolved to primary care organizations, which would decide how to meet the needs of the local population; second, the contracts of all primary care physicians had been renegotiated: in future, their salaries would be dependent on their fulfilment of prevention targets and their quality-of-care outcomes.

Dr DAYRIT (Philippines) drew the Board's attention to paragraph 19 of document EB113/11, which referred to WHO's efforts to identify health systems researchers, sources of funding and existing research agendas. In his own country, a number of reforms of the health system had taken place over the previous two decades. In 1992, the Government had introduced devolution of health services; in 1994, it had adopted legislation introducing compulsory social health insurance; and in 1998, it had launched a hospital privatization policy. Health systems were constantly developing, and it was not always clear whether reform initiatives were achieving the desired aims of lowering mortality and morbidity, increasing access to services and making services more cost-effective and affordable. He therefore welcomed WHO's emphasis on the strengthening of health systems research. The Philippines would work closely with the Organization, particularly on the issue of devolution, the value of which was being questioned.

Professor DANG DUC TRACH (Viet Nam) said that, in many low-income countries, health care was seen as basically the responsibility of the health sector, with limited involvement of other sectors. He would like to see an emphasis on "all for health" rather than "health for all", in order to promote active participation of the whole society in health care activities, particularly primary health care.

The CHAIRMAN, speaking in his capacity as the member for Ghana, said that his country agreed with the principles and recommendations set forth in paragraphs 6 to 8 of document EB113/11 and associated itself with the remarks of the member for the Czech Republic relating to health financing. His country had introduced an ambitious prepayment mechanism for health care, and the national health insurance scheme, developed with WHO support, would be launched in February 2004. One major concern that should be highlighted was the migration of health workers, particularly from developing to developed countries. Another was health systems research. His country had introduced a structural adjustment programme involving a sharp reduction in the number of intermediate-level health posts. So many skilled health workers had moved abroad that there was no one to take their place. That lack of professionals was one of the major obstacles to health care delivery and implementing the new health insurance system. About 60% of Ghana's health resources were allocated to the peripheral level, where they were expected to achieve a greater impact.

Mr AGARWAL (India)[1] said that the proposed "primary health care lens" referred to in document EB113/11 Add.1 would be useful for monitoring progress. Greater focus on primary health care was a highly cost-effective method of improving health indicators. Multisectoral collaboration and an appropriate public/private mix in health care would be required in order to promote primary health care. Since 2002, his country's health policy had proposed greater investment in primary health care.

A previous speaker had spoken emotionally of the futility of promoting health care when the lives of millions of children all over the world were threatened by armed conflict. Nobody denied the need to promote peace, which was an essential prerequisite for WHO's activities, and to eradicate the scourge of terrorism, but he did not think that WHO was an appropriate forum for the discussion of such issues.

Professor PAKDEE POTHISIRI (Thailand)[1] said that an adequate and equitable health system, including human resources for health, was the main prerequisite for achievement of the targets of the "3 by 5" initiative and the Millennium Development Goals. His country welcomed WHO's leadership in the strengthening of health systems, especially primary health care. However, it was important to move beyond community health workers and reach the general population. Individuals must be

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

educated and empowered, by means of the mass media and effective education, to take care of their own health and create a supportive environment.

WHO should study the effects of globalization and international trade on health systems, and particularly on the migration of health workers from developing countries to richer ones. Encouraging patients to go to other countries for treatment would reduce costs for richer countries and increase the *revenue of developing countries, but the impact on national health systems should be seriously* considered. WHO should support the participation of national health sectors in health-related trade negotiations, in order to minimize their adverse effects and to derive the greatest possible health benefit from international trade agreements.

Ms SACKSTEIN (International Alliance of Women), speaking at the invitation of the CHAIRMAN and also on behalf of the International Baby Food Action Network, welcomed the focus on the institutions, people and resources involved in the delivery of health care and services. The United Nations Commission on Human Rights, in its resolution 2002/32, had called upon States to ensure that their actions as members of international organizations took due account of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; and that the application of international agreements was supportive of public health policies which promoted broad access to safe, effective and affordable preventive, curative or palliative pharmaceuticals and medical technologies.

Private providers were increasingly involved in health care, and the links between the public and the private sector were generally weak. Her organization was concerned about the growing number of joint public-private initiatives, which might not always contribute to the achievement of the highest attainable standards of health or differentiate between national and global priorities. The pursuit of donor-oriented goals might limit the effectiveness of the donations. Such initiatives tended to be disease-selective and based on the commercial interests of the donor, biases that might distort national health strategies based on needs, long-term impact and sustainability. The emphasis on new technologies might lead to discrimination. Pressure from donors to favour a particular treatment might divert funds away from other health priorities; success of that treatment might improve the statistics in the short term, but fail to strengthen long-term access to health care for all. The failure to distinguish between public nongovernmental organizations and organizations linked to commercial interests had caused confusion and prevented the identification of potential conflicts of interest.

To strengthen health systems she suggested that joint public-private initiatives should aim to ensure an equitable and ethical approach and increase access to health care. Health systems indicators should be used to measure their performance. Public-private initiatives needed to involve recipient countries from the outset. Transparent criteria governing public-private contracts should be developed, following international guidelines and standards, to increase the accountability of all partners. WHO should support governments to design national monitoring mechanisms to assess the quality and impact of public-private initiatives, and it should take the lead in providing clear criteria and definitions to distinguish public nongovernmental organizations from those closely associated with business interests.

Dr HELLEMANN (World Organization of Family Doctors), speaking at the invitation of the CHAIRMAN, said that her organization existed to promote high standards of care in general practice and family medicine. Although many developing nations could not afford to employ enough family physicians, they could all afford to adopt the concept of family medicine for primary health care workers, thereby substantially improving the quality of health care. In 2000, her organization had published a guidebook entitled *Improving health systems: the contribution of family medicine*. In 2002, it had organized a global conference, cosponsored by WHO, on "Health for All Rural People", followed by a global action plan entitled "Creating Unity for Action: an action plan for rural health". Her organization urged the Board to submit a draft resolution on specific measures to support rural people to the Health Assembly.

Dr EVANS (Assistant Director-General) thanked members for their comments. On the issue of health financing, he said that a partnership on social health insurance had been established with ILO, the World Bank and bilateral donors. All interested parties would be kept informed of the opportunities that arose.

WHO had made efforts to strengthen health information systems at country level through the health metrics network. More information about the mandate and focus of the network was available on request. The principle of monitoring progress and gathering evidence was crucial, and WHO would continue to provide relevant technical support. A world summit on health research, to be held in Mexico in November 2004, would bring together ministers of health and policy-makers to discuss the health research policy agenda. He agreed with the member for the Philippines that the systems research agenda required particular attention if the United Nations Millennium Development Goals were to be achieved. Challenges such as devolution, appropriate financing systems and appropriate human resource policies were not at all straightforward and would require the best minds available to resolve them.

Thailand had referred to the interactions between international trade and health. WHO had been studying the health implications of the General Agreement on Trade in Services.

Two resources outside WHO were doing useful work in the monitoring of joint private-public initiatives. The Global Forum for Health Research had launched an initiative on public-private partnerships for health, with considerable discussion about the criteria for setting up and evaluating such partnerships and ensuring accountability and transparency. Canada's Global Health Research Initiative had also discussed the issue from a global perspective. WHO wanted to draw on such resources in its own activities.

The CHAIRMAN, speaking in his capacity as the member for Ghana, had referred to the problem of migration of health workers from developing countries. WHO had upgraded the unit dealing with human resources for health into a full department, since such a complex issue deserved more attention if the Organization was going to recommend best practices.

The CHAIRMAN took it that the Board wished to take note of the reports.

It was so agreed.

Influence of poverty on health: Item 3.15 of the Agenda (Document EB113/12)

Dr GEZAIRY (Regional Director for the Eastern Mediterranean), introducing the item, said that one of the challenges facing the Member States of the Eastern Mediterranean Region was how to use the data available at the national level on public health care-related issues, such as intersectoral cooperation, the environment, nutrition and water, to demonstrate clearly to policy- and decision-makers that investment in health translated into benefits for individuals and the community as well as furthering poverty reduction and development.

In December 2003, the Regional Office for the Eastern Mediterranean had presented a coherent strategy for sustainable health development and poverty reduction to the Regional Committee, which had endorsed it by consensus. For 20 years, the Regional Office had been advocating the idea that poverty reduction was part and parcel of health. It had been able to demonstrate in some 14 countries that spending between US$ 50 000 and US$ 70 000 per village could make a big difference to all indicators used to benchmark the health-for-all targets. It hoped to demonstrate that such work could be very effective if undertaken as a national programme. Djibouti, Pakistan and Yemen had already prepared poverty reduction strategy papers; Egypt and Sudan had embarked on the process.

That endeavour had also benefited from the work carried out by countries in response to the report of the Commission on Macroeconomics and Health. Several aids, including gender-sensitive management guidelines and tools, had been developed to build national and local capacities for the implementation of poverty reduction and health strategies. Support had been provided for a broad

range of socioeconomic projects in the Region that aimed to link disease-specific programmes, strengthen health systems and develop pro-poor national policies. However, further work had to be undertaken in the area of health financing.

Six countries in the Region had participated in the second WHO interministerial consultation on macroeconomics and health in October 2003, which, together with the High Level Forum on Health, Nutrition and Population-Related MDGs, held in January 2004, had helped move that agenda forward and forge closer ties between those involved.

Improving the health of the poor was a valid end in itself as well as being a social and economic goal. It was also a means of achieving the Millennium Development Goals, which would require seriousness of purpose, political resolve and an adequate flow of resources from high-income to low-income countries on a sustained and well-targeted basis if they were to be met. It was to be hoped that the leadership in each country and partner agency would take the broadest view of its responsibilities and focus more sharply on the health of the poor.

Mr GUNNARSSON (Iceland) said that it was important to remember that the Millennium Development Goals approved at the United Nations Millennium Summit in the autumn of 2000 clearly stated that two kinds of investment were needed to improve the health situation of the world: first, poverty had to be reduced to improve health both directly and indirectly; second, investments had to be made in the development of health services in poor States because of the obvious close link between health and economic development.

In its report to the Health Assembly in 2002, the Commission on Macroeconomics and Health had stated that 800 million people in the world did not have enough to eat, about 500 000 women died every year in childbirth, at least 130 million children did not attend school and one in 10 children in the developing world never reached the age of five. That state of affairs was totally unacceptable. The report's most compelling argument, however, was that additional investment in health in low-income countries would have huge economic benefits in the long run. It was interesting to note that since the report had been presented, more than 40 countries had taken steps to act on its recommendations with WHO support.

Poverty reduction was impossible without improvements in health status, higher educational levels, gender equity and a clean environment. Carrying out that task required an effective partnership between the rich and the poor worlds.

Dr MODESTE-CURWEN (Grenada), pointing to the undeniable nexus between poverty and health, asked how much progress had been made in eradicating poverty in the past 20 years. How many poverty-stricken countries had effectively managed to bring down the level of poverty and increase budget allocations for health? How many developing countries had pursued a policy that improved access to health care and information and provided an enabling environment, as recommended in the report? The report pointed to the need to tackle the health needs of poor people far more effectively, noting that dealing with inequities in health outcomes was less a question of identifying the so-called diseases of the poor than of designing policies and systems that ensured that poor people had access to the benefits of health technologies.

In order to make the right to health a reality, concrete and sustainable activities had to be undertaken. The report mentioned the development of a health investment plan linking poverty reduction to the attainment of the Millennium Development Goals. Some countries had started down that road, but many more had not. WHO should extend its assistance in facilitating the development of the plans wherever necessary. The poor had to cope with not only the scarcity of financial and material resources for the delivery of health services but also the necessary human resources. Even in instances where national funds had been used to train health professionals, those professionals subsequently migrated to other countries in search of better financial and material benefits. It was crucial to address that issue as an international matter and not as a national problem.

The report concluded by stating that an effective and equitable partnership between the rich and poor world was the only way of reducing the divide between them. Indeed, the need for meaningful

alliances between governments and donor countries and agencies could not be overemphasized. The generosity of donors had, however, to be matched by energetic, responsible and effective implementation and monitoring of programmes at the country level. WHO was strategically placed to facilitate such alliances and to provide technical guidance for the management of activities to maximize the outcome.

Grenada, like other developing countries, had benefited from the cooperation of many donor countries and agencies. In particular, it wished to express its heartfelt appreciation to WHO Directors-General past and present and to the Regional Office, for support provided in the areas of health and development. Support to countries had to be relevant and reflect the cultural background of the people for whom it was intended, but it did not always have to be extremely ambitious in its scope; sometimes simple, efficient improvements could make a great difference to the lives of the poor. For example, Cuba, in addition to providing scholarships, had also provided technical expertise to the fishermen of Grenada, enabling them to augment their income and to provide fish for local consumption and for export. Another donor had provided assistance in various health fields and had made a hands-on technology transfer to Grenada's agricultural programme, improving food crops, introducing new crops and helping to implement modern technology for irrigation so that food could be grown locally year-round. Those activities might seem simple, but they were sustainable and had had a visible effect on the poor farming population, especially at a time of crisis in the agricultural sector and in a country where imports exceeded exports.

Professor FURGAL (Russian Federation) said that the "3 by 5" initiative, which sought to provide antiretroviral therapy primarily to the poor populations of developing countries, was a good example of WHO's work to combat poverty from the health point of view. Poverty and health was a subject of relevance for his country, where, as in many other Member States in the European Region, a high level of economic poverty existed against a background of social poverty. It was not only traditional groups of the population that were poor, but also a large number of low-wage earners in the public sector. Although those people were educated and able to work, they were unable to attain an acceptable standard of living and medical care.

Efforts to reduce poverty and improve health should be undertaken at the country level, but it was clear that, for low- and middle-income countries, investment in the health sector and efforts to reduce poverty would be difficult to achieve without additional resources, including from foreign sources, and the establishment of a broad partnership with financial institutions and the private sector. WHO's task was fourfold: it should convince countries to increase investment in health; to cooperate actively with the governments of Member States; to provide practical assistance to national health services; and to help to mobilize resources.

Mr AISTON (Canada) welcomed WHO's leadership in focusing political attention on building the evidence base on the link between disease and poverty, especially concerning HIV/AIDS. There was a clear need for continuing work on that relationship and for specific global and national multisectoral measures to break the vicious circle. WHO and other bodies in the United Nations system, working together with governments, should increase their efforts to ensure that the health sector received an appropriate level of attention in national poverty-reduction strategies. Work to that end was crucial for health development in many developing countries, where poverty-reduction strategies shaped the level of investment in the health sector. It would also ensure a better resource base for pro-poor health policies.

Dr CAMARA (Guinea), noting that poverty reduction was currently the top priority for international institutions, governments and nongovernmental organizations, said that the often-discussed link between poverty and health merited further study, the aim being to enable the poor to have access to health services at all times so that they were not prevented from earning a living and did not die of diseases for which they could not seek treatment because of the exorbitant cost. There were a number of questions to be answered. What, for instance, should be done to attract investment to

health services? What should be done to ensure that health systems focused on solving the health problems of the most vulnerable, who were unfortunately also the poorest? How could poverty be reduced in poor countries when interest rates were so high and loans subject to conditionalities? All those factors kept poor countries in a state of poverty and made them even poorer. In those circumstances, it was hard to see how the Millennium Development Goals could be met and the right to health ensured for all. For there to be a genuine improvement in the health of the poor, many issues needed to be reconsidered.

Professor DANG DUC TRACH (Viet Nam) said that the relationship between health and poverty was a matter of great concern in many countries, especially in the developing world. Ministries of finance sometimes took the view that the health sector was not worth spending money on as it did not produce a visible economic return for society. Consequently, it was often difficult to convince governments to increase budgetary appropriations for health. In order to promote proper understanding of the importance of health in socioeconomic development and to mobilize more resources for health care activities, the title of the agenda item should be changed to "Influence of health on poverty reduction".

Mr ASLAM KHAN (alternate to Mr Khan, Pakistan) drew an analogy between the poverty cycle at the individual and national levels: in many developing countries, low income led to low investment in health, resulting in high mortality and morbidity rates in the poor sections of society and in further low productivity. Pakistan, taking its lead from the Commission on Macroeconomics and Health, had invested in health as a part of the Government's poverty-alleviation programme. The emphasis had been placed on expanding the provision of a basic package of services in areas such as immunization, reproductive health and control of communicable diseases, and on strengthening services in rural and peri-urban areas.

Pakistan was deeply indebted to WHO for providing a solution to poverty reduction using the basic development needs approach. It was particularly grateful to the Regional Director for the Eastern Mediterranean for taking a personal interest in Pakistan's flourishing basic development needs programme. Pakistan stood ready to share its experience with other Member States.

Professor EL TAYEB (alternate to Dr Tag-El-Din, Egypt) said that the main goal of primary health care programmes was to provide a basic package of services covering immunization, maternal health care and measures to combat communicable and noncommunicable diseases for the poor and disadvantaged. Since the better-off and abler members of society could fend for themselves more easily, Egypt had directed its efforts towards the disadvantaged. WHO's support for reorganizing the health sector in developing countries was vital for guaranteeing delivery of the basic package of primary health care services to the poor. The connection between health and development could not be overlooked or ignored. International politicians and economists and the developing countries in particular therefore had to put health at the top of their list of priorities. In that connection, the efforts made by the Regional Office for the Eastern Mediterranean to support health systems and primary health care programmes in the Region were deeply appreciated.

Dr YOOSUF (Maldives) said that, if a country's poverty was to be reduced and its productivity improved, its population had to be healthy. What mattered, therefore, was not poverty and health, but priority for health. Many countries allocated a very small percentage of gross domestic product for health but used considerable resources for far less useful activities. The report prepared by the Commission on Macroeconomics and Health was a useful advocacy tool, and it was to be hoped that more countries would follow the recommendations it made.

Maldives was a small country, but it set aside 8.5% of its gross domestic product for health care. That policy was showing results. In 20 years, the infant mortality rate had fallen from over 140 to 18 per 1000 live births. Under the Expanded Programme on Immunization the immunization coverage

rate had reached over 95%, and life expectancy had risen from 45 to 72 years for both men and women in the space of 25 years. What mattered, therefore, was to give priority to health.

Dr YIN Li (China) commended WHO's vision of health as an important factor in macroeconomic development. Improved health had an important role to play in poverty reduction. Health was not just a technical matter, it was also a socioeconomic issue. Addressing the problem would require political will, comprehensive socioeconomic measures and the mobilization of more resources.

Poverty and illness were two sides of the same coin. Health development fostered poverty reduction, and economic development further improved health and health reform. China's economic development over the past 20 years had proved the case.

In October 2003, the Chinese Government had launched its country report on macroeconomics and health at the interministerial consultation on macroeconomics and health convened by WHO. The report specified China's targets for health reform and development; key aims were to narrow the gap between rural and other areas; to improve the Government's input into health; and to improve coordination between the health, planning and financial departments. China stood ready to work with WHO, with other partners and with other governments to reduce poverty and improve health.

Ms GIBB (alternate to Dr Steiger, United States of America) said that the United States was committed to poverty reduction focused on better health as a precursor to improved economic status, enhanced ability to learn and increased social and human capital. That commitment emanated from the highest levels of government and had most recently been reflected in the President's Millennium Challenge Account, his Emergency Plan for AIDS Relief and the United States' strong support for the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The first step towards increasing resources invested in health was to work at the country level to enhance national leadership, transparency and accountability with a view to achieving better control of the major health problems that caused suffering and disease and hindered economic development. While most United Nations agencies were involved at the global and country levels in the United Nations Development Assistance Framework and poverty reduction strategies, WHO had one of the most important roles to play as a scientific and technical agency. Data and an evidence-based approach to policy development and programming enabled national vision to move beyond rhetoric to action. Accurate and disaggregated data and the evaluation of results could be one of the most powerful tools that policy-makers and politicians could use to fight poverty in an effective and sustainable way. The lack of such data was one of the biggest problems countries faced and one to which WHO was uniquely qualified to contribute.

Her Government was pleased that document EB113/12 focused on WHO's role at the country level in building technical capacity and developing and expanding disaggregated health profiles. Over the past 30 years, the United States had invested in developing individual country capacity and the global information base through the Demographic and Health Surveys. The resulting analyses had become increasingly disaggregated, enabling countries to review health conditions by poverty status. WHO should provide further information on its technical cooperation in developing the necessary data and surveillance; ongoing monitoring and evaluation; and the identification of indicators and benchmarks that could reinforce the links between investments in health and poverty reduction.

The United States was interested in WHO's work with United Nations human rights bodies and monitoring mechanisms on identifying indicators and benchmarks to track the progress of governmental action on health. That work was relevant to United States' efforts to track governments' commitment to investing in people through the Millennium Challenge Corporation, which was implementing the Millennium Challenge Account. Through that Corporation, the United States sought to form partnerships with governments that demonstrated a commitment to investing in the health of their people. Like WHO, it faced the challenge of determining how it could know that a government was making such investments. The Corporation looked to WHO and to other outside sources for

relevant data. At present, it was using WHO's tracking systems for access to essential drugs and immunization coverage.

On a point of clarification, the United States did not believe it was appropriate for WHO to state in document EB113/12 that General Comment No.14 of the United Nations Committee on Economic, Social and Cultural Rights clarified "the normative scope and content of the right to health". The Committee's General Comment was pertinent only to States Parties to that Covenant. Not all Member States of WHO were parties to the Covenant, and, even for States Parties, General Comments were not binding; they represented the view of a committee of independent experts.

Dr LEITNER (Assistant Director-General) said that she had noted members' comments. The debate as to whether the poor were sick or whether poverty made people sick was an age-old one. What was clear, however, was the strong link between the two issues, and the matter should be addressed from both angles. Work should be undertaken to reduce poverty, giving due consideration to the health situation of the poor, which would in turn promote economic growth and social stability. The definition of poverty went far beyond the income dimension: people could lift themselves out of poverty only when they were healthy. Although studies showed that progress was being made in that regard, more work was required to design strategic interventions to maximize impact in reducing poverty while improving the health situation of the poor. Partnerships, not only between the rich and poor countries, but also between rich and poorer segments of the population in the countries themselves, would be beneficial. Better links should be established with macroeconomic policies, and health should be factored into poverty reduction strategies. Efforts were being made to ensure that WHO was able to provide significant input into current poverty reduction exercises in a number of countries. Ministries of finance had to be convinced that it was worth investing in health, and the member for Maldives had given an example of the progress that could be made over time.

Pro-poor health policies must be country specific. The reference in the report to the United Nations Committee on Economic, Social and Cultural Rights was intended to draw attention to the fact that WHO was working closely on the issue with many bodies in the United Nations system. Efforts would be made to improve surveillance and develop indicators to ensure that the progress made could be monitored closely.

The Board noted the report.

Genomics and world health: report of the Advisory Committee on Health Research: Item 3.16 of the Agenda (Document EB113/13)

The CHAIRMAN invited the Board to consider the report contained in document EB113/13 and, in particular, the draft resolution set forth in paragraph 7.

Mr GUNNARSSON (Iceland) said that genomics was expensive and did not yet play a significant role in public health issues, even though the potential gains from its application in medical science were enormous. Most of the world's population faced health problems that lay outside the scope of genomics, and many of the most urgent global public health issues were fairly simple from a scientific point of view and relatively inexpensive to solve. It was imperative for the future welfare of the human race that such issues were not forgotten when the progress of genomics was discussed. Advances in the field of genomics must not be to the detriment of activities to solve general public health problems. Emphasis should always be given to solving the acute problems of the general population before focusing on the complex problems of the privileged. That being said, he recognized genomics' potential medical applications and valuable contribution to public health. Having noted that his country had been at the forefront of the discussions on the ethical issues associated with genomics and was ready to share its experiences with other nations, he expressed support for the draft resolution.

Mr ASLAM KHAN (alternate to Mr Khan, Pakistan) said that his country was optimistic about genomics research. Some of the results of the Human Genome Project were already being applied medically, and it was likely that new diagnostic agents, vaccines and therapeutic agents for communicable diseases would be available in the next few years. The time had come to plan how recombinant DNA technology and its potential clinical benefits could be distributed fairly to ensure that the new field did not simply widen the gap in health care between rich and poor countries. The current situation regarding the patenting of genes had already caused great concern in poorer countries. Promulgating a culture of ownership and high prices would inevitably lead to further inequalities in health care. A coherent policy framework was therefore urgently required.

All forms of recombinant DNA technology, including the modification of the genes of plants and animals, raised extremely important safety issues and required careful monitoring and control. Their potential risks and hazards must never be underestimated. Effective regulatory systems should be set up in countries in which work was either in its early stages or had not yet started, and all societies must prepare themselves for the ethical complexities of that emerging field of medicine. He supported the draft resolution.

Dr YIN Li (China) welcomed WHO's interest in the subject of genomics and world health. The complete sequencing of the human genome would play a positive role in disease prevention, diagnosis and control and improve human health. However, the practical application of genomics, particularly the patenting of genes, would raise legal, ethical, social and economic issues, and could even result in inequalities in health care. Human genes and the genes of other organisms were the common wealth of mankind, and inequalities between the developed and developing countries in terms of genomics should not be allowed to arise. The rights of developing countries should be emphasized and measures taken to protect the interests of the poor and vulnerable. He also expressed concern about the potential dangers of genetically modified crops and foods. WHO should foster broader cooperation and seek innovative and fair ways and means of reducing the disparities between countries. He supported the draft resolution.

Professor FURGAL (Russian Federation) said that genomics would radically change methods and approaches for diagnostics, treatment, prevention and rehabilitation. One of the main recommendations in the report of the Advisory Committee on Health Research was the formulation and articulation of a WHO policy and strategy to ensure that benefits and advances were applied to health improvement in developing countries. To that end, WHO should focus on the key areas of safety and public information. It should ensure that the use of genomics in practical health care was closely linked to the establishment of effective monitoring and control mechanisms, since those technologies could have ethical, legal, social and even economic consequences. National committees on bioethics should also review the way in which the technologies were used. WHO should develop a policy and strategy to ensure that genomics were used safely to improve the health of all. It should also play a vanguard role in providing advice comprehensible to the public on matters related to genomics, such as human cloning, and other sensitive issues. WHO should consider setting up a special unit to consider the safety of genomics and its potential uses to improve the health of the world's population. He supported the draft resolution, which accurately reflected the complex nature of the problem.

Dr ALONSO CUESTA (alternate to Dr Pastor Julián, Spain) said that, in the years since the discovery of the double helix, the world had witnessed major scientific and technological progress in the field of genetic research. Much was known about the role of genes and molecular mechanisms in the origin of many illnesses, and that knowledge had been used to find new therapies. At the same time, however, problems had arisen because research was not conducted or applied uniformly from one country to another. The same problem had occurred even within countries, because the pioneering knowledge obtained was sometimes applied experimentally and at great expense. In other words, as on

many other occasions in the history of medicine, health system equity had not developed at the same pace as the body of knowledge had increased.

In addition, genetic information gave rise to issues of privacy, since it could lead to discriminatory treatment, inadequate genetic advice and predictions not based on scientific evidence and broadly accepted ethical criteria. In that respect, it was important not to be taken in by scientific fads that not only used resources that would be better employed elsewhere but also fostered confusion in the public mind.

Genetics had a role to play in new approaches to international public health. Studies of genetic determinants and their distribution in the population should always be well designed and apply proper methods. Those studies could not be disassociated from the rights of patients and their families, which was why specific informed consent was a prerequisite in every situation and professionals must think about how to provide the population with feedback on their results. Genetic material required more careful handling with each passing day. Banks of DNA, cells, tissue and other biological samples had to be managed by institutions that could guarantee their proper storage and use and that were subject to some form of ethical control. They had to meet modern public health requirements, ensuring that unbiased studies could be made of susceptibility markers. The results would be used for diagnostic tests and new forms of treatment that should be available on an equal basis to all.

In Spain, a foundation for the development of research in genomics and proteomics (Genoma España) had been recently founded in an initiative promoted by the Ministry of Science and Technology and the Ministry of Health and Consumer Affairs. The foundation's aim was to promote and coordinate research in order to better apply the results, to act as an observatory for research conducted on genomics and proteomics, to engage in forward-looking work and, in particular, to stimulate civil society participation. As a result, three technological platforms had been established: the Virtual Institute of Bioinformatics, the National Centre for Genotyping and the Spanish DNA Bank. The aim was to study genetic variation in the Spanish population and to obtain reference DNA samples. Those platforms gave Spain the capacity to analyse the relationship between genome variations of individuals and the illnesses they suffered, their predisposition to those illnesses and their response to treatment. She saluted the joint effort being made by international organizations, strongly backed by scientific institutions in Member countries, to ensure a more equitable future and the ability to incorporate scientific progress in a timely manner. Spain supported the draft resolution.

Ms VALDEZ (alternate to Dr Steiger, United States of America) acknowledged the breadth and depth of the recommendations made by the Advisory Committee on Health Research, affirming that genetic research and genetic medicine held great promise for developed and developing countries alike. Although that field remained nascent for many countries, there was a growing global awareness of the need to ensure a better linkage between the results of the research and practical health care delivery. The global community must work to address the ethical complexities and research risks; WHO had a role to play in that regard, and collaboration with other bodies in the United Nations system, such as WIPO and UNESCO was essential.

The United States was proud of its contributions in the field of genomic research and the Human Genome Project, and had placed the ethical issues surrounding genomic research at the forefront of policy dialogue. The information generated as a result of the sequencing of the human genome had the potential to provide many improvements for the health and lives of people throughout the world.

She expressed concern that the report characterized intellectual property policy as an obstacle to access. Her country would not necessarily agree with the assertion that there was a lack of international consensus on the issue of patents on gene sequencing and other genomic elements. Nor would it agree that the granting of such patents would substantially restrict the ability of developing countries to derive benefit from genomics research. She expressed her full support for the draft resolution.

Professor EL TAYEB (alternate to Dr Tag-El-Din, Egypt) said that the enormous progress made in genomics constituted a great leap forward in terms of diagnosis and treatment as well as in other areas. It was a field fraught with ethical dangers and could have adverse health, legal, economic and social repercussions. It might also widen the gap between the rich and developed countries that were able to pursue research in the area and the poor, developing countries, which could not, thereby adversely affecting international relations. With those comments, he expressed support for the draft resolution.

