WHA68/2015/REC/3

WORLD HEALTH ORGANIZATION

SIXTY-EIGHTH WORLD HEALTH ASSEMBLY

GENEVA, 18–26 MAY 2015

SUMMARY RECORDS OF COMMITTEES

REPORTS OF COMMITTEES
LIST OF PARTICIPANTS

GENEVA
2015

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACHR – Advisory Committee on Health Research
ASEAN – Association of Southeast Asian Nations
CEB – United Nations System Chief Executives Board for Coordination
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
INCB – International Narcotics Control Board
ITU – International Telecommunication Union
OECD – Organisation for Economic Co-operation and Development
OIE – *Office International des Epizooties*
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 Sixty-eighth World Health Assembly was held at the Palais des Nations, Geneva, from 18 to 26 May 2015, in accordance with the decision of the Executive Board at its 135th session.[1]

[1] Decision EB135(8).

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[1] See document WHA68/2015/REC/1, Annex 3.

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[1] See document WHA68/2015/REC/1, Annex 4.

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A68/INF./5	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan Report at the request of the Permanent Observer of Palestine to the United Nations and Other International Organizations at Geneva
A68/INF./6	[Document cancelled]
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OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Mr Jagat Prakash NADDA (India)

Vice-Presidents

Dr LI Bin (China)
Mr John David Edward BOYCE (Barbados)
Dr Ferozudin FEROZ (Afghanistan)
Mr Francesco MUSSONI (San Marino)
Professor Awa Marie COLL SECK (Senegal)

Secretary

Dr Margaret CHAN, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Belgium, Colombia, Djibouti, Gabon, Guinea-Bissau, Honduras, Lesotho, Singapore, Switzerland, Tajikistan, Timor-Leste and Tonga.

Chairman: Mrs Muriel PENEVEYRE (Switzerland)
Vice-Chairman: Dr Médard TOUNG MVE (Gabon)
Secretary: Ms Joanne McKEOUGH, Principal Legal Officer

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the chairmen of the main committees, together with the delegates of the following Member States: Burkina Faso, Burundi, Comoros, Cuba, France, Ghana, Indonesia, Latvia, Montenegro, Oman, Peru, Russian Federation, South Sudan, Syrian Arab Republic, United Kingdom of Great Britain and Northern Ireland, United States of America and Viet Nam.

Chairman: Mr Jagat Prakash NADDA (India)
Secretary: Dr Margaret CHAN, Director-General

MAIN COMMITTEES

Under Rule 33 of the Rules of Procedure of the World Health Assembly, each delegation is entitled to be represented on each main committee by one of its members.

Committee A

Chairman: Dr Eduardo JARAMILLO NAVARRETE (Mexico)
Vice-Chairmen: Ms Dorcas MAKGATO (Botswana) and Dr Bahar Idreiss ABUGARADA ABULGASSIM (Sudan)
Rapporteur: Dr Liis ROOVÄLI (Estonia)
Secretary: Dr Timothy ARMSTRONG, Programme Manager, Surveillance and Population-based Prevention

Committee B

Chairman: Mr Michael MALABAG (Papua New Guinea)
Vice-Chairmen: Dr Raymond BUSUTTIL (Malta) and Mr Khaga Raj ADHIKARI (Nepal)
Rapporteur: Dr Guy FONES (Chile)
Secretary: Dr Clive ONDARI, Coordinator, Safety and Vigilance

REPRESENTATIVES OF THE EXECUTIVE BOARD

Dr Mariyam SHAKEELA (Maldives)
Dr Dirk CUYPERS (Belgium)
Dr Walid AMMAR (Lebanon)
Dr Yankalbe Paboung MATCHOCK MAHOURI (Chad)

PART I

SUMMARY RECORDS OF MEETINGS OF COMMITTEES

GENERAL COMMITTEE

FIRST MEETING

Monday, 18 May 2015, at 10:20

Chairman: Mr J.P. NADDA (India)
President of the World Health Assembly

1. ADOPTION OF THE AGENDA: Item 1.4 of the Agenda (Document A68/1)

The CHAIRMAN reminded the Committee that, under its terms of reference as defined in Rule 31 of the Rules of Procedure of the World Health Assembly, its first task was to consider the adoption of the agenda. In the absence of any objection, he took it that the Committee wished to recommend the deletion of three items included on the provisional agenda prepared by the Executive Board (document A68/1): item 5, Admission of new Members and Associate Members; item 21.3, Special arrangements for settlement of arrears; and item 21.5, Assessment of new Members and Associate Members, as, in each case, the status quo had remained unchanged. The Committee would also consider a proposal for a supplementary agenda item, "Mycetoma", from the Republic of Sudan (document A68/1 Add.1).

Deletion of agenda items

The CHAIRMAN indicated that, if there was no objection, three items on the provisional agenda would be deleted, namely item 5 (Admission of new Members and Associate Members); item 21.3 (Special arrangements for settlement of arrears); and item 21.5, (Assessment of new Members and Associate Members).

It was so agreed.

Supplementary agenda item

The CHAIRMAN drew attention to a proposal received from the Republic of Sudan for a supplementary agenda item and to a draft resolution on strengthening control of mycetoma disease contained in document A68/1 Add.1. He asked whether the Committee agreed to include the proposal on the agenda.

The observer of SUDAN[1] said mycetoma was a high-morbidity disease affecting countries in tropical and subtropical regions including India, Mexico, Senegal, Sudan and Yemen. Sudan had been combatting the disease for over two decades and it had established a centre that treated patients from Sudan and other countries. Sudan proposed that mycetoma should be added to the list of neglected tropical diseases prioritized by WHO.

[1] Participating by virtue of Rule 30 of the Rules of Procedure of the World Health Assembly.

The delegate of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that the addition of an agenda item would fall within the charge of the Chairmen of Committee A or Committee B; she asked whether the meeting was quorate in their absence.

Mr. BURCI (Legal Counsel) said there was no requirement for the Chairmen of Committee A and Committee B to be present; the quorum of the meeting had been established according to the number of members present.

The delegate of the UNITED STATES OF AMERICA said mycetoma was an important public health issue; he proposed that it should be referred to the regional committees for discussion, following which a more detailed proposal could be prepared for consideration at the Executive Board in January 2016.

The delegate of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND supported the proposal by the delegate of the United States of America; the agenda of the Health Assembly was already overweight and it would be difficult to do justice to the item given the late stage of submission.

The delegate of OMAN pointed out that mycetoma had already been discussed by the Regional Committee for the Eastern Mediterranean.

The delegate of SOUTH SUDAN said mycetoma was a significant public health problem that affected countries in several regions and for that reason it warranted inclusion on the agenda of the Health Assembly.

The CHAIRMAN said the Committee could accept the proposal by the observer of Sudan[1] or it could decide to refer the matter for consideration by the regional committees and, subsequently, the Executive Board.

The delegate of BURUNDI proposed that the first option should be adopted.

The delegate of GHANA also favoured the first option since the topic was related to the issue of health systems strengthening and it affected many regions.

The delegate of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said she strongly believed that the customary process should be followed, according to which the topic would be considered in the meetings of the regional committees in the autumn and then forwarded to the Executive Board. That process would allow time for the secretariat to provide a detailed and informative report which would be useful to delegations in preparing for discussion at the Health Assembly.

The delegate of INDONESIA acknowledged that it would be helpful to receive more information on that important topic before it was discussed at the Health Assembly.

The delegate of the UNITED STATES OF AMERICA agreed with the view of the delegate of the United Kingdom of Great Britain and Northern Ireland: if more time was allowed for the receipt of information from the secretariat and from Member States, there would be more meaningful treatment of the topic.

[1] Participating by virtue of Rule 30 of the Rules of Procedure of the World Health Assembly.

The observer of SUDAN[1] said mycetoma had already been discussed in the Regional Committees for Africa and the Eastern Mediterranean. He would prefer the topic to be considered by the present Health Assembly.

The DIRECTOR-GENERAL said that, from a practical perspective, little time remained for her to task the compilation of a detailed report and for its translation into six languages. She suggested that, in the interests of achieving a consensus, the Committee might wish to refer the topic to the 137th session of the Executive Board which would take place immediately after the Health Assembly.

The delegates of OMAN, PERU, UNITED STATES OF AMERICA, INDONESIA, LATVIA, FRANCE, UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND and CUBA and the observers of SENEGAL,[1] BARBADOS,[1] CHINA,[1] SAN MARINO[1] and INDIA[1] supported the proposal by the Director-General.

The observer of SUDAN[1] said that it was unfortunate that patients suffering from mycetoma would have to wait until the following year for the subject to be dealt with by the Health Assembly.

The CHAIRMAN took it that the Committee wished to accept the proposal to consider the supplementary agenda item on mycetoma at the 137th session of the Executive Board.

It was so agreed.

The CHAIRMAN took it that the Committee wished to recommend the adoption of the agenda, as amended.

It was so agreed.

2. ALLOCATION OF AGENDA ITEMS TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY: Item 1.4 of the Agenda (Documents A68/1 and A68/GC/1)

The CHAIRMAN said that the General Committee's recommendation on the adoption of the agenda would be transmitted to the Health Assembly at its second plenary meeting. He suggested that, given the heavy agenda, the Committee should review the progress of work. Given that Committee B usually completed consideration of the items allocated to it ahead of schedule, he proposed that agenda item 17, Health systems, should be moved from the agenda of Committee A to Committee B.

The observer of SENEGAL,[1] highlighted the importance of the issue and said that she could agree to that proposal provided that the item on health systems would be considered by Committee B at a time when all delegations could be present.

The CHAIRMAN took it that the Committee could agree to allocate agenda item 17 to Committee B on that understanding.

It was so agreed.

[1] Participating by virtue of Rule 30 of the Rules of Procedure of the World Health Assembly.

The CHAIRMAN said that, in view of the interest shown in agenda item 16.1 on the 2014 outbreak of Ebola virus disease, it was proposed that it would be considered at the fixed time of 14:30 on Tuesday, 19 May; agenda item 12, Programme and budget matters, would be discussed at 09:00 on Wednesday, 20 May. Agenda item 11, WHO reform, would be considered by Committee A during its first meeting on Monday 18 May.

The delegate of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that some of the smaller delegations in her region had expressed concern that the agenda item on programme and budget matters would be considered in parallel with agenda item 20, Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan.

Mrs ROSE-ODUYEMI (Office of Governing Bodies) said that it was proposed that agenda item 12 would be considered during the morning meeting of Committee A on Wednesday, 20 May while agenda item 20 would be considered by Committee B in the afternoon.

The delegate of OMAN said that many delegations would wish to be present during the discussions on both agenda items; he could agree to the timings proposed on the understanding that the items would not be considered in parallel.

The CHAIRMAN said that it was proposed that agenda item 22.3 concerning the appointment of the external auditor, would be taken up by Committee B on the afternoon of Thursday, 21 May.

Arrangements had been made to allow the prolongation of the afternoon plenary meetings on Monday, 18 May and Tuesday, 19 May, so that Committee B might begin its work on the afternoon of Wednesday, 20 May. In the absence of any objection, he took it that the Committee endorsed those arrangements.

It was so agreed.

The General Committee then drew up the programme of work for the Health Assembly until Wednesday, 20 May.

The CHAIRMAN drew attention to decision EB136(18), whereby the Executive Board had decided that the Sixty-eighth World Health Assembly should close no later than Tuesday, 26 May 2015. He took it that the proposal was acceptable.

It was so agreed.

The CHAIRMAN said that it was proposed that the next meeting of the General Committee would be held on Wednesday, 21 May at 17:30.

The DIRECTOR-GENERAL, responding to a question from the delegate of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, said that a further meeting of the General Committee could be held on Friday, 15 May, if needed.

The CHAIRMAN, referring to the list of speakers for the debate on item 3, proposed that, as on previous occasions, the order of the list of speakers should be strictly adhered to and that further inscriptions should be taken in the order in which they were made. Those inscriptions should be handed in to the Office of the Assistant to the Secretary of the Health Assembly, or during the plenary to the officer responsible for the list of speakers, on the rostrum. He further proposed that the list of

speakers be closed the following day at 10:00. In the absence of any objection, he would inform the Health Assembly of those arrangements at its second plenary meeting.

It was so agreed.

The meeting rose at 11:00.

SECOND MEETING

Wednesday, 20 May 2015, at 17:40

Chairman: Mr J.P. NADDA (India)
President of the World Health Assembly

1. PROPOSALS FOR THE ELECTION OF MEMBERS ENTITLED TO DESIGNATE A PERSON TO SERVE ON THE EXECUTIVE BOARD: (Document A68/GC/2)

The CHAIRMAN reminded Members that the procedure for drawing up the list of proposed names to be transmitted by the General Committee to the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board was governed by Article 24 of the Constitution and Rule 100 of the Rules of Procedure of the World Health Assembly. In accordance with those provisions, the Committee needed to nominate 12 new Member States for that purpose.

To assist the General Committee in its task, two documents were before it. The first indicated the present composition of the Executive Board by region, on which list were underlined the names of the 12 Members whose term of office would expire at the end of the Sixty-eighth World Health Assembly and which had to be replaced. The second (document A68/GC/2) contained a list, by region, of the 12 Members that it was suggested should be entitled to designate a person to serve on the Executive Board. Vacancies by region, were: Africa, 1; the Americas, 2; South-East Asia, 1; Europe, 4; Eastern Mediterranean, 2; and the Western Pacific, 2.

As no additional suggestion had been made by the General Committee, the CHAIRMAN noted that the number of candidates was the same as the number of vacant seats on the Executive Board. He therefore presumed that the General Committee wished, as was allowed under Rule 78 of the Rules of Procedure, to proceed without taking a vote.

There being no objection, he concluded that it was the Committee's decision, in accordance with Rule 100 of the Rules of Procedure, to transmit a list of the names of the following 12 Members of the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board: Canada, Congo, Dominican Republic, France, Jordan, Kazakhstan, Malta, New Zealand, Pakistan, Philippines, Sweden and Thailand.

It was so agreed.

2. ALLOCATION OF WORK TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

Dr JARAMILLO NAVARRETE (Mexico), Chairman of Committee A, and Mr MALABAG (Papua New Guinea), Chairman of Committee B, reported on the progress of the work of their respective committees.

The CHAIRMAN proposed a programme of work for Thursday, 21 May; for Friday, 22 May; and for Saturday, 23 May. He further proposed to review progress of the work with the chairmen of the committees and to revise the programme accordingly, if necessary.

It was so agreed.

The General Committee drew up the programme of work for Thursday, 21 May; for Friday, 22 May; and for Saturday, 23 May.

COMMITTEE A

FIRST MEETING

Monday, 18 May 2015, at 15:40

Chairman: Dr E. JARAMILLO NAVARRETE (Mexico)

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

The CHAIRMAN welcomed participants and introduced the representatives of the Executive Board, Mr Mohamed Shareef (Maldives), Dr Dirk Cuypers (Belgium), Dr Walid Ammar (Lebanon) and Dr Yankalbe Paboung Matchock Mahouri (Chad),[1] who would report on the Board's consideration of relevant items of the agenda. Accordingly, any views they expressed would be those of the Board, not of their respective governments. Mrs Kathryn Tyson (United Kingdom of Great Britain and Northern Ireland) was also present at the meeting to report on the discussions of the Programme, Budget and Administration Committee of the Executive Board.

Election of Vice-Chairmen and Rapporteur

Decision: Committee A elected Ms Dorcas Makgato (Botswana) and Dr Bahar Idreiss Abugarada Abulgassim (Sudan) as Vice-Chairmen and Dr Liis Rooväli (Estonia) as Rapporteur.[2]

Organization of work

Ms RABOVICA (Latvia) recalled that, following an exchange of letters in 2000 between WHO and the European Commission, the European Union had participated in the World Health Assembly as an observer. She requested that it should again be invited by the Committee to participate, without vote, in the deliberations of the meetings of subcommittees, drafting groups and other subdivisions dealing with matters falling within the competence of the European Union.

It was so agreed.

2. WHO REFORM: Item 11 of the Agenda

Overview of reform implementation: Item 11.1 of the Agenda (Documents A68/4 and A68/52)

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland), speaking in her capacity as Chairman of the meeting of the Programme, Budget and Administration Committee of the Executive Board held the previous week, summarized the Committee's discussions on the reform implementation process (see document A68/52).

[1] Participating by virtue of Rules 42 and 43 of the Rules of Procedure of the World Health Assembly.

[2] Decision WHA68(3).

Ms RABOVICA (Latvia), speaking on behalf of the European Union and its Member States, said that, although the reform package had the potential to guarantee the efficient use of resources, more work was needed to ensure cost-effectiveness. Improved vertical and horizontal coordination among the three levels of WHO would increase budget transparency and sustainability. Strengthening lines of accountability between the Director-General and the regional directors was a crucial next step in governance reform. She reiterated the European Union's request for a report to the governing bodies on WHO's work at country level.

WHO resolutions and decisions would benefit from a more robust procedure governing their financing and impact, and the role of the officers of the Executive Board should be reviewed to enable them to serve as a link between the Member States, the regions and the Secretariat. The framework of engagement with non-State actors would constitute an important part of the reform process. The European Union, encouraged by the constructive discussions at the First Open Member States Meeting on Governance Reform in May 2015, looked forward to building a solid governance reform package for consideration by the Executive Board in January 2016.

Dr AMMAR (Lebanon) said that, despite the recent achievements in reform implementation, programmatic evaluation and performance assessment must be improved in order to strengthen accountability. Change must be institutionalized at all three levels of the Organization, with particular emphasis on the country offices, which did not receive sufficient resources and were not sufficiently accountable. Their role must be strengthened, particularly in the context of complex emergencies, and bottlenecks in procurement of necessary supplies should be reduced. WHO should be recognized by all United Nations agencies and other partners as the lead agency for health interventions in such situations. The Director-General's proposal to strengthen country offices through development performance indicators and the implementation of the geographical mobility policy was welcome. The recent Ebola virus disease crisis had revealed gaps in decision-making at different organizational levels, as well as weaknesses in media and social communication: WHO must act early and invest in capacity building to enhance health system resilience.

Mr WEIBUST (Norway) said that regular consultations between the Director-General and the regional directors could contribute positively to strengthening corporate management. He expressed concern, however, regarding the use of the term "collective decision-making" in document A68/4, since his country considered that accountability and responsibility resided solely with the Director-General.

Dr AL-TAAE (Iraq) stressed the importance of investment of all financial resources received from donors; a regular and sustainable review of budget distribution between programmes and countries to reflect emerging priorities; integration of financial allocations with results-based management and with early preparedness and response; and the reduction of management costs through an integrated work plan. Country offices should be consolidated within the country's Ministry of Health to facilitate more efficient management.

Mr COTTERELL (Australia), noting the impact of the outbreak of Ebola virus disease on the reform implementation process but also the need for further reform, said that the successful implementation of reform would be dependent upon the accountability of, and leadership by, the entire Organization. Governance reform, and the alignment of that reform at all three levels of the Organization, should be prioritized and Member States should continue to provide concrete and realistic recommendations. It was also vital to finalize the framework of engagement with non-State actors at the current Health Assembly. He welcomed the efforts to strengthen the evaluation function, as there was often too much focus on delivering outcomes and too little on reviewing the way they had been achieved.

Mr KUEMMEL (Germany) said that the outbreak of Ebola virus disease and the Organization's response had opened it up to criticism in the media, which had affected the international community's perceptions of the efficiency and structures of WHO. However, the outbreak had also highlighted the relevance of WHO in a globalized world and demonstrated the need to intensify common efforts to reform the Organization so that it could fulfil Member States' expectations. Germany believed that the organizational and structural changes undertaken to date were not sufficient; increased political momentum was needed to learn lessons from the Ebola crisis and make structural changes over the next two years.

Mr JONES (Canada) said that the strengthening of country offices was crucial. Moreover, compliance, risk management, asset tracking and human resources needed to be addressed consistently at all levels of the Organization. The outbreak of Ebola virus disease had shown that increased cooperation was needed across programme areas, and more needed to be done to improve the planning, budgeting and financing cycle. He welcomed WHO's gender mainstreaming efforts but expressed concern at the slow rate of reform; further efforts were needed, including reducing the reliance of Member States on resolutions and decisions to guide the Organization's activities. Lastly, the Global Policy Group should remain an advisory body and decision-making authority should rest solely with the Director-General.

Ms COLE (United Kingdom of Great Britain and Northern Ireland) said that the outbreak of Ebola virus disease had clearly demonstrated the need for WHO to adapt as fast as possible, with clearer corporate management and accountability lines, a more robust compliance culture, and greater alignment at all three levels of the Organization. The Director-General must be empowered to act, especially during emergencies. Although the Global Policy Group had an important role to play, it should remain solely an advisory body, with the Director-General as the ultimate decision-maker.

Mr DIKMEN (Turkey), while welcoming the progress made in improving the financial dialogue, strengthening country offices and budget approval, as well as the work of the Global Policy Group and the Working Group on Governance Reform, noted that swift action was needed to increase the transparency, accountability and adaptability of WHO in a rapidly changing global health landscape. Reform discussions within the governing bodies should focus on the results of reforms rather than on implementation rates, and consensus was urgently needed on ongoing issues such as internal controls and the framework of engagement with non-State actors. Rapid action should be taken to increase the Organization's transparency, accountability, adaptability and human resources skills.

Mr TEGENE (Ethiopia) said that the reform process should be accelerated further and regularly assessed. In addition to the systematic reviews of programmatic and administrative performance, a clear accountability mechanism for results was essential. He welcomed the financing dialogue and the use of a bottom-up approach for resource allocation, but felt that more attention should be paid to flexibility of funding. Moreover, a clear mechanism was needed to ensure that resolutions adopted by the regional committees and the Executive Board were included and followed up in annual work plans.

Mr KOLKER (United States of America), welcoming the reforms undertaken to date, acknowledged the need to improve the functioning of the governing bodies to enable Member States to give more strategic direction to the Secretariat. In terms of human resources, additional hiring and assessment measures were required to improve the flexibility and accountability of the human resource system and to improve the ability of WHO to attract talented staff. The establishment of the Global Policy Group was a positive step forward, as was the development of the Programme budget web portal. However, the latter should include regional and country-level details, which were essential for results-based management. The Director-General must provide dynamic leadership for the reform efforts.

Dr HINOSHITA (Japan) said that more should be done to improve the timeliness of preparation of documentation on WHO reform, as the late availability of documents for the current Health Assembly had limited the preparations and discussion on the reform process that Member States could undertake at the domestic level.

Ms ZHANG Yang (China) welcomed the enhanced cooperation between WHO and the United Nations system at all three levels of the Organization and the increasingly coordinated nature of WHO activities. China was keen to work with Member States and the Secretariat to help improve the efficiency of the Organization.

Ms SAMIYA (Maldives) said that reform of the Organization's response to emergencies and disease outbreaks was urgently needed. While significant progress had been made in terms of management reform, governance reform continued to lag behind, and more efforts were needed. More should also be done to mainstream the reforms at the three levels of the Organization, with a particular focus on project management, change management and human resources. Lastly, it was essential to strengthen the performance of country offices and create indicators to measure progress.

Mr BANLU SUPAAKSORN (Thailand), expressing concern at the slow progress in governance reform, stressed the importance of reaching an agreement on the framework of engagement with non-State actors during the present Health Assembly. Governance reform had been initiated in the South-East Asia Region, but further work was needed to strengthen the competencies, leadership and capacity of WHO to respond to the needs of individual countries. He welcomed the WHO response to the recent earthquake in Nepal, which had used the convening power of the Organization to coordinate rescue operations, and the emergency contingency fund established by the Director-General. Lastly, his country was concerned that Member States' reluctance to pay higher assessed contributions and the increasing demands for WHO services would lead to an increase in the use of voluntary contributions; the majority of such contributions were earmarked for specific activities, which did not always correspond to programmatic priorities.

Dr ROA RODRIGUEZ (Panama) stressed the need to build upon the discussions and achievements in key areas, such as the Programme budget and engagement with non-State actors. The reforms undertaken to date had enabled the Organization to grow and improve its management and governance and ensure a culture of compliance. She hoped that human resources management would become more effective at all three levels of the Organization to enable rapid response to emergencies. She urged Member States to take steps to harmonize the decision-making processes of the World Health Assembly and accelerate governance reform through the deliberations of the Working Group on Governance Reform to facilitate a more homogeneous approach to pending issues.

Dr ROMAO (Mozambique), speaking on behalf of the Member States of the African Region, said that, despite some positive developments in reform implementation, more in-depth analysis and decisions were needed. Gaps had been identified, notably related to the working methods of the governing bodies, mandates and accountability and the alignment of governance at all three levels of the Organization. In that regard, she said that country and regional offices should be strengthened; equity, geographical representation and gender balance in managerial positions also needed to be ensured, particularly at headquarters. The implementation process should be accelerated, with a systematic review and clear mechanisms for accountability and funding when a draft resolution was submitted. More investment in human resources would be needed for the required changes.

Mr MOHAMED (Egypt) noted that, while the lessons learnt from the outbreak of Ebola virus disease were of great importance, the reform process had begun years before, inspired by the desire of all Member States to strengthen WHO's role in the system of multilateral organizations which were facing so many challenges.

Dr SMITH (Executive Director, Office of the Director-General), responding to points raised by delegates, confirmed that the Global Policy Group was an exclusively advisory body and that the Director-General retained full authority and accountability for the work of WHO. The budget increase for country-level work in the proposed programme budget 2016–2017 reflected the Organization's commitment to strengthening work at that level, but better metrics for assessing performance were needed. He acknowledged the request for a report on the work of WHO at the country level. Several Member States had called for a stronger culture of compliance, adherence to internal controls, and stronger accountability with the Organization; various initiatives related to internal controls were being prepared, which also entailed more investment at the country level.

The Committee noted the report contained in document A68/4.

Framework of engagement with non-State actors: Item 11.2 of the Agenda (Documents A68/5 and A68/53)

Following a summary of the discussion of the item in the Programme, Budget and Administration Committee the previous week by the Chairman of that session, Mrs TYSON (United Kingdom of Great Britain and Northern Ireland), the CHAIRMAN suggested that a drafting group should be convened under the chairmanship of Argentina to continue the informal discussions.

It was so agreed.

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

3. COMMUNICABLE DISEASES: Item 16 of the Agenda

Malaria: draft global technical strategy: post-2015: Item 16.2 of the Agenda (Documents A68/28 and EB136/2015/REC/1, resolution EB136.R1)

Dr CUYPERS (Belgium, representative of the Executive Board) said that, at the 136th session of the Executive Board, Member States had expressed their support for the draft global technical strategy for malaria 2016–2030 and the proposed milestones for 2020, 2025 and 2030. The Board had adopted resolution EB136.R1, which contained a draft resolution recommended to the Health Assembly for adoption.

Professor BAGGOLEY (Australia) said that his country was a sponsor of the draft resolution under consideration. He encouraged WHO to continue its leadership role in providing technical norms and standards and in-country support for the eradication of malaria, and called upon Member States in the Asia-Pacific region to support the malaria elimination road map being developed by the Asia-Pacific Leaders' Malaria Alliance. He urged WHO to work with its partners in malaria elimination to ensure coherence among country, regional and global eradication programmes.

Dr CICOGNA (Italy) said that the synergies among international, bilateral and government efforts and contributions channelled through the Global Fund to Fight AIDS, Tuberculosis and Malaria had decreased malaria deaths by 47 per cent globally between 2000 and 2013. Sixty-four countries were on track to reverse the incidence of malaria by 2015, yet malaria still represented a major cause of suffering and economic loss. He supported the draft resolution, draft global strategy and proposed global targets, and called for increased mobilization of national financial resources, particularly to tackle malaria in the poorest countries. He called upon the Secretariat to mobilize the required human

and financial resources to help Member States to implement the global technical strategy, including the requirement for detailed monitoring and reporting.