Dr DURHAM (New Zealand),[1] referring to paragraph 4 of the report, agreed with the point that the current situation regarding the patenting of genes had gone too far and, if allowed to continue, would inevitably lead to further health inequalities in global health care. It was not clear from the draft resolution how WHO suggested that the problem of patents would be tackled. Had WHO undertaken any economic analysis of the likely cost of genetic material patents on health care? Would those matters be considered by the proposed Commission on Intellectual Property Rights, Innovation and Public Health, referred to in document EB113/INF.DOC./1? If not, how did WHO intend to support Member States in tackling those very real and substantial problems?

Dr EVANS (Assistant Director-General), having thanked Member States for their support, said that a consistent theme in the comments made related to the responsible introduction of the genomic technologies. An interagency committee on bioethics had been established in 2003, and had already looked at genomics research as one area for collaboration. WHO also served as the secretariat for the Global Summit of National Bioethics Advisory Bodies, which met every two years to examine some of the ethical issues. With regard to intellectual property, he recalled that the Commission on Intellectual Property Rights, Innovation and Public Health was being set up, and noted that much work being undertaken outside WHO involved the issue of intellectual property. Documents produced in that connection outlined the issues to which WHO should be sensitive.

The CHAIRMAN said that, in the absence of any objection, he would take it that the Board wished to adopt the draft resolution contained in the report.

The resolution was adopted.[2]

The meeting rose at 18:30.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[2] Resolution EB113.R4.

SEVENTH MEETING

Thursday, 22 January 2004, at 09:10

Chairman: Dr K. AFRIYIE (Ghana)

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

Human organ and tissue transplantation: Item 3.17 of the Agenda (Document EB113/14)

Dr ALONSO CUESTA (alternate to Dr Pastor Julián, Spain), indicating that clear ethical issues were at stake, said that human organ and tissue transplantation constituted the only area of medicine and technology that could not make headway merely through more resources, investment or research and development. Operations depended on the support of society, because they could only be carried out through the willingness of individuals to donate their organs. There was a growing disparity between the demand for organs for transplanting and the level of donations. In the European Union alone, more than 50 000 patients were awaiting organ transplants, and, depending on the organ to be transplanted and the age of the donor, annually around 20% of people awaiting transplants died. Only between 1% and 1.5% of deceased persons could be donors of healthy organs. Most potential donors remained unregistered and their organs never became available for transplantation. A comprehensive international analysis of the process of organ donation, extraction and transplantation was essential if transplant results were to be improved.

It was essential to promote international cooperation. Neighbouring countries needed a flexible system for the exchange of organs and tissues; others needed an exchange of experience and know-how. Reference and contact points should be established to ensure traceability and to share information on undesirable effects; transplant centres needed to be accredited and continuous training, communication and social-awareness campaigns needed to be improved. Legislative frameworks and ethical guidelines should be harmonized. International cooperation was vital in order to combat successfully the commercialization of human organs for transplantation. WHO offered the perfect framework through which to put those ideas into practice and to harmonize legislation so as to give citizens greater confidence in transplant systems and safety.

Respect for human rights was a *sine qua non* for any medical action, including transplantation, whether techniques of proven efficacy or experimental procedures. Therefore, basic control standards had to be established for investigative procedures, transplant indications and organ distribution control systems.

It was also essential to ensure equitable access to transplant treatment, with effective, transparent and high-quality organizational, monitoring and medical intervention systems. In view of the great shortage of organs for donation, it was hardly surprising that the use of organs from live donors was increasing. In many countries, live donors accounted for some 50% to 60% of all kidney transplants and 10% to 15% of all liver transplants. Clearly, transplantation of live organs should be an option, but only when the use of organs from deceased donors was not possible. Transplanting a live organ posed a risk for the donor, and unfortunately encouraged financial and other types of remuneration of donors, which should either be avoided or closely controlled.

Spain welcomed WHO's renewed interest in organ transplantation issues, for it could play a decisive role in improving the care of patients needing transplants, and supported the draft resolution, which would provide the foundation for an effective work programme. Health professionals in Spain would be pleased to share their experience and knowledge in any of the fields of action it proposed. In recent years, Spain had cooperated closely with other European Union countries in setting quality and

safety standards in organ and tissue transplantation, and with the Council of Europe in drawing up clinical guidelines, consensus-based documents and the Additional Protocol to the Convention on Human Rights and Biomedicine, on Transplantation of Organs and Tissues of Human Origin.

Spain also wished to collaborate in establishing a worldwide register of transplant activities, and had been involved in such work with the Council of Europe since 1994. It had compiled transplant activity data and waiting list figures from 1989 to the present, and was willing to share with the international community its experiences of cooperation programmes with other countries.

Dr BOSHELL (Colombia) thanked Spain and the United States of America for their support of his country's initiative in raising again the important issue of human organ and tissue transplantation. The only way of controlling "transplant tourism" was to establish the legal and scientific mechanisms that would facilitate the regulated exchange of organs, tissues and cells. He therefore endorsed the comments of the member for Spain.

Referring to paragraph 1(1) of the draft resolution, under section I, "allogeneic transplantation", he requested clarification of the final phrase, since the paragraph did not specify to which body or bodies the transplantation of human material should be accountable; he assumed that they would be the official organizations in the countries concerned and an international authority, such as WHO. Paragraph 2(1) should also contain a reference to "epidemiology". A new paragraph 2(2) should be inserted after the current paragraph 2(1) to read: "(2) to promote international cooperation to increase the access of citizens to these therapeutic procedures;" with consequent renumbering of the next subparagraph.

Dr STEIGER (alternate to Mr Thompson, United States of America) thanked the Governments of Colombia and Spain for their leadership on the important issue of human organ and tissue transplantation.

Safe and effective transplantation of human organs, tissues and cells to alleviate disease should be available worldwide. Recognizing, however, that the demand for transplantable human organs, tissues and cells exceeded the global supply, he endorsed the comments of the previous speakers; the procurement and allocation of human materials for transplantation had to be conducted ethically and safely. Although living organ donation had been the subject of serious human rights abuses globally, it had substantial health benefits for the recipient. His country therefore believed that, when every effort had been made to determine that the offer to donate was altruistic and voluntary, living donation was acceptable.

The growing reliance on living donor transplantation worldwide and the fact that potential donors and recipients often crossed international borders to participate in such operations merited a comprehensive study of the practices and ethical issues surrounding living donation. Such information could help Member States to refine and develop their own living donor transplant systems and to advise their citizens about involvement in international organ exchanges. He agreed with the member for Colombia that legal, regulatory and public educational measures should be taken to avoid what he had termed transplant tourism.

Condemned prisoners should not be accepted as organ donors, because their circumstances militated against voluntary consent and risked transmitting infectious diseases. Member States should immediately join in a moratorium on that unethical and unsafe practice while WHO developed guidelines on safe practices and ethical issues involved in organ donation for use by Member States, which should be encouraged to cease such practices and prevent their citizens from becoming recipients of those organs.

It was possible to construct a global system in which human tissues could be recovered, processed and distributed, with appropriate regulatory oversight, in as safe a manner as possible in order to minimize the transmission of infectious disease. His country's Department of Health and Human Services, through the Food and Drug Administration, was developing a framework for the regulation of human cells and tissues that involved registration and product listing, donor eligibility,

and good tissue practice requirements. He intended to share the framework, when completed, with WHO and Member States.

His country had always been concerned about the infectious disease risks inherent in the transplantation, implantation or infusion into a human recipient of live cells, tissues or organs from a nonhuman animal source, or of human body fluids, cells, tissues or organs that had had *ex-vivo* contact with live nonhuman material. Diseases, such as swine influenza and severe acute respiratory syndrome (SARS), had been transmitted from animals to human beings, sometimes with severe public health consequences. While, to date, there had been no documented case of the spread of an infectious agent from animals to human beings through xenotransplantation, such transmission might be facilitated by the immunosuppressive therapy administered to the recipient of an organ or tissue. Moreover, such xenogeneic infectious agents might have the potential to be contagious. WHO was in a unique position to advocate stringent national regulation of xenotransplantation worldwide, to inhibit its use in countries in which oversight and monitoring were lacking, to promote international surveillance for infectious disease events connected with xenotransplantation and to curb the spread beyond national boundaries of any disease caused by "xenotransplant tourism". His country had adopted a cautious, science-based approach to xenotransplantation, by establishing a national oversight framework using existing regulations and expertise, appropriate safe practices, a national database and a public advisory committee. Regulatory oversight and surveillance were essential in every country in which xenotransplantation was performed. His country was ready to share that framework with Member States.

He endorsed the amendments proposed by Colombia, and proposed some further amendments on behalf of Spain and his own country. In paragraph 1(1) of section I, the word "national" should be inserted between "effective" and "oversight", a comma should be added after the word "procurement" and the word "processes" replaced by "processing". In paragraph 1(2), he proposed the addition of a comma and the word "processing" after the word "procurement", and, at the end of that paragraph, the addition of a phrase reading: "including development of minimum criteria for suitability of donors of tissues and cells". Paragraph 2(1) should be reworded to read: "(1) to continue examining and collecting global data on the practices, safety, quality, efficacy, and ethical issues of allogeneic transplantation, including living donation, in order to update the Guiding Principles on Human Organ Transplantation;".

In paragraph 1(1) of section II, he proposed the insertion of the word "national" between "effective" and "regulatory" and of the words "mechanisms overseen" after "surveillance". Paragraph 1(2) should be redrafted to read: "(2) to cooperate in the formulation of recommendations and guidelines to harmonize global practices, including protective measures to minimize or prevent the potential secondary transmission of any xenogeneic infectious agent that could have infected recipients of xenotransplants or contacts of recipients, and especially across national borders;". At the beginning of paragraph 2(1), he proposed the replacement of the words "to promote and facilitate" by the words "to provide leadership through the promotion and facilitation of". In paragraph 2(2), he suggested the replacement of the words "to create a global evidence base to permit" by "to collect data globally for".

Mr GUNNARSSON (Iceland), acknowledging that Spain was in the vanguard of research into organ transplant systems, said that organ trafficking was a matter of great concern, not least because it was affecting the poorest and most vulnerable groups of the population. The Council of Europe had placed organ trafficking and protection against abuse high on its agenda. As it was unlikely that the problem was confined to the European Region, WHO must take the initiative in tackling the issue globally. His Government therefore suggested that the phrase "and the need for special attention to the risks of organ trafficking" should be added to the end of the fourth preambular paragraph of the draft resolution.

Mr BRUNET (alternate to Professor Dab, France) said that French experts had been particularly pleased with the outcome of the meeting in Madrid. His country wanted WHO to draft a policy on

organ and tissue transplants and fund international projects in that field, in particular to provide support for countries where much work was still needed in the ethical and legislative spheres in order to ensure the safety and quality of transplants and access to transplantation. Data collection was vital in order to define the specific situation in each country so that public health strategies could be adjusted accordingly. Support could take the form of north-south or south-south cooperation. Programmes should centre on priority transplants such as kidney, tissue and corneal grafts. The ethical rules and regulations governing those programmes should be consonant with internationally recognized minimum standards, especially when live donors were concerned, and in that connection he endorsed the comments of the member for the United States. All those efforts should lead to an increase in transplants, an improvement in medical and surgical practices and better treatment of ailments such as kidney disease. His Government therefore fully supported the resolution as amended.

Dr ACHARYA (Nepal) said that, although organ transplantation had become the treatment of choice for many diseases, only renal transplants would be feasible in his country. An act on organ transplantation had been passed two years earlier, but it had not been enforced because of some controversial clauses which had since been amended. Nepalese doctors and nurses were receiving special training abroad, which would be completed by February 2004, with the intention that kidney transplant operations would start in April 2004. Patients with the necessary means had previously travelled abroad to receive kidney transplants, but many people had been unable to do so and were undergoing dialysis. About 75 dialyses were carried out every week in Kathmandu. Those patients were awaiting transplants. Nepal therefore needed support with training, equipment and expensive immunosuppressive drugs. WHO should also strive to prevent transplant tourism which exploited poor and vulnerable donors, a phenomenon that his country had experienced in the past. For that reason, his Government supported the draft resolution.

Mr ASLAM KHAN (alternate to Mr Khan, Pakistan) said that various ethical issues arose from the donation of organs. In developing countries, the "organ business" was thriving: organs were traded through third parties and the donor was exploited by middle men, who usually received a sizeable share of the price paid by the recipients. Many rich countries were party to such organ trading. He supported the concerns expressed in regard to so-called voluntary donors whose informed consent might be obtained by exploiting their poverty. WHO should examine the ethical aspect of organ transplantation from living humans with a view to curbing such exploitation.

Professor FURGAL (Russian Federation) welcomed the topical consideration of issues relating to quality, safety and availability of donor materials, ethics and legislation. The transplantation of human organs, cells and tissues was inseparably bound up with ethical and safety issues. Action by WHO would be crucial in helping countries to improve their national transplant programmes, ensuring that more effective and transparent mechanisms for donation of material were in place. WHO could provide advisory services enabling experience and approaches to be shared among countries with differing political, economic, social and religious systems, and also support in control and surveillance of transplantation, as emphasized in paragraph 15 of the report. Much remained to be done to eradicate the increasing illegal trade in human organs and tissues, and his country was particularly interested in fostering cooperation with WHO and other Member States in that area. Accordingly, it supported the draft resolution as amended by Colombia and the United States. He requested, however, that the final preambular paragraph of the draft resolution should be amended so as to conclude with the words: "and from xenotransplantation recipients to their contacts and the public at large".

Dr AL-MAZROU (Saudi Arabia) said that his country, like many others, suffered from transplant tourism. It had implemented various measures to attract donors, such as encouraging relatives to donate organs and harvesting organs from the victims of road accidents. Clerics in Saudi Arabia had confirmed the acceptability of such a policy. Several reputed centres undertook the operations. The Saudi Centre for Organ Transplants campaigned widely to encourage organ donation,

while drawing attention to the dangers of accepting organs from centres that had not been certified and from persons in poor health. The Centre also emphasized the ethical issues arising from exploitation of the needs of the poor. He fully supported the draft resolution with the amendments proposed.

Dr YIN Li (China) said that the technology used in organ and tissue transplantation had reached maturity. While transplantation played an important role in saving lives and improving quality of life, it raised crucial legislative, safety, social, ethical, economic and psychological issues. Further strengthening of macromanagement and technology programming was required.

China was appreciative of the proposals for action contained in the report whose recommendations could serve as guidelines for Member States.

In response to the new challenges posed by human organ and tissue transplantation, China was introducing new legislation regulating human organ transplantation, after wide consultation within China. In drafting that legislation, the Government would take fully into account the conditions prevailing in China and do its best to follow the rules and guidance agreed by WHO and by other international organizations. Regulation would fully reflect the principles of voluntary donation, informed consent and independent decision-making; it would prohibit commercialization and protect minors and vulnerable populations, upholding the principles of justice and humanitarian care.

Xenotransplantation was a new field in China, but could potentially become an alternative to the use of human materials. It raised certain ethical issues, however, and risked the transfer of pathogens to the human recipients. China looked to WHO for guidance on suitable regulatory issues. It was a matter for concern that the sale and purchase of organs persisted in some countries: such practices discriminated against the poorest and most vulnerable sectors of society. WHO could assist Member States in drafting regulations to curb that phenomenon. In that context, he proposed a new paragraph 1(3) in section I that would read: "to take measures to protect the poorest and vulnerable groups from 'transplant tourism' and the sale of tissues and organs".

Dr KARAM (Lebanon)[1] said that transplantation differed from other health issues in that it required the consent of both the donor and the recipient. Health education and wider public involvement were sorely needed. Societies that did not deal with the issue in a frank and sincere manner would be opening the door both to transplant tourism and to a tacit and illegal trade in human organs. It was unfortunate that some societies valued the body more for its commercial potential than for its intrinsic worth. Organ trafficking might not be as deleterious as drug trafficking, but it had potentially even more tragic consequences.

Member States would look to WHO for guidance in monitoring medical procedures and safeguarding ethical boundaries in their national programmes. He supported the amendments to the draft resolution proposed by the United States.

Mr AGARWAL (India)[1] supported the draft resolution. His country had adopted a law on transplantation in 1994 and possessed excellent facilities for kidney, liver, bone marrow, cornea and heart transplantation. Organ banks had been set up. In addition to cadaveric and live related transplantation, the Act allowed authorization committees to approve live unrelated donation, where there was genuine emotional bond between donor and recipient. It also banned trade in organs.

He strongly supported the recommendation that "transplant tourism" should be prevented. There was a need to strengthen organ-retrieval and banking facilities and to educate the public in that regard; legislation should be drafted to that effect. Efforts to promote research in organ regeneration should be encouraged.

Dr YOOSUF (Maldives) commended the report but expressed concerns about the unethical approaches to transplantation that frequently stemmed from a lack of available organs. Some reference

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

should be made in the draft resolution to the need to promote an increased awareness of and education on safe practices in respect of live and cadaveric transplants as advocated by the previous speaker.

Countries like Maldives did not possess transplantation technology and thus relied on other countries' facilities. However, current regulations did not facilitate transplantation for those patients; hence, in the formulation of safety regulations, the needs of countries with less developed technology should be kept in mind.

Mr DOWNHAM (International College of Surgeons), speaking at the invitation of the CHAIRMAN, said that the need to provide comprehensive data and oversight; monitoring of the supply of cells, tissues and organs from donors, whether living or deceased; and maintenance of proper standards of safety and ethical conduct were all critical considerations. His organization, with members in more than 100 countries, many of whom practised in the field of transplantation, was ready to work with WHO to improve standards, efficacy, quality and safety so that access to transplantation could be properly expanded around the world.

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

The resolution, as amended, was adopted.[1]

Control of human African trypanosomiasis: Item 3.18 of the Agenda (Document EB113/5)

The CHAIRMAN drew attention to document EB113/5 and the draft resolution entitled "Control of human African trypanosomiasis" proposed by Belgium, France, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Monaco and Portugal, which read:

> The Executive Board,
> Having considered the report on human African trypanosomiasis,[2]
>
> RECOMMENDS to the Fifty-seventh World Health Assembly the adoption of the following resolution:
>
> > The Fifty-seventh World Health Assembly,
> > Recalling resolutions WHA50.36 and WHA56.7;
> > Deeply concerned by the resurgence of African trypanosomiasis and its devastating effect on human and livestock populations on the African continent;
> > Recognizing that the human form of this disease constitutes a major public health problem because of its invariably fatal outcome in untreated cases, the frequency of permanent neurological impairments in treated cases including, especially, permanent mental and psychomotor impairments in children, and its propensity to occur in epidemics;
> > Further concerned by the growing problems of drug resistance and treatment failure;
> > Welcoming the high level of political commitment to combat human African trypanosomiasis expressed by government leaders of countries in which the disease is endemic;
> > Further welcoming the renewed commitment to control this disease expressed in recent initiatives and public-private partnerships, which have greatly relieved the problem of inadequate access to existing drugs;

[1] Resolution EB113.R5.

[2] Document EB113/5.

Noting that, although great strides are being made in controlling this disease, better control tools, including safer and more effective drugs and simplified diagnostic tests, are badly needed,

1. URGES Member States:
(1) to continue to give high priority to the control of human African trypanosomiasis;
(2) in endemic areas, to increase human resources and dedicated financing, drawing as appropriate on funds previously used for the purchase of drugs; and to strengthen case detection, diagnosis and treatment, and the infrastructure for doing so;

2. REQUESTS the Director-General:
(1) to continue to refine control strategies so as to make maximum use of national and international resources and to prevent further epidemic spread;
(2) to promote among the various sectors and agencies concerned an integrated approach that takes into account the importance of vector control and of control of disease in livestock;
(3) to continue to collaborate closely with all partners concerned on research to develop safer and more effective drugs and simplified tests for trypanosomal detection;
(4) to keep the Health Assembly periodically informed of progress.

Mr BRUNET (alternate to Professor Dab, France) expressed gratitude for the excellent report that highlighted the suffering experienced by some of the most isolated populations in Africa. WHO estimated that between 300 000 and 500 000 people were affected by the illness and that about 60 million people were exposed to the risk of being infected in the most deprived areas. Currently, thanks to an exemplary public-private partnership involving several pharmaceutical firms, medicines were available free. Those medicines were, however, toxic and difficult to administer; in addition, resistance to them was increasing worryingly. The lack of simple diagnostic tools meant that the illness was seriously underestimated and, in the absence of treatment, fatal. All the factors cited were major obstacles to treating infected populations.

France and Belgium, for historical reasons, had devoted research efforts to combating the illness for some time. For that reason, they had wholeheartedly supported WHO's efforts at headquarters and at regional level with both financial and human resources. It was therefore gratifying to see that WHO had succeeded in bringing that neglected illness to the attention of major research institutes, affected governments, donors and large private groups who were working in partnership on treatment and on developing new medicines and diagnostic tests. Thus, at long last, it seemed reasonable to conclude that the eradication of trypanosomiasis was achievable. The draft resolution was the first to focus on treatment and diagnosis and thus complemented the valuable initiatives taken by African Heads of State to eradicate tsetse flies.

Dr CAMARA (Guinea) said that he, too, commended the report. In response to a resurgence of trypanosomiasis, which had become a major public health problem in Guinea, his Government had formulated a national programme to combat it. He thanked WHO and those countries, in particular France, that had provided the financial and technical resources his country lacked. He underlined his support for the draft resolution, of which his country had been a sponsor.

Dr SÁ NOGUEIRA (Guinea-Bissau) thanked all those countries that had sponsored the draft resolution. The report had updated him about the current epidemiological situation and clinical features of the illness and the strategies and the encouraging results of action undertaken by WHO to support the efforts of countries in the region in a significant framework of partnerships. He drew

attention to paragraph 14 of the report, on focused screening; such campaigns had revealed numerous cases in regions where the illness had been thought to have low prevalence. The time had come for WHO to consider epidemiological assessment in all regions where the illness was thought likely to re-emerge.

Human trypanosomiasis was becoming a grave public health problem, owing to its harmful socioeconomic impact, in particular in sub-Saharan Africa. Accordingly, Guinea-Bissau supported the draft resolution with a view to eventually eliminating the illness.

Dr LARIVIÈRE (alternate to Mr Aiston, Canada), endorsing the comments of previous speakers, supported the intensification of WHO's work to control human African trypanosomiasis as resurgence of the disease was creating a major public health problem. He would also encourage the Treatment and Drug Resistance Network for Sleeping Sickness to continue its efforts to develop better tools, especially for dealing with severe pathology.

During the Fifty-sixth World Health Assembly, as a follow-up to resolution WHA56.7, a small gathering had been organized by the pharmaceutical industry to highlight initiatives for the free provision of key drugs. He expressed his appreciation to the industry, in particular Aventis Pharma, for the critical role it had played in the battle against trypanosomiasis, which constituted a very serious obstacle to development. Canada was a strong supporter of such initiatives, which were a powerful tool for combating neglected and underfunded "orphan diseases".

He proposed that the words "notably through the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases" should be inserted after "all partners concerned" in paragraph 2(3) of the draft resolution.

Ms GIBB (alternate to Mr Thompson, United States of America) commended WHO's leadership in tackling the resurgence of human African trypanosomiasis by raising public awareness, securing funding, coordinating partner activities, securing the availability of treatment drugs and enhancing countries' ability to design and implement coherent control strategies. The United States supported the Pan African Tsetse and Trypanosomiasis Eradication Campaign and welcomed the commitment of African governments to trypanosomiasis control programmes. It remained a committed partner, with WHO and Member States, in the trypanosomiasis elimination programme, which it saw as a global alliance for strengthening existing trypanosomiasis control efforts and creating conditions for the ultimate elimination of the disease. The United States also supported the draft resolution.

Mr JADA (alternate to Dr Osman, Sudan) congratulated WHO for taking the lead in the campaign to combat human African trypanosomiasis. In many countries affected by conflicts, the disease was widespread among human populations and in animals and livestock, a distribution that increased the magnitude of the problem. Sudan wished to be added to the list of sponsors of the draft resolution. He endorsed the view expressed by the member for France that human African trypanosomiasis was a neglected disease, and considered that the time had come to take action.

The CHAIRMAN invited the Board to consider the draft resolution as amended.

The resolution, as amended, was adopted.[1]

[1] Resolution EB113.R6.

2. MATTERS FOR INFORMATION: Item 8 of the Agenda

Expert committees and study groups: Item 8.1 of the Agenda (Documents EB113/30 and EB113/30 Add.1)

Mrs LAMBERT (South Africa)[1] commended WHO's efforts to improve gender balance in the committees and panels, but, according to the report, only one committee had been composed of an equal number of men and women. Given the number of highly skilled and experienced women in all health-related fields, she urged WHO to redouble its efforts and, if necessary, to use extraordinary means to recruit more women into all its bodies.

The CHAIRMAN said that he took it that the Board wished to thank the experts who had taken part in the meetings, to request that their recommendations should be followed up, as appropriate, in implementing the Organization's programmes, and to take note of the report contained in document EB113/30 Add.1.

It was so agreed.

Reducing global measles mortality: Item 8.2 of the Agenda (Document EB113/32)

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that vaccination coverage should be increased in countries in two regions where coverage rates were low; to increase coverage, however, in the 45 countries that accounted for 95% of deaths would require additional funding. WHO and UNICEF had agreed on how to implement a strategic plan to reduce measles mortality, but actions taken would need to be carefully monitored and appropriate technical support and advice provided. WHO should be striving not only to reduce measles mortality, but to eradicate the disease altogether. It might therefore consider drawing up a medium-term strategy for achieving that end.

Dr KAMAL (alternate to Mr Aiston, Canada) said that Canada concurred with the approach outlined in the report. The Canadian International Development Agency had provided more than Can$ 30 million to help 12 emergency measles immunization campaigns in 10 countries, focusing on supporting campaigns in countries where low routine coverage left large populations susceptible to the disease, and where humanitarian crises threatened to increase measles transmission and mortality. According to Canada's partners, WHO and UNICEF, 75 million children would have been vaccinated by December 2004 as a result of the campaigns in those countries, thereby averting an estimated 130 000 deaths a year. Canada's experience was that supporting such initiatives had been among the most cost-effective ways of providing life-saving interventions to underserved and emergency affected communities.

In October 2003, a number of partners, including Canada, had signed the Cape Town Measles Declaration on the sustainable reduction of measles mortality. He welcomed the WHO-UNICEF strategic plan for 2001-2005 and underlined the importance of integrating efforts to reduce measles mortality within other health activities at country level.

Dr TAG-EL-DIN (Egypt) welcomed the report and the recommendations it contained. He also expressed appreciation for the international effort to reduce measles mortality. It would require an even greater effort on the part of WHO and the other organizations involved in the Measles Initiative Partnership, however, to meet the goal of ending deaths from the disease. Measles affected many children worldwide and could lead to serious complications, particularly those affecting the respiratory system.

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[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Dr DAYRIT (Philippines) thanked WHO and UNICEF for the assistance given to his country. The Philippines had implemented an immunization programme for several million children in 1998, and planned to immunize a further 19 million children in February 2004, an activity for which the Government of Japan had generously provided US$ 7.8 million.

Professor FURGAL (Russian Federation) supported the measures being taken at national and regional levels to reduce measles mortality with the active participation of WHO, UNICEF and other organizations. He endorsed the comments made by the member for Cuba, and drew attention to the absence in the document of solid objectives and of any mention of the global elimination of measles. The European and Eastern Mediterranean Regions had already devised strategies firmly grounded in practical experience that aimed to eliminate measles in both regions by 2007 and 2010, respectively. The goal of reducing measles mortality by 2005 provided a good basis for total elimination of the disease in the future.

Ms BLACKWOOD (alternate to Mr Thompson, United States of America) expressed appreciation for the update on progress towards achieving the 2005 measles mortality reduction goal and applauded the progress of many Member States, especially in the African Region. The target of a 50% reduction in measles mortality as compared with 1999 levels seemed likely to be achieved ahead of schedule. In 2003, the United States had provided US$ 42 million for vaccine to control outbreaks and other supplementary immunizations activities, surveillance and short- and long-term assignments of staff to priority countries. A key component in measles mortality reduction was partnerships, including those with United Nations organizations and agencies, other concerned bodies and individual health ministries. She urged Member States to provide additional support to WHO and UNICEF so that the 2005 measles mortality reduction goal could be achieved and even surpassed.

Professor DANG DUC TRACH (Viet Nam) said that Viet Nam had been implementing the WHO-UNICEF strategic plan for measles mortality reduction by strengthening routine vaccination programmes and providing a second opportunity for vaccination to all children under 10 years. As a result, the incidence of measles had declined from several thousand cases annually before implementation of the strategy to 36 in northern Viet Nam in 2003. He thanked those international organizations that had contributed towards that achievement, in particular WHO for its technical support, and the Government of Japan for having generously provided vaccine and assisted in setting up a laboratory in Hanoi for local manufacture of the vaccine. Such activities should lead to measles being totally eliminated in Viet Nam in the foreseeable future.

Mr GUNNARSSON (Iceland) welcomed the recommendations contained in the report. In order to meet the global goal of halving the number of deaths from measles by 2005, vaccination coverage had to be improved. So long as measles remained endemic in some countries, it posed a threat to those that had successfully eliminated the disease. Even in countries where extensive coverage provided protection to unvaccinated individuals, they were not immune from infection from people from areas where measles was endemic. Another cause for concern was the anti-vaccination campaigns in developed countries that could lead to reduced coverage and undermine the protection provided by blanket immunity.

Dr CAMARA (Guinea) expressed satisfaction with the technical quality of the report. While much had been achieved through implementation of the WHO-UNICEF strategic plan for measles mortality reduction, a great deal remained to be done. He thanked Member States, in particular Canada and Japan, as well as UNICEF for having provided financial assistance to Guinea to enable it to carry out its vaccination programme. He agreed with the member for Cuba on the importance of eliminating the disease completely, given the damage it was inflicting on the economies of developing countries.

Dr ALONSO CUESTA (alternate to Dr Pastor Julián, Spain) said that the deadline set for the elimination of measles within the European Region was 2010. Measles had been notifiable in Spain since 2001. The level of vaccination coverage was high; elimination of indigenous virus might be achieved by 2005. Once vaccination coverage reached an adequate level and transmission of measles virus had been interrupted, suspected cases must continue to be reported as outbreaks may occur in susceptible pockets of the population owing to importation of the virus from areas where measles was still prevalent. Hence, international cooperation was essential. Since molecular epidemiology had described the geographical distribution of the various genotypes of measles virus, the availability of viral genetic material allowed native and imported cases of measles to be distinguished. The last meeting on measles elimination in Spain in 2003 had been informed that there was little if any circulation of indigenous virus in Spain and that most cases of measles were caused by imported viruses. The maintenance of a national surveillance network was essential. In recent years Spain had collaborated with the Region of the Americas in trying to eliminate the disease.

The Board noted the report.

Severe acute respiratory syndrome (SARS): Item 8.3 of the Agenda (Document EB113/33)

Dr YIN Li (China) recalled that China had borne the brunt of the previous year's SARS outbreak. Thanks to his Government's leadership, the disease had been rapidly controlled and he expressed gratitude to WHO and other organizations and countries for their support in those efforts.

Regarding the recent situation, three cases of SARS had been identified and confirmed in Guangdong Province since 26 December 2003. All three had been cured and had left hospital within a few days, and none of their contacts, who numbered more than 200 and had been placed in quarantine and under medical observation, had been infected. To date, no other suspected case of SARS had been identified in China. However, those three cases, the first in China since June 2003, showed that SARS had not been eliminated altogether and remained a public health threat, although epidemiological studies showed that: the three cases were independent; transmission was weak; and the symptoms were mild compared with the virulent outbreak of the previous year. The three cases had yielded no laboratory-produced viruses.

His Government attached great importance to a comprehensive process of SARS prevention and control, from extensive laboratory testing, in close consultation with WHO and independent experts, to immediate and appropriate hospital treatment, contact tracing and observation and communication of information on current developments.

Measures taken included formulation of plans by every province for SARS control; strengthened surveillance at transport terminals and public places in outbreak areas; early detection and reporting of suspected cases at clinics; improved management of designated SARS laboratories; setting up of inspection and monitoring teams; wider geographical surveillance network coverage; improvements to the communicable disease reporting system; and improved epidemiological surveillance and research into the pathology of the disease.

No full picture had yet emerged as to the source of the causative virus, its mode of transmission or prevalence, and there was as yet no specific diagnosis of infection. SARS should be tackled with the cooperation of WHO and all countries. The priorities were to step up laboratory research on diagnosis and to formulate case definitions; to cooperate in the study of the etiology, source and mode of transmission; and to further scientific exchanges to advance etiological and epidemiological research and improve surveillance and therapeutic methods. The fight against SARS would ultimately depend on science and international cooperation and communication, to which Chinese scientists were willing to contribute their rich experience.

Mr AISTON (Canada) welcomed the update on the situation in China, and supported WHO's efforts to prevent the re-emergence of SARS and control it in future by continuing to support and strengthen newly established clinical, laboratory and epidemiological networks. Canada recommended

the establishment of an international communications network, given the crucial importance of rapid sharing and consistency of information when a global health threat emerged. The establishment of the SARS Scientific Advisory Committee was an important step towards ensuring that key research issues were identified and addressed promptly, and Canada remained a committed partner in addressing such research needs. Canada also strongly supported WHO's leadership in strengthening the evidence base for travel-related recommendations, and noted that WHO had requested a complete line listing of cases of SARS in the country. It favoured and would participate in further discussions of the need for a minimum global data set in the event of an emerging infectious disease.

Mr GUNNARSSON (Iceland) stressed the significance of SARS as a public health threat. A suspect case in Iceland, not reported to WHO as it had not entirely met the reporting criteria and was subsequently proved to have been a false alarm, had made the health authorities in Iceland acutely aware of the extremely difficult decisions facing affected nations and the economic and other implications of health crises of that kind, whether or not the cases were real. The crisis demonstrated the importance of national and international preparedness plans for biological incidents, and of the role of WHO in dealing with them. It was gratifying to note that plans in the event of a resurgence of SARS were already in place. A vaccine was needed, as were viral ecological studies in order to understand the origin of the new disease.

Dr STEIGER (alternate to Mr Thompson, United States of America) commended WHO's work on SARS. His Government was proud of its increased cooperation and partnership with WHO on the ground. Emphasizing the importance of transparency and openness on the part of all Member States, he said that he was particularly encouraged by the report from China and its cooperation over the previous year. His Government had had extensive contacts with WHO and the Chinese leadership in connection with the recent SARS outbreak. Regarding public health preparedness in the United States, his Government recently announced a ban on the import of civet cats, even though the very few civet cats currently legally imported into the United States were from Africa.

The United States would be submitting some specific technical comments on the report. In the meantime, the Board might consider two areas for further refinement. One concerned the management of travel advisories and the circumstances under which WHO issued recommendations: what was needed was a series of graduated alert and advisory measures, rather than ad hoc measures as in the past. A better protocol for removal of alerts at the end of an outbreak was also needed. The other area concerned case definitions: continued work was needed with WHO to ensure clarity about reporting.

The setting up of a situation room at WHO was a positive step towards dealing with health crises such as SARS.

Mr BRUNET (alternate to Professor Dab, France) said that the events of the previous year had seriously challenged the international public health community, and he commended WHO's leadership in responding to the crisis. The SARS outbreak had further revealed the rapid response capacity of affected countries like Canada, China and Viet Nam. France was carefully watching the current re-emergence of SARS in China and was heartened to see the progress made in cooperation and information exchange. It was cooperating with China with a view to enhancing laboratory safety there.

The recent SARS cases had coincided with a new outbreak of avian influenza, which posed the same challenges as did SARS the previous year. International cooperation in that area was important.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), welcoming the report and the thorough update given on the situation in China, also stressed the importance of the question of issuing travel advisories. During outbreaks, travel advisories had far-reaching implications, not only for travellers but also for citizens and governments and the world economy; the criteria for issuing and lifting them should be well set out in advance, and should be evidence-based and well understood by everyone. There was considerable public pressure to introduce mass screening of travellers, even though experience showed that such screening had serious limitations. Public pressure

could be resisted if there was a sound evidence base against mass screening which should be made clear and widely communicated. He agreed with the member for the United States that some form of staged process would be practical.

Regarding the vulnerability of countries to major outbreaks of disease, it must be recognized that the main weakness in the chain was hospital hygiene. The linkage with other WHO programmes should be established in that connection. On a related point, he asked whether a brief update could be provided on avian influenza.

Professor FURGAL (Russian Federation) commended WHO's work on the prevention and control of atypical pneumonia. The first SARS outbreak had been successfully dealt with through the collective response of Member States, coordinated by WHO. SARS might not be the most dangerous and contagious of the new diseases that humanity might have to face, and appropriate conclusions should be drawn from the events of the previous year. It could be seen from the report that serious measures were being taken to deal with newly-emerging infectious diseases. He therefore endorsed the comment by the member for the United States on the importance of setting up a WHO situation room in order to ensure a rapid response to new circumstances.

Dr DAYRIT (Philippines) applauded WHO's action in dealing with the SARS outbreak. The Ministry of Health of the Philippines had invested heavily in SARS prevention and control facilities. Although recognizing that screening, at airports for example, would not prevent the entry of the disease, his Government had felt the need to reassure the population and had installed screening equipment as a form of security blanket. He agreed that clarity about screening and the issuing and lifting of travel advisories would be most useful.

He further highlighted the role of the media in controlling public anxiety at the outbreak of a new disease like SARS. He welcomed the establishment of a situation room at WHO and suggested that health ministries should be informed promptly of any breaking news on the issue, for example through cell phone communication.

Dr TAG-EL-DIN (Egypt), referring to comments made by the previous two speakers, pointed out that, although SARS had come to be used as the name for the syndrome associated with the outbreak of disease in 2002-2003 due to a coronavirus, strictly speaking it was a term that could be used to describe any severe acute respiratory syndrome, whatever the causal agent, whether viral or bacterial.

Mr AISTON (Canada) endorsed the suggestions on the use of a graduated scale in relation to travel advisories. WHO should make use of existing research in that area. He expressed appreciation for the considerable help offered to Canada during its SARS outbreak by the United States Government.

Dr KARAM (Lebanon)[1] commended the control strategies that China had adopted and the efforts it had made in combating the SARS epidemic. With vigilance and adequate research, it should be possible to control such outbreaks in the future. WHO had a pivotal role to play in that respect.

Ms HUNT (Belize)[1] said that the SARS epidemic had shown that diseases knew no boundaries and that putting politics ahead of health could place global health at risk. She expressed appreciation for the efforts made by China to improve transparency and cooperation in respect of recent cases of SARS in the south of the country and also paid tribute to health achievements in Taiwan, China.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The DIRECTOR-GENERAL informed the Board that one recent case of SARS had been reported in Taiwan, China, and that technical support had been provided by WHO. WHO technical experts had visited the area and filed a report.

Dr OMI (Regional Director for the Western Pacific) recalled that on 5 January 2004 the Government of Viet Nam had informed WHO of the admissions to hospital in Hanoi of 12 patients with a severe respiratory illness associated with high mortality. WHO had provided prompt advice to the Vietnamese health authorities on diagnostic investigation. On 11 January 2004, the presence of *Influenzavirus A* subtype H5N1 had been confirmed by an external influenza reference laboratory. So far there had been laboratory confirmation of infection with that virus in five patients, all of whom had died. A further 38 cases were being investigated. Infection of chickens with the virus had been confirmed in Japan, Republic of Korea and Viet Nam and was suspected in Cambodia and Thailand. FAO and the Office International des Epizooties had been informed immediately at regional and country levels. Meanwhile WHO had received confirmation through FAO of suspected outbreaks of avian influenza in poultry in the south of Viet Nam. WHO urged health authorities to liaise closely with ministries of agriculture, since elimination of the animal reservoir represented one of the most important solutions to the public health threat from the disease.

The Board noted the report.

Smallpox eradication: destruction of variola virus stocks: Item 8.4 of the Agenda (Document EB113/34)

Dr OM (Republic of Korea) paid tribute to the members of the WHO Advisory Committee on Variola Virus Research and to experts and laboratories around the world for their significant contribution to knowledge about variola virus. Much progress had been made since the endorsement of the Director-General's recommendations at the Board's 109th session. WHO should continue to support research activities on the virus and report the results to the Health Assembly.

Professor FURGAL (Russian Federation) endorsed the recommendations of the Advisory Committee, in particular the need to undertake additional research on antiviral drugs and safer vaccines, despite the considerable progress made in that area. In accordance with resolutions WHA52.10 and WHA55.15, the Russian Federation had developed a national research plan with a view to developing new diagnostic and prophylactic materials and drug treatments against variola virus infection. All the research was being undertaken at the WHO collaborating centre VECTOR in strict compliance with recommendations and requirements and under the supervision of WHO. Significant results were being obtained in four main areas: strengthening a reference database for use in identifying variola virus strains; the identification of new chemical compounds with strong antiviral activity; the development of a mathematical model and a computer software programme for the analysis of scenarios of the evolution of smallpox epidemics; and the development of clinical tests for bivalent vaccines against smallpox and hepatitis B. On behalf of VECTOR, he urged WHO to provide more active support for the exchange of information on variola virus research. He thanked all partners, in particular the United States of America, for their participation in joint research activities under the aegis of WHO, and looked forward to the continuation of that work.

Dr YIN Li (China) paid tribute to the work of the Advisory Committee and welcomed the progress made in the various areas of research. Results should be disseminated in a timely manner so that all Member States could benefit. He endorsed the Committee's recommendations, in particular that set out in paragraph 5(b) relating to the destruction of viral isolates whose retention had no scientific justification. Given the potential danger posed by variola virus stocks, research should be

accelerated, with development of a research plan and timetable. Stocks that could be dispensed with should be destroyed as soon as possible.

The Board noted the report.

Eradication of poliomyelitis: Item 8.5 of the Agenda (Document EB113/35)

Dr HEYMANN (Representative of the Director-General for Polio Eradication) said that, at a recent panel discussion in New York, the core partners in the Global Polio Eradication Initiative – countries, UNICEF, Rotary International, the United States Centers for Disease Control and Prevention and WHO – had confirmed their commitment to complete poliomyelitis eradication. The disease remained endemic in six countries, some with large populations. In 2003, four of those countries had recorded the lowest ever number of cases and had not seen the usual peaks of transmission in the high-transmission season. There was therefore an unprecedented opportunity to stop transmission during the low-transmission season. It was technically and epidemiologically feasible to interrupt transmission in those countries and in the remaining two countries endemic for the disease, if they could improve the quality of immunization campaigns and increase coverage.

Solutions were being found for local problems, such as low levels of access to children and false rumours about vaccine safety. For example, recruitment of women as vaccinators was increasing access to children, and intensive work at state and community levels to counter false rumours was under way, although additional international measures might be needed in respect of the latter.

Political will was increasing in the six disease-endemic countries as a result of their recognition of the opportunity to achieve a poliomyelitis-free world. Ministers of health of those countries had just signed a declaration committing them to intensifying immunization activities with the goal of interrupting transmission by the end of 2004. Heads of State were increasingly becoming engaged in eradication activities and had been invited by the United Nations Secretary-General to report on progress to the United Nations General Assembly at its fifty-ninth session later in the year. The urgency of interrupting transmission in the endemic countries was paramount, however, since for the first time the number of countries in which imported cases had been recorded in 2003 (seven) exceeded the number of poliomyelitis-endemic countries. Additional immunization campaigns in those countries had cost US$ 20 million, exceeding the contingency budget for emergency responses.

International political will for the completion of eradication was also increasing. The leaders of the African Union had resolved to complete eradication by 2004, the G8 countries had made a commitment to provide increased funding and the Organization of the Islamic Conference had resolved to do both. Those commitments must be translated into action to intensify eradication activities and secure the necessary funding. The Russian Federation had fulfilled its pledge made at the G8 summit in 2003, becoming a partner in the Global Polio Eradication Initiative with a contribution of US$ 4 million.

The Global Polio Eradication Strategic Plan 2004-2008 set out the actions necessary to complete and certify eradication and in due course to stop immunization with oral poliovirus vaccine. Success was contingent on bridging the funding gap of US$ 150 million.

Dr UTON RAFEI (Regional Director for South-East Asia) said that, at the launch of the poliomyelitis eradication campaign in 1988, his Region had accounted for more than 50% of the world's poliomyelitis burden, most cases occurring in India. By 2000, every country in the Region except India had eliminated the disease, demonstrating the success of the eradication strategies and the unprecedented cooperation between Member States, Regions and other partners. He paid particular tribute to the role of the Regional Director for the Eastern Mediterranean in facilitating cross-border collaboration between his Office and Pakistan.

Despite the progress made in the Region, in 2002 India had experienced the largest outbreak in recent history, with 1600 children becoming paralysed. Since then it had mobilized political, religious and local community leaders to intensify immunization efforts. Women vaccinators were playing a

critical role, especially in minority and underserved communities. As a result 2003 had seen the lowest level of the disease ever, with 220 cases recorded. On 15 January 2004 the Minister of Health of India was among those who had made a commitment to interrupt transmission by the end of 2004, and had confirmed that his Government would allocate US$ 100 million to the national effort. The greatest challenge was to reach every child in western Uttar Pradesh, the only area of the country that had never been free from the disease.

Dr TAG-EL-DIN (Egypt) said that Egypt had recorded only one case in 2003, which had been successfully contained. The country's First Lady had given full support to the eradication campaign. In 2003 all children in the target group, namely those between the ages of one day and five years, had been immunized with additional coverage of some older children. Immunization activities had been completed within a period of four months, with special emphasis on vaccinations after birth and those in areas considered to be at higher risk. Egypt had achieved success through political and technical will and thanks to support from WHO, UNICEF and other partners. The outcome had been well documented and corroborated. Preventive measures were continuing and it was hoped that the country would soon be declared free from the disease.

Mr ASLAM KHAN (alternate to Mr Khan, Pakistan) said that his country was fully committed to the elimination of poliomyelitis by the end of 2004 and had been successful in keeping the number of cases below 100 over the previous two years. On 15 January 2004, it had joined other endemic countries in reaffirming its commitment to the interruption of transmission by the end of 2004. The President was taking a personal interest in monitoring the progress of immunization. Thanks were due to the many partners who were supporting Pakistan's eradication efforts.

Dr KAMAL (alternate to Mr Aiston, Canada) endorsed the approaches set out in the report. Canada had long been a champion of poliomyelitis eradication, and the Canadian International Development Agency had contributed a total of Can$ 92.4 million to the Global Polio Eradication Initiative since 1999, of which more than half had been announced at the 2002 G8 Summit as part of the Canada Fund for Africa. He emphasized the importance of completing eradication within the small window of opportunity that was currently available. He welcomed efforts to find efficient and effective ways of integrating the current eradication infrastructure into general health care services at the country level where appropriate.

Mr BRUNET (alternate to Professor Dab, France) welcomed the report, which clearly highlighted the difficulties being encountered in the current critical phase of the eradication campaign. The appearance of imported cases in countries considered free from the disease was particularly striking. International efforts must therefore be intensified. He was pleased to announce that his Government would be contributing a further €30 million to underpin those efforts.

Professor FURGAL (Russian Federation) said that impressive progress towards the eradication of poliomyelitis had been achieved, but there would need to be greater political will, more partnerships and additional financing if the objectives of the Global Polio Eradication Strategic Plan 2004-2008 were to be met. Achieving those goals would be a major task for WHO at all levels of the Organization. The European Regional Office had supported the Russian Federation and other Member States in the areas of laboratory and epidemiological surveillance services, diagnosis of acute flaccid paralysis and development and implementation of national plans of action to support poliomyelitis-free status.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that eradication of poliomyelitis was possible. Everyone would benefit from a world free of the disease and from the positive impact of the global action being taken. His Government recognized the need to bridge the funding gap for the final phase of eradication and had contributed a further £10 million,

disbursed before the end of 2003, in addition to the US$ 56 million already committed for 2003-2005. He hoped that that action would encourage other donors to make additional contributions and stimulate the political will needed to complete eradication. Welcoming the report, he commended the activities for the post-certification period and the proposals for the continued integration of poliomyelitis-related activities into general health systems. Financial commitment must be complemented by political commitment at the highest levels in endemic countries. Eradication of the disease and sustainable health gains would result from the build-up of routine immunization with supplementary campaigns as necessary.

The meeting rose at 12:45.

EIGHTH MEETING

Thursday, 22 January 2004, at 14:15

Chairman: Dr K. AFRIYIE (Ghana)
later: Dr C. MODESTE-CURWEN (Grenada)

1. MATTERS FOR INFORMATION: Item 8 of the Agenda (continued)

Eradication of poliomyelitis: Item 8.5 of the Agenda (Document EB113/35) (continued)

Mr GUNNARSSON (Iceland) welcomed the positive results of immunization initiatives against poliomyelitis and measles. Agreeing with the member for Canada, he requested that the need for future strengthening of national immunization programmes integrated into the regular health systems should be taken into consideration.

Dr YIN Li (China) noted with satisfaction the progress made in eradicating poliomyelitis worldwide. In 2002, China had been certified free of poliomyelitis, and, in order to preserve that status and protect its population from imported cases from neighbouring countries, it was maintaining a high level of oral vaccination coverage and strengthening the surveillance system for acute flaccid paralysis. Owing to the remarkable success in poliomyelitis eradication, some international donors had unfortunately reduced their support for country immunization work with the result that some developing countries were unable to continue their activities. He therefore urged WHO to support those countries by encouraging governments to confirm their commitment to complete eradication and mobilize the necessary funding.

Dr KEBEDE (Ethiopia) welcomed the indications of further funding given at the preceding meeting. It was essential that countries not only complete the eradication process but that they also, for some time thereafter, continue routine immunization and surveillance activities. Additional funding would continue to be necessary until global eradication was achieved. He therefore wondered whether the reduced funding gap of US$ 130 million referred to in paragraph 8 of the report included the sums just promised or whether further funds were expected. Countries struggling to contain poliovirus transmission needed assurance that their efforts would not be wasted.

Dr BOSHELL (Colombia) expressed his country's deep appreciation of WHO's determined efforts in the area of immunization and surveillance of vaccine-preventable diseases in all Member States. The periodic problems that arose in different parts of the world after vaccination were nevertheless a matter of concern and he impressed on Members the need to keep the Organization informed of such difficulties as and when they arose so that the root causes could be identified.

Dr DAYRIT (Philippines) said that, although his country had been certified free of poliomyelitis, it was aware of the importance of maintaining high immunization rates if it were to remain free of wild-type poliovirus. Drawing attention to the reference in paragraph 9 of the report to vaccine-derived polioviruses, he reported that in 2001 the Philippines had suffered three cases of infection with such viruses in areas where routine immunization rates had dropped. Two rounds of immunization had consequently been required the following year, covering some 12 million children. The exercise had been expensive and served to underline the importance of maintaining high immunization rates.

Mr THOMPSON (United States of America) commended the efforts against poliomyelitis worldwide of WHO and Rotary International, which had raised funds for poliomyelitis eradication for many years. The United States Department of Health and Human Services had appropriated US$ 134 million for the current year for poliomyelitis eradication; in addition it had seconded some 20 people to WHO in countries around the world to help with eradication work. The world was on the threshold of eradicating a virus that had crippled and killed a great many people. That mission could be accomplished by 2005 if efforts were redoubled in 2004. As 2004 was therefore a crucial year, he intended to visit Afghanistan, India and Pakistan in April with officers from Rotary International, and he invited the Director-General to join them. Their objective was to publicize the international support for the campaign and to show other countries that poliomyelitis eradication was a serious issue, not only for the six countries where poliomyelitis was endemic but also for those that were free of the disease but needed to continue certification to ensure that, once the virus had been stamped out, it could never reappear. He assured the member for Ethiopia of his Government's assistance in the fight, which could be won.

Dr CAMARA (Guinea) said that the Global Polio Eradication Initiative had undoubtedly achieved tangible results, with an increasing number of countries free of the virus and the number of cases steadily falling. He thanked all those who had contributed the indispensable funds, including the United States of America (and its Centers for Disease Control and Prevention in Atlanta, Georgia), Canada and Japan. However, since the virus was highly transmissible and easily crossed borders, continued financial support was essential so that poliomyelitis could at last, like smallpox, be confined to the history books.

The CHAIRMAN, speaking in his capacity as the member for Ghana, said that his country had had some imported cases of wild-type poliovirus in 2003 after being free of it for almost four years. As a result of those new cases, the Government had had to commit US$ 1 million of its scarce resources and engage in a major national effort to participate in synchronized national immunization days with neighbouring states. Ghana was extremely grateful to its development partners, especially Rotary International and WHO, and to the many anonymous health workers, especially village volunteers, throughout Africa for their support. Ghana intended to work with all countries, including those in its subregion, to eradicate wild-type poliovirus. The last stage of the campaign called more for political and social dialogue than for technical input. He undertook to urge his own President to finish the job and urged fellow Board members to exert pressure on their respective governments to do likewise.

Dr TAG-EL-DIN (Egypt) said that Egypt had benefited from WHO support both from headquarters and from its Regional Office and from other agencies. He endorsed the statement by the member for the United States: his Government's assistance in eradicating poliomyelitis was essential, particularly in the crucial current year. In 2003 Egypt had had only one case of poliomyelitis and it was to be hoped that that would be the last. He thanked the United States for its support and invited the member to visit Egypt as well in April.

Mr HACKETT (Rotary International), speaking at the invitation of the CHAIRMAN, pledged his organization's continued involvement in the fight to eradicate poliomyelitis by the end of 2005; it was committed to continue its support until eradication was officially certified. WHO's dedication to the mutual goal of ensuring vaccination against that scourge for every child was exemplary: no child should ever have to suffer from poliomyelitis again.

Poliomyelitis eradication had been Rotary's top priority for the past 25 years and, by the time the world was certified poliomyelitis-free, it would have contributed about US$ 600 million to the campaign. In addition, about one million Rotarians had spent countless volunteer hours to help to immunize some 2000 million children in 122 countries. In 2003, Rotarians had raised US$ 111.5 million to continue the fight. Over the previous 25 years much progress had been made,

from the 1000 children infected a day in 1988 to elimination of the disease from all but six countries, and it was vital that eradication should be completed in those remaining areas. Fortunately, governments had cooperated in ways once thought impossible, by synchronizing immunization campaigns to prevent the virus from spreading across borders, for example. There had also been unprecedented cooperation between governments, bodies in the United Nations system and the private sector, with international investment from governments, foundations and private citizens of more than US$ 3000 million. Tragically, some volunteers, including Rotarians and health workers had lost their lives in areas of conflict, but the effort had been worthwhile. It was the biggest health initiative in history and had been hailed as a model for others. Rotary International had found WHO to be an ideal partner and felt privileged to work with the Organization in the final push to free the world from poliomyelitis. (*Applause*)

The Board took note of the report.

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

Integrated prevention of noncommunicable diseases: Item 3.7 of the Agenda (Documents EB113/36, EB113/44 and EB113/44 Add.1) (continued from the fourth meeting)

The CHAIRMAN drew attention to the revised draft resolution on a draft global strategy on diet, physical activity and health, which read:

> The Executive Board,
>
> Having considered the report of the Secretariat and the draft global strategy on diet, physical activity and health;[1]
>
> Noting that the draft strategy will be open until 29 February 2004 to comments by Member States which will be made available to all Member States and that a revised draft strategy on diet, physical activity and health taking into account those comments will be submitted to the Fifty-seventh World Health Assembly,
>
> RECOMMENDS to the Fifty-seventh World Health Assembly the adoption of the following resolution:
>
> > The Fifty-seventh World Health Assembly,
> >
> > Recalling resolutions WHA51.18, WHA53.17 and WHA55.23 on prevention and control of noncommunicable diseases;
> >
> > Recalling *The world health report 2002*, which indicates that mortality, morbidity and disability attributed to the major noncommunicable diseases currently account for about 60% of all deaths and 47% of the global burden of disease, which figures are expected to rise to 73% and 60%, respectively, by 2020;
> >
> > Noting that 66% of the deaths attributed to noncommunicable diseases occur in developing countries where those affected are on average younger than in developed countries;
> >
> > Alarmed by these rising figures that are a consequence of evolving trends in demography and lifestyles, including those related to unhealthy diet and physical inactivity;

[1] Documents EB113/44 and EB113/44 Add.1

Recognizing the existing, vast body of knowledge and public health potential, the need to reduce the level of exposure to the major risks resulting from unhealthy diet and physical inactivity, and the largely preventable nature of the consequent diseases;

Mindful also that these major behavioural and environmental risk factors are amenable to modification through implementation of concerted essential public-health action, as has been demonstrated in several Member States;

Recognizing the interdependence of nations, communities and individuals and that governments have a central role, in cooperation with other stakeholders, to create an environment that empowers and encourages individuals, families and communities to make positive, life-enhancing decisions on healthy diet and physical activity;

Recognizing the importance of a global strategy for diet, physical activity and health, within the integrated prevention and control of noncommunicable diseases, including support of healthy lifestyles, facilitation of healthier environments, provision of public information and health services, and the major involvement of the health and relevant professions and of all concerned stakeholders and sectors committed to reducing the risks of noncommunicable diseases in improving the lifestyles and health of individuals and communities;

Convinced that it is time for governments, civil society and the international community, including the private sector, to renew their commitment to encouraging healthy patterns of diet and physical activity;

Noting that resolution WHA56.23 urged Member States to make full use of Codex Alimentarius Commission standards for the protection of human health throughout the food chain, including assistance with making healthy choices regarding nutrition and diet,

1. [ENDORSES the global strategy on diet, physical activity and health;]

2. URGES Member States:

(1) to develop, implement and evaluate actions recommended in the strategy, as appropriate to national circumstances as part of their overall policies and programmes, to promote individual and community health through healthy diet and physical activity, and to reduce the risks and incidence of noncommunicable diseases;

(2) to promote lifestyles that include a healthy diet and physical activity and foster energy balance;

(3) to strengthen existing, or establish new, structures for implementing the strategy through the health and other concerned sectors, for monitoring and evaluating its effectiveness, and for guiding resource investment and management to reduce the prevalence of noncommunicable diseases and the risks related to unhealthy diet and physical inactivity;

(4) to define for this purpose, consistent with national circumstances:

(a) national goals and objectives,

(b) a realistic timetable for their achievement,

(c) measurable process and output indicators that will permit accurate monitoring and evaluation of action taken and a rapid response to identified needs;

(5) to encourage mobilization of all concerned social and economic groups, including scientific, professional, nongovernmental, voluntary, private-sector, civil society, and industry associations, and to engage them actively in implementing the strategy and achieving its aims and objectives;

(6) to encourage and foster a favourable environment for the exercise of individual responsibility for health through the adoption of lifestyles that include a healthy diet and physical activity;

3. CALLS UPON other international organizations and bodies to give high priority within their respective mandates and programmes to, and invites public and private stakeholders including the donor community to join and support governments in, the promotion of healthy diets and physical activity to improve health outcomes;

4. REQUESTS the Codex Alimentarius Commission to continue to give full consideration, within the framework of its operational mandate, to evidence-based action it might take to improve the health standards of foods consistent with the aims and objectives of the strategy;

5. REQUESTS the Director-General:

(1) to provide technical advice and support at both global and regional levels to Member States, when requested, in implementing the strategy and in monitoring and evaluating implementation;

(2) to monitor on an ongoing basis international scientific developments relative to diet, physical activity and health to enable Member States to adapt their programmes to the most up-to-date knowledge;

(3) to continue to prepare and disseminate technical information, guidelines, studies, evaluations, advocacy and training materials so that Member States are better aware of the cost/benefits and contributions of healthy diet and physical activity as they address the growing global burden of noncommunicable diseases;

(4) to strengthen international cooperation with other organizations of the United Nations system and bilateral agencies in promoting healthy diet and physical activity;

(5) to cooperate with civil society and with public and private stakeholders committed to reducing the risks of noncommunicable diseases in implementation of the strategy and promotion of healthy diet and physical activity, while ensuring avoidance of potential conflicts of interest.

Dr BELLO DE KEMPER (Dominican Republic)[1] expressed astonishment that neither the report nor the resolution before the Board made reference to the role of educational establishments in health promotion. She therefore proposed the insertion of a new paragraph urging promotion of the benefits of a healthy diet and physical activity in schools, in keeping with the local cultural and social environment, to be consistent with action already taken by PAHO and with WHO's health-promoting schools initiative.

Mr SHARMA (India)[1] asked why the first paragraph of the draft resolution was in square brackets.

Mr AITKEN (Director, Office of the Director-General) replied that the brackets indicated that the draft strategy was still subject possibly to further revision, as it would continue to be subject to comments by Member States until the end of February 2004.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The CHAIRMAN invited the Executive Board to consider the revised draft resolution.