Dr NASUTION (Indonesia), speaking on behalf of the Member States of the South-East Asia Region, supported the draft global technical strategy, which would help Member States to create stronger and more sustainable multisectoral responses to eliminate malaria and prevent its resurgence. The Region supported the draft resolution. However, a number of issues should be emphasized, including regional and international collaboration, financial support and drug resistance. Countries in the Region needed support to produce malaria diagnostic supplies, medicines and insecticide-treated nets. Climate change and the challenges of tackling vivax malaria should also be considered. Systematic operational research was required to find innovative ways of ensuring universal coverage with interventions against malaria.

Dr AL-TAAE (Iraq) expressed support for the draft resolution. He said that the Organization should focus on support for malaria surveillance systems through the application of the International Health Regulations (2005). Work to eradicate malaria must take place within a contingency work plan that took into account all epidemiological factors at country level. Additional support should be provided for countries, including his own, that maintained their malaria-free status in difficult circumstances. Afghanistan, Iraq, the Islamic Republic of Iran, Pakistan and WHO had launched an initiative to combat communicable diseases, with the emphasis on malaria: Member States should be encouraged to collaborate, with technical support from WHO, and the Organization should integrate its programmes related to malaria, with due consideration of the WHO reform process and policy on collaboration with non-State actors.

Mr ZHANG Yong (China) endorsed the draft resolution. Artemisinin resistance was potentially a major problem in Africa: it should be carefully monitored and WHO technical guidance updated as necessary. Heightened attention should be paid to artemisinin-resistant malaria; WHO should use testing to monitor the situation in Africa and identify any emergence of artemisinin-resistant malaria through the reaction of plasmodium to artemisinin sensitivity, and should update guidance on monitoring accordingly. His country stood ready to share its experience and provide technical assistance to highly infected areas in Africa. His country produced high-quality, low-priced antimalarial products and supplies, and it was hoped that their affordability could be increased further with WHO support.

Ms CABELLO SARUBBI (Paraguay) supported the draft resolution. Her country would soon achieve malaria-free certification, which would require the introduction of technical amendments such as those described in the draft global technical strategy. It was particularly important to consider the link between malaria and the climate and the introduction of an integrated vector control strategy.

Dr RONQUILLO (Philippines) noted that his country had exceeded its Millennium Development Goal targets for malaria morbidity and mortality, but that more work was needed to strengthen malaria surveillance and response. He endorsed the draft global technical strategy.

Ms PALMIER (Canada) supported the draft resolution. She welcomed the draft strategy's emphasis on data-driven programme development to transform malaria surveillance into a core intervention, and expressed support for the ongoing dialogue on innovative financing models, which would ensure that funds were available to meet the draft strategy's targets.

Dr HINOSHITO (Japan) said that his country's experience had shown the importance of a community-based approach to achieving universal coverage with antimalaria measures, especially among rural and socially vulnerable populations. A strengthened surveillance system was essential for monitoring disease prevalence and the effectiveness of countermeasures. The final stage of elimination

in low-prevalence areas was particularly difficult. He supported the draft strategy and draft resolution and asked to be included as a sponsor of the draft resolution.

Dr KALILANI (Malawi), speaking on behalf of the Member States of the African Region, said that 90 per cent of global malaria deaths in 2013 had occurred in Africa, although there had been a significant reduction in mortality, especially among children under five years of age.

The fight against malaria was at a critical stage: there was an urgent need to accelerate progress through the use of existing and new strategies and new tools. Elimination and surveillance were key issues, alongside challenges that included the emergence of resistance to antimalarial medicines among parasites, resistance to insecticides among mosquitoes, poor health systems and a lack of robust, predictable and sustainable international and domestic financing for malaria control activities. Political commitment to eliminating malaria in Africa had been reinforced.

She welcomed the emphasis on harnessing innovation and expanding research in the draft global technical strategy. Research should continue on a malaria vaccine and new insecticides. The African Region stressed the need to strengthen the capacities and human resources of WHO at all levels, particularly African country offices, in order to support Member States in their work to eliminate malaria by 2030. She supported the draft resolution.

Ms DUSSEY-CAVASSINI (Switzerland) said that her country was a sponsor of the draft resolution. She welcomed the draft strategy's emphasis on strengthening health systems and on a collaborative, multisectoral approach and regional programmes. Its effective implementation would require a stable partnership between all countries, with the leading role being played by endemic countries. The Roll Back Malaria governance model should include all actors involved in malaria control and eradication. She called for approval of the draft resolution.

Mr PABLOS-MENDEZ (United States of America) welcomed the commitment in the draft strategy to working with partners and stakeholders to provide normative guidance on malaria control. However, the estimated cost of implementation of the draft strategy was significantly higher than previous estimates of the global cost of combating malaria. He therefore recommended an initial review and periodic reviews of the models and methodology used to calculate that cost, so that it could be adjusted as appropriate. With that proviso, he endorsed the draft resolution.

Mr BASKOZOS (Greece) said that his country had successfully tackled a small outbreak of malaria in 2012, and was working with other countries in the Mediterranean region to develop an integrated action plan for malaria prevention and treatment for people entering Mediterranean countries as refugees.

Dr HASSAN (Egypt) said that, after dealing with an unprecedented outbreak of malaria among migrants in 2013, her country believed that the draft strategy should include the issue of medical care for migrants in all countries.

Dr AL HAJERI (Bahrain), expressing support for the draft global technical strategy, said that malaria had been eradicated from Bahrain, where there had been no cases of transmission since 1979, thanks to a national anti-malaria programme and capacity-building efforts. Bahrain was also promoting eradication of the disease in the Arabian Peninsula by providing technical support and capacity building through the Gulf Cooperation Council. In implementing the strategy, priority should be given to building national capacities in malaria control planning and management with the aim of eradication, to which end regional cooperation was vital. WHO must play a part in finding technical solutions for strengthening health and surveillance systems in support of countries most affected by the disease. She endorsed the draft resolution.

Mr ROBB (United Kingdom of Great Britain and Northern Ireland) expressed support for the draft strategy. More investment in high-quality surveillance would be needed to help stratify the malaria epidemic, and for clear technical guidance to help countries establish strategic responses adapted to their circumstances. WHO should provide Member States with strong technical support and guidance in the implementation, national adaptation and operationalization of the strategy. He supported the draft resolution.

Dr PONGTORN CHARTPITUCK (Thailand) fully endorsed the draft strategy. He proposed two amendments to the draft resolution contained in Executive Board resolution EB136.R1. A new subparagraph should be added after the current subparagraph 2(6), reading: "to develop a comprehensive cross-border malaria control and treatment model, where appropriate, to strengthen cross-border collaboration, improve the effectiveness of malaria elimination using primary health care as the main platform [and] integrate the model into the broader health delivery systems". While contributions by international development partners were appreciated, the main concern was programmatic and financial sustainability: in that regard, he proposed adding at the end of subparagraph 4(3) the words: "and integrate donor-supported programmes into national health systems to achieve long-term programmatic and financial sustainability".

Mr LUTZOW STEINER (Mexico) supported the draft strategy. The Millennium Development Goal target on malaria had been achieved in his country but efforts should continue at both the national and regional levels to strengthen, consolidate and increase achievements.

Ms SMIRNOVA (Russian Federation), speaking on behalf of Armenia, Belarus, Kyrgyzstan, the Russian Federation and Tajikistan expressed support for the draft strategy. If financing was maintained, a 40% reduction in the malaria mortality rate by 2020 was realistic. However, the eradication of malaria by 2030 could only be achieved by increasing investment and developing innovative technologies. An important element of the draft strategy would be the creation of training programmes for professionals working in malaria-endemic countries. The countries for which she spoke were committed to continuing their collaboration with WHO and sharing their knowledge and experience.

Mr SVERSUT (Brazil) said that his country's partnership with PAHO had been essential in eradicating malaria in Brazil. His Government was committed to combating the disease with its neighbours and with other Portuguese-speaking countries. It supported the draft strategy, which would help to safeguard the progress achieved. His country was a sponsor of the Executive Board resolution.

Dr GOUYA (Islamic Republic of Iran) supported the draft resolution and the draft global technical strategy, stressing the importance of strong political commitment and subregional collaboration. If challenges such as parasite resistance to antimalarial medicines and mosquito resistance to insecticides were not addressed, they might render some tools ineffective and allow the results of considerable investment to go to waste. He said that global mechanisms must be established to strengthen systems for rapid response to malaria epidemics. In that regard, he said that WHO had a crucial role to play in strengthening information and integrated surveillance systems: and furthermore, that it was crucial that Member States, which had succeeded in, or were close to, eliminating malaria, should work to prevent reintroduction. Civil unrest in the Eastern Mediterranean Region spanned both endemic and malaria-free areas: regional malaria funds should be established to cover the gaps in malaria control that would inevitably appear.

Dr BIRHANE (Ethiopia) said that malaria must be given due emphasis in the new sustainable development goals. Particular attention should be paid to research and development related to resistance to antimalarial medicines and insecticides, and to a mechanism to promote innovation and shape the market for insecticides, for instance by building the capacity of local and regional

manufacturers. In countries where elimination of malaria throughout the country would not be possible in the medium term, WHO should assist in establishing mechanisms for elimination at the subnational level. It was important to build national capacities in malaria expertise, and WHO and other development partners should invest in capacity building, particularly in the areas of human resources, entomology, surveillance, monitoring and evaluation in endemic countries.

Dr KONG INSIK (Republic of Korea) supported the draft global technical strategy and called for the timely adoption of the draft resolution. His country would collaborate with WHO, the Asia and Pacific Malaria Elimination Network and Asia Pacific Leaders Malaria Alliance and contribute to technical cooperation and research, particularly for the development of new drugs to overcome the problem of artemisinin resistance.

The meeting rose at 18:05.

SECOND MEETING

Tuesday, 19 May 2015, at 09:10

Chairman: Dr E. JARAMILLO NAVARRETE (Mexico)

COMMUNICABLE DISEASES: Item 16 of the Agenda (continued)

Malaria: draft global technical strategy: post 2015: Item 16.2 of the Agenda (Documents A68/28 and EB136/2015/REC/1, resolution EB136.R1) (continued)

Mr PRAKASH (India) said the desired results of the draft global technical strategy for malaria 2016–2030 could only be achieved through effective preventive measures, integrated vector management and effective surveillance, which called for adequate numbers of entomologists. Early detection using rapid diagnostic and point-of-care kits and early and complete treatment were essential, as were prompt action to halt artemisinin resistance, a focus on vulnerable populations and research on and development of vaccines. The technical strategy should be supported by an effective communications strategy to ensure community participation. Concerted global action would be needed to achieve elimination targets. India was implementing a successful national strategy and collaborating with other countries in the Asia-Pacific Leaders Malaria Alliance.

Dr MALECELA (United Republic of Tanzania), commending the draft strategy, said that over the previous decade her Government had scaled up proven interventions and thus seen a decline in malaria prevalence, incidence and deaths. The support of development partners, including the private sector, had been essential in that success. Without cohesive strategies to ensure long-term funding and increased government budgets, however, the gains would be lost. There was a need to strengthen surveillance, including with respect to insecticide and drug resistance, and to increase the capacity of research institutions to provide new tools in response to changing vector behaviour. If effectively implemented, the strategy would contribute to the elimination of malaria in countries such as Tanzania.

Dr JESSAMINE (New Zealand) said that implementation of the draft strategy would improve the capacity of health services and surveillance systems and strengthen overall health systems in affected countries. The strategy would also help to reduce the prevalence and distribution of mosquito species associated with transmission of the dengue, Zika and chikungunya viruses in the Western Pacific Region.

Ms MORÓN DE PORRAS (Bolivarian Republic of Venezuela) expressed support for the draft strategy, which would provide a framework for countries to develop programmes to accelerate elimination of malaria. Her Government was implementing preventive measures and providing free diagnostic testing and treatment. Control and eradication efforts focused on two remote regions where malaria was present.

Mr MEUNIER (France), welcoming the draft strategy, said that his Government was firmly committed to the goal of eliminating malaria. France was a major donor to the Global Fund to Fight AIDS, Tuberculosis and Malaria and to UNITAID. He agreed with delegates who had highlighted the need to address artemisinin resistance, particularly in the South-East Asia Region. The impact of

climate change was another major challenge to halting malaria transmission, which should be acknowledged in the draft resolution contained in resolution EB136.R1.

Dr VICKNESHWARAN MUTHU (Malaysia) said that his country had achieved considerable success in eliminating malaria and aimed to be malaria-free by 2020. However, there were gaps in knowledge about the dynamics of transmission of the infection, including the risk factors for transmission, the mosquito vectors and human-to-human transmission. Further study on the emergence of zoonotic malaria and interdisciplinary research from various fields, including primatology, should be encouraged. Malaysia strongly supported the draft strategy and the draft resolution.

Dr KUNENE (Swaziland), commending the consultative process used in developing the draft strategy, said that his country's strategic plan for malaria elimination reflected the issues set out in the Secretariat's report (document A68/28). His Government called on the Secretariat to provide technical capacity to support implementation of the strategy and urged development partners to continue to provide support to countries that were successfully combating the disease.

Dr SHEIKH (Pakistan) said reduction of the malaria burden in Pakistan, which numbered some 1.6 million cases annually, was a national priority. The country's national strategy was in line with the recommended activities for vector control in the draft strategy, which Pakistan supported. However, the post-2015 framework should include indicators relating to social determinants of health and health system processes, outputs and outcomes. Under pillar 1 of the strategy, Pakistan favoured the use of indoor residual spraying over long-lasting insecticidal nets as the front-line defence.

Dr ABDALLRAHIM ELFADUL (Sudan) said that Sudan had introduced a programme to combat malaria, and the number of recorded cases had decreased by some 72% since the year 2000. The programme had benefitted from the support of WHO and other partners. A number of successful initiatives had shown the value of good organization and use of local resources. Sudan looked forward to implementing the draft strategy with continued support from development partners.

Dr DAKULALA (Papua New Guinea) said that Papua New Guinea had the highest malaria burden in the Pacific, although it had made significant progress in controlling the disease in the previous five years. The country's successful malaria control strategy had been supported by private-sector partners and the Global Fund to Fight AIDS, Tuberculosis and Malaria. In order to sustain the gains made, the Government would seek ongoing technical support from partners and explore ways to eliminate malaria in collaboration with other island States. Special consideration should be given to providing support to small island States. Papua New Guinea welcomed the draft strategy and supported the draft resolution.