The resolution was adopted.[1]

3. MATTERS FOR INFORMATION: Item 8 of the Agenda (resumed)

Quality of care: patient safety: Item 8.6 of the Agenda (Document EB113/37)

Dr DANZON (Regional Director for Europe), introducing the item, said that quality of care was a key element in the new policy of health for all on which Europe was working. It was crucial to European public health values and a practical component of any health policy especially in view of the introduction of accreditation programmes and services. In developing health systems, it had to be understood that poor quality was costly, as evidenced by the problems of iatrogenic infections. Patient safety was central to the concept of quality, and should apply to the health system as a whole, including the areas of prevention, health promotion and health information. The subject deserved greater priority in the programmes of Member States and WHO.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that, over the past two years, WHO had shown outstanding leadership and had seized a major opportunity to change thinking internationally on patient safety. Its initiatives in relation to taxonomy, estimating hazards and the development of reporting and learning systems would prove invaluable to all health-care professionals and health systems. It had also brought together top technical experts to discuss the areas outlined in the report, making it possible to harness their individual expertise in support of the global agenda.

Since the Fifty-fifth World Health Assembly, the United Kingdom had worked in collaboration with WHO and many Member States, in particular the United States of America, to support the implementation of resolution WHA55.18. Steps to initiate an international alliance on patient safety were taken at a meeting of world experts in London in November 2003. Such an alliance could play a fundamental role in facilitating the development of patient-safety policy and practice in all Member States through the delivery of core functions and other initiatives. In view of the great interest generated by the London meeting, WHO's high-quality team working in that area should be strengthened so that more work could be done in the coming year.

His Government looked forward to working with WHO, Member States, international experts and specialist agencies to ensure that the proposed alliance would be a significant step forward in the battle to create health organizations characterized by a culture in which the reporting of adverse events formed the basis of an uncompromising quest for quality, so that the bad experience of one patient could lead to learning that would benefit another.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) suggested that WHO should strengthen its support in areas such as the dissemination of information on taxonomy, estimating hazards, reporting and learning systems, the preparation of best practice guidelines and promoting their adoption in countries. He wondered whether patient safety fell within the remit of the situation room recently set up by the Organization. With regard to the safety of products and services, WHO should disseminate experience on the implementation of regulations. It should also take action to reduce the cost of single-use and auto-disable syringes through technology transfer and their manufacture in certain developing countries in order to ensure safe injections and immunization. The international alliance would provide

[1] Resolution EB113.R7.

an excellent forum for the exchange of experience, and the coordination of measures and mechanisms should be sought to ensure the actual or virtual participation of all Member States.

Dr AL-MAZROU (Saudi Arabia) emphasized the importance attached by his country to patient safety. Saudi Arabia would shortly be hosting a conference to discuss the subject. In future the report might usefully cover technical aspects of patient safety that could affect the safety of health institutions.

Mr GUNNARSSON (Iceland), observing that safety was a prerequisite for quality, said that the planned work on product safety was conventional and in tune with previous work by WHO, both in respect of drug monitoring and medical devices. The report covered most of the important aspects of quality of care but two further points needed highlighting: the impact of the shortage of human resources, particularly nurses and midwives, in developing countries, and the importance of reporting adverse events, including "near misses", so that the information gained could be used in the learning process to prevent their recurrence. WHO should urge Member States to pay due attention to patient safety and should develop global norms and standards in that area.

Dr NEIRA GONZÁLEZ (alternate to Dr Pastor Julián, Spain), welcoming the report, wondered whether the standardized nomenclature and taxonomy of medical errors and health-care system failures might not be adapted for incorporation into the International Nomenclature of Diseases, given the latter's widespread use. It should be fairly straightforward to produce a register that could be used to determine the cause of risks and thereby promote quality of care and patient safety.

Mr AISTON (Canada) welcomed the actions taken since the adoption of resolution WHA55.18. The recent creation of the international alliance for patient safety was an excellent initiative which should play a role in identifying and assessing best practices. The recommendations contained in a recent expert report in Canada should enhance his country's ability to assess risks better and take speedy action to promote patient safety. International cooperation and sharing of information was central to further progress and should feature in all national action plans.

Mr THOMPSON (United States of America) said that, in view of the large number of deaths resulting from medical treatment, patient safety had to be made a priority. He commended the United Kingdom's initiative in creating the international alliance for patient safety. The United States administration, through his own Department of Health and Human Services, spent millions of dollars on improving patient safety and was currently urging Congress to authorize measures such as an informatics system and the bar-coding of all drugs. His department was ready to take part in all measures and to make its resources available as part of its efforts.

Dr KEBEDE (Ethiopia) said that the initiatives taken pursuant to resolution WHA55.18 had already benefited many countries. For example the Global Alliance for Vaccines and Immunization, a public/private collaboration, had contributed greatly towards safer immunization and the eradication of poliomyelitis and its continued work should be encouraged. Another benefit was safer blood transfusion, which had helped in the campaign against HIV and other viruses and diseases; the efforts taken in that regard under the initiative of the President of the United States of America were to be welcomed. Such activities made a significant contribution to improved patient care in general, and Ethiopia thanked WHO and all participants for the progress made.

Professor DANG DUC TRACH (Viet Nam) expressed particular appreciation for the information relating to immunization safety. Since 2003, 70% of the syringes used in Viet Nam's expanded vaccination programme were auto-disable syringes manufactured locally through technology transfer. Although they cost more than conventional syringes, the benefits in terms of

preventing transmission of hepatitis B virus, hepatitis C virus and HIV were considerable, as a simple cost-benefit analysis would illustrate.

Professor KULZHANOV (Kazakhstan) said that the recently created international alliance on patient safety was of great interest to his country, where considerable work on the subject was also being done. Research was the more important in view of the impact of improved quality of care on scarce resources. Kazakhstan would continue its cooperation with other countries and regions and was grateful for WHO's continued support.

His country's efforts to improve the level of safety included measures to raise standards of care so as to align them as closely as possible with those already accepted internationally, especially in hospitals and other health centres. Kazakhstan supported the initiative to produce new training modules and hold special seminars for doctors and other health personnel, and understood that WHO would continue to provide support, especially in work to draft appropriate legislation.

Professor FURGAL (Russian Federation) said that discussion of issues relating to quality of care was essential, bearing in mind that medical services could well constitute an additional risk to the healthy as well as to the sick. WHO had done much useful work and deserved the support of all. However, the report might also have mentioned other points, such as the extent to which WHO recommendations were being implemented at the national level, how Member States were applying them in practice, with what results and how such results were assessed. Furthermore, the report surprisingly contained little or no information on the considerable work carried out in the European Region, including the United Kingdom. Further details of the activity of the international alliance for patient safety and of the prospects for the success of its work with WHO would be useful.

Dr TAG-EL-DIN (Egypt) said that quality of care was crucial to health services, since it had a bearing on the safety of all people. The preparation of a suitable strategy, especially for primary health care purposes, was an important element in that regard, as was the need for capacity to provide rapid diagnosis and appropriate treatment. The authorities in Egypt were working with the international community to eradicate disease, recognizing that prevention was one of the most important aspects of health care. Good care was a prerequisite for prevention.

The CHAIRMAN, speaking in his capacity as the member for Ghana, said that, when the Executive Board had met in retreat in Accra, the members would have seen, at a local hospital, a patients' charter, which had been one outcome of the initiative and was, in effect, a patients' bill of rights and a reference point for safety standards. Such measures had the potential to raise standards in the quality of care, especially in countries, such as many in Africa, where resources were scarce and illiteracy rates high. They were also helpful in raising awareness, among health workers, of the importance of quality and safety.

Mr AGARWAL (India)[1] said that the issue of patient safety should be pursued vigorously, given the high cost of poor quality in terms of morbidity and mortality, resulting from hospital-based infection. The same high standards of procedures and checks should be introduced in health care as had been introduced in the airline industry, and it was high time for iatrogenic mortality rates to be considered in the same way as maternal and infant mortality rates, for example.

Dr EVANS (Assistant Director-General) expressed his gratitude for the many helpful comments. The agenda was ambitious, part of the wider health systems agenda, and cut across all WHO's work. There was much background documentation, which would all be made available on a new web site to be opened shortly, with a view to launching the alliance towards the end of 2004.

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[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The CHAIRMAN said that he took it that the Executive Board wished to note the report and to express its appreciation to Sir Liam Donaldson for his work in bringing the matter before the Board.

It was so agreed.

Infant and young child nutrition and progress in implementing the International Code of Marketing of Breast-milk Substitutes: Item 8.7 of the Agenda (Document EB113/38 Rev.2)

Mr GUNNARSSON (Iceland) said that the subject would make an important contribution to meeting the Millennium Development Goals. Iceland appreciated WHO's evidence-based approach to formulating public health recommendations. It emphasized that sound evidence and constant updating were crucial to worldwide confidence in WHO's recommendations, and further research must be promoted wherever sound information was lacking. He particularly appreciated the important work carried out on zinc deficiency and its effects on children, and on feeding options in respect of HIV-infected children and children of HIV-positive mothers. The recognition of environmental differences as a main growth determinant and the effort to establish breastfeeding as the norm in new standards were likewise positive steps. Iceland welcomed the forthcoming FAO/WHO workshop to study available evidence on microorganisms in powdered infant formula as a good basis for the revision of the hygienic code of practice for such foods.

Dr HUERTA MONTALVO (Ecuador) said that, in the interests of ensuring that WHO's prestige remained unchallenged, the document before the Board should be revised by an expert committee composed of the chairpersons of committees dealing with infant and child nutrition and maternal and child health over the past three years. At the very least, the controversial paragraph linking pathogens to breast-milk substitutes should be reviewed. On the one hand, it was important to stress the value of breastfeeding; on the other, caution and in-depth research were required before condemning breast-milk substitutes out of hand, especially since such a move might jeopardize WHO's reputation. Although Ecuador would go on advocating measures to minimize the use of such substitutes, the current report did not reflect previous texts and might cause undue alarm.

Ms VALDEZ (alternate to Mr Thompson, United States of America) said that her country was committed to the improved nutrition of infants and young children, nationally and globally, as evidenced, inter alia, by the Surgeon General's 2001 plan of action for breastfeeding that had provided an evidence-based guide in support of breastfeeding in the United States, copies of which had been circulated at the Fifty-fifth World Health Assembly. She shared the concern voiced by the two previous speakers, particularly in respect of the fifth sentence of paragraph 23 and the suggested association between being infant-formula fed and increased risks of obesity and hypertension later in life. The comment was based on the report of the Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases,[1] and the source was one study carried out in the United Kingdom. Although WHO might consider the statement to be technically correct, it was inappropriate to base it on one or two sources to the exclusion of others with different conclusions. In fact, the available evidence was not yet strong enough for the purpose of public recommendations and more research was needed. She therefore requested that the paragraph be reviewed or even deleted before the text was submitted to the Health Assembly. United States experts urged WHO to focus on the overall benefits of breastfeeding rather than target the potential risks of breast-milk substitutes.

Mr ASLAM KHAN (alternate to Mr Khan, Pakistan) said that the need for legislation to implement the International Code could not be denied. Many countries, including his own, had enacted laws for that purpose, but it was difficult to implement them in the absence of infrastructure

[1] WHO Technical Report Series, No. 916, 2003.

and capacity at the grass-roots level. Baby formula and breast-milk substitute manufacturers were great spoilers. Hence the urgent need for WHO to take steps to implement the Code in letter and spirit. Pakistan strongly advocated the establishment of a committee on legislative measures relating to the marketing of breast-milk substitutes which would be responsible for providing support to Member States in the formulation and implementation of laws.

Another issue was the wider prevalence of iron deficiency anaemia and vitamin A deficiency in children, which led to high mortality in mothers and blindness in children. Pakistan had put in place a national nutrition programme at a cost of some 350 million rupees, but WHO's leadership was needed to mobilize international financial support to prevent micronutrient deficiency in children. WHO was also requested to play a leading role in food fortification, a very effective strategy for correcting iron and micronutrient deficiencies.

Dr LARIVIÈRE (alternate to Mr Aiston, Canada) said that infant and young child nutrition must continue to be given the attention it deserved as both a technical and policy issue. Proper nutrition early in life, including exclusive breastfeeding in the first six months, was critical for normal growth and a condition for healthy living in adolescence and adulthood. Canada supported the aim and objectives of the International Code and had been implementing it since its adoption in 1981.

Since the Health Assembly's adoption of the Code as the basis for a recommendation to Member States, Canada had consistently and actively promoted breastfeeding as the optimal form of infant nutrition through programmes and initiatives aimed at parents, professionals and the general public as well as at health establishments. Recent national data and progress reports gave reason to be optimistic about the growth of breastfeeding rates in Canada. Initiation rates had reached 82% but could be improved; progress was still needed in maintaining breastfeeding. Canada continued to work with provincial and territorial governments and other stakeholders to promote the creation of environments more supportive of breastfeeding in order to give infants the best possible start in life.

Dr BOSHELL (Colombia), endorsing important points made by previous speakers, observed that paragraph 23 of the report stigmatized breast-milk substitutes as causing childhood cancers and various chronic diseases, including type 1 diabetes, without providing any real scientific data in support of that contention. Some evidence suggested just the opposite. The fact that breast-milk substitutes existed and were referred to in a WHO document did not mean that WHO was promoting their use rather than breast milk. On the contrary: the Executive Board had been saying for years that there was no substitute for breast milk, but what of the infants who could not consume it? He objected to paragraph 23, which had no place in a reputable WHO document unless the assertions contained therein were more firmly grounded in scientific evidence. If the report were to be submitted to the Health Assembly, paragraph 23 should be reconsidered with a view to deleting the phrase linking breast-milk substitutes with chronic diseases or the entire paragraph, as proposed by the United States.

Professor FURGAL (Russian Federation) said that infant and young child nutrition was a crucial issue that must be addressed in order to achieve the health-related objectives in the Millennium Development Goals. Action by WHO in five areas in particular would be of immense benefit to Member States: national criteria for monitoring the situation in respect of breastfeeding must be developed; criteria for assessing the work of medical institutions to promote breastfeeding should be elaborated; criteria for assessing the application of the baby-friendly hospital initiative must be formulated; programmes to promote awareness of modern approaches to breastfeeding must be carried out for the population in general and mothers' support groups in particular; and WHO training seminars should be held for national specialists. A study of the impact of various types of infant and young child feeding practices on long-term health would be highly useful. That subject was given little attention in the report but merited further consideration, particularly by WHO's collaborating centres.

The Russian Federation supported exclusive breastfeeding as the optimal form of feeding infants, but could not agree with the suggestion in paragraph 23 that short-term breastfeeding was

associated with a risk of type 1 diabetes, coeliac disease, inflammatory bowel disease and some childhood cancers. There was not enough empirical scientific evidence for such a weighty conclusion.

Dr NEIRA GONZÁLEZ (alternate to Dr Pastor Julián, Spain) said that Spain agreed with the proposed emphasis on the strategy for infant nutrition with a view to achieving the Millennium Development Goals. Like other speakers, she had been surprised by the categorical statement in paragraph 23 on the possible adverse effects of feeding breast-milk substitutes, and would like to see the deletion of that part of the paragraph; it placed undue emphasis on certain negative effects which had been demonstrated in a technical study, although other studies had emphasized the reverse. On the other hand, she strongly endorsed the final two sentences of the paragraph, which should be retained.

Ms LINNECAR (International Organization of Consumers Unions (Consumers International)), speaking at the invitation of the CHAIRMAN, and speaking also on behalf of the International Baby Food Action Network, said that 2004 marked the twenty-fifth anniversary of the joint WHO/UNICEF Meeting on Infant and Young Child Feeding in 1979 which had given rise to the International Code of Marketing of Breast-milk Substitutes. It was also a year for reporting on implementation of the International Code and of the global strategy on infant and young child feeding. Her organization had organized regional meetings on implementation of the strategy in Burkina Faso, India, Poland and Viet Nam. The alliances formed to work together to achieve its aims and objectives should be fully transparent and consistent with accepted principles for avoiding conflicts of interest.

One of her organization's roles was to identify threats to infant health and obstacles to breastfeeding. Three key issues required the Board's urgent attention. The first was the safety of powdered infant formula. Contamination by *Enterobacter sakazakii, Clostridium botulinum, Staphylococcus aureus* and *Salmonella* spp. had been identified by the Codex Committee on Food Hygiene as a known public health risk. The joint FAO/WHO workshop on the problem to be held in February 2004 was welcome. Powdered infant formula was not a commercially sterile product, but unfortunately the public and health workers thought that it was. WHO and FAO should immediately call for measures to alert parents and care providers to that fact and ensure that extra precautions were taken. Labels and education materials must carry more explicit warning than those required by Article 9.2 of the Code. She would welcome WHO providing information on its web site for parents.

Secondly, commercial sponsorship had increased significantly in recent years, and as a result, several countries had strengthened their laws to implement the Code. In Azerbaijan, Brazil and India, new legislation prevented breast-milk substitute manufacturers from funding health workers or any association thereof and from providing sponsorship for educational courses or research. It was essential that research on which health policies were based was funded from independent sources. That requirement was critically important when public health risks such as pathogens in tins of infant formula were evaluated. She urged that the next Health Assembly adopt a resolution incorporating such safeguards.

Thirdly, she called attention to the way that manufacturers were using health and nutrition claims to promote their products for infants and young children. Nutrition and health claims contravened Article 9 of the International Code because they idealized the product and inevitably undermined breastfeeding. Commercial interests were lobbying for such health claims to be allowed, hence the need for the next Health Assembly to adopt a resolution confirming that health and nutrition claims for infants and young children were not permissible.

Dr BRONNER (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, affirmed her organization's commitment to combat malnutrition by seeking to develop better products for the specific nutritional needs of infants and young children. Her organization strongly supported the report's findings on the implementation of the International Code and encouraged governments to increase their efforts to put related national legislation or guidelines in place. As such mechanisms were the only way fairly and reliably to implement the International Code,

it was regrettable that only three Member States had provided information on new implementation efforts since the previous report to the Health Assembly.

Referring to paragraph 23 of the report, she expressed strong concern that certain statements misrepresented current scientific evidence. The basis for the conclusions in that paragraph, drawn from the Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases,[1] would be considered as neither "convincing" nor "probable" if they were judged in the light of the WHO criteria for the strength of evidence as set out in that technical report. The assertion that breast-milk substitutes were associated with a greater risk of chronic disease was poorly substantiated and did not reflect a balanced review of current scientific evidence, nor was it consistent with the Health Assembly resolutions on the Global Strategy for Infant and Young Child Feeding or with the Codex Alimentarius Commission's own standards, which recognized infant formula as the only nutritionally safe alternative to breastfeeding. Unsubstantiated conclusions had the potential to undermine public trust in WHO and diminish its credibility in the broader scientific community. Moreover those assertions might create public concern over the safety of infant formulas. WHO should ensure consistency and the highest standards of scientific investigation. For that reason it should either delete paragraph 23 entirely or its fifth sentence. The primary use of infant formula was not to replace breast milk, but to replace inferior and low-quality breast-milk substitutes such as sugar and water, cereal and water, or rice and water. Infant formula played a critical public-health role when, for whatever reason, a breast-milk substitute was needed.

Mrs PHUMAPHI (Assistant Director-General), responding to the references to contamination of infant formula, said that, at its session in February 2003, the Codex Committee on Food Hygiene had noted the potentially life-threatening nature of infection with *E. sakazakii* in susceptible infants and the low, sporadic levels of pathogens found in certain infant formulas. The products in question had been generally in conformity with the microbiological requirements of the International Code of Hygienic Practice for Foods for Infants and Children, which was due to be revised. WHO and FAO were to hold a workshop in Geneva in February 2004 on the contamination of infant formula with *E. sakazakii* and other microorganisms.

The lack of information in the report on the implementation of the International Code of Marketing of Breast-milk Substitutes was partly explained by size limits imposed on reports submitted to the Board. Also, most countries only reported to the Director-General when new developments took place, and most Member States (162 out of 192) had already reported at least once on their implementation of the International Code. The Global Strategy for Infant and Young Child Feeding had reaffirmed the urgency of giving effect to the International Code and subsequent Health Assembly resolutions.

Regarding members' criticisms of paragraph 23 of the report, she stressed that the report was intended only to bring members up to date with current research in the international community on the effects of breast-milk substitutes, and was neither a statement of WHO's position on the issue nor a proposal for a draft resolution. The paragraph was largely based on the conclusions of the Joint WHO/FAO Expert Consultation. Since then, evidence from various settings in Brazil, the United Kingdom and the United States had appeared in peer-reviewed journals, suggesting an association between formula feeding and later development of chronic disease, in particular hypertension and obesity. Paragraph 23 referred to "some" recent evidence, since the available evidence was not considered to be conclusive, and had stressed the need for further research.

Dr HUERTA MONTALVO (Ecuador), reiterating his earlier points, said that there was no conclusive evidence of a link between infant formula contamination and the development of chronic diseases in later life. The Board must not be seen to make such a suggestion. After all, the present meeting was a public one, and it would not do for the media to report that the Board blamed infant

[1] WHO Technical Report Series, No. 916, 2003.

formula for diabetes, cancer and hypertension: mothers would panic all over the world. If it could be proved that some infant formula was contaminated with microorganisms, then of course that product must be removed from sale. In any case, any reference to contaminated infant formula should be very carefully phrased, since in poor communities infant formula could be made up with contaminated drinking-water. It was worth reiterating the fact that water should always be boiled before use.

Mr ASLAM KHAN (alternate to Mr Khan, Pakistan) pointed out, in response to the remarks made by the representative of Consumers International, that only certain products, such as injectables and eye medicines, were produced in sterile areas and laboratory-tested by the manufacturer. Oral preparations, such as infant formulas, did not come under the same quality-control regulations.

Ms VALDEZ (alternate to Mr Thompson, United States of America) asked whether there was an intention to alter paragraph 23, in response to the criticisms made, before the document went to the Health Assembly. Such reports were freely available on the WHO web site and elsewhere and thus carried a certain authority.

Mrs PHUMAPHI (Assistant Director-General) confirmed that members' comments would be taken into account and the document reviewed.

The Board took note of the report.

Dr Modeste-Curwen took the Chair.

High Level Forum on Health, Nutrition and Population-Related MDGs: Item 8.8 of the Agenda (Document EB113/INF.DOC./4)

Dr LEITNER (Assistant Director-General) said that the High Level Forum on Health, Nutrition and Population-Related MDGs (Geneva, 8 and 9 January 2004) had been intended to provide an opportunity for informal discussions between donors, technical agencies and developing countries. It had been attended by senior officials from 17 developing countries, nine health ministers and three ministers of finance, economic planning or local government, 11 bilateral and eight multilateral donor agencies, and nine foundations, regional organizations and global partnerships. The Forum had noted that progress towards the health-related Millennium Development Goals was too slow. The International Conference on Financing for Development (Monterrey, Mexico, March 2002), had produced an agreement between developed and developing countries that the flow of aid would increase over the next 10-15 years; the Forum had concentrated on the need to fulfil that agreement. Several future lines of action had been agreed. There would be a massive expansion of interventions that had proved effective; that would require harmonization of donor and recipient procedures. National investment plans, poverty-reduction strategies and sector-wide approaches must be made compatible with the Goals, with due attention paid to human resources for health as well as to health infrastructure and health technology. Monitoring of the Goals must be improved, using the health metrics network, for which WHO would provide the secretariat. Finally, the scope of action must be expanded to include countries in crisis.

The High Level Forum would hold a maximum of four meetings, the next being later in 2004, probably in Africa. It was working with the Commission on Macroeconomics and Health. The follow-up work of the Commission focused on strengthening national efforts to develop health plans in support of the Goals, while the High Level Forum focused on donor policies and other international action to support recipient countries.

Dr KAMAL (alternate to Mr Aiston, Canada) said that his country fully supported the High Level Forum's work. However, without additional concerted efforts, better utilization of existing resources, appropriate policy frameworks and mobilization of additional financial resources, most

developing countries would fail to achieve the health, nutrition and population-related Millennium Development Goals. He therefore welcomed WHO's efforts to ensure that sector-wide approaches and poverty-reduction strategy papers were compatible with the Goals at country level.

Several global health initiatives had emerged in recent years, intended to promote the health, nutrition and population-related Goals, such as the health metrics initiative and the Global Health Equity Initiative. Canada supported those efforts, but it would like to see them better coordinated in order to ensure that complementarity.

Ms GIBB (alternate to Mr Thompson, United States of America) welcomed the initiative of WHO and the World Bank in hosting a forum on the health-related Goals. Her country's own efforts in that area included the President's Emergency Plan for AIDS Relief and a joint initiative with WHO, UNICEF and host countries to improve child survival, beginning with a recent joint mission in Ethiopia.

The High Level Forum had allowed her country to share insights on progress and problems and to discuss ways of removing obstacles to the achievement of the Goals. Greater involvement of the private sector was essential. Efforts to scale up health interventions must make full use of the private sector. Early assessments of the country coordinating mechanisms of the Global Fund to Fight AIDS, Tuberculosis and Malaria had noted that private for-profit bodies were least likely to be represented, which reflected the mutual mistrust between the public and private sectors. It was essential to build trust between the various sectors and to give governmental parties the skills they needed to work with the private sector.

Human resources for health had long been a challenge. The High Level Forum had addressed the contentious issue of how external donor funding could best be used to alleviate staffing constraints.

It was essential to monitor progress towards the Goals, and resource-poor countries were probably the furthest behind in that task. The health metrics network had the potential to improve the quality of monitoring. Her country would help to define the technical content of that network, while continuing to promote the development of country health information systems in general.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that, over the next two years, the High Level Forum would provide a unique opportunity to develop a framework for action and to accelerate the progress of health sectors. His Government attached great importance to the establishment of the High Level Forum and considered that the framework produced should focus on increased coverage and use of basic health services; WHO should maintain the momentum created by its first meeting. He encouraged WHO to view the High Level Forum as a platform for its efforts to support the strengthening of pro-poor health services in developing countries, and accord it the priority it deserved.

Ms MANGAN (Ireland)[1] praised the Governments of Canada and the United Kingdom for the High Level Forum initiative. The dialogue thus facilitated would contribute to the achievement of the Millennium Development Goals, and the initiative itself attested to the determination of both governments and partners to focus on those Goals as highest priorities.

HIV/AIDS remained the largest single obstacle to reducing poverty and achieving the Goals. During Ireland's presidency of the European Union, HIV/AIDS was a priority on the development agenda. In February 2004, Ireland would be hosting a ministerial-level conference, organized in cooperation with WHO, UNAIDS and UNICEF, to highlight the problem of the massively increasing rates of HIV infection in Europe and Central Asia. Ireland had been pleased to participate in the High Level Forum, and looked forward to continued involvement in its proceedings.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Professor LING (International Council for Control of Iodine Deficiency Disorders), speaking at the invitation of the CHAIRMAN and on behalf of the Global Network for the Sustained Elimination of Iodine Deficiency, said that iodine deficiency was the single most common cause of mental retardation and brain damage; it affected learning capacity, productivity and economic development. With some 2000 million people being deficient in iodine, it remained a public health problem in 54 countries. The goal of virtually eliminating iodine deficiency disorders had first been adopted in 1990 by the Health Assembly and the World Summit for Children, and had been reaffirmed by the United Nations General Assembly at its special session on children, which had asked that the goal be achieved by 2005 as part of the Millennium Development Goals. WHO had been at the forefront of the global efforts in that regard. Since 1990 the number of households using iodized salt – the principal weapon against iodine deficiency disorders – had doubled. Iodized salt had protected 79 million newborn infants against iodine deficiency disorders in 2002. However, much remained to be done.

A worrying trend was emerging: the progress made by some countries with respect to prevailing iodine deficiency disorders was being reversed. In October 2003, the Global Network, in cooperation with the Chinese Government, had organized an international meeting to review critical issues for the sustained elimination of iodine deficiency disorders. The need to reinvigorate the global programme had been emphasized, and a consensus calling for specific national follow-up actions had been adopted. The Health Assembly and regional committees should remind Member States of their commitment to work towards the goal of virtually eliminating iodine deficiency disorders as part of the Goals, reviewing the issues related to the public health implications of those disorders.

The Board noted the report.

Intellectual property rights, innovation and public health: terms of reference for review group: Item 8.9 of the Agenda (Document EB113/INF.DOC./1)

Mr AISTON (Canada) said that the issue of access to medicines had been comprehensively addressed in the report of the Commission on Macroeconomics and Health.[1] Clearly industry's needs for incentives had to be balanced against the poor's needs for access, but the fact that the medicines to treat so many diseases were lacking in much of the world had given rise to the humanitarian call for action expressed in resolution WHA56.27.

Canadians took pride in their country's health system and firmly believed in supporting efforts to improve health around the world. The Government had therefore tabled legislation allowing Canadian generic medicine companies to export cheaper versions of patented medicines to poor countries affected by HIV/AIDS, tuberculosis, malaria, and other epidemics. In order to stimulate research into largely neglected global health problems, Canada had also created the Global Health Research Initiative, a cooperative partnership between federal government departments, the aim of which was to build upon and coordinate Canada's activities in that field. The partnership recognized the need to help draw up an international health research agenda to address the fact that 90% of the world's health research funding was spent on diseases affecting 10% of the world's population.

He suggested that the terms of reference of the WHO Commission on Intellectual Property Rights, Innovation and Public Health should focus on the key problem stated in resolution WHA56.27, namely: "... appropriate funding and incentive mechanisms for the creation of new medicines and other products against diseases that disproportionately affect developing countries ...". Much work had already been done in that area, and the proposed Commission should therefore use existing available information and avoid overlap and duplication of research. The Canadian Government, academic institutions, research organizations and other nongovernmental stakeholders were ready to take part in that work. The Commission must be time-limited, with a clear mandate and should be given a

[1] *Macroeconomics and health: investing in health for economic development*. Report of the Commission on Macroeconomics and Health. Geneva, World Health Organization, 2001.

reasonable budget as soon as possible. Ideally it would present its conclusions to the Board in advance of its 115th session and would propose solutions that could be implemented in the near future. The terms of reference met the criteria he had laid out. The Commission's work was extremely important, and it was to be hoped that WHO would provide the resources necessary for successful conduct of deliberations.

Dr HUERTA MONTALVO (Ecuador), speaking on behalf of the Latin American and Caribbean Group, agreed with the previous speaker. The note by the Director-General correctly reflected resolution WHA56.27. The establishment of the Commission and its mandate constituted great progress in the search for new medicines and other products against diseases that chiefly affected developing countries. WHO was to be congratulated on having established a budget line for the Commission, on the undertaking to provide support in the form of a secretariat and on facilitating contacts within the Organization and with bodies in the United Nations system. The success of the Commission's work would depend on compliance with the parameters for the selection of the Commission members. Special importance was attached to the fact that the members would serve in their individual capacities; that independence would enable them to produce an impartial and objective report. The Commission should be established and start its deliberations as soon as possible so that it could fulfil its mandate within the allotted time.