Dr MUSAONBAŞIOĞLU (Turkey) said the draft global technical strategy would serve as a guide for the preparation of regional and national strategies. The draft strategy included important targets aimed at reducing malaria incidence and deaths. A multisectoral approach was required for malaria elimination that included diagnostics, vector control, surveillance and measures to prevent drug resistance. The Secretariat had an important role to play in combating the disease and in supporting Member States' efforts. Turkey supported the draft strategy and the draft resolution.

Dr AZZOUZI SIDI (Morocco), welcoming the draft strategy and draft resolution, said that Morocco had been declared malaria-free but maintained surveillance and control activities in risk areas. The Government wished to highlight the importance of cross-border collaboration in order to prevent the importion of cases, particularly in a context of increased risk as a result of climate change.

Dr HASSAN (Egypt) said that the draft strategy should address the issues of re-emergence of malaria owing to cross-border migration and medical care for infected migrants. Egypt had a programme of epidemiological and entomological surveillance and had maintained its malaria-free status for some years. However, as the vector was still present in some areas of the country, cross-border migrants carrying the disease posed a risk with respect to re-emergence.

Dr GULSUM GURBANOVA (Azerbaijan) said that her Government had cooperated with international partners such as WHO and the Global Fund to Fight AIDS, Tuberculosis and Malaria in order to combat malaria. Some cases persisted, but the situation was under control. Azerbaijan supported the draft strategy and stood ready to share its experience in malaria control with other Member States.

Dr KAN TUN (Myanmar) said that, although malaria affected most areas in Myanmar, there had been significant declines in morbidity and mortality in recent years. The draft strategy differentiated between the control phase, with a focus on universal coverage, and the elimination phase, where the focus was on surveillance and rapid interruption of transmission. Countries that were nearing the elimination phase should set up mechanisms now to ensure the necessary surveillance. Myanmar looked forward to the elimination of malaria by 2030.

Dr FORSTER (Namibia) welcomed the changes made to the draft strategy since its examination by the Executive Board and the consultative process used in developing the strategy. He sought clarification regarding the relationship between the strategy indicators and the monitoring framework and indicators for the post-2015 sustainable development goals. Cross-border collaboration was an important aspect of achieving elimination and one which Namibia pursued through its association with other countries in southern Africa. As a sponsor of the draft resolution, Namibia recommended its adoption.

Dr KORIOM (South Sudan) said that South Sudan firmly supported the draft strategy and was committed to achieving malaria-free status, although considerable effort would be needed to attain that goal, as coverage of malaria control measures was still limited. Significant progress had been made in the distribution of insecticide-treated mosquito nets, but human resources and financing for malaria control remained inadequate and protocols for vector control needed review. South Sudan was grateful to its development partners for their support for its malaria elimination endeavours.

Professor Dr HUQ (Bangladesh) said that his country had made significant progress in reducing malaria-related mortality. It had reviewed and updated its national malaria strategy, focussing on state-of-the-art technology and evidence-based information, and would undertake a further review in order to align the national strategy with the global strategy. He suggested that the proposed indicators for malaria progress monitoring should be in line with the Global Reference List of 100 Core Health Indicators, in order to make reporting less burdensome.

Dr PAUVADAY (Mauritius) said that malaria had been eradicated in Mauritius, but it had once been a serious health issue. Mauritius supported the draft resolution.

Ms An-Chi LAI (Chinese Taipei) said that, although malaria had been eliminated in Chinese Taipei, the vector was still present and there was therefore a risk of re-establishment of the disease. Early diagnosis and treatment of imported cases were crucial, as were continued surveillance and vector control. Climate change, resistance to antimalarial drugs and insecticides, and increased international travel and trade were major challenges to malaria prevention and control. Chinese Taipei stood ready to join international efforts towards a malaria-free world.

Ms ZAKARIA (International Organization for Migration), noting that malaria did not recognize borders, said that migration from high-transmission areas could reintroduce malaria in low-transmission or malaria-free areas. Migrants and displaced populations often lacked access to adequate health services, which rendered them vulnerable to malaria-related illness and death. Attention to the health needs of migrants and cross-border populations was crucial to malaria control and elimination, and she would welcome the inclusion of a reference to those populations in the draft resolution. The International Organization for Migration stood ready to work with WHO and other partners in the implementation of effective, migrant-inclusive approaches to malaria control and elimination.

Ms GREWAL DAUMERIE (Medicines for Malaria Venture) welcomed the emphasis on research and innovation in the draft global technical strategy. New tools were needed to tackle emerging challenges. Concerted global efforts to increase access to vector control measures, rapid diagnostic tests and artemisinin-based combination therapies had led to a significant reduction in the number of deaths from malaria, but insecticide and drug resistance threatened those gains. Constant vigilance, targeted tools and rapid action were required to improve access to existing and new interventions.

Dr NAKATANI (Assistant Director-General) thanked Members States for their strong positive response to the draft global strategy and said that they were to be commended for their remarkable progress towards the elimination of malaria. Those gains had provided the basis for the global strategy and had inspired a new set of goals and targets. The new strategy changed the paradigm from malaria control to an effort to bring the end the disease close by 2030.

The draft global technical strategy addressed many concerns expressed by Member States, including: parasite resistance to drugs, mosquito resistance to insecticides, concentration of cases among hard-to-reach populations, the importance of cross-border cooperation, and the need to expand access to antimalarial commodities. In regard to the latter, he noted that the Secretariat had stepped up its prequalification activities and had already prequalified several antimalarial medicines manufactured in China, which were widely used. Member States had also drawn attention to the need for investment in research and development in order to achieve the new targets and to the need to build countries' capacities to implement the global strategy and improve malaria surveillance – all of which were unquestionably important. Sustainable funding was also crucial. As to specific malaria-related indicators to be included in the indicators for the proposed post-2015 sustainable development goals, the Secretariat was recommending only two: incidence and mortality rates. In addition, under universal health coverage, it was proposed to include indicators relating to availability of malaria treatment and insecticide-treated bednets.

The CHAIRMAN asked the Secretary of the Committee to read out the proposed amendments to the draft resolution contained in resolution EB136.R1.

Dr ABELA-RIDDER (Assistant Secretary, Committee A) said that the delegation of Thailand had proposed the addition of a new subparagraph after paragraph 2(6), which would read: "to develop a comprehensive cross-border malaria control and treatment model, where appropriate, to strengthen cross-border collaboration, improve the effectiveness of malaria elimination using primary health care as the main platform, and integrate the model into the broader health delivery system." The delegation of Thailand had also proposed that "and integrate donor-supported programmes into national health systems to achieve long term programmatic and financial stability" should be added at the end of subparagraph 4(3).

Mr MAMACOS (United States of America) said that, while he appreciated the need for integration of donor-supported programmes, the intent of the proposed amendment to subparagraph 4(3) was not clear and he therefore could not support it.

Dr THAMARANGSI (Thailand) explained that the proposed amendment, which was addressed to WHO's international partners, was aimed at avoiding the fragmentation that occurred when programmes supported by various donors were not well integrated into national systems and at ensuring the long-term sustainability of such programmes.

In response to a request from Professor DOKEKIAS (Congo), the CHAIRMAN suggested that the Committee should suspend consideration of the draft resolution until the proposed amendments had been circulated in all official languages.

It was so agreed.

(For continuation of the discussion and approval of the draft resolution, see the summary record of the fifth meeting, section 2.)

Dengue: prevention and control: Item 16.3 of the Agenda (Document A68/29)

Dr DA SILVA ALMEIDA (Timor-Leste), speaking on behalf of the Member States of the South-East Asia Region, said that more than half of the Region's population was at risk for dengue and the incidence of the disease was rising. In response, the countries of the Region had made dengue prevention and control a public health priority and had built national capacities for case management, integrated vector management, surveillance and community empowerment. Mortality rates had remained low as a result. Dengue was not simply a health issue, however; poverty, climate change and other environmental factors influenced dengue epidemiology, and multisectoral responses were therefore required. Intercountry and interregional collaboration and technical support from the Secretariat were also needed.

Mr SEY (Gambia), speaking on behalf of the Member States of the African Region, said that the Region needed enhanced capacity for early detection and diagnosis, vector surveillance and rapid deployment of vector control interventions in order to halt dengue transmission and contain outbreaks. Countries also needed to integrate dengue surveillance and monitoring activities into their master plans for neglected tropical diseases. Good collaboration between national entomology and virology services and research institutions was required, as was multisectoral cooperation. He encouraged the Secretariat to support the countries of the Region in implementing the global strategy for dengue prevention and control, especially those that had experienced outbreaks or sporadic cases of dengue, and to support global advocacy, partnership and engagement of all relevant stakeholders.

Professor BAGGOLEY (Australia) said that the global strategy provided flexibility for countries to act in accordance with national circumstances and need and should continue to be implemented. The limited success of dengue control efforts, as evidenced by the rise in dengue outbreaks globally, highlighted the need for strong surveillance and preparedness measures. The best means of achieving the global strategy targets was by strengthening local health systems and regional cooperation on surveillance and vector control. An intersectoral approach and the integration of standalone prevention programmes into more inclusive health delivery structures were also essential. He looked forward to the release of revised guidelines for diagnosis, treatment, prevention and control of dengue in 2015.

Dr GORGOLON (Philippines) said that the national dengue prevention and control programme in the Philippines was guided by the principles underlying the Dengue Strategic Plan for the Asia Pacific Region. The country was implementing integrated vector management and taking steps to strengthen laboratory diagnosis of dengue. It remained committed to attaining the global strategy targets for 2020.

Dr PAUVADAY (Mauritius) said that, although dengue was more common among travellers to Mauritius, locally transmitted cases had recently been detected. He requested further guidance on the use insecticides and their effect on the environment, noting in that regard their potentially damaging effect, as well as the increase in insecticide resistance. Mauritius had begun trials to evaluate the effectiveness of environmentally friendly sterile insect-control methods. Research, innovation and knowledge were essential components of dengue control, and additional funding for research on vector eradication and vaccine development was needed.

Mr ZHANG Yong (China) said that dengue had become increasingly prevalent in China, in particular following outbreaks in 2014. Dengue surveillance, prevention and control measures had been put in place and new strategies formulated to tackle the current epidemiological situation, as part of which regions had taken steps to scale up detection and reporting, increase early detection and treatment, control vectors and prevent the spread of the disease. Case surveillance, sustainable vector control and effective prevention and control measures would facilitate the global fight against dengue. He hoped that the Secretariat would continue to provide support and guidance to Member States in that fight, in which China would continue to participate.

Dr HINOSHITA (Japan) said that periodic revision of WHO's dengue guidelines would ensure more effective implementation of the global strategy. International cooperation was important in order to address the increasing risk of dengue outbreaks. Following a re-emergence of the disease in Japan, the Government had implemented a range of measures, including public information, prevention and control strategies, enhanced surveillance and distribution of guidelines to medical institutions. Japan was willing to share its experience with other countries.

Mr SVERSUT (Brazil) said that Brazil's efforts to combat dengue centred on multi-stakeholder involvement and strategic partnerships, which were key in the search for innovative solutions. The global strategy was a tool for improving coordination among national and international stakeholders, identifying obstacles and promoting sharing of good practices. Brazil was ready to share its experiences with other Member States. As chikungunya was transmitted by the same vector as dengue, the services offered by health systems to tackle it should be provided in conjunction with and accorded the same importance as those to combat dengue.

Mr LUTZOW STEINER (Mexico), expressing support for the global strategy, said that the five technical elements defined therein had been incorporated into the national dengue surveillance prevention and control programme. Laboratories played an important role in early detection and treatment. Improved epidemiological and entomological surveillance had enabled health authorities to create risk maps and indicators, as a result of which Mexico was better prepared to respond to outbreaks. It participated in multisectoral projects on various facets of dengue control in the Region of the Americas, including entomological surveillance and monitoring of insecticide resistance. Studies were under way to gain a better understanding of the dynamics of dengue transmission in order to improve prevention and control strategies. Health promotion and education at the local level were important, as social participation was essential to integrated vector management.

Other vector-borne diseases, including chikungunya, posed a threat in Mexico and other countries in the Region, and enhanced cooperation among Member States was needed to combat them. As insecticide resistance was one of the principal obstacles to prevention and control of such diseases, in 2014 Mexico had conducted a study to monitor the effect of insecticides and identify those that were appropriate to the national conditions. It was considering publishing the results of the study in a manual, which might be useful to other Member States for quickly assessing vector resistance to insecticides.

Dr AL-TAAE (Iraq) noted the importance of strengthening national surveillance systems, focusing in particular on field epidemiological studies, in collaboration with other countries and with support from the Secretariat. Entomological surveillance should take account of national and regional variables; epidemiological maps of the disease should be developed through interregional collaboration. Further research was needed on environmental factors affecting transmission of dengue. Prevention and control of dengue should be introduced into strategies to tackle communicable diseases at primary care level. Vector control programmes should also be integrated at primary care level.

Dr GOUYA (Islamic Republic of Iran) said that, in the light of the growing global public health threat posed by dengue, there was an urgent need to consolidate efforts to support implementation of the global strategy through a health system approach that harnessed multisectoral participation at the local level and ensured active engagement of communities. Additional research was needed to enhance understanding of ecosystems and other factors affecting vector control, which was the most important dengue prevention measure. Specialized training for health workers engaged in vector control was also needed. Best practices should be documented. The development of risk stratification maps should be prioritized at the national and regional levels. Countries in which the disease occurred should share information with their neighbours and strengthen cross-border surveillance and integrated vector control. Although it might prove challenging, it was essential to establish guidelines and implement regulations related to international trade, via which dried mosquito eggs could be transported.

Dr TILLUCKDHARRY (Trinidad and Tobago), expressing support for the global strategy, said that Trinidad and Tobago had put in place systems for prevention of dengue, including through vector control that also targeted insect vectors of other diseases. Health personnel had been trained in line with the WHO case management guidelines. The country had implemented an integrated dengue management strategy that emphasized early diagnosis and effective case management and involved government health agencies responsible for vector control, surveillance, laboratories and health education. The dengue strategy had also proved to be effective in tackling the current epidemic of chikungunya affecting Caribbean countries. National studies on insecticide resistance were ongoing and new methods of mosquito eradication had been adopted. Bed nets had been distributed to interrupt local spread of the disease as part of the integrated approach to controlling mosquito-borne diseases.