Mr GUNNARSSON (Iceland) said that he supported the gathering and analysis of data on the sensitive and complicated issue of intellectual property rights and public health. Although intellectual property rights were important for the development of the complex medicines intended for markets with high purchasing power, they had failed to promote the development of medicines for diseases which primarily affected developing countries. He therefore welcomed the establishment of the Commission. Its members should be selected on the basis of clear criteria in an open and transparent process, and appropriately resourced to enable it to work effectively and efficiently.

Mr LATIF (adviser to Dr Tag-El-Din, Egypt) said that Egypt attached great importance to intellectual property rights, innovation and public health in general, and to the proposed work of the Commission. That body would provide a valuable opportunity to examine the appropriateness of the priorities set in terms of innovation and scientific research into drugs and the effectiveness of existing mechanisms in that field, including to protect intellectual property rights. It was to be hoped that the Commission would work to the fullest extent possible in line with the spirit and content of resolution WHA56.27, and that it would produce specific and practical proposals on ways of promoting innovation in the field of medicines in order to improve public health, especially in the developing countries. Resolution WHA56.27 specifically mentioned diseases disproportionately affecting developing countries. The Commission had to work transparently and have a balanced membership, in particular in terms of geographical representation, expertise and skill; the membership should be drawn from both developing and developed countries, and the members had to independent.

Mr HOHMAN (alternate to Mr Thompson, United States of America), recalling that the United States had been an active participant in the Fifty-sixth World Health Assembly, which had unanimously adopted resolution WHA56.27, commended the Director-General's establishing the terms of reference called for in that resolution. The Commission would take into account the role of intellectual property rights in promoting innovation relevant to public health. Intellectual property was the leading incentive for the production of new medicines.

The Commission had a technical mandate to summarize and review existing evidence, research, development and innovation efforts on the prevalence of diseases relevant to public health, particularly those affecting the poor, before producing its proposals. When considering the importance of incentive and funding mechanisms in stimulating research and in the creation of new medicines, the Commission should explore the benefits of existing legislation, such as the United States Orphan Drug

Act, and funding regimes such as the Global Fund to Fight AIDS, Tuberculosis and Malaria. Given its one-year mandate, the Commission should begin its work in the near future.

Dr PRESERN (alternate to Sir Liam Donaldson, United Kingdom of Great Britain and Northern Ireland) welcomed the initiative to identify forward-looking ways of promoting research and development into the new medicines needed by developing countries. Intellectual property rights were only one of the factors that needed to be considered. The debate on the operation of the Agreement on Trade-Related Aspects of Intellectual Property Rights for existing medicines should not be reopened. Practical solutions should be devised that could readily be translated into effective action. For the Commission to meet its objectives, its membership had to be representative and balanced, with appropriate expertise enabling them to participate effectively, and including people from the pharmaceutical industry with direct experience of research and development, business, patents, and public/private partnerships. The individual members should be appointed in their personal capacity for their expertise in that field, not as representatives of the institutions to which they belonged. The process of appointment should be as transparent as possible, with a board of some kind choosing from a selection of candidates in accordance with established criteria. The Commission should be seen to be as independent as possible. Its accountability, and the reporting process it would use, should be clearly set out with clarification of how its recommendations would be addressed by WHO and others.

Dr NEIRA GONZÁLEZ (alternate to Dr Pastor Julián, Spain) wished to clarify whether the first bullet point in paragraph 6 of document EB113/INF.DOC./1 referred to diseases that particularly affected poor people or to diseases affecting developing countries. She suggested that, rather than saying that the Commission would "summarize" the existing evidence, the same bullet point could say that it would avoid duplication of work by using existing data, given that no organization was currently better placed in that respect than WHO. The Commission's work was extremely important and would depend on its members being selected for their expertise and experience, and on their serving in their individual capacity and not as a representative of an institution.

Dr BOSHELL (Colombia) endorsed the statement made by the member for Ecuador. The most appropriate methodology had been chosen. It included the support of qualified personnel from the Organization, coordination by the regional offices and easy communication with other agencies and other sectors of society. The terms of reference and the criteria for the selection of the Commission's members would guarantee the transparency and effectiveness of its work.

Mrs LEPATAN (alternate to Dr Dayrit, Philippines) endorsed the statement of the member for Ecuador and the views expressed by the member for Egypt. As a developing country, the Philippines considered the issue of intellectual property rights to be of great importance. Along with the member for Egypt, she expected the Commission to work in a transparent fashion and take account of developing country concerns.

Dr ZEPEDA BERMUDEZ (Brazil)[1] said that two points were crucial if the proposed Commission were to strike a balance between the need for innovation and access to effective and safe products. First, every effort should be made to avoid conflicts of interest among the members of the Commission by using WHO's criteria for selecting the members of expert committees. Industry's interference in academic work had been well publicized in the press and in scientific journals. Second, WHO was to be applauded for having allocated an initial budget line to ensure that the Commission's work could start. In the past, the lack of resources had sometimes been used as a pretext not to carry out certain tasks requested by Member States. One example was the preparation of a database on the price of medicines, which for years had met with stiff resistance in the Organization.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Dr DURHAM (New Zealand)[1] said that the Commission's terms of reference should reflect the wider context in which it would be conducting its work and ensure coherence with the work being done by international bodies such as WTO. The terms of reference should therefore explicitly state that the Commission's task was not to revisit the Agreement on Trade-Related Aspects of Intellectual Property Rights or to dispute anew the outcome reached in October 2003 on paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health.

To date, insufficient weight had been given to the public health analysis in relation to intellectual property rights and innovation. WHO should bring its own particular expertise and experience to bear in that area.

Echoing the comment made by the representative of South Africa under agenda item 8.1, Expert committees and study groups, in relation to the representation of women on such bodies, she expressed confidence that the Director-General would be able to appoint many outstanding women with the necessary expertise to make a major contribution to the Commission in a personal capacity and maintaining their independence, and looked forward to seeing that at least 50% of the Commission's members were women.

Mr SAHA (India)[1] expressed concern that the terms of reference did not refer to developing countries at all but to diseases that particularly affected poor people. The two things were not the same, even though the poor of the world were to be found predominantly in developing countries. The terms of reference should explicitly reflect the underlying concern that had informed resolution WHA56.27, namely the diseases that disproportionately affected developing countries.

He asked for reassurance that the possible adverse effects of intellectual property rights on the health of people in developing countries had not been altogether lost sight of. He recalled that paragraphs 17 and 18 of document A56/17 had underscored the importance of reconciling the needs of patients and patent-holders to improve access to essential health care. Numerous studies had identified the serious negative effects of protecting intellectual property rights, just as others had identified the part played by intellectual property rights in providing the incentive for investment in research and development. At the same time, however, the growing evidence of the benefits on medical research of publicly-generated and freely-available research data should not be overlooked.

Those considerations pointed to the need for an independent commission made up of persons with unquestioned objectivity and unimpeachable credentials who had in-depth knowledge of the issues relating to the subject. Subject to those paramount considerations, it was important to have an equitable balance between developed and developing countries on the Commission. Its members from developed countries should include experts who had a demonstrated record of objective analysis and had not been selected merely because of their advocacy in favour of intellectual property protection. Most important, there should be no conflict of interest that could prevent a member of the Commission from acting objectively. Any such conflict would undermine the standing and credibility of the Commission's recommendations.

Ms MAFUBELU (South Africa)[1] expected the Commission to help to improve access to affordable essential medicines and other health technologies. She was pleased to note, among the selection criteria, the aspects of geographical distribution, gender balance, and a balance between developed and developing countries. Steps should be taken to search for suitable candidates within the African Region. The need for transparency in the selection of members could not be overemphasized. She endorsed the comments of the member for Canada regarding the importance of avoiding overlap and duplication of work, and expressed support for the remarks made by Mr Saha concerning the need to mention developing countries in the terms of reference.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Dr FUKUDA (Japan)[1] said that his Government was ready to cooperate with the Commission. With regard to the terms of reference, which his country supported, he pointed out that while the Commission was to consider mechanisms to stimulate the creation of new medicines, the proposals it made would deal with facilitating access to those medicines. Its research and proposals should relate to the same subject. Furthermore, if the terms of reference were to be extended to include the collection and analysis of information, and the making of concrete proposals on intellectual property rights, it was essential that WIPO was formally involved.

Dr TÜRMEN (Representative of the Director-General) welcomed the comments made, which had been carefully noted. With regard to the remark by India, she said that the terms of reference were intended to reflect the concerns of paragraphs 17 and 18 of document A56/17.

The Director-General would appoint the members of the Commission in the light of the suggestions made by the Board. Sufficient funding had been made available for the Commission, which would be guided by the principles of transparency and independence in its work. A web site would be set up to ensure that information on the activities of the Commission would be available to interested parties. With regard to the comments of the previous speaker concerning the involvement of WIPO, she said that consultative mechanisms would be set up with other bodies in the United Nations system including WIPO and WTO with a view to harmonizing the discussions on the issue. The input of those and other agencies would be highly regarded.

Mrs DE LA MATA (European Commission), speaking at the invitation of the CHAIRMAN, noted the importance of intellectual property rights, which were essential in stimulating the creation of new medicines. She drew attention to another important issue, namely improving poor countries' access to medicines. The WTO Decision of 30 August 2003 on paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health was a useful step in that regard. The European Community supported the Commission's terms of reference and method of work, as well as the criteria regarding its future composition. It was essential to strike a balance in the designation of members of the Commission. In the interests of transparency, future members should provide information about any conflicts of interest that they might have, or might have had, with any companies or organizations involved in the Commission's field of work.

The CHAIRMAN took it that the Board wished to take note of the information contained in document EB113/INF.DOC./1.

It was so agreed.

The meeting rose at 18:05.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

NINTH MEETING

Friday, 23 January 2004, at 10:00

Chairman: Dr K. AFRIYIE (Ghana)

An open meeting was held from 09:15 to 09:45 and resumed in public session at 10:00.

1. OTHER MANAGEMENT MATTERS: Item 7 of the Agenda

Appointment of the Regional Director for South-East Asia: Item 7.1 of the Agenda (Document EB113/21).

Dr YOOSUF (Maldives), Rapporteur, read out the following resolution adopted by the Board in open session:[1]

> The Executive Board,
> Considering the provisions of Article 52 of the Constitution of WHO; and
> Considering the nomination and recommendation made by the Regional Committee for South-East Asia at its fifty-sixth session,
>
> 1. APPOINTS Dr Samlee Plianbangchang as Regional Director for South-East Asia as from 1 March 2004;
>
> 2. AUTHORIZES the Director-General to issue a contract to Dr Samlee Plianbangchang for a period of five years from 1 March 2004, subject to the provisions of the Staff Regulations and Staff Rules.

The CHAIRMAN congratulated Dr Samlee Plianbangchang on his appointment as Regional Director for South-East Asia.

At the invitation of the CHAIRMAN, Dr SAMLEE PLIANBANGCHANG took the oath of office contained in Staff Regulation 1.10.

Dr SAMLEE PLIANBANGCHANG (Regional Director-Elect for South-East Asia) said that he was deeply honoured to be appointed as Regional Director for South-East Asia. He was most grateful to the Member States of the Region for nominating him and to his Government for supporting him. He re-dedicated himself to the achievement of better health for all the people of South-East Asia, a region with a population of more than 1500 million people – about 25% of the world's population, but 40% of the world's poor. Having had the privilege of serving WHO in South-East Asia for more than 16 years, he was looking forward to introducing initiatives that would be of major benefit to the Region.

The South-East Asia Region had much of which it could be justifiably proud, but perhaps more about which to be concerned. For example, although life expectancy had increased significantly in all countries, and infant mortality rates had registered an average annual decline of 5% over the previous few years, the maternal mortality ratio in some countries was still unacceptably high: in certain cases,

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[1] Resolution EB113.R8.

it was over 400 per 100 000 live births. Considerable progress had been made in the elimination of leprosy and the eradication of poliomyelitis, but it remained an unfinished agenda, to be completed soon. Other diseases such as tuberculosis and malaria continued to pose serious health challenges and the number of cases of HIV/AIDS had risen alarmingly in some countries. Indeed, the epidemic was spreading faster in Asia than on any other continent.

Compounding those problems was the scarcity of resources. Despite the considerable support from the Global Fund to Fight AIDS, Tuberculosis and Malaria and other sources, the gap between the funds available and those needed remained wide and had to be narrowed. The Region would work harder to make the "3 by 5" initiative a reality in the Region.

Health systems remained weak in many countries. A solid foundation was needed to tackle major health issues effectively and promote good health. He stressed the urgent need for human resources development through the strengthening of public health education and practice.

However grim the scenario, Member States did not lack dedication and commitment. WHO too was ready to ensure that the health gains achieved thus far were sustained, and that efforts were redoubled for further development progress. In order to meet the needs of Member States, WHO's country presence needed to be strengthened, with technical support moved closer, particularly to the countries in greatest need. Decentralizing activities and responsibilities to countries would be one of his overriding priorities, and no effort would be spared in implementing the strategic framework outlined by the Director-General. Overall, the Region's policy direction had been firmly laid out, but priorities required constant review to ensure compatibility with the Millennium Development Goals. It was also important to ensure that the core principles guiding WHO's work were implemented in letter and in spirit.

Under the policy guidance of the Director-General, he looked forward to working with his fellow Regional Directors and to continuing close cooperation with the Western Pacific Region, with which his Region was to some extent interwoven. He pledged to work together even more closely with that Region to make best use of resources.

He wished to place on record his gratitude for the guidance and leadership provided by Dr Uton Rafei, on whose achievements he could continue to build. Health would be not just a privilege for some, but a right for all.

Dr LARIVIÈRE (alternate to Mr Aiston, Canada), Mr ASLAM KHAN (alternate to Mr Khan, Pakistan), Dr DAYRIT (Philippines), Dr ACHARYA (Nepal) and Mr THOMPSON (United States of America) congratulated Dr Samlee Plianbangchang warmly on his appointment, drew attention to his sound experience and achievements in the field of public health and wished him a successful term in office.

Retirement of Dr Uton Rafei as Regional Director for South-East Asia

Dr YOOSUF (Maldives), Rapporteur, drew attention to the following resolution adopted by the Board:[1]

> The Executive Board,
>
> Desiring, on the occasion of the retirement of Dr Uton Muchtar Rafei as Regional Director for South-East Asia, to express its appreciation of his services to the World Health Organization;
>
> Mindful of his lifelong devotion to the cause of international health, and recalling especially his 10 years of service as Regional Director for South-East Asia,

[1] Resolution EB113.R9.

1. EXPRESSES its profound gratitude and appreciation to Dr Uton Muchtar Rafei for his invaluable contribution to the work of WHO;

2. ADDRESSES to him on this occasion its sincere good wishes for many further years of service to humanity.

Dr UTON RAFEI (Regional Director for South-East Asia) said that the more than two decades he had spent in the service of WHO had been the highlight of his career in public health. Much had been achieved; much remained to be done.

The 11 Member States comprising the South-East Asia Region contained one-quarter of humankind and bore a disproportionately high burden of communicable and noncommunicable diseases. Globally, the Region had the largest number of people affected by leprosy, malaria and tuberculosis and recently had experienced some of the most rapid increases in HIV/AIDS rates. Compounding the situation was the persistent lack of both human and financial resources. Formidable though the challenges had been, the Region had met them successfully through sustained determination and commitment, and was steadily marching towards the goal of better health for all its people. The results could clearly be seen in the Region's increased life expectancy, reduced infant mortality rates, high rates of immunization coverage and the new thrust on promoting healthy lifestyles. Dracunculiasis had been eradicated and the Region was well on its way to eliminating leprosy and to achieving the target of poliomyelitis eradication. Gratifyingly, the Region was attracting more extrabudgetary resources than ever before, reflecting the growing confidence of the donor community and the Region's capability to utilize the funds effectively, since there were no donor countries nor donor agencies in the Region.

Over the years, partnerships with other players in health development had been fostered and strengthened. Memoranda of understanding had been signed between WHO and the South Asian Association for Regional Cooperation as well as with ASEAN to promote health in the Region. That, in turn, had helped further to strengthen collaboration with the Regional Offices for the Eastern Mediterranean and for the Western Pacific. The fullest support and cooperation had been received. In addition, there had been collaboration with PAHO in the area of essential medicines, with the Regional Office for Africa in the control of communicable diseases, and with the Regional Office for Europe in the healthy settings approach. More recently, a Memorandum of Understanding had been signed with the International Federation of Red Cross and Red Crescent Societies to forge greater cooperation in the area of emergency health preparedness and response. Initiatives had been taken to establish and strengthen a network of public health institutions in the Region to develop human resources for health.

Gender parity had also received attention. Since he had taken over as Regional Director in 1994, the percentage of female professional staff members had risen from 13% to 33%. He expressed confidence that under the able leadership of his successor, those and other initiatives would be successfully taken forward.

None of the achievements mentioned could have been made without the support of an excellent staff and the trust and confidence of the Member countries. He saluted those who continued to wage a relentless war against disease and poverty. Their sustained efforts would undoubtedly lead to the fulfilment of WHO's cherished dreams.

He was sure that the Region would soon shed its legacy of being a leader in disease burden and emerge as a leader in health development. He expressed his thanks and gratitude to all his colleagues at headquarters, all members of the Board and to the Directors-General with whom he had worked. To his fellow Regional Directors, he owed a special word of appreciation for their cooperation in further cementing their ties in the spirit of "one WHO". With such collective wisdom and its spirit of solidarity, WHO could achieve its goal of a healthier, happier and more peaceful world. He himself was grateful for the memories he had accumulated during his service which he would cherish forever.

Professor MYA OO (Myanmar), Dr ACHARYA (Nepal) and Dr DAYRIT (Philippines) paid warm tribute to the achievements of Dr Uton Rafei during the two terms he had served as Regional Director for South-East Asia, expressing appreciation in particular for his endeavours to make WHO more responsive to the needs of Member countries. They wished him well for the future.

Appointment of the Regional Director for the Western Pacific: Item 7.2 of the Agenda (Document EB113/22)

Dr YOOSUF (Maldives), Rapporteur, read out the following resolution adopted by the Board in open session:[1]

> The Executive Board,
> Considering the provisions of Article 52 of the Constitution of WHO;
> Considering the nomination and recommendation made by the Regional Committee for the Western Pacific at its fifty-fourth session,
>
> 1. REAPPOINTS Dr Shigeru Omi as Regional Director for the Western Pacific as from 1 February 2004;
>
> 2. AUTHORIZES the Director-General to issue a contract to Dr Shigeru Omi for a period of five years from 1 February 2004, subject to the provisions of the Staff Regulations and Staff Rules.

The CHAIRMAN congratulated Dr Omi on his reappointment and conveyed the Board's best wishes for continuing success in all his endeavours in the Western Pacific Region.

Dr OMI (Regional Director for the Western Pacific) said that he was deeply honoured to be appointed to serve for a second term and expressed thanks on behalf of his colleagues throughout the Region for the vote of confidence in their work. Since his appointment five years ago, much had been achieved in areas such as disease control, health promotion and the strengthening of health services.

On assuming the position of Regional Director, he had initiated a wide-ranging consultation with Member States to determine priorities for the Region. Almost without exception, the unacceptably high level of tuberculosis had been cited as the most urgent issue. In 1999, he had therefore made Stop TB a special project in the Region. The Member States had set ambitious targets for tuberculosis control at the sessions of the Regional Committee in 1999 and 2000 and considerable progress had already been made towards meeting those targets. Tuberculosis services offering the appropriate treatment were currently available to 80% of tuberculosis patients and cure rates had already exceeded the 85% target.

Progress in all areas of work had been due to the unwavering commitment of Member States, the hard work of WHO staff, and the mutual trust between the two at all levels. Without such back-up, the response to the emergence of severe acute respiratory syndrome (SARS) might have been very different. More than 95% of cases had occurred in the Western Pacific Region. National and WHO staff, epidemiologists, virologists and hospital infection-control experts had worked ceaselessly to combat the new disease. The solidarity shown by WHO, its Member States and members of the international scientific community had enabled the initial outbreaks to be contained, although recent events had demonstrated that the threat had not been eradicated.

During his second term as Regional Director, he planned to focus on two main areas: redoubling regional efforts to address the unfinished agenda in communicable and noncommunicable diseases, health promotion and support for health systems; and concentrating on more qualitative issues, such as

[1] Resolution EB113.R10.

patient safety. It was also time to move beyond merely treating diseases towards a more holistic approach to health care. People's needs had to be met in the context of their human dignity, rights, families, culture and society. In order to achieve the objectives in both areas, the advantages that came from being part of WHO had to be maximized. He would work closely with the Director-General and his team at headquarters to ensure that global priorities, such as the "3 by 5" initiative, applied in the Western Pacific Region. He also planned to strengthen links with other WHO regions, in particular, the South-East Asia Region; he had already had fruitful discussions with the new Regional Director. He looked forward to the next five years with optimism and humility. He was optimistic because of the many opportunities that lay ahead to protect and improve the health of people in the Western Pacific Region. He was humble because of the grave responsibilities placed on his shoulders. He would strive to repay the trust shown in him.

The DIRECTOR-GENERAL congratulated Dr Samlee and Dr Omi, noting that he had worked closely with both in the past and had every confidence in their continued fruitful cooperation. He also thanked Dr Uton for his dedication to improving the health and well-being of the people in the South-East Asia Region and drew attention to his many achievements as Regional Director.

Both South-East Asia and the Western Pacific Regions had been hard hit by avian influenza and SARS in recent months. Malaria and HIV/AIDS were also major problems for some countries. However, the main priority in both regions was poverty reduction, in line with the United Nations Millennium Development Goals. Because of the enormous challenges facing WHO in so many areas, working for the Organization at every level should be regarded as a mission, the seamless continuity of which should not be interrupted, even by changes in the management team.

Dr YIN Li (China), Dr DAYRIT (Philippines), Dr OM (Republic of Korea), Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), Mr THOMPSON (United States of America) and Professor DANG DUC TRACH (Viet Nam) congratulated Dr Omi warmly on his reappointment, drew attention to his many attributes and wished him a successful term of office.

Dr DURHAM (New Zealand),[1] speaking also on behalf of Australia, congratulated Dr Omi on his reappointment and assured him of the continued cooperation of both countries in pursuing the programme he had outlined. Over the past five years he had shown outstanding leadership and had succeeded in making a significant contribution to the health of a diverse region.

2. PROGRAMME AND BUDGET MATTERS: Item 4 of the Agenda

Programme budget 2004-2005: progress report: Item 4.2 of the Agenda (Documents EB113/42 and EB113/42 Add.1)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of the Administration, Budget and Finance Committee of the Executive Board, said that, in its review of the progress report of the programme budget for 2004-2005, the Committee had noted with appreciation the Director-General's intention to strengthen activities in countries and to accord higher priorities to some aspects of the Organization's work. It had noted that the projected increase in resources at country level should, as far as possible, support programme activities.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Mr THOMPSON (United States of America) commended the Director-General's leadership in developing an integrated approach to results-based budgeting and planning that incorporated both regular budget and extrabudgetary sources of funds. He welcomed the progress made in the agreed policies and priorities and was confident that further improvements could ensue. He particularly welcomed the greater emphasis on the achievement of expected results and looked forward to WHO's work in refining indicators in that regard for all sources of funding in the current and future bienniums. He noted with pleasure that WHO was seeking to establish the most realistic picture of current and possible future voluntary contributions. He also noted the flexibility of up to 10% afforded to the Director-General to make budget transfers. Such latitude, which was a token of Member States' confidence, was essential in management. In the interests of transparency and accountability, Member States should be kept informed on the way in which it was applied. He further welcomed the commitment to spending a higher proportion of resources at the country level, but asked that WHO's normative functions at headquarters should not be disrupted in the process. The progress report was a blueprint for success and showed that WHO was moving in the right direction.

Mr MACPHEE (alternate to Mr Aiston, Canada) welcomed WHO's efforts to develop an integrated results-based budget incorporating assessed and extrabudgetary sources of funding. Other points that it would be important to cover in the reporting process during the biennium were actual expenditures and an assessment of actual results against expected results and actual expenditures. The progress report would provide a useful base for developing the new biennial programme budget. He noted the forecast increase in the level of extrabudgetary resources and the revision of the resources to be allocated to regional offices and to the country level. He agreed with the Committee's recommendation that the increase in resources at the country level should, as far as possible, be used to support programme activities, noting further that a major fund-raising effort would be required. It would be useful to compare the expected and the actual amounts of extrabudgetary funding received during the 2002-2003 biennium and to consider any resulting implications for the 2006-2007 programme budget.

Considerable information and work would be required to ensure that the 2006-2007 programme budget placed greater emphasis on the planning and achievement of expected results. The assessment of actual results achieved in the 2002-2003 biennium would be useful for setting the emphases of the 2006-2007 budget; hence the importance of including effective indicators, including baseline indicators, in the next programme budget. How did WHO intend to report on its results-based assessment of the previous biennium to Member States? Reports should also include more information on such areas as the trends in the allocation of extrabudgetary funds to regions and by programme over the previous two or three bienniums. Canada also supported the evaluations being carried out by the Office of Internal Audit and Oversight, which should be provided with appropriate resources.

The current year provided a unique opportunity to review WHO's strategic priorities for the next decade and to begin planning the appropriate level of programme expenditure in the 2006-2007 programme budget on the basis of those strategic directions. In order to ensure a broad consensus among the membership, there should be an interactive process between WHO and its Member States, to begin shortly after the Fifty-seventh World Health Assembly.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) noted that extrabudgetary funding accounted for a record 60% of total financial resources and he welcomed the new approach which laid more emphasis on the achievement of expected results than on the source of funds. He noted with pleasure that 70% of overall programme resources were to be allocated to activities in the regions. Although a sound set of indicators had been developed to assess programme implementation and results, he was not convinced that they were being used to assess regional activities. He therefore requested further details about the way in which the use of the funds transferred to the regions would be measured. What indicators would be used to measure the implementation and impact of those funds?

Mr GUNNARSSON (Iceland) welcomed the Director-General's commitment to allocate a larger proportion of total resources to regions and countries. Those additional resources must, to the extent possible, support programme activities in the poorest countries. He further commended the important ongoing efforts to implement a results-based programme budget incorporating regular and voluntary contributions. That work would make it easier for WHO to allocate its financial resources to the areas where they were most needed. It was also important to ensure transparency in all the working phases of the programme budget. In order to achieve the goal of a unified budget, WHO must pursue its efforts to report on the results achieved in relation to the goals set in the budget.

Dr YIN Li (China) noted with appreciation the higher priority given to work on HIV/AIDS, malaria and tuberculosis, and the increased allocation of extrabudgetary resources for country-level and regional activities. As implementation of the 2004-2005 programme budget had already begun, there should be no substantial changes to agreed programme activities. Noting that extrabudgetary resources had become the main source of income, he stressed the importance of WHO's cooperation with its partners to ensure that those funds were received in time to meet global health needs. They must be equitably distributed, used where they were most needed, and that use analysed and assessed for efficiency. China looked forward to the rapid implementation of the decision to devote 70% of overall programme resources to activities outside headquarters and to a report on progress in that area.

Dr AL-MAZROU (Saudi Arabia) applauded the proposed increased allocations to regions and countries. Extrabudgetary resources allocated to the Eastern Mediterranean Region were generous, but were primarily concentrated on two areas, eradication of poliomyelitis and assistance in health emergencies, whereas the extrabudgetary allocation to other important health issues such as the eradication of noncommunicable diseases was a mere 2.7% of the extrabudgetary allocation. He therefore requested WHO to review the distribution of resources.

Dr AL-SAIF (alternate to Dr Al-Jarallah, Kuwait) noted that the Eastern Mediterranean Region had seen substantial budget cuts in recent years. Might the distribution of the budget among the regions be reconsidered?

Dr OSMAN (Sudan) drew the Board's attention to the fact that, excluding allocations for immunization campaigns and humanitarian emergencies, only 6.5% of extrabudgetary resources had been allocated to the Eastern Mediterranean Region. Some countries in that Region were located in Africa and were afflicted by a high incidence of disease and high maternal and infant mortality rates. The amount allocated to maternity care, for example, was inadequate. He therefore endorsed the comment by the member for Saudi Arabia and likewise proposed that the distribution of extrabudgetary resources should take a broader perspective that encompassed the serious problems facing some countries.

Dr ALONSO CUESTA (alternate to Dr Pastor Julián, Spain) welcomed the integrated approach to budgeting incorporating all sources of funds and the increased emphasis on the achievement of expected results. She asked for the information that had been provided during the informal retreat in Ghana (comparing the 2002-2003 budget with actual implementation and expenditure) to be made available to the Board. It was an important monitoring tool for the programme as a whole as well as for individual programmes and provided input for the next programme budget. She further welcomed the proposal to decentralize 70% of the budget to the regions. She agreed with the members for China and Cuba that indicator-based evaluation systems should apply to the regions as well.

Dr CAMARA (Guinea) commended the Director-General's commitment to a policy of decentralization with a view to strengthening national health systems. He supported the manner in which the model for determining the regular budget allocation to the regions had been applied and

endorsed its evaluation. The African Region, which was the poorest region, had benefited greatly from the application of the model; it was grateful to the regions that had experienced reductions in allocations for their tolerance and solidarity, and to the United States of America for its expression of support.

Mr SAHA (India)[1] said that, as indicated in the Director-General's report, the composition of the overall budget of WHO had changed considerably over the past 30 years. The effective freeze on the regular budget plus the growing need for health-sector resources had inevitably reduced the proportion of the total represented by assessed contributions. He noted that the integrated approach being developed laid more emphasis on the achievement of expected results as set out in the programme budget and less on the source of funding. However, innovative solutions were needed to overcome the obstacles to planning caused by the unpredictability of extrabudgetary funding, which currently accounted for more than 60% of the budget. Given the policy of zero nominal growth in the regular budget, which appeared to be becoming entrenched, consideration should be given to assigning some extrabudgetary funds to the regular budget, in addition to assessed contributions. Such a system was already used by other organizations. It would solve the current stagnation in the regular budget, permitting it to grow in accordance with needs, and allowing more stable planning, while donor countries would remain free to offer further extrabudgetary contributions. He supported the increase in allocations to the regional and country levels but emphasized the need to make the best use of those resources, channelling them to programme activities such as immunization rather than to the employment of costly international personnel.