Dr ASSIRI (Saudi Arabia) urged all countries endemic for dengue to commit themselves to strengthening health system preparedness, improving cross-border surveillance and information exchange and enhancing integrated vector control. The issuance of recommendations by the Strategic Advisory Group of Experts on Immunization on the public health utility of the candidate dengue vaccine should be fast-tracked. Linkages with the Global Fund to Fight AIDS, Tuberculosis and Malaria should be explored, particularly with regard to surveillance and vector control, and research should be conducted at the regional and global levels to understand the factors and ecosystems involved in transmission and document best practices in dengue control.

Dr E.M. NDIAYE (Senegal) said that the number of dengue cases in Senegal was underreported owing to the absence of a national programme to tackle the disease, insufficient awareness of the disease among health service providers and lack of diagnostic tools. The current surveillance system did not monitor dengue at all levels; however, community surveillance of the disease was now being conducted from 14 sentinel sites. Surveillance systems in public and private health care facilities had been strengthened and clinicians had received dengue-related training.

Mr MATUTE HERNÁNDEZ (Colombia) said that the global strategy should be complemented by measures to strengthen health systems and build national capacities, including through increased technical cooperation and identification of additional sources of funding. The Secretariat should further enhance the support provided to enable Member States to improve diagnostic tools, for example through studies on rapid testing methods. Increased participation by decision-makers at the

local level would allow for more effective risk communication and facilitate collaboration among partners to prevent dengue. With the aim of contributing to global dengue control efforts, Colombia was actively involved in work to develop a vaccine. It was also working to strengthen dengue surveillance.

Ms CABELLO SARUBBI (Paraguay) said that dengue was a problem of singular importance for Paraguay, given its economic and social impact and the burden it placed on the health sector. The country's climatic, ecological, socioeconomic, cultural and structural conditions made it particularly vulnerable to the disease. Her Government contributed to regional prevention and control initiatives, in line with the global strategy. Advances had been made in developing national capacity for vector surveillance, vector control and laboratory diagnosis. However, challenges remained, such as enhancing communication and ensuring an integrated vector management approach. A dengue vaccine would not solve the entire problem of dengue; it would simply be one of the range of tools identified under the global strategy. Additional resources for dengue prevention and control should be mobilized from other sectors, especially those related to environmental management, and research should be conducted to identify new insecticides, as vector resistance to existing products was increasing. The emergence of chikungunya in Paraguay and other countries, and the recent introduction of the Zika virus were exacerbating the challenges posed by dengue in the Region of the Americas.

Dr MALECELA (United Republic of Tanzania) said that, during a major dengue epidemic in 2014, her country had faced significant challenges in relation to differential diagnosis and a lack of diagnostic tools at points of care. The global strategy had been used to develop a national strategic plan and significant headway had been made in ensuring the availability of rapid diagnostic kits, building health workers' capacity, strengthening surveillance and control, and using research data to understand vector breeding habits and dengue etiology. However, support was needed for operational research to enable implementation of national strategic activities. The Secretariat should continue to provide support to African countries in building surveillance systems and facilitating their collaboration with countries that had successfully controlled the disease. It was essential to understand the epidemiological situation prevailing in Africa in order to implement effective preparedness plans. Her Government welcomed the research on a dengue vaccine, which would be crucial for dengue prevention.

Dr ISMAIL (Brunei Darussalam) said that Brunei Darussalam had experienced an alarming rise in dengue incidence over the previous five decades. The increase had occurred in spite of intensive integrated vector management, community awareness-raising, case management measures and enhanced monitoring of vector control activities conducted by other sectors. He welcomed the Organization's continued focus on dengue through the activities set out in the global strategy and looked forward to regular updates on the progress achieved in the development of a vaccine, cross-border prevention and control, and other areas.

Ms MORÓN DE PORRAS (Bolivarian Republic of Venezuela) observed that international trade and movement of goods had facilitated the spread of vectors that transmitted not only dengue but also chikungunya and Zika virus infection, for which her country was currently at risk. Integrated epidemiological and entomological surveillance should be incorporated into information systems as part of vector control activities. Communities and local and national governments must be involved in the fight against vector-borne diseases, which was not only a health issue. There was an urgent need to revise and update vector control measures in order to achieve tangible results. In addition to applying existing and new control methods, enhanced integration of vector control was needed to ensure more sustainable, cost-effective implementation of the global strategy.

Mr DEANE (Barbados) said that technical capacity for dengue vector management was severely limited. In Barbados, despite previously effective control strategies, seasonal outbreaks had begun to occur. New vector control strategies were needed. The Secretariat should use its scientific resources to assess and report on the effectiveness of new vector control technologies, such as the introduction of genetically altered mosquitoes. Barbados would appreciate technical support for the establishment of modern insectaries and the provision training in public health entomology.

Mr SIDDIG ELHAG (Sudan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that repeated dengue outbreaks were occurring in urban centres in some countries in the Region, and vectors were beginning to spread to rural areas. A consolidated global response with the involvement of all stakeholders was required. The active engagement of local communities was critical in order to reverse current epidemiological trends and ensure sustainable prevention and control. The countries of the Region called for renewed global commitment to dengue prevention and control and requested that the issuance of recommendations on the public health utility of the candidate dengue vaccine be fast-tracked.

Mr GONZÁLEZ FERNÁNDEZ (Cuba) affirmed that international trade and the circulation of goods had facilitated the spread of vectors and vector-borne diseases, including dengue, chikungunya and Zika virus infection. The vector for those diseases was present in Cuba, which had put in place an epidemiological surveillance system and was emphasizing vector control. As others had noted, a multisectoral approach and the participation of local communities were essential to effective vector control.

Ms KAMPF (United States of America) said that, in order to meet the goals set out in the global strategy, the Secretariat should work with technical partners to update the WHO guidelines on dengue diagnosis, treatment, prevention and control, published in 2009. Given the increasing incidence of dengue, it was essential to find tools for primary prevention and acknowledge the role of clinical management in reducing mortality and other adverse outcomes.

Dr CESARIK (Croatia) said that local transmission of dengue had been reported in several European countries in recent years and imported cases detected in more than ten. Climate change was furthering the spread of vectors and thus increasing the risk of dengue and other neglected tropical diseases. Support from the Secretariat in enhancing national capacities for awareness-raising, prevention, case detection and patient management would be welcome.

Dr SOE LWIN NYEIN (Myanmar), expressing the hope that an affordable dengue vaccine would become available in the near future, said that the Secretariat should provide technical support and funding for research, entomological and environmental interventions, enhancing laboratory capacity, ensuring the availability of necessary drugs and equipment and strengthening capacity-building and health systems.

Dr HUQ (Bangladesh) said that Bangladesh had been unprepared for the dengue epidemic it had experienced in 2000. Since then, however, the number of cases had been reduced considerably, reflecting the effectiveness of dengue control efforts and dengue management training for health professionals. Dengue control was linked to the control of malaria and other vector-borne diseases. Surges in dengue incidence tended to occur twice a year in Bangladesh, and research had been undertaken to identify the virus serotypes present.

Mr HAMILTON (Saint Kitts and Nevis), calling on the Secretariat to provide Member States in the Caribbean Community with support for training and the acquisition of vector eradication technologies, noted that the Caribbean region was currently affected by both dengue and chikungunya. Both diseases had adverse implications for development; prolonged sick leave in sectors such as

tourism, manufacturing and agriculture could have a negative impact on the economies of small island nations. News of a disease outbreak could also have serious implications for tourism-based economies. Vector control must therefore be central to prevention and control efforts and must be given maximum, sustained attention.

Dr BOOSBUN CHUA-INTRA (Thailand) said that concerted commitment by all stakeholders would be needed to meet the global strategy targets for 2020. The Secretariat should issue evidence-based technical and strategic guidelines for the introduction and scaling-up of the use of the dengue vaccine as a tool for prevention and control. The vaccine's cost-effectiveness should be assessed and its long-term budgetary impact for countries evaluated. Evidence from phase IV clinical trials should be made available to the public. The Secretariat should also facilitate the development of affordable new tools for prevention, diagnosis and treatment of dengue for use in resource-poor settings; facilitate information-sharing between countries in which dengue was endemic; and update the dengue classification criteria with a view to achieving a harmonized dengue classification scheme.

Mr RODRÍGUEZ MONEGRO (Dominican Republic) noted that, despite the use of integrated approaches of demonstrated effectiveness, dengue epidemics continued. In his view, two aspects of the integrated approach had fallen short: community participation and inter-institutional coordination. Education and awareness-raising were crucial to ensure that the public understood the importance of eliminating mosquito breeding sites. A multisectoral approach was also essential, and each public institution must acknowledge its responsibility, particularly with regard to the elimination of poverty, as dengue was a poverty-related disease. To combat such diseases, countries needed integrated development policies in which the importance of health as a pillar of development was recognized and sufficient resources were allocated for health in national budgets. As poverty elimination was a long-range undertaking, however, efforts in the short term should focus on the development of a dengue vaccine.

Dr ROA RODRIGUEZ (Panama) said that, after a hiatus of almost 30 years, dengue had been reintroduced in Panama in 1990. Although the measures taken to reduce dengue cases and deaths had been relatively successful, real dengue control could not be achieved without the participation of all of society, particularly in the elimination of breeding sites. Better environmental management and integrated vector control were also needed. Dengue was not purely a health problem, and it must therefore be tackled from a multisectoral perspective. Public policies aimed at minimizing the risk of infection from dengue and other vector-borne diseases were essential.

Dr TESFAZION (Eritrea) said that dengue had previously occurred mainly in the lowlands of Eritrea but was spreading elsewhere, probably as a result of climate change. Incidence of both yellow fever and dengue had risen around the world. Despite the considerable public health impact of the two closely related diseases, however, few attempts had been made to collect comprehensive data on their spatial and temporal distribution. Integrated vector control was important, as the two diseases were transmitted by the same vector and occurred in similar geographic areas. Surveillance and data system strengthening were equally important.

Dr ISMAIL (Malaysia), noting that dengue was largely a man-made problem, said that incidence of the disease was increasing in Malaysia. It had previously been a seasonal, cyclical disease that peaked during the rainy season, but was now a year-round public health threat. Countries should work together on drug and vaccine development, surveillance, innovative vector control and outbreak prediction. The Secretariat had an important role to play facilitating such collaboration. Given the increasing burden of dengue, consideration should perhaps be given to whether it should continue to be regarded as a neglected disease.

Dr EDWARDS (Jamaica) said that dengue cases in Jamaica had increased in recent years. The country's health system had also been severely impacted by an outbreak of chikungunya, which had peaked in October 2014. Health care facilities had been overwhelmed as a result of high infection rates among both patients and medical staff. That situation had shown the importance of building capacity at all levels of care to respond effectively to outbreaks and disasters.

Dr SHEIKH (Pakistan) said that incidence of dengue and dengue haemorrhagic fever had increased dramatically in Pakistan between 2005 and 2013, and Pakistan should be categorized as an area with regular outbreaks of the disease. Its national guidelines for dengue control emphasized interruption of transmission by reducing vector density at local level. Larval source management should be considered a priority intervention, and greater focus should be placed on monitoring and evaluation and assessing the impact of dengue interventions.

Dr AZZOUZI SIDI (Morocco) said that, although Morocco had had no cases of dengue, it was located in a zone classified as being at risk for transmission of the virus owing to the presence of *Aedes aegypti* and the potential for introduction of *Aedes albopictus.* Vigilance must therefore be exercised. The Ministry of Health had established guidelines for the preparation of an integrated multisectoral national strategy for prevention and control of emerging and re-emerging diseases which was in line with the global strategy on dengue.

Dr RAJAPAKSA HEWAGEEGANA (Sri Lanka) said that the dengue case fatality rate in Sri Lanka had been reduced to 0.2% through the application of integrated surveillance throughout the country, high levels of political commitment, public awareness-raising through "mosquito control weeks" and improved case management.

Dr GOMEZ (Bahamas) said that a dengue outbreak in the Bahamas in 2011 had highlighted the importance of improved, low-cost, rapid diagnostic tools with high sensitivity and specificity in order to improve dengue diagnosis at points of care. Entomological data had also been particularly useful. Ongoing coordination between public health and environmental services was essential for vector control and surveillance and for reducing morbidity rates. Dengue control efforts had also helped to mitigate an outbreak of chikungunya. The Bahamas awaited a safe, cost-effective vaccine that would lead to the eradication of dengue.

Dr TANOH (Côte d'Ivoire) said that, after eight cases of dengue had been detected nationally between 2006 and 2012, steps had been taken to strengthen entomological surveillance, mosquito control and larvae elimination efforts, and diagnostic capacity. The Secretariat should strive to ensure the availability of diagnostic tools and, as it was often difficult to distinguish dengue from malaria, strengthen countries' capacity for differential diagnosis.

Dr MITCHELL (Grenada) said that Grenada had made strenuous efforts to implement an integrated dengue management strategy with support from PAHO. Nevertheless, vector control continued to pose a significant challenge, as demonstrated by an outbreak of chikungunya in 2014, which had taken a significant economic toll on the country. It would require support from the Secretariat and from the Pan American Sanitary Bureau in identifying innovative best practices for controlling vector-borne diseases, including emerging diseases such as Zika virus disease.

Dr BATRES (Honduras) said that the control of vector-borne disease was a priority for her country. The president was leading efforts to combat dengue and chikungunya, drawing on the integrated strategy recommended by PAHO and taking a multisectoral approach to the problem. Committees had been set up at local level to implement the integrated strategy with the participation of government agencies, private enterprise and civil society, and steps were being taken to strengthen patient care, diagnostic procedures, epidemiological surveillance, risk communication and vector

control. However, rates of dengue and chikungunya remained high, and efforts to combat them must be redoubled.

Dr Song-En HUANG (Chinese Taipei) said that, after an outbreak of dengue in 2014, a centre had been established in Chinese Taipei to integrate research on dengue epidemiology, clinical care and vector control. Chinese Taipei would continue to implement the WHO global strategy. As climate change would continue to increase the risk of dengue and other vector-borne diseases, she urged WHO to support the development of a dengue vaccine.