Mr SAWERS (Australia)[1] supported the comments on the importance of developing clear and measurable performance targets and checking performance regularly against them. Results-based budgeting and planning must indicate clearly whether value for money and improved productivity were being achieved. He looked forward to the report on WHO's performance in relation to the goals, objectives, expected results and indicators set out in the 2002-2003 programme budget and, like Canada, encouraged WHO to undertake early consultations on the Eleventh General Programme of Work and the 2006-2007 programme budget. He commended the Director-General's commitment to reorienting resources towards the regional and country levels.

Professor EL TAYEB (alternate to Dr Tag-El-Din, Egypt) commended the Director-General's commitment to decentralization, and the budgeting and planning work undertaken so far. He supported the views expressed by the members for Saudi Arabia, Kuwait and Sudan on the allocation to the Eastern Mediterranean Region, which was experiencing enormous health problems. He also supported the call made by previous speakers for the establishment of accurate indicators of performance, to which precise reference could be made when programme budgets were reviewed.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean) pointed out that WHO was a technical rather than a funding agency, its strength being its capacity to provide technical support to countries. He welcomed the Director-General's decision to increase the allocation of financial and human resources to regional and country offices. Although international staff were indeed costly, the Regional Offices tried to recruit less expensive national staff at country level when the technical expertise was available.

Dr NORDSTRÖM (Assistant Director-General) thanked members for their support for the general direction being taken in programme budget planning and financing. The changes involved an incremental process requiring adjustment, within WHO and in Member States, to a different way of working. His visits to other organizations and to WHO regional and country offices had shown that

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

WHO was well advanced in implementing results-based budgeting and planning, and that the development of WHO regional and country contributions to the process was already impressive. There were still many shortcomings, however. Three exercises were currently under way: refinement of the progress report on operational planning for 2004-2005; preparation of the performance assessment for 2002-2003, comparing programme and financial targets with the results achieved; and preliminary preparation for the 2006-2007 programme budget, drawing lessons from 2002-2003 and from processes at all levels. The performance assessment for 2002-2003 was due to be considered by the Health Assembly in 2005, but it was hoped to provide a draft report to the Health Assembly in May 2004 to permit discussion of what should be included.

Since the adoption of the 2004-2005 programme budget by the Fifty-sixth World Health Assembly, detailed operational planning had taken place, with emphasis on joint planning and reorientation towards an integrated results-based approach. The report before the Board provided an update on that process. The outcome reflected the historical situation that some extrabudgetary funds were earmarked by donors for specific purposes. It was hoped that in future WHO would decide on the priorities and expected results and try to match those aspirations with resources. The precise source of funding would thereby become less important.

Replying to a comment on the flexibility permitted to the Director-General to transfer up to 10% of allocations by resolution WHA56.32, he said that better systems for performance monitoring and use of resources should ensure that reallocations made under that provision would respond to real needs.

The 2002-2003 programme budget had set out expected expenditures in relation to extrabudgetary funds. The total had been estimated at US$ 1300 million but had in fact totalled some US$ 1900 million, which was encouraging, although WHO's actual income had gone down during the 2002-2003 biennium. He had taken note of requests for more figures and trends for such comparisons, and intended to provide additional analytical information at the forthcoming Health Assembly.

He agreed that predictability of funding was extremely important and urged donors to make better long-term projections of when resources would become available. He had noted the interesting suggestion made by India and said that such options should be explored with a view to achieving greater stability.

Planning for results included planning for the staff that would be needed to achieve them. However, more work was required to determine how best to allocate resources to different kinds of costs in order to obtain the maximum value from the funds available.

He welcomed the clear support shown for decentralization. Work was under way to see how best to strengthen country offices and improve country performance, for example by improving information technology systems and staffing policies.

The CHAIRMAN said that, in the absence of further comments, he took it that the Board wished to take note of the report contained in document EB113/42 and the updated figures for the 2004-2005 programme budget set out in document EB113/42 Add.1.

It was so agreed.

Regular budget allocations to regions: Item 4.3 of the Agenda (Document EB113/43)

Dr DAYRIT (Philippines) said that the Regional Committee for the Western Pacific had considered the item at its fifty-fourth session in September 2003, and had expressed concern over the impact of implementation of resolution WHA51.31 on WHO's work in the Region. As indicated in Annex 2 to the report before the Board, the total reduction in the regional allocation over three bienniums was around US$ 20 million, a figure that did not take into account reductions due to cost increases. As a consequence, reductions in country allocations and the Regional Office intercountry programme, and cuts in posts in important areas such as immunization, environmental health and health promotion had had to be made. The Regional Director and his team had made every effort to

absorb the reductions through efficiencies, but the amount had proved too great. The SARS outbreak had shown the importance of efficient and effective regional and country offices.

In some quarters it was considered that resolution WHA51.31 should continue to be implemented until the 18% reduction, equivalent to 3% per annum over three bienniums, had been achieved. In fact the resolution stated that the reduction should not exceed 3% annually, and could therefore be less than 3%, and that the reductions should take place only over three bienniums. The Regional Committee for the Western Pacific considered that the resolution had been implemented in full and that its effects should not be felt beyond 2005. The Regional Committee had therefore adopted a resolution requesting Board members from the Region to convey its views to the Board and to request that future allocation methods should be equitable and should take into account the Director-General's commitment to shifting resources to regional and country levels.

Mr ASLAM KHAN (alternate to Mr Khan, Pakistan) said that the formula for regional allocations set out in resolution WHA51.31 had resulted in an increase of funds to the African and European Regions but a reduction for other regions. The Member States of the former were therefore in favour of the model, while the Regional Committees of those who had experienced reductions had adopted resolutions expressing dissatisfaction. Pakistan belonged to the Eastern Mediterranean Region and had the lowest UNDP Human Development Index in the Region after Afghanistan. The reduction in the allocation to the Region had adversely affected vital programme activities, including those designed to reduce poverty and infant and maternal mortality rates. Pakistan therefore called for the model to be revised.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that in future the principles of equity and support for those in greatest need must be respected and allocations to regions and countries increased until they accounted for 80% of the budget, the remaining 20% being allocated to headquarters as against the current 33%. Allocations to countries, regions and WHO headquarters should be reviewed each biennium. He agreed with the member for the Philippines that resolution WHA51.31 applied to only three bienniums, and strongly supported the statement that would be made on behalf of the Latin American and Caribbean Group.

Mr GUNNARSSON (Iceland) said that the Director-General's evaluation should determine whether WHO was doing better than before and whether the model responded to the areas most in need. More information on that issue would be useful. Iceland favoured full implementation of resolution WHA51.31 but appreciated the concerns expressed by previous speakers. Priorities must therefore be set, with preference in all regions to the poorest countries.

WHO could still strengthen the methodology used for allocations. The principle of fairness and equitable distribution should apply to all funds and the assessment of needs should be more transparent.

Dr HUERTA MONTALVO (Ecuador), speaking on behalf of the Latin American and Caribbean Group, expressed concern at the reduction in the regular budgetary resources allocated to the Region of the Americas over the past six years and the small proportion of extrabudgetary funds that it had received. The two factors combined had seriously affected WHO and PAHO programmes in the Region and the Regional Office itself. Continued reductions would affect WHO's objective of supporting national health systems, especially primary health care and would run counter to the aim of delegating 70% of resources in 2004-2005, 75% in 2006-2007 and 80% in 2008-2009 to the regions. The Latin American and Caribbean Group supported the idea that resource allocation should take account of global health requirements and priorities. Accordingly, the Region should receive more resources to combat communicable and noncommunicable diseases. Furthermore, most of its countries were in the midst of an economic crisis that was undermining the effectiveness of their health systems and increasing poverty, with a major impact on health and on the achievement of the Millennium Development Goals. The Regional Committee for the Americas at its fifty-fifth session in

September 2003 had consequently adopted a resolution[1] for transmission to WHO's governing bodies stating that the reduction in the regional allocation pursuant to resolution WHA51.31 should apply only for three bienniums, ending with the period 2004-2005, and that that resolution should be revoked by the Fifty-seventh World Health Assembly. He endorsed the points made by the member for Cuba: a common position should be developed with Board members from other similarly affected Regions, taking into account the views of their regional committees.

Professor KULZHANOV (Kazakhstan), referring to the increase in allocations to the European Region, pointed out that that Region included countries that had formerly been part of the former Soviet Union and were experiencing extremely difficult economic situations, with deteriorating social and health conditions and the emergence of poverty. According to World Bank statistics, one third of the population in Kazakhstan was living below the poverty threshold and the figures for certain other of those countries were even worse. Unofficial data, which were probably more accurate, showed a dire health situation, with high levels of tuberculosis, HIV spreading rapidly and high rates of maternal and infant mortality. In addition, cardiovascular diseases and certain types of cancer were widespread. As the European Region was not homogeneous, averages were meaningless: each country needed to be taken individually. The Region, and particularly the countries in eastern Europe and central Asia, needed the additional resources provided. Despite their problems those countries remained optimistic and would achieve their objectives with the cooperation, support and encouragement of WHO. He appreciated the difficulty of ensuring a method of resource allocation acceptable to all, but appealed for an appreciation of the situation and continued provision of additional financial resources to his Region.

Dr OM (Republic of Korea), expressing support for the statement by the member for the Philippines, added that at its fifty-fourth session the Regional Committee for the Western Pacific had noted the big reduction in allocations to the region over the six years with the implementation of resolution WHA51.31 and the region's tiny share of total extrabudgetary resources, which had amounted to 3.3% in 2000-2001. Since the adoption of the resolution, WHO's extrabudgetary funds had increased significantly and currently accounted for almost 60% of its resources. The Regional Committee for the Western Pacific therefore requested that in future total resources be taken into account in the method used for allocation which, as previous speakers had said, must be fair and equitable.

Dr YIN Li (China) said that WHO should make a comprehensive study of the divergent views in the regions and produce a more workable and more equitable regular budget allocation plan acceptable to all parties. He supported the views of the members for the Philippines and Republic of Korea. The report clearly described the shortcomings of the present allocation model, and WHO should comprehensively and systematically evaluate the model and the results of its use during the period 2000-2005, and make clear proposals in respect of future allocations, combining regular budget and extrabudgetary resources. In the meantime, implementation of resolution WHA51.31 should be suspended. Resource allocation must become more objective and more transparent and respond to needs at headquarters, in the regions, and in each country, making the maximum use of limited resources.

Mr KOCHETKOV (alternate to Professor Furgal, Russian Federation) supported the views expressed by the member for Kazakhstan. Although the implementation of resolution WHA51.31 had produced positive results (allocating resources to regions in accordance with the UNDP Human Development Index) and had stimulated progress, a future model must ensure that funds were allocated equitably to regions in which they would have the most useful impact and meet the greatest

[1] Regional Committee for the Americas, resolution CD44.R5

needs. The increase in allocations to a region should follow a logical step-by-step approach to avoid sudden imbalances between regions. At the same time new programmes should be developed where allocations were increased, and regional increases should benefit programme activities at country level. He supported the request for information on the effectiveness of resolution WHA51.31 and the model itself, which would help all members to clarify their positions on the issue.

Dr ALONSO CUESTA (alternate to Dr Pastor Julián, Spain), noting the difficulties encountered in implementing resolution WHA51.31, expressed support for greater decentralization to countries, to ensure that programmes met real needs and were adapted to the local situation. Decentralization required strong leadership at headquarters, the continued technical excellence of WHO and good coordination of activity. The criteria for allocations should be variable, with the Millennium Development Goals being needed as a reference point in budgetary allocations, especially at country level, although in many countries reliable health information was still difficult to obtain.

She agreed with previous speakers that extrabudgetary funding should be included in the model. That should be easy to achieve as future disbursements were being planned and 10 donors contributed 70% of extrabudgetary funds. The aim of delegating 70% of resources to countries and regions in the biennium 2004-2005 seemed ambitious and she wondered whether it would be achieved by allocating headquarters staff engaged in projects for specific countries or regions to those countries or regions for budget purposes even though they continue to work at headquarters?

Ms BLACKWOOD (alternate to Mr Thompson, United States of America), emphasizing the need to ensure the fair and equitable distribution of resources, said that WHO needed to examine how its headquarters budget might be considered in the future allocation process while ensuring continuity in its essential normative functions and, as the previous speaker had said, maintaining strong leadership from headquarters. The impact of voluntary resources on the overall resource picture also needed to be considered, while retaining the flexibility for donors to earmark resources for specific purposes or countries. The United States was encouraged by comments from the Secretariat on the previous item in that regard. Clearly all resources provided to WHO must be allocated and used in each country, region and at headquarters with due attention to accountability, absorptive capacity, and public health results and performance. She noted the large variation in the number of countries in each WHO region, resulting in a country allocation in one region being much smaller than that of a similar country in another region. WHO could draw upon health and economic data and even gross domestic product information to help it achieve a more equitable distribution of resources. Special concern and attention should continue to be given to the least developed countries both at the global and at the regional levels of planning.

The meeting rose at 12:45.

TENTH MEETING

Friday, 23 January 2004, at 14:05

Chairman: Dr K. AFRIYIE (Ghana)

1. PROGRAMME AND BUDGET MATTERS: Item 4 of the Agenda (continued)

Regular budget allocations to regions: Item 4.3 of the Agenda (Document EB113/43) (continued)

Mr AISTON (Canada) stated that the assessment exercise should focus on the report's impact on the regions. Canada had supported and continued to support resolution CD44.R5 adopted at the fifty-fifth session of the Regional Committee for the Americas, for the reasons already given by the members for Cuba and Ecuador. Although Canada continued to support increased allocations for the African Region, as provided for in resolution WHA51.31, those resource flows could come from various sources, such as headquarters through transfers, extrabudgetary resources, within the Region through reallocations and the Region itself. That applied also to other regions (especially those with a mix of high- and low-income countries). Resolution WHA51.31 had done its work and it was time to move on. Further discussions on the issue could be divisive, and he therefore urged Member States not to reopen the debate at the next Health Assembly.

Dr YOOSUF (Maldives) supported a review of resolution WHA51.31. Despite having about 25% of the world's population and about 40% of the global disease burden and most of its 11 countries faring badly in the UNDP Human Development Index, the South-East Asia Region was not receiving its fair share of extrabudgetary resources; indeed, it had suffered a US$ 18 million budget cut under resolution WHA51.31. The Regional Director should review the distribution mechanism for the regular budget and extrabudgetary resources with a view to increasing transparency. At the same time, he appreciated the US$ 128 million it was planned to allocate to the Region, largely for the poliomyelitis eradication programme.

Dr AL-SAIF (Kuwait) commended the Director-General's efforts to ensure equitable distribution of the budget among the regions. However, noting the reduction in the budget for the Eastern Mediterranean Region referred to by the member for Pakistan, he called for a redistribution of the budget to ensure that the countries of that Region were not adversely affected.

Mr BRUNET (alternate to Professor Dab, France) said that the model for allocation of resources could not be held responsible for the lower shares allocated to certain regions, since extrabudgetary funds played a compensatory role. Furthermore, the Director-General's wish to increase resources to regions and countries created a new situation in which the negative consequences of resolution WHA51.31 could be alleviated. That resolution had brought improved objectivity and transparency to the mechanism for resource allocation; he agreed with the members for Iceland and the Russian Federation that those principles should be applied even if, over time and with better criteria, some of the results might be called into question.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that the report was right to suggest that allocation of resources must evolve between biennial budgets in the light of changing global priorities. Resources must be directed to the countries with the greatest need. In view of countries' differing health needs and requirements, even within regions, the Director-

General should prepare options for equitable allocation, based on objective criteria. Such proposals could be considered informally before the next Health Assembly.

Dr AL-MAZROU (Saudi Arabia) emphasized that the Eastern Mediterranean Region had shouldered the greatest burden as a result of the adoption of resolution WHA51.31. However, the Director-General could lighten that burden, for example through the use of extrabudgetary resources and transfers from headquarters.

Mr SAHA (India)[1] said that, in view of the proportions of the global population and the world's poor in the South-East Asia Region, common sense suggested that its allocation should be between 30% and 40%. The reason it received only 11% of the budget lay in the convoluted formula used to determine regional allocations. Allocations should be based on population-weighted health indicators, with due account taken of the need factor. He therefore urged the Director-General to make a comprehensive review of the model to ensure that, in the future, allocations were made rationally, taking account of objectively assessed needs.

Dr FUKUDA (Japan),[1] speaking also on behalf of Australia and New Zealand, supported the views expressed by the members for China, the Philippines, and the Republic of Korea. The practice of determining the regional budget allocations introduced by resolution WHA51.31 had brought a flexibility to regular budget allocations to the regions, which had previously been decided on a historical basis. Japan especially acknowledged the efforts made in that regard by regions whose budgets had been reduced. However, since the introduction of that allocation model, results-based budgeting had been implemented and WHO's capacity to identify health needs at regional and country levels had improved. As a result, the original rationale for the model no longer held and the existing model should not be retained beyond the current biennium. He supported the proposal by China for a comprehensive evaluation in consultation with Member States and the regions. The evaluation should consider whether a second tier of allocation was required over and above the results-based budget; and, if it revealed that a new model was needed, it should recommend the relative weighting of the factors that had to be taken into account. If a new model were considered appropriate, it should be applied to all the funds, both regular and extrabudgetary, and should cover the allocation for headquarters. Japan had no problem with the idea of each region having its own method for allocating funds to countries, as long as there was transparency and a sharing of experience between regions.

Mr KEENAN (Ireland)[1] said that equity and transparency in the allocation of resources between regions and countries were vital. Resolution WHA51.31 had represented a move towards a new approach to the allocation of regular budget funds. The changes brought about by the resolution had been made on a basis that took into account the position of countries in greatest need. The Director-General had announced that the apportionment of total resources to regions and countries would be 80% for the 2008-2009 biennium; the strong commitment to rapid decentralization of resources from headquarters to regions and countries was much appreciated. The response to the concerns raised during the discussion lay in refocusing resources more directly on priorities and results at regional and country levels. He encouraged the Director-General to continue with the changes he was implementing and, at an early date, to identify measures to ensure an equitable and transparent distribution of resources based on objective criteria.

The DIRECTOR-GENERAL said that, in considering the formula that should be used in allocating the regional budgets to the various regions, he was guided by the overriding principle that it should serve the best interests of WHO as a whole, both regional structures and headquarters, in order that Member States derived the maximum benefit from the Organization. WHO's extensive regional

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

structure fully justified the decentralization process, but that should be done in a manner that did not weaken the capacity of its headquarters. Budget allocations would be made on the basis of need, and staffing levels would be determined by the extent of resources allocated. It was clear, therefore, that staff numbers could not be artificially maintained at the same level, either at headquarters or in the regions, if budget allocations decreased. The current practice was being evaluated, and he intended that proposals on practical solutions to the issue of regional budget allocation would be submitted to the Health Assembly at its session in May 2004.

Although he recognized that members of the Board in effect reflected the interests of their own countries and regions, he urged them to consider the broader picture and the interests of the Organization as a whole when appraising budget allocation formulas.

The CHAIRMAN said that he took it that the Executive Board wished to request the Director-General, during his preparation of the report to the Fifty-seventh World Health Assembly, to take into consideration the comments that had been made.

It was so agreed.

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

Family health in the context of the tenth anniversary of the International Year of the Family: Item 3.10 of the Agenda (Document EB113/45) (continued from the fifth meeting)

Mr HOHMAN (alternate to Dr Steiger, United States of America) said that an informal group had met to discuss the various revisions to a draft resolution proposed by Australia, Philippines, Republic of Korea, Russian Federation and United States of America, on family health in the context of the tenth anniversary of the International Year of the Family, which consequently read:

> The Executive Board,
>
> Having considered the report on family health in the context of the tenth anniversary of the International Year of the Family,[1]
>
> RECOMMENDS to the Fifty-seventh World Health Assembly the adoption of the following resolution:
>
> > The Fifty-seventh World Health Assembly,
> >
> > Recalling that the Constitution of the World Health Organization states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;
> >
> > Recognizing and promoting the equal rights of men and women and emphasizing that equality between women and men and respect for the rights of all family members are essential to family well-being and to society at large;
> >
> > Recalling also the commitments, goals, and outcomes of United Nations conferences and summits that address health issues related to family members, individuals, and communities;
> >
> > Recalling further that relevant United Nations instruments on human rights and relevant global plans and programmes of action call for the widest possible protection and

[1] Document EB113/45.

assistance to be accorded to the family, bearing in mind that, in different cultural, political and social systems, various forms of the family exist;

Also recognizing that parents, families, legal guardians and other care-givers have the primary role and responsibility for the well-being of children, and must be supported in the performance of their child-rearing responsibilities;

Further recognizing that cultural norms, socioeconomic conditions, gender equality and education are significant determinants of health;

Acknowledging that strong and supportive families and social networks have a positive impact on the health of all family members, while inadequate access to health care, child abuse, neglect, spousal and domestic violence, alcohol and substance abuse, neglect of older persons and persons with disabilities and the adverse consequences of migration are a significant concern;

Noting with concern the devastating effects of the HIV/AIDS pandemic on families, family members, individuals and communities, especially in families headed by children and older persons;

Noting that the tenth anniversary of the International Year of the Family is being observed in 2004,

1. URGES Member States:

(1) to assess government policies with a view to assisting families to provide a supportive environment for all their members;

(2) to ensure the availability of appropriate legal, social and physical infrastructures to support mothers and fathers, families, legal guardians and other care-givers, particularly older women and men, to strengthen their capability to provide care, nurturing and protection in the best interest of every child in their care;

(3) to take measures to ensure that gender-sensitive health policies, plans and programmes recognize and address the rights and comprehensive health and development needs of each family member, with special attention to families at risk of being unable to meet the basic needs of their members, including those families in which child abuse, domestic violence or neglect occur;

(4) to develop, use, and maintain systems to provide data, disaggregated by sex, age and other determinants of health, to underpin the planning, implementation, monitoring and evaluation of evidence-based health interventions relevant to all family members;

(5) to develop or strengthen alliances and partnerships with all relevant governmental and nongovernmental partners to assist families to meet the health and development needs of all their members;

(6) to strengthen national actions to ensure sufficient resources to fulfil the international commitments, goals and outcomes of relevant United Nations conferences and summits related to the health of family members;

(7) to fulfil their obligations under international instruments relevant to family and health development, such as the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child, as specified in resolution WHA46.27 on the International Year of the Family;

2. REQUESTS the Director-General:

(1) to raise awareness of health issues relevant to families, family members, individuals and the community and to support Member States to increase their efforts to strengthen health policies on these issues;

(2) to support Member States, upon request, to develop, use, and maintain systems to provide data, disaggregated by sex, age and other determinants of

health, to underpin the planning, implementation, monitoring and evaluation of evidence-based health interventions relevant to families and their members;

(3) to support Member States in their efforts to fulfil their commitments to the goals and outcomes of relevant United Nations conferences and summits related to the health of family members, in collaboration with relevant partners;

(4) to pay due attention to issues related to the health of family members in relevant policies and programmes of the Organization;

(5) to work closely with the United Nations Department of Economic and Social Affairs and other relevant organizations of the United Nations system, such as UNICEF and UNFPA, on issues related to families and their members by sharing experiences and findings;

(6) to report to the Fifty-ninth World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

He proposed three additional amendments to the recommended resolution. At the end of the fifth preambular paragraph, he proposed the addition of the words "in all actions related to children, the best interests of the child shall be a primary consideration". That was an agreed text from the outcome document of the United Nations General Assembly's special session on children, held in May 2002. In the seventh preambular paragraph, he proposed the replacement of the words "the adverse consequences of migration" with "the potential effects of prolonged periods of separation, such as those resulting from migration". At the end of paragraph 1(2), he proposed the addition of the words "the views of the child being given due weight in accordance with the age and maturity of the child". That wording was also agreed language from the outcome document of the special session.

The resolution, as amended, was adopted.[1]

Reproductive health: Item 3.11 of the Agenda (Documents EB113/15 and EB113/15 Add.1) (continued from the fifth meeting)

The CHAIRMAN drew attention to a draft resolution proposed by Australia, Belgium, Brazil, Canada, China, Colombia, Cuba, Denmark, Egypt, Eritrea, Ethiopia, Finland, France, Gabon, Gambia, Ghana, Guinea, Iceland, Luxembourg, Netherlands, Norway, Portugal, Romania, South Africa, Sudan, Sweden, Switzerland, Thailand, United Kingdom of Great Britain and Northern Ireland and Viet Nam, on reproductive health: draft strategy to accelerate progress towards the attainment of international development goals and targets, which read:

The Executive Board,

Having reviewed and considered the draft strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health,[2]

RECOMMENDS to the Fifty-seventh World Health Assembly the adoption of the following resolution:

The Fifty-seventh World Health Assembly,

Having considered the draft strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health;

Recalling and recognizing the Programme of Action of the International Conference on Population and Development (Cairo, 1994) and key actions for the further

[1] Resolution EB113.R12.

[2] Document EB113/15 Add.1.

implementation of the Programme of Action of the International Conference on Population and Development adopted by the twenty-first special session of the United Nations General Assembly in July 1999;

Recalling and recognizing further the Beijing Platform for Action (Beijing, 1995) and the further actions and initiatives to implement the Beijing Declaration and the Platform for Action adopted at the twenty-third special session of the United Nations General Assembly in June 2000;

Reaffirming the development goals as contained in the Millennium Declaration adopted by the United Nations General Assembly at its fifty-fifth session in September 2000,[1] and in the Road Map towards the implementation of the United Nations Millennium Declaration,[2] and other international development goals and targets;

Recognizing that attainment of the development goals of the United Nations Millennium Declaration and other international goals and targets require, as a priority, strong investment and political commitment in reproductive and sexual health;

Recalling that resolution WHA55.19 requested the Director-General, *inter alia*, to develop a strategy for accelerating progress towards attainment of international development goals and targets related to reproductive health,

1. ENDORSES the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health;

2. URGES Member States, as a matter of urgency:

(1) to adopt and implement the strategy as part of national efforts to achieve the development goals of the United Nations Millennium Declaration and other international development goals and targets, and to mobilize political will and financial resources for that purpose;

(2) to make reproductive and sexual health an integral part of national planning and budgeting;

(3) to strengthen the capacity of health systems to achieve universal access to sexual and reproductive health care, with particular attention to maternal and neonatal health in those countries where related mortality and morbidity are highest;

(4) to monitor implementation of the strategy to ensure that it benefits the poor and other marginalized groups, and that it strengthens reproductive and sexual health care and programmes at all levels;

(5) to ensure that all aspects of reproductive and sexual health including, *inter alia*, maternal and neonatal health, are included within national monitoring and reporting of progress towards attainment of the development goals of the United Nations Millennium Declaration;

3. REQUESTS the Director-General:

(1) to provide support to Member States, on request, in implementing the strategy and evaluating its impact and effectiveness;

(2) to devote sufficient organizational priority, commitment and resources to supporting effective promotion and implementation of the reproductive health strategy and the "necessary actions" that it highlights;

(3) to give particular attention to maternal and neonatal health in WHO's first progress report on reproductive and sexual health in 2005, as part of its

[1] United Nations General Assembly resolution 55/2.

[2] Document A/56/326.

contribution to the Secretary-General's report to the United Nations General Assembly on progress towards attainment of the development goals of the United Nations Millennium Declaration;

(4) to provide regular (at least biennial) progress reports on implementation of the strategy to the Health Assembly, through the Executive Board.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) announced that Ecuador, Grenada, India, Kenya, Maldives and Nepal wished to be added to the list of sponsors of the draft resolution. He said that, if he had inadvertently omitted any Member State wishing to sponsor the draft resolution, he hoped that they would forgive that omission and would make their interest known.

The resolution was adopted.[1]

3. FINANCIAL MATTERS: Item 5 of the Agenda

Status of collection of assessed contributions: Item 5.1 of the Agenda (Documents EB113/16, EB113/16 Corr.1 and EBABFC20/3)

Dr YOOSUF (Maldives), speaking as Chairman of the Administration, Budget and Finance Committee of the Executive Board (ABFC), said that the Committee had noted the contents of documents EB113/16 and EB113/16 Corr.1, which contained information as at 31 December. Developments since that date were outlined in the report of the twentieth meeting of the Committee (document EBABFC20/3). The rate of collection for 2003 had risen to 91% and the number of Member States having paid their contributions in full had increased to 137. ABFC had welcomed the improvement in the rate of collection and the reduction in arrears and had continued to stress that the timely payment of assessed contributions was important to ensure full implementation of the regular budget.

At its twenty-first meeting in May 2004, ABFC would prepare recommendations in respect of Members in arrears to an extent that would justify invoking Article 7 of the Constitution, for consideration by the Fifty-seventh World Health Assembly.

Mr MACPHEE (alternate to Mr Aiston, Canada), welcoming the improvement in the payment of assessed contributions in 2003, expressed concern, however, that more than half the total amount of assessed contributions had been received late in the year. Had that had an impact on the Organization's functioning, in particular, its ability to earn interest and finance programmes? He requested the inclusion in future reports to the governing bodies of information on the Member States that had availed themselves of the adjustment mechanism for relief from increased assessments. He commended those Member States that had chosen not to resort to that mechanism. Canada paid its contribution in full, on time and without condition, and he urged other Member States to do likewise.

Ms WILD (Comptroller), in response, said that the late payment of substantial amounts of the assessed contributions reduced WHO's ability to earn interest, which contributed towards the miscellaneous income account, although the current low interest rates mitigated that effect to some extent. The late payment of contributions also affected the Organization's capacity to finance the regular budget through the use of internal borrowing resources and the Working Capital Fund. The late

[1] Resolution EB113.R11.

payment of an even higher proportion of contributions would pose significant problems for the Organization.

The information requested by the member for Canada would be included in future reports to the Executive Board and the Health Assembly.

The Board noted the report.

Scale of assessments: Item 5.3 of the Agenda (Documents EB113/46 and EB113/46 Corr.1)

Dr YOOSUF (Maldives), speaking as Chairman of ABFC, said that the Committee had noted that, by resolution WHA56.33, the Health Assembly had adopted a scale of assessments for the financial period 2004-2005 based on the latest available United Nations scale of assessments. The reports set out the scale of assessments for 2005 that would result from the implementation at WHO of the United Nations scale.

The Committee's report listed the Member States that had requested compensation under the adjustment mechanism in respect of their assessments for 2004-2005. ABFC had requested that further information on the new scale of assessments and the adjustment mechanism be provided to the Fifty-seventh World Health Assembly in order to facilitate further discussion. The information requested was the impact in United States dollar terms of the revised scale for 2005 on Member States' assessment; the impact of the revised scale for 2005 on the amounts that would be available to Member States under the adjustment mechanism established by resolution WHA56.34; the amounts claimed by Member States under the adjustment mechanism; updated information on the expected level of miscellaneous income in 2004-2005 from which the amount of US$ 12.4 million had been appropriated for the adjustment mechanism; and the impact on the financing of WHO's regular budget for 2004-2005.