Mr LI Wing Sum (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, said that the current profit-driven biomedical research and development model had failed to generate treatments for a disease that primarily affected people in resource-poor settings. He urged the Secretariat and Member States to adopt innovative research and development strategies that de-linked the price of medicines from research and development costs and to incorporate a technical element into the global strategy for dengue prevention and control that recognized the gap in research on dengue and other neglected diseases.

Dr NAKATANI (Assistant Director-General) said that work on the dengue guidelines was due to be completed by the end of 2015. In order to raise awareness and enhance capacity with regard to vector control, the Director-General had selected vector-borne diseases as the theme for World Health Day 2014. As to chikungunya, the Strategic and Technical Advisory Group for Neglected Tropical Diseases had recommended that new guidelines be drafted that took account of the experience gained in the South-East Asia Region and the Region of the Americas. He was concerned, however, about the development of too many separate sets of guidelines, and suggested that it might be preferable to integrate chikungunya guidelines into the dengue guidelines. With regard to a dengue vaccine, he was hopeful that a functional national regulatory authority would soon license the candidate vaccine currently in clinical trials, after which the Secretariat, with guidance from the Strategic Advisory Group of Experts, would issue recommendations for use of the vaccine. Concerning the lack of rapid diagnostic tools and effective treatment, he agreed that innovative solutions were required, but not only with regard to biomedical considerations; innovative ways of involving communities and civil society were also needed.

The Committee noted the report.

Global vaccine action plan: Item 16.4 of the Agenda (Documents A68/30)

The CHAIRMAN drew attention to a draft resolution proposed by the delegation of Libya, which read:

> The Sixty-eighth World Health Assembly,
>
> **PP1** Having considered the report on the Global vaccine action plan;[1]
>
> **PP2** Emphasizing the importance of immunization as one of the most effective interventions in public health and access to immunization as a key step towards universal health coverage;
>
> **PP3** Acknowledging the progress made in global immunization and the commitment under the 2011–2020 Decade of Vaccines to achieve immunization goals and milestones;
>
> **PP4** Recalling resolutions WHA58.15 and WHA61.15 on the global immunization strategy, resolution WHA65.17 on the global vaccine action plan, resolution WHA61.21 on the

[1] Document A68/30.

global strategy and plan of action on public health, innovation and intellectual property and resolution WHA54.11 on the WHO medicines strategy;

PP5 Noting with concern that globally immunization coverage has increased only marginally since the late 2000s; and that in 2013 more than 21 million children under one year of age did not complete the three-dose series of diphtheria-tetanus-pertussis (DTP) vaccine;

PP6 Recognizing that the availability of new vaccines against important causes of killer diseases such as pneumonia, diarrhoea and cervical cancer can prevent leading causes of childhood and women's death;

PP7 Acknowledging that successful national immunization programmes require sustainable political and financial support of Member States;

PP8 Appreciating the contributions of WHO, UNICEF, Gavi, the Vaccine Alliance, and all partners in their efforts to support the introduction of new vaccines in developing countries and strengthen immunization services;

PP9 Concerned that inequities between Member States are growing due to the increased financial burden of new vaccines and based upon those that are eligible or ineligible for financial and technical support from global partners; and that mechanisms which lower the price of vaccines are not accessible to developing and middle-income Member States;

PP10 Concerned that many developing countries are not able to access life-saving new vaccines particularly because of the costs related to procurement and introduction of these vaccines; and concerned of the increase of costs of overall immunization programmes because of increase in price of the WHO recommended vaccines;

PP11 Recognizing that publicly available data on vaccine prices is scarce, and that availability of price information is important for facilitating Member States' efforts towards introduction of new vaccines;

PP12 Recalling many Member States' interventions on the WHA immunization agenda item each year expressing concern over the unaffordable cost of new vaccines and appealing to the global community to support strategies that will reduce prices;

PP13 Recalling the WHO global framework for expanding access to essential drugs, and its four components: the rational selection and use of medicines, reliable health and supply systems, sustainable financing, and affordable prices;

PP14 Taking into account the importance of competition to reduce prices and the need to expand the number of manufacturers, particularly in developing countries, that can produce WHO-prequalified vaccines and create a competitive market;

PP15 Stressing the critical life-saving role of vaccines and immunization programmes and striving to make immunization available to all,

(OP1) URGES Member States:

(1) to allocate adequate financial and human resources for introduction of life-saving vaccines into national immunization schedules and sustaining strong immunization programmes in accordance with national priorities;

(2) to strengthen efforts for pooling vaccine volumes in regional and interregional or other groupings as appropriate that will increase affordability by leveraging economies of scale;

(3) to consider providing timely vaccine price data to WHO for publication, with the goal of increasing affordability through improved price transparency, particularly for the new vaccines;

(4) to seek opportunities for establishing national and regional vaccine manufacturing capacity, in accordance with national priorities, that can produce to the standards required for WHO-prequalification;

(5) to create norms and mechanisms to increase available information on government funding to vaccine development and ensure that government investments in vaccine

development be put towards improving the public's health through affordable vaccine prices;

(6) to support the ongoing efforts of various partners coordinated by WHO to design and implement the strategies to address the vaccines and immunization gaps faced by the middle-income countries;

(OP2) REQUESTS the Director-General:

(7) to secure funding to fully implement collaborative efforts with international partners, donors, and vaccine manufacturers to support low- and middle-income countries in accessing affordable vaccines of assured-quality in adequate supply;

(8) to continue developing and adequately managing publically available vaccine price databases, like the WHO Vaccine Product, Price and Procurement project, working with Member States to increase availability of price information;

(9) to monitor vaccine prices through annual reporting of the Global Vaccine Action Plan;

(10) to provide technical support and facilitate financial resources for establishing pooled procurement mechanisms where appropriate for use by Member States;

(11) to strengthen the WHO prequalification programme and provide technical assistance to support capacity building for research and development, technology transfer, and other relevant strategies, to enable the entrance of vaccine manufacturers in developing countries that can produce to the standards required for WHO-prequalification;

(12) to report upon technical and legal barriers, including regulatory and intellectual property barriers, that may undermine robust competition that can enable price reductions for new vaccines;

(13) to call on Member States to finance a coordinated strategy to provide relevant technical support needed by low and middle-income Member States.

Dr AL-MOKHTAR (Libya) said that, as noted in the assessment report by the Strategic Advisory Group of Experts, the goals of the Global vaccine action plan were not being met. Urgent action was needed to ensure that vaccination programmes were not disrupted as a result of conflict and humanitarian crises and to ensure that refugee populations had access to vaccination services. The Secretariat should expand its guidance on vaccination provision during humanitarian crises and increase support to countries in implementing the existing guidance. In order to extend vaccination to all and reduce inequities in immunization, it was essential to ensure the affordability of vaccines. His delegation had put forward the draft resolution with a view to addressing that issue, particularly in respect of countries that were not eligible, or no longer eligible, for subsidies from the GAVI Alliance. The measures called for in the draft resolution had been shown to increase vaccine affordability and were in the interests of all governments wishing to ensure an affordable and sustainable supply of vaccines.

Mr MAGNÚSSON (Iceland), speaking on behalf of the Nordic and Baltic States, Denmark, Estonia, Finland, Iceland, Latvia, Lithuania, Norway and Sweden, said that the Director-General should give high priority to overcoming the obstacles to achievement of the five goals of the action plan. Immunization services should be coordinated with other health services, and primary health care workers should be encouraged to offer vaccinations when treating patients for other reasons. As misinformation about the possible risks of vaccination was a major obstacle in some regions, health care workers should be properly informed so that they could give accurate, evidence-based advice on issues such as contraindications.

Mr CORRALES HIDALGO (Panama), speaking on behalf of the Member States of the Region of the Americas, said that immunization was one of the most cost-effective interventions in public health and a key element of universal health coverage. The Region had eradicated smallpox and poliomyelitis and had also been declared free of endemic rubella transmission – successes achieved as a result of immunization. The international community should support strategies to reduce the cost of vaccines, especially costly new ones such as the human papillomavirus vaccine, which could save the lives of many women. Member States should exchange more information on the pricing of medicines in order to promote transparency and forge alliances to minimize financial inequalities. The regional pooling of resources was an effective way of ensuring the affordability of high-quality vaccines, as demonstrated by the PAHO Revolving Fund for Vaccine Procurement.

Dr MUÑOZ (Chile) said that he supported the recommendation that countries with vaccination coverage rates below 80% should meet so that they could identify solutions that were tailored to the particular challenges they faced. With support from the Secretariat, they should design and implement national plans; progress should be evaluated after one year. While it was important to involve nongovernmental organizations and health care workers in the design of immunization programmes, it was governments that must take responsibility for those programmes and ensure that they were adequately financed and that immunization was provided free of charge to target populations. Advocacy was needed in order to persuade decision-makers of the cost-effectiveness of funding immunization programmes. Bulk purchasing mechanisms should be strengthened and Member States should share information on vaccine pricing in their respective markets. The Secretariat had a role to play in improving such mechanisms. It should also ensure that it had the capacity to counter false and misleading information about vaccines and vaccination and should take care to avoid making ambiguous recommendations on topics such as the use of thiomersal in vaccines, which could lead States to make decisions about vaccines without adequate analysis of the scientific evidence.

Professor BAGGOLEY (Australia) said that the assessment of the Strategic Advisory Group of Experts was an important reminder of the slow progress towards achieving the action plan's targets. Member States should increase their focus on routine immunization as a highly cost-effective investment in health and health security. Australia broadly supported the draft resolution proposed by the delegation of Libya and shared the concerns expressed therein about the sustainability of vaccine financing, especially for middle- and low-income countries when they no longer qualified for GAVI support. While contractual constraints currently prevented Australia from sharing information about vaccine pricing, the possibility of sharing such information in future was being investigated. As the Global vaccine action plan had had little impact on global diphtheria-tetanus-pertussis (DTP3) immunization coverage, Australia called for collective prioritization of resources to focus on countries with coverage of less than 80%. Improving immunization rates was a key indicator of WHO's performance at country level.

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

The meeting rose at 12:30.

THIRD MEETING

Tuesday, 19 May 2015, at 14:40

Chairman: Dr E. JARAMILLO NAVARRETE (Mexico)

COMMUNICABLE DISEASES: Item 16 of the Agenda (continued)

2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on the Ebola Emergency: Item 16.1 of the Agenda (Documents A68/24, A68/25, A68/26, A68/27, A68/51 Rev.1 and A68/56)

Introducing the item, the CHAIRMAN drew attention to the draft decision contained in document A68/51 Rev.1, which read as follows:

Further to the submission of the reports on 2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on the Ebola Emergency (documents A68/24, A68/25, A68/26 and A68/27), the Health Assembly is invited to consider the following draft decision.

The Sixty-eighth World Health Assembly, having recalled the resolution adopted by the Executive Board in its Special Session of 25 January 2015,[1]

Interim assessment

- Welcomed the preliminary report of the Ebola Interim Assessment Panel appearing in document A68/25;
- Thanked the Ebola Interim Assessment Panel for its work to date;
- Requested the Ebola Interim Assessment Panel to continue its work, and to issue a final report to be made available to the Director-General not later than 31 July 2015.

International Health Regulations (2005)

- Requested the Director-General to establish a Review Committee under the International Health Regulations (2005) to examine the role of the International Health Regulations (2005) in the Ebola outbreak and response, with the following objectives:
  - to assess the effectiveness of the International Health Regulations (2005) with regard to the prevention of, preparedness for and response to the Ebola outbreak, with a particular focus on notification and related incentives, temporary recommendations, additional measures, declaration of a Public Health Emergency of International Concern and national core capacities;

[1] Resolution EBSS3.R1.

  - to assess the status of implementation of recommendations from the previous Review Committee in 2011[1] and related impact on the current Ebola outbreak;
  - to recommend steps to improve the functioning, transparency, effectiveness and efficiency of the International Health Regulations (2005) and to strengthen preparedness and response for future emergencies with health consequences, with proposed timelines for any such steps.
- Requested the Director-General to convene the International Health Regulations (2005) Review Committee in July 2015, and to report on its progress to the Sixty-ninth World Health Assembly in May 2016;
- Agreed to support west and central African States and other at-risk States to achieve full implementation International Health Regulations (2005) by June 2019;
- Endorsed the proposal of the Ebola Interim Assessment Panel that peer review or other equivalent external validation be part of any assessment of the status of national core capacities under the International Health Regulations (2005).

Global health emergency workforce

- Welcomed and concurred with the Director-General's conceptual plan for a Global Health Emergency Workforce to respond to acute or protracted risks and emergencies with health consequences;
- Requested the Director-General to report on progress on the establishment, coordination and management of the Global Health Emergency Workforce to the Executive Board at its 138th session in January 2016.

Contingency fund

- **[Welcomed the parameters described in document A68/26, which include the guiding principles that must govern the fund, such as:** size, scope, sustainability, operations, sources of financing and accountability mechanisms**;]** ***(Panama)***
- Decided to create a **[specific,]** ***(Finland)*** **[revolving]** ***(Egypt)*** contingency fund
  [merging the existing two WHO funds[2]**,]** ***(Finland)***
  with a target capitalization of US$ 100 million [[in fully flexible funds] / **[, fully funded by flexible voluntary contributions]** ***(Spain, Portugal, Italy)***,
  [so as to provide enhanced response to all possible concurrent emergencies] (*Egypt*)
  to reliably**[, transparently and in an accountable manner, including financial reporting, and applying the principles and practices of neutrality, humanity, impartiality and independence of good humanitarian donorship in its use,]** ***(Finland)***
  finance and rapidly scale up WHO's initial response**[, including through other partners,** ***(UK)***
  to [[emergencies with health consequences] / **[an escalating health emergency, using the objective criteria set out in the ERF]**] ***(UK)*** for a period of **[up to]** three [to six] months [from the start of an emergency of grade 2[3] or higher and to address, if and when necessary, factors that could prevent the escalation of a given emergency or risk] ***(UK)***;
- Decided that the Contingency Fund would be under the authority of the Director-General **[, or his or her delegate]** ***(UK)***, with disbursement at his or her discretion;

[1] See document A64/10.

[2] [**WHO's Rapid Response Account and WHO-Nuclear Threat Initiative Emergency Outbreak Response Fund.]** ***(Finland)***

[3] [As per the criteria articulated in WHO's Emergency Response Framework.]

- **[Requested the Director-General to establish a mechanism for monitoring and evaluation of the operations of the contingency fund.] *(Panama)***
- Thanked Member States for contributions already committed to the Contingency Fund;
- Requested the Director-General to approach donors to encourage contribution to the Contingency Fund, including through the next round of the Financing Dialogue;
- Requested the Director-General to report on the performance of the Contingency Fund, including amount raised and spent, and for what purpose, to the Sixty-ninth World Health Assembly in May 2016, through the Executive Board at its 138th session in January 2016.
- **[Requested the Director-General, in consultation with the Executive Board, to establish procedures for transparency and submission of accounts.] *(Panama, Argentina, Mexico)***
- **Requested the Director-General to prioritize in-field operations in affected countries when using contingency fund. *(Panama, Mexico)***

Research and development

- Appreciated the key coordination role played by WHO for ongoing work in development of vaccines, diagnostics and medicines for the Ebola virus disease;
- Endorsed the development of a framework for advancing research and development of medical products for other infectious diseases of epidemic potential, taking into account other relevant work streams within WHO.

Health systems strengthening

- Welcomed the development of the robust, costed national health system recovery plans for Guinea, Liberia and Sierra Leone, which were presented at the World Bank Spring Meetings on 17 April 2015, as the basis for donor coordination and strategic investments;
- Requested WHO to continue its coordination role in support of national administrations as they prepare for the United Nations Secretary General's high-level pledging conference on Ebola, to be held on 10 July 2015;
- Acknowledged the leadership shown by the Ministries of Health of the three countries in focusing, with support of WHO country offices, on early recovery through emphases on infection prevention and control, reactivation of essential services, immediate health workforce priorities and integrated disease surveillance;
- Requested the Director-General to continue and enhance the work of the Organization in supporting Member States to be better prepared to respond to emergencies with health consequences by strengthening national health systems.

Way forward

- Welcomed the Director-General's commitment to reform the work of WHO in emergencies with health consequences;
- Requested the Director-General to report on progress on these reforms, and on the other decisions taken herein, to the Executive Board at its 138th session in January 2016.

Dame Barbara STOCKING, Chairman of the Ebola Interim Assessment Panel, said that the Panel's report was intended to highlight, as a matter of urgency, all the lessons learnt or to be learnt from the Ebola crisis. It would be followed by a final report in July 2015. In its work, the Panel had focused on three main areas, namely: the International Health Regulations (2005); the development of WHO, in the sense primarily of the Secretariat, as an emergency agency; and the links between the health emergency system and the wider humanitarian system. Firstly, the Panel was convinced that if the recommendations contained in the Report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009 had been implemented,

there would have been a far better basis for management of the outbreak of Ebola virus disease. Urgent action was needed to enhance Member State preparedness. That would require funding, and WHO should work with the World Bank in that respect. Action was needed in many areas, including the implementation of outside assessment of countries' surveillance systems in order to increase trust in them; strengthening of capacity for community engagement; data aggregation across agencies, using common definitions and standards; and a more progressive classification of public health emergencies. There was a need for incentives, such as the reinsurance mechanisms proposed by the World Bank, to encourage countries to declare outbreaks as soon as possible; at present major disincentives existed, such as the threats to the economy, transport and trade which would arise from declaration of an outbreak. In response to the Ebola virus disease outbreak, over 40 countries had introduced more restrictive protective measures than WHO had suggested, including trade and transport barriers. WHO should have more powers in that regard, but additional mechanisms should be investigated, such as sanctions through the World Trade Organization.

Welcoming the commitment of the Secretariat, as expressed by the Director-General, to position WHO as an emergency agency for all aspects of health crises, the Panel endorsed her concept of a single entity within WHO to bring together the International Health Regulations (2005) issues and the emergency response issues, but considered that creating a separate agency was not a sensible approach. Setting it up would be time consuming and costly and emergency response was a logical component of WHO's core mandate of managing global public health. Nevertheless, it was important to be aware of the lack of public trust in WHO resulting from the Ebola virus disease crisis; a significant cultural change within the Organization to do with handling emergencies would be needed. Accountability mechanisms, to monitor the change efforts of the Secretariat, would also be a vital component, as would the establishment of deeper partnerships with other agencies. In terms of links between the public health system and the United Nations emergency response architecture, although WHO was the lead agency in the health cluster, the two sides had only limited understanding of the other's roles and activities. The Panel intended to highlight the issue of greater mutual comprehension in discussions with the United Nations Secretary-General's High-Level Panel on the Global Response to Health Crises.

Dr JUAN LOPEZ (Mexico) welcomed the work and recommendations of the Ebola Interim Assessment Panel, particularly in terms of identifying areas for improvement both at the country level and within the Secretariat. Mexico had developed an action plan to tackle such outbreaks, as had many other countries, and the results of the independent assessment would be an extremely useful contribution.

Ms RABOVICA (Latvia), speaking on behalf of the European Union and its Member States, said that they remained fully committed to reaching zero cases, helping the affected countries recover and strengthening the preparedness of those and other countries. The Panel's first report provided very pertinent recommendations for improving WHO's emergency response, as well as accurately describing the gaps and delays in WHO's response in the early stages of the crisis, and she looked forward to further analysis in the Panel's final report. She would hope for more focus on the relationship between WHO and other partners in the field, together with further analysis of WHO's management of the foreign medical teams. She welcomed the emphasis given by the Panel to improving implementation of the International Health Regulations (2005). That was of particular importance for outbreaks in vulnerable countries, which had limited capacity to respond effectively without additional support. However, it was important that proposals did not go beyond the remit of the Regulations. Noting the report's recommendation concerning a cultural and organizational shift in emergency response within the Organization, she said that the ongoing reform of WHO should help to close the gaps in leadership and crisis coordination. The European Union and its Member States were undertaking a review of lessons learnt from the Ebola virus disease outbreak, and examining their own preparedness and response. Finally, the conclusions of the Panel should feed into the deliberations of the United Nations Secretary-General's High-Level Panel on the Global Response to Health Crises.

Dr AMMAR (Lebanon) said that WHO should be better prepared and equipped for public health events of international concern; moreover, many Member States required the urgent support of the Organization to accelerate their preparedness and to build the core capacities stipulated by the International Health Regulations (2005). Independent assessment of capacities in that regard, such as that conducted by the Regional Office for the Eastern Mediterranean in some countries in the Region, would enhance Member States' accountability at both the country and global levels. In emergency situations, exceptional measures should be permitted in order to overcome WHO bureaucratic bottlenecks and ensure a rapid and appropriate response. As noted by the Panel, WHO suffered from a lack of political and financial commitment from its Member States, despite global health risks. The continuing policy of zero nominal growth was a key example: it was time to revisit that policy and to create a core fund for emergency response. The countries of the African and the Eastern Mediterranean Regions had already indicated their readiness to accept an increase in assessed contributions to that end.

Dr HINOSHITA (Japan) observed that it was essential to have in place and to have rehearsed an emergency response plan; capacity building for health care workers, particularly at the country level, was indispensable in that regard. The proposed contingency fund should be efficient and take other relevant funding mechanisms into account. Also, it would be important to clarify the difference between the activities supported by the contingency fund and other existing and future programmes. Lastly, he acknowledged the importance of strengthening core capacities as stipulated by the International Health Regulations (2005), in order to build resilient health systems.

Ms LANTERI (Monaco), stressing the importance of the Panel's report in identifying and rectifying the problems and failures that had arisen during the Ebola virus disease outbreak and that could recur in future, said that it was essential to work together and undertake measures to enable Member States to react to situations as effectively as possible and to empower WHO to fulfil its mandate. She requested further information on the interactions between the Ebola Interim Assessment Panel and the United Nations Secretary-General's High-Level Panel on the Global Response to Health Crises.

Mr STAUR (Denmark) said that his delegation fully supported the Director-General's endeavours to ensure that WHO played its rightful role in disease outbreaks, humanitarian emergencies and global health security issues. WHO must ensure that it had robust emergency operations in place and was fit for purpose and accountable. He called on the Director-General to lead the substantial changes across all levels of the Organization that would be required. He looked forward to the Interim Assessment Panel's final report, including a clear indication of what had and had not worked at each level of the Organization. Meanwhile, he supported the plan for a global health emergency workforce and the proposed framework for a contingency fund.

Dr BOKENGE BOSUA (Democratic Republic of the Congo) recalled that the Democratic Republic of the Congo had dealt with six Ebola virus disease outbreaks since 1976. The latest had been in August 2014 and had been brought fully under control in 45 days by means of an experience-based national strategy in line with the International Health Regulations (2005), relying on community vigilance, multisectoral coordination, strengthening of diagnostic capacities and the deployment of multidisciplinary teams.

Dr ENNIS (Jamaica) said that WHO should as a priority provide increased support to countries to assist them in achieving the International Health Regulations (2005) core surveillance and response capacity requirements. At present, there was a lack of confidence in the system, as the tools to respond were non-existent. It was essential that the Region have a stockpile of personal protective equipment, to which end WHO must establish a regional hub. Jamaica and other countries did not have the human and financial capacities to adequately deal with an outbreak of the magnitude of the recent Ebola virus

disease. Therefore, the plan to expand the global health emergency workforce and establish a contingency fund should be swiftly implemented. WHO must rebuild the trust of its Member States, which could be done through inaugurating a more organized humanitarian and emergency response, with timely and clear decision-making. Jamaica supported the actions recommended by the Panel and looked forward to the final report.

Dr HASSAN (Egypt) said that since the beginning of the Ebola virus disease outbreak, Egypt had had measures in place to deal with it and had provided help to some African countries. The comments made in an assessment by WHO showed no appreciation for the steps taken by the Egyptian Ministry of Health and other authorities, and Egypt understood that the same was happening in several other countries. WHO was transferring the responsibility for preparedness and response to its Member States alone, whereas it should be a joint effort of the Secretariat and the Member States together. She asked whether there would be repercussions for Member States that did not implement the International Health Regulations (2005).

Dr AL SHARQAWI (Bahrain), speaking on behalf of the Eastern Mediterranean Region, said that it was in the best interests of the global community to have a strong and responsive WHO, with the right resources and means to address international health threats adequately and effectively. WHO must reform its existing emergency response structure and address its organizational weaknesses. His delegation endorsed the conclusion of the IHR Review Committee's assessment of the Ebola crisis with regard to weaknesses and gaps in the notification and information-sharing process.

Dr ASSIRI (Saudi Arabia) said that as WHO's capacity to respond effectively to multiple public health emergencies remained constrained, the recommendations of the Ebola Interim Assessment Panel needed to be considered seriously. The required core capacities under the International Health Regulations (2005) must be achieved and sustained. The proposed IHR Review Committee assessment of the Ebola crisis should examine the weaknesses and gaps and make recommendations for improvements.

Mr GULDVÅG (Norway) said that the report of the Ebola Interim Assessment Panel provided a convincing analysis of structural shortcomings in need of urgent correction. It was the responsibility both of the Member States and of the Secretariat to fulfil the provisions of resolution EBSS3.R1. Member States needed to provide the resources and the political backing to enable the Director-General to make the necessary changes, to continue to develop her concepts for reform and to implement them throughout the Organization. With the outbreak having demonstrated the Organization's lack of capacity to handle complex emergencies, he welcomed the commitment to address such shortcomings, emphasizing that structural changes must accompany the reform elements decided at the Special Session of the Executive Board on the Ebola Emergency. Effective crisis management required information-sharing systems across the Organization as well as mechanisms for quick decision-making and unified lines of command. WHO should also cultivate partnerships with other United Nations system entities, non-State actors and the private sector.

Dr AARABI (Islamic Republic of Iran) emphasized that in order to address future epidemics of international concern, a strong global health system was needed with the capacity to detect outbreaks early. Rapid response teams at global, regional and national levels must be created. Military forces could assist with logistics and transportation, as well as securing the area. The Secretariat and the Member States should organize simulations and drills to help identify performance gaps. They also needed to foster advanced research into and development of vaccines, medicines and diagnostics, which would not only improve global preparedness against public health emergencies of international concern but would also strengthen primary health care systems and reduce the inequities in health services. Member States should prioritize surveillance, preparedness and response capacities.

Additionally, the more advanced Member States should share their experience and capacities with less developed countries, as Iran was prepared to do.

Dr AL-TAEE (Iraq) said that the Ebola virus disease outbreak had tested the robustness of the International Health Regulations (2005), the health system and partnership development. Emphasis should be placed on the effectiveness of the Regulations; the role of WHO in coordinating activities related to the Regulations; and the roles of other, non-health, sectors. The approach to funding should include strengthening budget transfers within regular programmes for emergency preparedness and response and following a carefully prepared contingency work plan for investing the resources of WHO and other international organizations. More generally, the focus should be on strengthening health system building blocks and the relation of funding with universal health coverage, including emergency preparedness and response.

Dr MUÑOZ PORRAS (Chile) welcomed the initiatives aimed at improving countries' capacities in order to avoid or diminish the effects of health crises such as the Ebola disease virus outbreak. The International Health Regulations (2005) helped align countries to create a safer world, but their effectiveness was proportionate to Member State compliance. In view of the difficulties expressed by many countries in implementing the capacities within the established time frame and given the practical and logistical problems that increased the risk of Ebola disease virus importation, a global early detection and prevention effort was needed, based on collaborative support between Member States and with international organizations. He supported the creation of a contingency fund for emergencies. His country's recent emergencies and the threat of the Ebola virus disease had demonstrated how important it was to have a functioning system for assessing detection, analysis, notification and response capacities. Urging that current efforts be strengthened in order to share the lessons learnt from the crisis among Member States, he supported the conclusions of the report and the implementation of the recommendations.