Dr YIN Li (China) expressed concern that, according to the scale of assessment being considered for 2004-2005, the assessed contributions of more than 70 countries would increase, substantially for some. China's scale of assessment had been increasing since 2001, and under the new scale its contributions would more than double, making it the Organization's eighth largest contributor. Although his country agreed to the adjustment of the scale of assessments in accordance with the relevant resolution, it considered that, while adjusting the WHO scale of assessments according to the new United Nations scale for 2005 and thereafter, WHO should strictly adhere to the adjustment mechanisms for the contributions for the period 2005-2007 in accordance with the requirements of the resolutions adopted by the previous Health Assembly.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that his country had had insufficient time in which to study the document because of its late issuance. He requested adherence to Rule 5 of the Rules of Procedure of the Executive Board concerning the dispatch of documentation to the members of the Board.

The amended scale of assessments, which had been the subject of much debate, had unfortunately resulted in the least developed countries being obliged to make up for the reductions in the assessed contributions of other countries. However, the Constitution did not oblige WHO automatically to follow the United Nations scale of assessments, and he therefore suggested that a proposal for an adjusted scale should instead be submitted to the Health Assembly. Under the amended scale of assessments, his country's contributions would be four times greater than the amount that it currently paid. He therefore called for a solution similar to the one applied for the current biennium, and for support to countries faced with increased contributions.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), seconded by Mr MACPHEE (alternate to Mr Aiston, Canada), Ms BLACKWOOD (alternate to Dr Steiger, United States of America), Mr GUNNARSSON (Iceland) and Mr KOCHETKOV (alternate to

Professor Furgal, Russian Federation), fully agreed with the proposal that the Board should recommend to the Health Assembly the adoption of the revised scale of assessments for 2005.

Mrs AUER (alternate to Professor Dab, France), supported by Dr NEIRA GONZÁLEZ (alternate to Dr Pastor Julián, Spain), endorsed the view of previous speakers that the scale of assessments should be amended in accordance with the latest available United Nations scale of assessments, and said that, as the Fifty-sixth World Health Assembly had already discussed the issue at great length, it would be inappropriate for the Board to resume the debate.

Mr SAHA (India)[1] said that, although he recognized that the Health Assembly had reached broad agreement on an amended scale of assessments, the possibility that it might wish to reopen discussion of the issue should not be dismissed, since circumstances changed, and the capacity of Member States to pay their contributions would undoubtedly also change. He agreed with the proposal to adopt an amended scale of assessments for 2005 that was in accordance with the United Nations scale, although the change would entail a significant increase in India's contributions, as well as in those of several other countries.

He expressed concern over the paucity of funds available to meet the needs of countries that would experience a significant increase in their contributions under the new arrangement. Of the US$ 12.4 million earmarked for the 2004-2005 biennium, US$ 7.7 million had already been used, which left less than US$ 4.7 million for 2005. It was unclear how it was proposed to make good that shortfall in the likely event that the balance available would be insufficient to meet the increased claims that would undoubtedly be made on it by countries that were eligible to draw upon those funds.

Mr SAWERS (Australia)[1] also endorsed the view of the member for the United Kingdom. The principle regarding the application of the latest United Nations scale of assessments, adopted at the Fifty-sixth World Health Assembly, was clear, and as a consequence, the Fifty-seventh World Health Assembly should formally consider adopting the new scale.

Ms WILD (Comptroller), referring to comments regarding the late issuance of the report and the availability of funds to meet the adjustment mechanism, noted that the General Assembly had adopted the resolution on the scale of assessments for 2004-2006 only in December 2003. In resolution WHA56.33, the Health Assembly had decided to adopt henceforth the latest available United Nations scale of assessments, and in resolution WHA56.34 it had decided on an adjustment mechanism for the 2004-2005 and 2006-2007 bienniums. It was clearly for the Health Assembly to decide what to do in respect of any future scale of assessments.

The CHAIRMAN said that, in the absence of further comments, he took it that the Board wished to adopt a decision recommending that the Health Assembly, acting in accordance with Financial Regulation 6.1, should consider amending the scale of assessments to be applied in 2005, the second year of the present financial period.

It was so decided.[2]

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[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[2] Decision EB113(9).

4. STAFFING MATTERS: Item 6 of the Agenda

Human resources: Item 6.1 of the Agenda

- **Annual report** (Document EB113/17)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of ABFC, said that the Committee had taken note of the preview of WHO's staffing profile, noting that the annual report, with complete data to 31 December 2003, would be submitted to the Fifty-seventh World Health Assembly in May 2004. The Committee recommended that the Board should take note of the preview.

The Board noted the report.

- **Recruitment strategy integrating gender and geographical balance** (Document EB113/18)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of ABFC, said that the action plan in document EB113/18 summarized the overall recruitment strategy to integrate gender and geographical balance as outlined in resolutions WHA56.17 and WHA56.35. The future targets for WHO globally were for 60% of all appointments over the next two years in the professional and higher graded categories to be of nationals of unrepresented and underrepresented countries, in particular developing countries and for 50% of appointments of women to be to professional and higher category posts.

The Committee had welcomed the information on the recruitment strategy designed to achieve gender and geographical balance as requested in resolutions WHA56.17 and WHA56.35. It had been noted that it would take time to achieve the target set by the Health Assembly. The action plan was seen as a positive and realistic first step towards those goals. Cooperation with Member States, particularly those that were unrepresented and underrepresented, was an important element in implementing the strategy. The need to raise awareness of WHO as an employer of choice had been recognized. Wider dissemination of information on employment opportunities would ensure that WHO received more applicants from priority countries. The use of the web-based recruitment system had been successful, but attention must continue to be paid to attracting candidates from areas where connectivity with the Internet was poor or where the level of expertise in the use of information technology was low. It had been agreed that WHO would provide coaching on how to complete application forms, particularly on-line, and to explain the Organization's selection process involving written tests and competence-based interviews.

Concern had been expressed about the need to ensure that equal opportunity was provided to both external and internal candidates. The challenge remained for the Organization to strike the most appropriate balance between contract duration and the need to maintain attractiveness as an employer. There had been consensus that monitoring and evaluation were an important aspect of the recruitment strategy. Regular reports should be provided on achievements and experience to date.

The Committee had recommended that the Board take note of the recruitment strategy.

Dr HUERTA MONTALVO (Ecuador) said that concerns remained in countries in Latin America and the Caribbean about their underrepresentation at the P5 level and above. The presence in executive positions of WHO staff members from the region would improve the management and follow-up of programmes. With regard to both the gradual increase in recruitment of women and the target of 60% of all appointments by 2005 in the professional and higher graded categories being of nationals of unrepresented and underrepresented countries, in particular developing countries, only timid progress had been made, particularly as far as Latin American and Caribbean countries were concerned. Those countries called on the Director-General to address those commitments made at the Fifty-sixth World Health Assembly with renewed energy. With regard to outreach to candidates, those

countries called for recommendations from unrepresented or underrepresented Member States, particularly developing countries, to be given priority. More information should also be provided on the recruitment missions focused on priority countries and the list of major public health schools with which WHO was strengthening its ties with a view to recruiting competent staff from developing countries.

Mr MACPHEE (alternate to Mr Aiston, Canada) said that his country fully supported the action plan presented in the report, but was aware that it would take time to achieve the targets set out in resolution WHA56.35. Also, cooperation with Member States would be important, particularly in increasing recruitment of staff from unrepresented and underrepresented Member States and of women in professional posts, especially at the higher level.

In late 2003, as part of the "3 by 5" initiative, the task force on HIV/AIDS in the WHO workplace had presented some policy recommendations designed to deal with gaps in insurance coverage for WHO staff living with HIV/AIDS. Those recommendations provided options to ensure that such staff had access to antiretroviral therapy and related care, regardless of the type of contract held. Increased measures to ensure the confidentiality of medical information, access to treatment, care and support for all such staff members were also recommended. Canada urged WHO to consider those recommendations promptly and take appropriate action. It also wanted more precise time frames and indicators and regular monitoring and evaluation against such indicators included in the strategy and reflected in the next programme budget.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) endorsed the comments made by the member for Ecuador. WHO must strive to achieve the target of wide geographical representation without compromising on the quality of the staff selected. The action plan was acceptable, although less emphasis should be placed on the financial contributions of countries and more on their level of representation – perhaps 40% and 50% respectively. That would be more in conformity with resolution WHA56.35, which referred to a scheme that placed less emphasis on financial contributions. The action plan to be submitted to the next Health Assembly should incorporate time frames and indicative targets for evaluation purposes.

Mr GUNNARSSON (Iceland) endorsed the contents of the report and said that, with the reform of human resources management, WHO had shown its commitment to improving and harmonizing its management practices and thereby promoting efficiency and effectiveness in its operations. Iceland fully agreed about the importance of gender and geographical balance, but it was most important, especially for the poor and sick of the world, for WHO to be the most effective organization possible. The importance of selecting the most highly qualified and competent candidate for each post must be constantly borne in mind. The reform of human resources management was aimed at ensuring that the Organization's work would be undertaken by an excellent, dedicated and well managed workforce.

Dr PILLAY (South Africa)[1] commended the Director-General's appointment of three women to his Cabinet, but noted that the proportion of women at that level remained the same as in the previous Cabinet. Only 38.4% of appointments had been of women, against the target of 50%. His country therefore encouraged the Director-General to continue his efforts to meet the target set by the Health Assembly.

Mr SAWERS (Australia)[1] commended the progress achieved so far. The strategy represented a comprehensive and sensible approach to ensuring that the Organization met the twin objectives of improving its geographical and gender balance and ensuring that the quality of the staff selected was

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

not compromised. An evaluation of the outcomes and cost-effectiveness of the strategy should be included in the WHO evaluation plan for 2005.

Mr HENNING (Director, Human Resources Services), replying to the comments made, said that the importance attached by Board members to evaluation and reporting to the governing bodies on actual indicators of progress had been duly noted. Concerning the possible expansion of sources for recruitment in Latin America and the Caribbean, country representatives from that region had already provided an extensive list of institutions, some of which were already being contacted with a view to publicizing WHO as a potential employer. In all regions, WHO was counting on the support of governments in identifying as many sources as possible for recruitment.

The DIRECTOR-GENERAL said that positive action would be taken with regard to insurance coverage for short-term staff. He wholeheartedly concurred with the many views expressed about the need for a better gender balance. At present it was about 40%, better than in many United Nations agencies; but WHO would nevertheless strive to do even better. Recruitment from unrepresented, underrepresented and developing countries was an extremely difficult issue. Japan, for example, was WHO's second largest contributor but its nationals accounted for only 40 staff members Organization-wide – a mere 30% of the figure to be expected. Efforts must be made to find suitable candidates from the three groups just mentioned, particularly from unrepresented countries. A global health leadership programme under which about 10 candidates would be trained with a view to their recruitment would soon be launched. That programme represented a form of positive outreach, a proactive way of identifying candidates.

The Board noted the report.

- **Report of the International Civil Service Commission** (Document EB113/19)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of ABFC, said that document EB113/19 summarized the main decisions and recommendations of the International Civil Service Commission set out in its annual report for 2003. As part of its ongoing comprehensive review of the pay and benefits scheme, work was being done in priority areas: testing, validation and promulgation of a revised and simplified evaluation system for the classification of professional posts; a pilot study of a broad-banded pay model and related pay-for-performance mechanisms; and development work on the establishment of a senior management service to be carried out under the auspices of the United Nations System Chief Executives Board.

With regard to conditions of service in the professional and higher categories, the Commission had recommended to the United Nations General Assembly that the United States federal civil service's nationwide General Schedule scale, excluding locality pay, should be used as a reference point for the United Nations base/floor salary scale. As a result, the base/floor salary scale was maintained at its current level for the time being and allowances that were pegged to the scale remained unchanged.

The Commission had upheld its prior decision to increase hazard pay to 30% of the mid-point of the local base salary scales, to take effect on 1 January 2004. However, the General Assembly had again requested the Commission to consider instituting a smaller increase in hazard pay for local staff, taking into account the symbolic nature of the payment, and to report back to the General Assembly at its fifty-ninth session.

With regard to paternity leave, in January 2001 the Executive Board had confirmed the introduction of five days' paternity leave on a trial basis for two years, to be reviewed in the light of developments in the common system. The trial period had been extended until January 2004, as the Commission was expected to have completed its review by that date. Since the review was scheduled to start in 2004, the Director-General had extended the trial period for a further year. The footnote to Staff Rule 760 would reflect the extension of the trial period until January 2005.

Document EB113/19 contained a draft resolution which ABFC recommended that the Executive Board should adopt.

Mr KOCHETKOV (alternate to Professor Furgal, Russian Federation) said that his country attached great importance to implementation of the recommendations of all bodies of the common system, including the Commission. The recommendations in question would enhance the effectiveness of work in secretariats throughout the United Nations system. Reform of the job evaluation system and the introduction of broad-banded and pay-for-performance systems were noteworthy subjects in the Commission's Report. WHO should start to prepare for such measures and carefully observe the progress of the relevant pilot projects. In so doing, it should increase its coordination with the Commission.

The CHAIRMAN said that, in the absence of further comments, he took it that the Board wished to adopt the draft resolution contained in the report.

The resolution was adopted.[1]

Statement by the representative of the WHO staff associations: Item 6.2 of the Agenda (Document EB113/INF.DOC./3)

Ms FARRINGTON (president of the WHO staff associations) updated the Board on matters of human resources policy and practice, and placed on record some of the staff associations' concerns, some of which had been raised a year before but required highlighting again. With regard to security, they mourned the loss of United Nations staff, including their WHO colleagues Nadia Younes and Ahmed Shukry. An initial assessment of security had revealed gaps, and they called on the Board to build up support for WHO staff in conflict areas.

The staff associations welcomed the partnership approach to staff/management relations, and looked forward to continued development of a partnership agreement. She expressed concern that progress in dealing with issues of "long-term short-term staff" had been uneven, and that the dramatic rise in the number of staff hired on short-term contracts over the past two years stored up potential trouble for the future. With regard to career development, she called for a skills inventory to ensure that each staff member's specific strengths were used to the maximum benefit of the Organization and to increase job satisfaction among staff members. She highlighted the need for staff development and training, in particular in management practices. With regard to rewards and recognition, the staff associations called for the limited restoration of promotion and salary increases for merit to foster career development.

She reiterated the concern about the hiring and rehiring of retirees. She advised the Board of staff concerns about the devaluation of salaries payable in local currencies, due to currency fluctuations, and called for a comprehensive study of the consequences of fluctuations in the dollar exchange rate on pensions.

Although she welcomed steps that had been taken to address long-standing issues, much more needed to be done, in particular in respect of the employment rights of staff.

Dr LARIVIÈRE (alternate to Mr Aiston, Canada), affirming that WHO's personnel were its most important resource, said that staff costs accounted for more than 60% of the regular budget and must be optimally managed. He welcomed the progress made on the partnership agreement between the Organization and its staff. The meetings of the pre-sessional committees had given him a greater awareness of the plans to strengthen career planning and improve the situation of "long-term short-term" staff.

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[1] Resolution EB113.R13.

Staff security was a concern of all Board members. Much could be done at the level of the United Nations common system, including compensation for staff exposed to a high degree of risk. However, each organization could also take its own measures to protect its staff, and he commended WHO's efforts in that regard.

The fluctuation of local currencies against the United States dollar was properly a matter for the United Nations common system. However, because WHO was a global employer and currency problems might adversely affect staff morale and performance, the Board should keep itself informed of the situation.

The DIRECTOR-GENERAL referred to the issue of short-term staff, on whom the Organization relied. There were often good reasons for issuing short-term contracts, for instance, for a professional to perform a particular task or for general service staff to organize a conference. However, staff often had one short-term contract after another. In the past year, it had been possible to convert about 80 staff from "long-term short-term" contracts to genuine fixed-term contracts.

Members should remember that not all duty stations were as congenial as Geneva. Some staff members worked on repeated short-term contracts in hardship posts for many years. It was a challenge to rotate staff postings appropriately, particularly given the current trend towards decentralization, which meant fewer posts at headquarters and in the regional offices.

In respect of career planning, members should bear in mind that the Secretariat required people to manage the Organization and people to facilitate its technical work. Long-term members of staff must, of course, be highly competent administrators. Fixed-term staff were recruited for a certain time at a certain grade. WHO, unlike governments, universities or industry, tended not to recruit staff at a low level who would then spend their whole career moving up through the Organization. Mid-level or senior staff were not necessarily expected to stay for many years, especially since there were comparatively few senior management posts for them to aspire to. WHO also drew on the expertise of world-class professionals who were members of its expert committees: they were responsible for products that appeared bearing WHO's name, but they were not WHO staff.

The Board noted the statement by the representative of the WHO staff associations.

5. OTHER MANAGEMENT MATTERS: Item 7 of the Agenda (continued)

Reports of the Executive Board committees, including awards: Item 7.3 of the Agenda

Programme Development Committee (Document EBPDC10/7)

Dr DAYRIT (Philippines), speaking in his capacity as Chairman of the Programme Development Committee, said that at its tenth meeting, held on 16 January 2004, the Committee had considered reports on programme evaluation activities in 2003 and evaluations proposed for 2004, and had been informed of recent changes in the location of evaluation functions within the Secretariat. The Committee had welcomed the proposed evaluation of the Fellowship Programme and the launch of country evaluations for 2004, but had asked for more detailed information about the results of the evaluations.

The Committee had also discussed the Eleventh General Programme of Work and the Proposed programme budget for 2006-2007. While considering the proposed 10-year timeframe for the Eleventh General Programme of Work to be ambitious, it agreed that the Programme should be extended to 2015, matching the timeframe of the Millennium Development Goals. The Committee had agreed that relatively few changes should be made to the areas of work laid down in the Proposed programme budget for 2006-2007. It had welcomed the proposal that the various sources of financing be shown more clearly.

The Committee had discussed the streamlining of procedures for draft resolutions to be submitted to the Health Assembly, using a report on relevant procedures in other bodies of the United Nations system. All proposed resolutions should be considered by the Board before submission to the Health Assembly, except in the case of sudden health emergencies. The Committee had stressed the importance of full compliance with the Rules of Procedure of the World Health Assembly, especially Rule 52, which required that proposals be circulated in writing two days in advance. Proposed resolutions should be submitted to the Board at the session before the Health Assembly at which they were to be considered. They would then be considered by the Board and submitted to the Health Assembly as conference papers.

Finally, the Committee had considered the review of the WHO/UNICEF/UNFPA Coordinating Committee on Health (document EBPDC10/5), which had recommended the abolition of that Committee. The Programme Development Committee had not made any recommendation, preferring to submit the issue to the Board, where it was due to be discussed under agenda item 7.6.

Dr LARIVIÈRE (alternate to Mr Aiston, Canada) said that his delegation had attended the meeting of the Programme Development Committee as an observer and found it very useful. He welcomed the approach taken to the preparations for the Eleventh Proposed Programme of Work and the regular budget for 2006-2007.

The Board noted the report.

Administration, Budget and Finance Committee (Document EBABFC20/3)

The Board noted the report.

Audit Committee (Document EBAC9/5)

Professor EL TAYEB (alternate to Dr Tag-El-Din, Egypt), speaking in his capacity as Chairman of the Audit Committee, said that at its ninth meeting, held on 14 January 2004, the Committee had studied a report by the External Auditors which had indicated satisfaction with the progress made in implementing their recommendations. It had further considered the report of the Internal Auditor, and had underlined the importance of having effective indicators in the Programme budget as a basis for monitoring performance.

The Committee had noted that the Board's work would be facilitated if documents of different types for the governing bodies were more easily identifiable. For instance, documents outlining progress towards the implementation of Health Assembly resolutions should be clearly distinguished from those provided for information only.

The Committee had also discussed the report of the Joint Inspection Unit, which the Board would consider under agenda item 7.5.

The Board noted the report.

Standing Commitee on Nongovernmental Organizations (Document EB113/23)

Dr ALEMU (Eritrea), speaking as Chairman of the Standing Committee on Nongovernmental Organizations, said the Committee had expressed its appreciation of the work of the applicant organizations, especially those whose activities had been reviewed. He drew attention to the proposed draft resolution and draft decision contained in section III of the document.

Mrs LAMBERT (South Africa)[1] expressed concern at the proposed admission into official relations with WHO of the International Council of Grocery Manufacturers Associations (ICGMA) and the Confederation of the Food and Drink Industries of the EU (CIAA). Paragraph 3.1 of the Principles Governing Relations between the World Health Organization and Nongovernmental Organizations stipulated that the main area of competence of the nongovernmental organization should fall within the purview of WHO and that its aims and activities should be in conformity with the spirit, purposes and principles of the Constitution of WHO, should centre on development work in health or health-related fields, and should be free from concerns which were primarily of a commercial or profit-making nature.

Paragraph 6 of document EB113/23 stated that ICGMA was an organization of associations "concerned with the manufacture and distribution of foods, beverages and other grocery products". She did not understand how such an organization could be seen to be doing development work in health or health-related fields, or how it could be free of concerns that were primarily commercial or of a profit-making nature. It was also stated that ICGMA had access to "a variety of data and know-how that was unavailable elsewhere". WHO could of course consult with such an organization to obtain information, but that did not necessarily mean that that organization would have to be admitted into official relations. Concerning CIAA, paragraph 7 of the document stated that its aims included the resolution of problems in the food and drink industries, an aim that she did not consider to be health-related. Such potential conflicts of interest should be of paramount concern to WHO when considering the admission of such organizations into official relations.

Ms DURHAM (New Zealand)[1] shared the concerns expressed by the previous speaker. She noted that paragraph 7.2 of the Principles Governing Relations between the World Health Organization and Nongovernmental Organizations stipulated that such organizations should utilize the opportunities available to them through their normal work to disseminate information on WHO policies and programmes. She sought assurance that the "other grocery products" handled by ICGMA did not include tobacco products, and that the aims of CIAA were consistent with WHO's draft global strategy on diet, physical activity and health.

Dr HUERTA MONTALVO (Ecuador) considered that the mechanisms by which such organizations were admitted into official relations with WHO should be clarified. It appeared that a nongovernmental organization was considered international if it was working on at least two continents, but in practice that left out all such organizations in the Region of the Americas, because they worked on only one continent. A second issue was the kind of relations the organizations had with WHO, since in some cases those relations were financial. Thirdly, concerns had been raised as to the requirement that reports had to be provided to maintain official relations, in view of the fact that previous committees had been somewhat lax and had recommended that such relations be maintained even though the required reports had not been forthcoming.

Apart from strictly legal considerations, the question arose as to what defined a nongovernmental organization: was it simply an organization that had no links with the executive powers of a given country, or was it an organization that was non-profit making? In order to avoid ambiguity, clearer rules needed to be established.

Dr ALEMU (Eritrea), speaking in his capacity as Chairman of the Standing Committee on Nongovernmental Organizations, said that all the applications considered had been the subject of intensive discussion. Although concerns had been raised about the two organizations referred to, the Committee had decided, in view of the fact that neither was profit-making and that they provided WHO with technical assistance, to propose that they be admitted into official relations with WHO.

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[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Mr HOHMAN (alternate to Dr Steiger, United States of America) agreed with the member for Ecuador about the need to clarify policy. The Board would be discussing relations with nongovernmental organizations further under item 7.4 of its agenda, and the subject of bodies that represented commercial interests would certainly be of concern. Some organizations currently in official relations with WHO represented commercial interests to varying degrees. South Africa had made an important point, which should be given careful consideration when the policy was discussed. On the other hand, both ICGMA and CIAA had contributions to make to the discussion on the draft global strategy on diet, physical activity and health, since on that issue all stakeholders should be involved and working with WHO. He therefore supported both the draft resolution and the draft decision.

Mr BRUNET (alternate to Professor Dab, France), seconded by Dr AL-MAZROU (Saudi Arabia) and Mr ASLAM KHAN (alternate to Mr Khan, Pakistan), suggested that the Board should defer a decision on ICGMA and CIAA pending the receipt of further information.

Mr GUNNARSSON (Iceland) said that he could see both sides of the argument. On the one hand, institutions concerned with food and drink had a great deal to do with health, and WHO should therefore enter into dialogue with them as stakeholders. On the other hand, the point raised by South Africa and New Zealand about conflicts of interest was important. He suggested that the Board should defer consideration of both the draft resolution and the draft decision until the new Principles had been adopted.

Dr LARIVIÈRE (alternate to Mr Aiston, Canada) said that, if WHO wanted to develop proper relations with stakeholders and influence those that did not entirely share the Organization's goals and objectives, it would have to invite them to sit round the table. He suggested that part of the problem might lie in the wording of paragraph 7 of document EB113/23, which stated that CIAA represented the interests of the food and drink manufacturing industry in the European Union, but did not state that it shared the goals of the Organization. He supported the proposal to defer a decision pending receipt of further information.

Mr HOHMAN (alternate to Dr Steiger, United States of America) asked why the applications from ICGMA and CIAA had not been screened for connections to the tobacco industry.

Mr AITKEN (Director, Office of the Director-General) said that, under current procedures, the applicants had not been screened for connections to the tobacco industry; under the new procedures, such screening would take place.

Mr SAWERS (Australia)[1] endorsed the comments made by the members for the United States of America, Iceland and Canada. He asked for more information on the extent to which ICGMA and CIAA supported WHO activities.

Mr AITKEN (Director, Office of the Director-General) said that ICGMA and CIAA had in fact collaborated with the Organization by working extensively with the Food Safety Group on matters relating to food safety and by participating in the consultation process for the draft global strategy on diet, physical activity and health.

Dr BEHBEHANI (Assistant Director-General) added that the charters of both organizations specified that they were non-profit-making.

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[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The CHAIRMAN suggested that, pending further enquiry into the issues raised, the Executive Board should adopt the draft resolution with the deletion of the reference to the two nongovernmental organizations concerned from paragraph 1. The Standing Committee on Nongovernmental Organizations would report back to the Executive Board at its 114th session, and in the meantime WHO would continue collaborating with both institutions.

It was so decided and the resolution, as amended, was adopted.[1]

The CHAIRMAN proposed that the Executive Board adopt the draft decision contained in document EB113/23.

The decision was adopted.[2]

Awards (Document EB113/RESTR.DOC./1)

The CHAIRMAN proposed that the Board should consider the item in open meeting.

It was so decided.

Jacques Parisot Foundation Fellowship

The CHAIRMAN said that, owing to scheduling difficulties in the Regional Office for the Americas, the nomination for the Jacques Parisot Foundation Fellowship award had not yet been reviewed by the Regional Committee, as required by its regulations. After discussion with its members, the Selection Panel had decided not to meet. The recommendation of the Regional Committee would be presented to the Panel the following year.

The Board noted that information.

Ihsan Dogramaci Family Health Foundation Prize

The CHAIRMAN said that the Health Foundation Selection Panel had proposed no recipient for the prize for 2004 as a decrease of the capital was not permissible under the current statutes.

The Board noted that information.

Dr A.T. Shousha Foundation Prize and Fellowship

Decision: The Executive Board, having considered the report of the Dr A.T. Shousha Foundation Committee, awarded the Dr A.T. Shousha Foundation Prize for 2004 to Dr Saleh Mohammed Al-Khusaiby (Oman) for his most significant contribution to health care in the geographical area in which Dr Shousha served the World Health Organization.

The Board awarded the Dr A.T. Shousha Foundation Fellowship to Dr Masoud Mostafaie (Islamic Republic of Iran). The laureate will receive a grant of US$ 15 000 for a doctoral scholarship; expenses over and above that amount remain the responsibility of the laureate.[3]

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[1] Resolution EB113.R14.

[2] Decision EB113(1).

[3] Decision EB113(2).

Sasakawa Health Prize

Decision: The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel, awarded the Sasakawa Health Prize for 2004 to the Family Planning Association of Sri Lanka (Sri Lanka). The laureate will receive an amount of US$ 40 000 for its outstanding work in health development.[1]

United Arab Emirates Health Foundation Prize

Decision: The Executive Board, having considered the report of the United Arab Emirates Health Foundation Selection Panel, awarded the United Arab Emirates Health Foundation Prize for 2004 jointly to the Shaukat Khanum Memorial Cancer Hospital and Research Center (Pakistan) and Mrs Stella Lubayelea Obasanjo (Nigeria) for their outstanding contribution to health development. The laureates will each receive US$ 20 000.[2]

Policy for relations with nongovernmental organizations: Item 7.4 of the Agenda (Document EB113/24)

The CHAIRMAN recalled that the Board had discussed the new policy for relations with nongovernmental organizations at its 111th session in January 2003 and had recommended its endorsement by the Fifty-sixth World Health Assembly. The Health Assembly had decided to refer the policy back to the Board for further review at the current session. Informal consultations had been carried out with a view to reaching a consensus.

Mr BRUNET (alternate to Professor Dab, France), reporting on the informal consultations, said that three meetings had taken place. Although the atmosphere had been constructive, it had not been possible to reach a consensus. More in-depth consideration of the amendments was required given their importance and implications, and some countries had to consult their capitals. An open-ended working group should be established in Geneva with interested Member States to work on the basis of document EB113/24 and take into account the proposals submitted in writing by Member States after the consultations. The working group should be set up as soon as possible and should complete its work by the end of February, so that the Fifty-seventh World Health Assembly could be informed of the results achieved.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) agreed that the matter required further consideration, as much was still to be clarified. The Fifty-sixth World Health Assembly had not been able to reach an agreement on the issue. Furthermore, the draft resolution circulated to members of the Board was not the amended version, but the one that had been submitted to the Health Assembly. The document placed greater emphasis on WHO's relations with nongovernmental organizations than on the specific nature and characteristics of those organizations. As the member for Ecuador had already said, certain concepts remained to be defined. WHO established relations with a nongovernmental organization because their interests coincided and no conflict of interests existed. He therefore supported the suggestion that a working group be set up to look into the issue further.

Dr LHOTSKA (International Organisation of Consumers Unions (Consumers International)), speaking at the invitation of the CHAIRMAN and on behalf of the International Baby Food Action Network, Health Action International, the Ecumenical Pharmaceutical Network and the International Alliance of Women, expressed concerns about the suggested policy. The inclusion in the definition of

[1] Decision EB113(3).

[2] Decision EB113(4).

nongovernmental organizations of "not-for-profit organizations that represent or are closely linked with commercial interests" did not provide for the vital distinction between nongovernmental organizations serving public interests and those serving business interests, even if they were not-for-profit. The key was the detection and proper management of conflicts of interest, and the objective was to prevent those with financial interest in public policy-making from having undue influence. She recalled the principle in paragraph 14(d) of the policy (document EB113/24, Appendix) that collaboration should not compromise the independence and objectivity of WHO and should avoid any conflict of interest. A key safeguard contained in the version of the policy submitted to the Board at its 111th session on cooperation with nongovernmental organizations representing commercial interests had, however, been deleted from the current version and should be reintroduced with an explicit reference to the WHO Guidelines on Interaction with Commercial Enterprises. The Board had expressed serious concerns about the adequacy of those Guidelines when they had first been introduced, and she suggested that they and other mechanisms and procedures should be revised and updated in view of the growing interaction between WHO and the private sector and the increasing attempts of industry to undermine public policy-making. In addition, the proposed policy did not adequately address the need for positive action in developing relationships and collaboration with nongovernmental organizations from developing countries and countries in transition. WHO should develop a clear and transparent system in that regard.

Ms MULVEY (Infact), speaking at the invitation of the CHAIRMAN, and on behalf of the Network for Accountability of Tobacco Transnationals, strongly supported the objective of enhancing the participation of nongovernmental organizations, which lay behind the proposed new policy. Although their involvement in the negotiations had contributed positively to the drafting of the WHO Framework Convention on Tobacco Control, the successful outcome could also be attributed to the fact that the tobacco industry had not been permitted to interfere in the negotiations. Infact therefore urged WHO Member States not to include groups with industry-affiliation or commercial interests in the proposed definition of nongovernmental organizations. According to the current principles governing relations between WHO and nongovernmental organizations, only those nongovernmental organizations that were free from concerns primarily of a commercial or profit-making nature could enter into official relations with WHO, and she therefore welcomed the Board's decision to postpone the admission of two business associations. Corporations had long tried to advance their interests by forming pseudo-nongovernmental organizations, and terms such as "partner" or "stakeholder" further blurred distinctions among different sectors of society. The proposed new definition of a nongovernmental organization would make it more difficult for Board members and Member States to distinguish between organizations representing the public interest and those representing business interests. WHO should formally establish a private-sector category, distinct and separate from civil society including nongovernmental organizations, using the WHO Guidelines on Interaction with Commercial Enterprises as a basis. At the very least, it should retain the former definition of nongovernmental organizations or delete the phrase "not-for-profit organizations that represent or are closely linked with commercial interests". It was vital to WHO's integrity and to its capacity to achieve future breakthroughs in public health that conflicts of interest were avoided, including in relations with nongovernmental organizations.

Dr BALE (International Federation of Pharmaceutical Manufacturers Associations) said that the Federation was a transparent, not-for-profit nongovernmental organization, with more than 30 years of experience in official relations with WHO as a legitimate representative of the research-based pharmaceutical industry, an important stakeholder in public health. That sector of the industry provided invaluable resources and expertise to improve health around the world, including in the context of WHO's "3 by 5" initiative. Close and constructive relations between WHO and the Federation remained vital. The research and development industry provided vaccines for programmes to eradicate poliomyelitis and medicines to fight leprosy, lymphatic filiariasis, onchocerciasis, trachoma, mother-to-child transmission of HIV and many other diseases affecting developing

countries, free of charge to those in need. On 16 January 2004, company members of a task force of the Federation had donated more than 125 000 doses of influenza vaccine to help prevent an outbreak of avian influenza. Furthermore, it was the pharmaceutical industry that had developed the vast majority of life-saving medicines and vaccines, and it was in WHO's strategic interest to foster and promote partnerships with the industry as well as with other nongovernmental organizations.

The issue was not one of private sector versus public sector, but rather of how WHO could strengthen partnerships to fight diseases. Transparency, not exclusion, was the key solution. Drawing a false distinction between nongovernmental organizations working in the public interest and those working in the business interest would only cause confusion among partners, and denigrate the achievements of successful partnerships. The Federation, for its part, was not a business and looked forward to continuing its productive collaboration with WHO for the benefit of people around the world.

Dr BRONNER (International Special Dietary Foods Industries) recalled that the non-profit organization supported the draft resolution and the new policy for relations with nongovernmental organizations for the following reasons. First, the United Nations community recognized industry as an important stakeholder and partner, and acknowledged that nongovernmental organizations representing consumers, business and industry were important sources of knowledge, technology and resources. Secondly, WHO supported transparency in its relations with the nongovernmental sector. All nongovernmental organizations should be afforded the same rights to participate and collaborate in WHO processes and be subject to the same high levels of scrutiny and accountability. All should be required to disclose mission statements, organizational affiliations and sources of funding, and demonstrate that they were genuine. Lastly, the effort to streamline the accreditation and collaboration requirements was a welcome reform, and the members of his organization stood ready to help advance the work of WHO by sharing their scientific expertise and ongoing advances in research.

Dr NEIRA GONZÁLEZ (alternate to Dr Pastor Julián, Spain) agreed that it would be appropriate to establish a working group to consider the matter further and, in particular, the contribution to be made by those nongovernmental organizations admitted into official relations with WHO. In that connection, the changes in the world over the past 20 years should be taken into account. It would not be advisable for two categories to be created, those organizations not having been admitted into official relations with WHO being viewed with suspicion and considered less favourably than those with official relations, particularly as it was perfectly possible for the former to cooperate with WHO.

The CHAIRMAN said that, in the absence of any objection, he would take it that the Board agreed that the Director-General should be requested to convene a consultation mechanism open to Member States to discuss the issues further. The Director-General would report on the outcome of those consultations at the Fifty-seventh World Health Assembly, if possible providing a draft resolution and policy document on the subject. The consultations should be convened without delay to enable work to be finalized by the end of February, in order to allow for adequate and timely dissemination of documents before the Fifty-seventh World Health Assembly.

It was so agreed.

Reports of the Joint Inspection Unit: Item 7.5 of the Agenda (Documents EB113/25 and EB113/26)

Professor EL TAYEB (alternate to Dr Tag-El-Din, Egypt), speaking in his capacity as Chairman of the Audit Committee, said that the Committee had been pleased to note the collaboration between WHO and the Joint Inspection Unit (JIU), especially the establishment of a WHO focal point within the Unit. One of the three JIU reports of relevance to WHO had dealt with managing information in organizations in the United Nations system. The Committee had emphasized the importance of the

new systems being planned and of the progress reports on their implementation, and had agreed that such reports should be provided as part of the regular reporting procedure. With regard to the report on the "Evaluation of United Nations system response in East Timor", the Committee had applauded the new strategy for health action in a crisis. In considering the report on the implementation of multilingualism in the United Nations system, it had stressed the need for good practice and clear policy.

WHO's future plans for staff development and inventories of language skills had been welcomed by the Committee. It had emphasized that support costs related to extrabudgetary activities should be sufficient to meet the true cost of supporting the programmes in question, so that assessed contributions were not used to subsidize them. The Committee had noted that any proposals to change WHO support cost policy would require a Health Assembly resolution. In response to a comment from the JIU representative that the Board did not always take specific action on every recommendation addressed to the legislative organs, the Committee had suggested that, should a recommendation require a policy change, the Board's attention should be drawn to that fact.

Dr LARIVIÈRE (alternate to Mr Aiston, Canada) welcomed the identification of a WHO focal point within the JIU. His Government fully endorsed the view that the development at WHO of the new management information system and the provision of regular progress reports on its implementation were important. Canada strongly supported the continued development of a clear policy and good practice with regard to multilingualism in WHO and consequently welcomed the decision to review support cost policy: in that connection, an opportunity for the participation and input of Member States would be appreciated. Support costs should meet the real costs of programmes funded on a voluntary basis, so that there would be no need to subsidize them from the assessed budget. His Government also fully supported the conclusions and recommendations of the ninth meeting of the Audit Committee.

Mr KOCHETKOV (alternate to Professor Furgal, Russian Federation) underlined the significance of the report on the implementation of multilingualism in the United Nations system, as WHO's ability effectively to disseminate health information in the Commonwealth of Independent States was predicated on the circulation of that information in Russian, above all through the Organization's web site. For that reason, his Government welcomed the Director-General's decision to include more languages on the site. The Board should perhaps recommend that the Director-General draft a paper on the subject for the next Board meeting.

Ms BLACKWOOD (alternate to Dr Steiger, United States of America) said that her Government commended WHO's forthright response to the recommendations contained in the three JIU reports, and urged their continued implementation. Recommendations 1 and 2 in the report on managing information in the United Nations system organizations were excellent, and her Government was pleased to see that WHO was taking appropriate action on them. It would be useful for the new Director of Information Technology to make a cost estimate of what WHO was spending on its management information systems, as that was a key piece of information needed to determine whether it was receiving a good return on its investment in those systems.

Recommendation 4 in the report on the evaluation of the United Nations system response in East Timor was excellent, provided that it was fulfilled within existing staffing and budget levels. The increased involvement of United Nations agencies, funds and programmes in the implementation of projects funded or managed by the World Bank called for in recommendation 11 would not necessarily improve each and every situation. Involvement of the United Nations or World Bank was useful in some circumstances, but it should take place on an ad hoc rather than a systematic basis.

Mr BRUNET (alternate to Professor Dab, France) endorsed the comments of the member for the Russian Federation on multilingualism. How was it intended to carry out recommendations 4(a) and 7(b) of the report on the implementation of multilingualism in the United Nations system, and the

recommendations on cooperation between United Nations system organizations with a view to cutting costs? Total expenditure on installing management information systems in all the organizations had amounted to US$ 1000 million over the previous 10 years, a considerable sum when compared with the funds earmarked for the "3 by 5" initiative. What savings could be achieved through closer consultation and coordination between organizations?

Dr YIN Li (China) endorsed the statements made by the members for Canada, the Russian Federation and France regarding multilingualism. There was still room for improvement in the regional offices in that respect.

Ms MAFUBELU (alternate to Mrs Lambert, South Africa)[1] said that, with regard to the report on the implementation of multilingualism in the United Nations system, South Africa strongly supported recommendation 3(e) because it would strengthen the implementation of WHO's recruitment strategy as reflected in document EB113/18. It was, however, concerned at a response to that recommendation, set out in document EB113/25, namely that security concerns might preclude the use of the office of the WHO Representative for the submission of online applications by external candidates. Given that other bodies within the United Nations system did not appear to share those concerns, why was WHO the exception?

Dr AL-MAZROU (Saudi Arabia) said that the infrequent use of Arabic in WHO scientific documents had a negative impact on the proper use of available information. The Director-General and the Regional Office for the Eastern Mediterranean should therefore implement the JIU recommendation.

Dr HUERTA MONTALVO (Ecuador) supported the views expressed by the member for the Russian Federation regarding multilingualism. All the conclusions of meetings should be published on the WHO web site.

Dr NORDSTRÖM (Assistant Director-General) said that WHO greatly appreciated the JIU's excellent collaboration and its helpful recommendations. Turning to the question of the use of several languages in the Organization, he said that intensive discussions had been held in order to determine the best way of improving communication. The provision of certain documents in all the official languages was obligatory, but in some countries documentation had to be supplied in non-official ones as well, and certain documents had therefore to be translated into 27 different languages. WHO could not afford to provide that service for all documents, and so priorities had to be set. Dialogue with the Member States would make it possible to ascertain exact information needs.

The report on management information systems had been particularly useful, as it had helped to pinpoint some shortcomings in WHO's system. In order to remedy those deficiencies, a Director for Information and Telecommunications would be appointed in the near future, and a more explicit strategy for information technology and management was about to be introduced for the whole Organization. WHO had also embarked on an ambitious exercise to set up a new global management system, and in doing so was closely cooperating with other organizations in the United Nations system in order to learn from their experience. The new system, which should be introduced within two years, should allow access to better information, especially for Member States.

Security posed a problem in countries with only a small WHO office and where, for practical reasons, it would be impossible to provide a computer that could be used by candidates for posts to submit their applications. However, he had taken note of the concerns expressed by South Africa and would endeavour to find a solution.

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[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Dr OUEDRAGO (Vice-Chairman, Joint Inspection Unit) said that, as co-author of the report on the implementation of multilingualism in the United Nations system, he considered that access by the public to WHO information was vital. The JIU had transmitted to the Director-General a more specific report entitled "Multilingualisme et accès à l'information: étude de cas sur l'Organisation mondiale de la Santé", which, once it had been translated, would be submitted to the Board at a forthcoming session. It was important to remember that there would be pressure on resources if the governing bodies demanded more multilingualism. That issue had been dealt with at length in the last chapter of the report, where the point had been made that secretariats and Member States were jointly responsible for improving the situation. Plainly it was illusory to expect that all documents could be translated into all official languages, but programme budgets should be in tune with the targets set for the Organization. At FAO, for example, a special fund had been set up to finance the translation of large databases which had hitherto been available in English only.

The Board noted the reports.

Governing body matters: Item 7.6 of the Agenda

- **Executive Board retreat: Chairman's report** (Document EB113/39)

The CHAIRMAN said that discussions at the retreat (Accra, 18 and 19 November 2003) had centred on the Millennium Development Goals and on health targets, partnerships, country focus and the financing of WHO. Board members had supported the Director-General's vision for WHO's future, with its emphasis on the need for continuity in terms of leadership, priorities and resources. His first priorities were achieving results in countries, strengthening the surveillance of global disease and developing health systems and human resources. Making WHO more effective at country level through the decentralization of resources and the improvement of communications and connectivity were likewise of fundamental importance. Major steps would also be taken in the spheres of noncommunicable diseases, maternal health, reproductive health and child survival. In order to achieve those aims, it had been suggested that Member States should concentrate on priorities that had already been defined, rather than adding new ones and running the risk of diverting human and financial resources. WHO had a central role to play in coordinating and defining priorities for the international health agenda.

Discussions on the Millennium Development Goals and health targets had revolved around the "3 by 5" initiative. HIV/AIDS was a global health emergency; WHO could not handle it on its own, but should take the lead. The general consensus had been that prevention measures should not suffer as a consequence of the stress placed on access to antiretroviral treatment. Despite the firm political resolve to combat HIV/AIDS, there were insufficient financial resources to implement the initiative. At the same time, it was essential to ensure that the latter should not divert attention from measures to combat the global burden of malaria. Several participants had stressed the need to act at the regional and subregional levels as well as at the global level. Furthermore, the "3 by 5" initiative should have a beneficial impact on WHO's endeavours to strengthen health systems and should be fully integrated into country focus activities. A strong theoretical and scientific basis for the initiative should be developed, and the Board should discuss fully its costing and timeframe.

The rapid growth in global partnerships for health in recent years, in many of which WHO had been involved, had been acknowledged. WHO was reviewing its role in those partnerships with a view to identifying best practice. Some members had felt that it was important to review partnerships in both the public and the private sector, while others had voiced the opinion that clearer definitions were needed of the concept of partnership and the role that WHO could play. The conclusion had been reached that engagement of regional and national groups was also vital, especially at the grass-roots level, and that it was essential for all partners to be equally committed and to coordinate work effectively with each other, while recognizing their respective mandates.

It had been generally agreed that WHO's country focus should be encouraged and supported, since a more effective WHO field presence would result in improved health outcomes and systems in individual countries. WHO should be able to continue its normative functions in addition to providing technical support, working together with countries, not in place of them, for example when planning country cooperation strategies, as each country had distinct needs. The Director-General's proposals reflected a pledge of a more effective WHO presence with an increased resource allocation to regions and countries. WHO's policies and strategies had to adapt to changing demands, and the WHO field-level staff profile had to be modified as necessary. The impact of WHO's contribution to national health systems development should be analysed, in order to support countries in attaining their goal of better health.

The limited resources available warranted an in-depth discussion. Although WHO's regular budget had been stable for many years despite increasing demands, extrabudgetary funding had increased rapidly. The new results-based approach had been generally supported; many speakers had stressed the need for more resources to be allocated to the regions and countries, and had endorsed the increase to 70% by the end of 2005. The greater clarity in presenting the regular budget had been appreciated, and the importance of linking programme budget planning to evaluation had been stressed. There had been a request for greater integration of regular-budget and extrabudgetary resources, concern being voiced that too much of the latter was spent at headquarters rather than in regions and countries. Accountability, transparency and effectiveness, by the Secretariat and Board members alike, had been stressed.

Board members had been able to visit several local health centres and research institutes. The President of Ghana had received Board members at the official residence, and a dinner hosted by the Vice-President had been held in their honour.

He appreciated the honour that the Board had bestowed on his country in attending the retreat in Accra.

- **Governing body sessions: timing and duration** (Document EB113/27)

Dr KEAN (Director, Governance) said that on 27 November 2003 a consultative meeting with Missions to the United Nations in Geneva had been convened to facilitate preliminary discussion on the timing and duration of governing body sessions and the Executive Board committee system. The current cycle of meetings had been in effect since 1970, reviews in 1980 and 1989 having resulted in no change. The meeting had taken up several questions raised by the intergovernmental working group to review the working methods of the Executive Board in 2002-2003, including the balance between the Board's January and May sessions. Most speakers had advocated a more substantive session in May so as to relieve pressure on the January agenda, but many had stressed that a two-week session was the longest realistic period for attendance. One suggestion had been to hold the May session at a separate time from the Health Assembly, but matters of time and cost had been raised as a problem in that regard.

Many participants had said that the holding of the January session towards the end of the month should be considered, to give governments more time for preparation; there had also been support for holding the Health Assembly in late May. There had been no overall support for amending the current cycle, apart from the possibility of meeting later in January and May. Access to meeting documentation as early as possible continued to be a concern.

Dr YIN Li (China) suggested that consideration of the timing and duration should take into account the avoidance of national holiday dates.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that nothing was to be gained by disrupting the current cycle of meetings. As for duration, the Board's agendas were becoming ever longer, and some flexibility might be needed in the length of sessions and the way work was allocated. Items for later consideration by the Health Assembly should take

priority in the Board's January sessions, so that technical items could be properly discussed. He did not favour increasing the duration of the Board's May session.

Professor FURGAL (Russian Federation) supported the previous speaker; he had failed to find, in the document, any objective reason for altering the timing of the sessions. As for their duration, sufficient time was needed for careful study and decision-taking; too many agenda items in recent sessions of the Board and Health Assemblies had been deferred. Either the agenda should be prepared carefully, with a smaller number of items, or the sessions should be lengthened. He preferred the former.

Mr ASLAM KHAN (alternate to Mr Khan, Pakistan) said that the matter of timely availability of documents was of great concern to many countries. He requested that all documentation be made available on the Internet at least one month before the beginning of each session.

Dr LARIVIÈRE (alternate to Mr Aiston, Canada) said that a four-month interval between the meetings of major governing bodies made sense, since it allowed for an adequate flow of information. It was probably reasonable to hold the Board's January sessions at the end of the month, and Health Assemblies at the end of May. Meetings of the regional committees, it should be noted, covered a six-week period – a major factor in itself. The evolving nature of international health work – more partners, multisectoral approaches, growing complexity of issues – meant that, Board and Health Assembly alike had too much to do in too little time. It would indeed be possible to work within current schedules if essential policy was focused on, reporting was streamlined and document distribution was timely. The question of avoiding national holidays had been raised in the past, and had even been reflected as part of a Board resolution; it had been ruled that any such consideration should be decided upon by the Board, not left to the Secretariat, so as to avoid creating any awkward precedent.

The CHAIRMAN said that he took it that the Board wished to maintain the current timing and duration of governing bodies, on the understanding that the agenda of its May session should be more substantive, that the January session should be held as late in the month as possible, the Health Assembly itself convening in late May, and that documentation availability should be strictly in accordance with the Rules of Procedure.

It was so agreed.

- **Executive Board: committee system** (Document EB113/28)

Dr KEAN (Director, Governance) said that, at the consultative meeting in November, Missions to the United Nations in Geneva had been briefed on the numerous changes to the system of standing committees on programmes, budget, finance, administration and audit issues since 1948. Discussion had focused on the need for transparency in documentation and participation, and on ways to improve the Board's work, including the handling of committee reports, the potential value of the Audit Committee in problem situations and certain clarifications on current terms of reference and procedure. Many speakers had supported the option of amalgamating ABFC, the Programme Development Committee and the Audit Committee; but no common view had been reached on the size of membership, suggestions having ranged from 6 to 18 members. Concern had been voiced on the need to maintain expertise, especially in auditing, and to have clear terms of reference regarding the Board itself and a more prominent role for the Committee's reporting to the Board, perhaps on the lines adopted in the Regional Committee for Europe, in which the standing committee's report was presented early in the session. Some speakers had cited the recommendation of the Joint Inspection Unit in 2001 in favour of a single merged committee (document JIU/REP/2001/4, page 6).

The Programme Development Committee had also considered another committee of the Board, the WHO/UNICEF/UNFPA Coordinating Committee on Health. Since the meeting of the Programme Development Committee, the Executive Board of UNICEF had also discussed that issue. It had adopted a resolution on the subject, and endorsed the recommendation in the review of the Coordinating Committee on Health (document EBPDC10/5) that, in the light of alternative collaboration arrangements developed since its establishment in 1997 and the balance of costs and achievements, that Committee should be discontinued. The Board recommended that the secretariats of the three organizations should continue to strengthen coordination among themselves in the area of health.

Dr LARIVIÈRE (alternate to Mr Aiston, Canada) stated a preference for merging the three committees. He suggested a membership of 12, two members per region, with an officer of the Board participating *ex officio*. Perhaps more important than the number of committees, however, was the matter of functions, including timely submission of reports, in order to uphold the credibility and authority of the committee process through increasing the efficiency of the Executive Board. The WHO/UNICEF/UNFPA Coordinating Committee on Health should be abolished, since it had increasingly tended to focus on programmes. That was a task better carried out by organizations themselves or through other institutionalized mechanisms of the United Nations system.

Mr HOHMAN (alternate to Dr Steiger, United States of America) said that he too supported the merging of three committees into one. For the latter, a membership of two from each region would be simplest; but regions differed in number of countries, so some other arrangement might be deemed more appropriate. If a decision were to be taken before the next session of the Board, the Secretariat could perhaps study the questions of composition and terms of reference. He agreed that the Coordinating Committee on Health should be abolished.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) strongly favoured simplification of the committee structure, on the lines set out in paragraph 14(a) of document EB113/28. He stressed that the new committee should focus on important issues, especially the reporting on audit matters, and that the membership's competence should be commensurate with the need to handle any matters regarding probity that might arise. He expressed reservations about the use of the term "standing committee" – although the concept was necessary under Rule 16 of the Rules of Procedure; perhaps the use of the term should be reviewed, since it could be confusing to outsiders.

Dr YIN Li (China) supported the proposed merging of the committees and could accept the option set forth in paragraph 14(a) of document EB113/28. However, consideration of the membership should take into account not only geographical balance in general but that between developed and developing countries.

Professor EL-TAYEB (alternate to Dr Tag-El-Din, Egypt) said that the proposals relating to the three standing committees were basically of a procedural nature; he failed to see, however, any mention of objective issues such as the competence required for membership or the terms of reference. The Board needed the support of such committees; moreover, to merge the three into one might adversely affect transparency. Although efforts to improve performance and effectiveness were welcome, such measures should take the form of strengthening committees rather than merging them. The Audit Committee should certainly not be merged; its terms of reference were different, and its functions deriving therefrom required that it remained independent and work in a specific way. The report before the Board had not dealt with that committee, although it had dwelt on the other two. He supported the status quo.

The CHAIRMAN, noting the majority view, took it that the Board agreed in principle to merge ABFC, the Programme Development Committee and the Audit Committee into a single committee

and for that purpose it agreed to request the Secretariat to prepare draft terms of reference and options for membership, for consideration by the Board at its 114th session.

It was so agreed.

The CHAIRMAN also took it that the Board had decided to discontinue the WHO/UNICEF/UNFPA Coordinating Committee on Health.

Dr KEAN (Director, Governance) read out the text of a proposed draft resolution, which, owing to time constraints, had not been circulated:

> The Executive Board,
>
> Noting the report of the tenth meeting of the Programme Development Committee[1] and the review of the WHO/UNICEF/UNFPA Coordinating Committee on Health,[2] and recalling resolution EB103.R17 establishing the WHO/UNICEF/UNFPA Coordinating Committee on Health;
>
> Taking into account the increased collaboration between the three organizations since the establishment of the Coordinating Committee on Health in 1997, and the balance between costs and achievements,
>
> 1. DECIDES that the WHO/UNICEF/UNFPA Coordinating Committee on Health should be disestablished;
>
> 2. REQUESTS the Director-General:
>
> (1) to transmit this resolution to the Executive Board of UNICEF and of UNFPA;
>
> (2) to continue to strengthen coordination between WHO, UNICEF and UNFPA in the area of health.

The CHAIRMAN said that he took it that the Board agreed to adopt the draft resolution.

The resolution was adopted.[3]

- **Provisional agenda of the Fifty-seventh World Health Assembly and date and place of the 114th session of the Executive Board** (Document EB113/29)

The CHAIRMAN, introducing the item, drew attention to minor changes in the wording proposed for provisional agenda items 14 and 15 set forth in Annex 1 in document EB113/29. Provisional item 14, Internal audit and oversight matters, would remain, with one substantive subitem, Report of the Internal Auditor and comments thereon made on behalf of the Executive Board. Provisional item 15, Financial matters, would include as a first substantive subitem Financial report on the accounts of WHO for 2002-2003; report of the External Auditor and comments thereon made on behalf of the Executive Board. He also drew attention to the draft decision contained in paragraph 4 of document EB113/29.

Dr KEAN (Director, Governance) said that two further items, Health promotion and healthy lifestyles and Family and health in the context of the tenth anniversary of the International Year of the

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[1] Document EBPDC10/7.

[2] Document EBPDC10/5.

[3] Resolution EB113.R15.

Family, had been added to the provisional agenda of Committee A, following on from the adoption of resolutions EB113.R2 and EB113.R12 on those two subjects. In addition, the first subitem under provisional item 12.13 would instead be made a full item, Control of human African trypanosomiasis, in accordance with resolution EB113.R6. The questions of scale of assessments for 2005 and of regular budget allocations to regions would be taken up under provisional items 15.1 and 16, respectively.

Mr GUNNARSSON (Iceland) suggested that the subject of oral health might be discussed under the new provisional item, Health promotion and healthy lifestyles.

Mr AITKEN (Director, Office of the Director-General) replied that, in accordance with normal practice, the subject should first be discussed by the Board before transmittal to the Health Assembly.

Mr HOHMAN (alternate to Dr Steiger, United States of America) said that provisional item 12.10, Intellectual property rights, innovation and public health, and provisional item 12.12, WHO Framework Convention on Tobacco Control, should perhaps be discussed under provisional item 12.13, Implementation of resolutions (progress reports), given the specific reference to progress reports made in resolutions WHA56.27 and WHA56.1 on those two particular subjects.

Dr KEAN (Director, Governance) confirmed that interpretation and said that provisional items 12.10 and 12.12 would therefore be discussed as subitems under provisional item 12.13.

The CHAIRMAN said that he took it that the Board wished to approve the draft decision contained in paragraph 4 of document EB113/29, as amended.

The decision, as amended, was adopted.[1]

Date and place of the 114th session of the Executive Board

The CHAIRMAN drew attention to resolution EB112.R1 which had decided that the Board's session following the Health Assembly should in principle be extended to permit a more even and effective distribution of substantive work between the two sessions. The 114th session would therefore be held over four days.

Decision: The Executive Board decided that its 114th session should be convened on Monday, 24 May 2004, at WHO headquarters, Geneva, and should close no later than 27 May 2004.[2]

The CHAIRMAN said that, in compliance with Rule 8 of the Rules of Procedure of the Executive Board, the Director-General would draw up a draft provisional agenda for the 114th session of the Board for circulation to Members States and Associate Members within four weeks of the closure of the current session.

Awards: establishment of new prize foundations: Item 7.7 of the Agenda (Document EB113/31)

The CHAIRMAN, referring to decision EB111(13) of the Executive Board to approve, in principle, the establishment of an award for research in the area of health promotion proposed by the State of Kuwait, drew attention to the draft statutes of the State of Kuwait Health Promotion Foundation contained in document EB113/31, Annex 1, and submitted to the Board for approval. He

[1] Decision EB113(5).

[2] Decision EB113(6).

also drew attention to resolution EM/RC50/R.13 of the Regional Committee for the Eastern Mediterranean, contained in Annex 2 of the same document, which recommended for approval by the Board at its current session the establishment of a Foundation for the State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes in the Eastern Mediterranean Region.

Dr AL-SAIF (Kuwait) mentioned that health promotion was a subject of major universal interest and had been discussed during the current session. It was, therefore, to be hoped that the Board would approve the draft statutes of the State of Kuwait Health Promotion Foundation with a view to stimulating yet further interest in the subject, and that it would also approve the recommendation of the Regional Committee for the Eastern Mediterranean. Kuwait had proposed the establishment of the Prize in the hope of reducing the high incidence of cancer, cardiovascular diseases and diabetes in that Region.

Dr LARIVIÈRE (alternate to Mr Aiston, Canada), seconded by Mr GUNNARSSON (Iceland), endorsed the establishment of both prize foundations. He thanked the Kuwaiti Government for its generous endowment, which he regarded as trust funds to be administered by WHO.

Dr AL-MAZROU (Saudi Arabia) also thanked Kuwait for its proposal to establish the two prize foundations; the first, for research in health promotion, was extremely timely, bearing in mind the Board's discussion of the subject, and the second related to key health issues of priority in the Eastern Mediterranean Region.

Decision: The Executive Board, subsequent to its decision EB111(13), decided to approve the draft statutes of the State of Kuwait Health Promotion Foundation submitted to it.[1]

Decision: The Executive Board, having considered resolution EM/RC50/R.13 adopted by the Regional Committee for the Eastern Mediterranean at its fiftieth session recommending the establishment of The State of Kuwait Prize for the Control of Cancer, Cardiovascular Diseases and Diabetes Foundation, in the Eastern Mediterranean Region, decided to approve the establishment of the Foundation and its proposed statutes, subject to arrangements being made to cover the administrative cost incurred with respect to such award, consistent with the arrangements made in respect of two other awards.[2]

6. CLOSURE OF THE SESSION: Item 9 of the Agenda

After the customary exchange of courtesies, the CHAIRMAN declared the session closed.

The meeting rose at 19:25.

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[1] Decision EB113(7).

[2] Decision EB113(8).