Mr CARIKCI (Turkey) said that Member States could strengthen WHO capacities during emergencies and outbreaks by providing human resources, financing, partnerships and communication capabilities. While much had been achieved in dealing with the Ebola virus disease outbreak, it was important to stay vigilant in order to reach the target of zero cases. Preparedness and resilience were key elements of response to emergencies. A fully-fledged resource mobilization effort was needed in order to achieve those two elements, with a focus on building resilient health systems and strengthening primary health care and universal health coverage. The capacity-building efforts in fragile countries should be supported through strong partnerships. Urging that the affected countries not be economically or socially isolated, he described the support that Turkey had provided and would continue to provide to them.

Mr KONYNDYK (United States of America) said that his country greatly appreciated the report of the Ebola Interim Assessment Panel, which provided a compelling analysis of the underlying causes for the weakness of WHO's initial repose to the Ebola virus disease outbreak. He noted that while the United Nations Mission for Ebola Emergency Response had attempted to identify appropriate linkages and burden-sharing between the global health and humanitarian response communities, that might not be the best model for organizing future responses to global health crises. To address those shortcomings, a strong and empowered emergency response section within WHO should be developed. A clear and unified command and control structure was central to effective emergency management. He endorsed the report's observation that self-reporting on implementation of the International Health Regulations (2005) was not adequate and the scope of the Regulations was not large enough to protect against inappropriate international travel and trade restrictions. He strongly supported an external validation framework to help accelerate complete compliance with the Regulations.

Dr MMBANDO (United Republic of Tanzania) said that the Ebola outbreak had tested the health systems of developing and developed countries alike, with panic being expressed by all nations. He called on WHO to support countries in building a robust surveillance and response system as part of resilient health systems, address Ebola and other neglected diseases in a holistic manner and support countries that were building laboratory capacity for emerging and re-emerging diseases. He welcomed WHO's proposals to revisit the global health infrastructure, at all levels, examining coordination and finances, and noted the importance of building countries' core capacities to ensure implementation of the International Health Regulations (2005).

Dr E.M. NDIAYE (Senegal) welcomed the report.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) asked when the final report of the Ebola Interim Assessment Panel would be made available to Member States. The International Health Regulations (2005) were a useful tool and more emphasis should be placed on developing core capacities in all Member States. Strong emphasis should be placed on epidemiological surveillance, community participation and the involvement of all sectors, contributing to the ability of each country to detect a public health emergency of international concern. He described the steps taken in Cuba and other countries of the Region to tackle Ebola or similar outbreaks. The capacity of WHO to confront emergency situations and draw lessons from them should be increased. He agreed that greater synergy was needed between the broader United Nations system and WHO, with the latter continuing to take the lead in health-related activities.

Professor DELFRAISSY (France) said that lessons must be learnt and conclusions drawn as to the work of WHO from the crisis. The gains made were due to having a robust strategy and appropriate human and financial resources; cooperation among all actors, in particular the local communities affected by the epidemic, was crucial to maintaining those gains. Member States had learnt that they needed to be better prepared for major health emergencies, which had an impact on many areas in addition to health. The Assembly should work to introduce a contingency fund and financially sustainable and robust health reserves for rapid mobilization. His country would participate actively in those discussions. He described the assistance being provided by France to Guinea, one of the affected countries. Research into tropical and emerging diseases was crucial, and epidemiological surveillance should be coordinated at regional level, since disease did not recognize borders. The effective implementation of the International Health Regulations (2005) was a fundamental step in creating resilient health systems as part of a broader sustainable development goal. His country would continue to support WHO in responding to health crises as the lead of the United Nations health cluster, and to support reform that would increase effectiveness.

Dr MELNIKOVA (Russian Federation) supported most of the recommendations made by the Panel. In order to strengthen the emergency response to crises like Ebola, react adequately and effectively to emergency situations, response management crises should be centralized under the auspices of WHO and the use of Member States' resources should be optimized. WHO must also work more effectively on coordinating those resources. Member States' resources, including staff, laboratories, transport and medical supplies should form the basis of a global reserve for responding to public health emergencies. There should be a clear unified method for mobilizing Member States' resources in crisis situations, and her country stood ready to contribute specialist staff and resources to an emergency response led by WHO. She welcomed the Panel's assertion that the main work, such as strengthening countries' ability to respond, should be performed between crises, not during them. She supported the establishment of a contingency fund based on voluntary additional donations from Member States and operating efficiently and transparently. The Russian Federation would continue its active international participation in efforts to tackle Ebola, to which it had already contributed more than US$ 60 million, and would maintain support for affected countries in Africa once the outbreak had come to an end.

Ms DUSSEY-CAVASSINI (Switzerland) welcomed the report of the Ebola Interim Assessment Panel, as an analysis of the response to Ebola was important, both to WHO itself and to the United Nations system. She encouraged coordination between the Ebola Interim Assessment Panel and the High-Level Panel on Global Response to Health Crises. Efforts to strengthen health systems and the implementation of the International Health Regulations (2005) should be intensified and she welcomed the establishment of the IHR Review Committee. WHO should take its due role of leadership of the health cluster in humanitarian response, assigned to it more than a decade previously. A change in culture would be needed within the WHO unit responsible for managing emergency response, since crisis management was far different from development of standards or directives. WHO must develop adequate professional competencies to provide a flexible response to health emergencies. When responding to emergencies, there was no place for competition within the United Nations system and, while the capacity of WHO should be strengthened, there should be no duplication of work performed elsewhere in the system. She welcomed the planned conclusion of agreements between WHO and other agencies, both within and outside the international system, preferably before any crisis occurred.

Mr KUEMMEL (Germany) remarked on the importance of learning from the mistakes of all, including WHO, in order to strengthen the Organization's capacity and allow it to regain its credibility and role in global health. The Panel should address the importance of better understanding the role of WHO country offices in the event of disease outbreaks. Member States bore much of the responsibility for WHO's emergency response capacities, since the resources underpinning the Secretariat's capacity to monitor International Health Regulations (2005) implementation and provide related technical support had been reduced to a level that was now inadequate. The policy of zero nominal growth in assessed contributions had clearly eroded the work of the Secretariat, and Member States' financing of the Organization had contributed significantly to its failure to meet expectations. Making WHO fit for purpose in the area of emergency response would require major investments and firm political will on the part of all Member States. He strongly supported the Panel's key conclusion that the present was the moment for empowering WHO to lead in global public health.

Mr ZHANG Guoxin (China) supported the establishment of a contingency fund and a global health emergency workforce and his country stood ready to participate in those initiatives. He suggested that, instead of making the effective implementation of the International Health Regulations (2005) a priority, Member States should instead be helped to improve their capacity to cope with public health emergencies, including by establishing and improving robust public health systems in Africa.

Dr AHMED SIDAHMED MOHAMMED (Sudan) noted that her country's previous experience of Ebola had encouraged it to develop a preparedness plan when the Ebola outbreak had been announced, largely based on International Health Regulations (2005) core capacities. The fight against epidemics should start with increased financial and technical support for countries like hers that had asked for a further extension of the implementation deadline for the Regulations. Since rapid, decisive action was required from WHO in emergency situations she welcomed the establishment of a specific programme to deal with health emergencies within WHO, and the development of a contingency fund. While a global health emergency workforce was a key issue, since most countries affected by health emergencies had a severe shortage of human resources for health, she stressed the parallel importance of developing the capacities of national health personnel.

Dr PHAAHLA (South Africa), speaking on behalf of the African Region, said that Ebola presented one of the biggest public health challenges experienced in Africa and around the world and that the high rates of infection among health workers and the consequent impact on health systems were a particular cause of concern. The situation had nonetheless improved, due in large part to the swift response and bold leadership of some countries of the African continent. He expressed the hope

that Member States appreciated the impact of the Ebola outbreak on health systems in Africa and would offer support to strengthen those health systems.

Mr DE ANDRADE FILHO (Brazil) said that, although health was the responsibility of States, international collective action was needed to respond to health threats at global level. Global preparedness should be ensured by implementing the International Health Regulations (2005). He supported a central role for WHO in the timely response to global public health emergencies and noted that the Organization would be as effective as the synergies and coordination it established with other partners, particularly other United Nations agencies. That work should be undertaken while strengthening the leadership of WHO as an independent source of technical and normative health standards and recommendations. The introduction, during the Ebola outbreak, of measures that interfered with travel and trade and that were contrary to the recommendations set forth by the Director-General on the advice of the IHR Emergency Committee was a cause for concern that should be addressed in discussions on future disease outbreak responses. Existing incentives for research and development had not met the need for research and development of diagnostics, vaccines and treatments for Ebola. An expanded and trained health emergency workforce should be reinforced by partnerships with different actors and be guided by the interests of public health.

Ms OUTHWAITE (Canada) supported the leadership role of WHO in managing global public health events. The present was a defining moment for WHO, entailing a collective responsibility to address weaknesses in health crisis prevention and response. While it was important to establish stronger reporting incentives for the International Health Regulations (2005), a clear and robust policy basis was also needed to address the question of border measures raised by the Panel. Steps should be taken to ensure that WHO was strengthened and appropriately structured to lead the international response to emergencies with public health consequences.

Dr GOMEZ (Bahamas), speaking on behalf of the Caribbean Community, said that maritime trade and porous borders contributed to the vulnerabilities of some of the countries of the Region of the Americas in the event of global public health emergencies. As of 2014, no country in the Region had met the core requirements of the International Health Regulations (2005). He therefore welcomed the announcement that those regulations would be re-examined, which would provide an opportunity to address the core capacity requirements of small island developing States. He requested that the Director-General should pay special attention to strengthening the health systems and core capacities of the countries of the Caribbean Community, in order to prepare for public health emergencies of international concern.

Professor NASIDI (Nigeria), recalling that his country had been one of the first to be affected by Ebola, described the steps taken to tackle the disease in Nigeria and then, after being declared Ebola-free, to move on to supporting the other affected countries. He welcomed the findings of the Ebola Interim Assessment Panel's report and called on all nations to support efforts in Africa to establish an African centre for disease control. The Centre would not replace WHO but would apply the partnership model established between PAHO and the Centre for Disease Control in the United States of America.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland) welcomed the insightful assessment and recommendations made by the Ebola Interim Assessment Panel, in particular those highlighting significant gaps in WHO's response and recognizing that the public health emergency of international concern should have been declared earlier. The United Kingdom agreed with the report that greater consideration should be given to different levels of alert and that WHO outbreak's and humanitarian emergency response activities should be merged. She welcomed the recommendation to boost WHO response capacity, including by establishing a global health

emergency workforce, but stressed that such measures should be aligned with existing cluster arrangements within the Organization's humanitarian mandate.

Dr TILLUCKDHARRY (Trinidad and Tobago) said that the threat of the Ebola virus disease had provided an opportunity to operationalize the International Health Regulations (2005) and assess their effectiveness. He therefore supported the establishment of a review committee as a step towards building trust and commitment. He also supported the extension, without stigma, of the target date for implementation of the Regulations, which should apply to any Member State still facing implementation difficulties. His country was committed to engaging in humanitarian action and supported proactive resource mobilization which was not necessarily Ebola-specific, such as the proposed contingency fund. He strongly advocated strengthening national, regional and global health security infrastructures.

Dr AHMED (Bangladesh) said that the crisis had raised awareness regarding the lack of resilience in health systems in certain countries. He outlined the response actions taken in Bangladesh following the declaration of the emergency and called on WHO to mobilize more resources to prepare States for such emergencies.

Dr ROA RODRIGUEZ (Panama) agreed with other speakers that there was a need for adequate funding to enable WHO to manage health emergencies rapidly and effectively. A reserve budget should be established to provide immediate operational support in countries where need was increasing owing to a health emergency. The contingency fund should be financed by voluntary contributions and abide by the principles established under document A68/26, including measures to ensure transparency and accountability, and should be reviewed after two years.

Dr DANG QUANG TAN (Viet Nam) said that the review of the response to the Ebola virus disease outbreak would provide valuable lessons for future actions. He suggested that WHO should develop a comprehensive plan and should undertake the necessary reforms to prepare for future emergencies. Further, the Organization should maintain and enhance its partnership capacities with United Nations agencies and other organizations in preparedness planning and response. Member States should strengthen their health systems and core capacities as required by the International Health Regulations (2005) and he called on WHO to continue providing support to that end. In view of the importance of regional and global collaboration in emergency responses, he supported WHO's initiative to establish a joint team to support affected countries in Africa.

Dr AZZOUZI SIDI (Morocco) welcomed the report and the recommendations of the Ebola Interim Assessment Panel. He was convinced of the need for a strong WHO, in terms both of the qualifications of its staff and its resources. There was a clear need for political commitment on the part of all its Member States, as well as for reinforced capacities to implement the International Health Regulations (2005). In health crises, humanitarian considerations were paramount. Urging that the problem of cross-border transmission be addressed in that light, with the aim of isolating diseases rather than countries, he described how Morocco had sought to implement that principle.

Dr GUERRA (Italy) said that a skilled and competent WHO was crucial to the achievement of a truly global response to health emergencies. The Organization could not be left to work in isolation but was called on to complement national capacities. Responses should go beyond simply increasing financial resources, and involved deciding how resources would be used, developing partnerships with other stakeholders, and ensuring a competent workforce was available when needed. The role of WHO was to promote research, develop standards, and provide authoritative and timely coordination. He highlighted the importance of a regional response to global health crises, and the need to strengthen WHO's organizational levels accordingly. The Organization's credibility needed to be strengthened

and, in that light, he welcomed the review exercise. The results should be used to establish a better and more transparent response system and a more resilient WHO.

Professor LEVENTHAL (Israel) said that the Ebola crisis shed light on contradictions in the expectations that the Member States had of WHO. If they wished it to remain small and efficient, they should act as its extension in the deployment of manpower, equipment and medicines. A chapter should be added to the International Health Regulations (2005) to give WHO the leadership and coordination role in any future emergency response, such that the Secretariat and the Member States would act as one organization. Expressing his support for the Director-General and her leadership of the Organization, he called for the same level of support from all Member States.

Mr BOWLES (Australia) said that the report of the Ebola Interim Assessment Panel should give the 138th session of the Executive Board a more complete picture of how WHO's reforms had to strengthen its emergency response structures. He agreed with an earlier speaker that border measures under the International Health Regulations (2005) needed to have a strong policy basis. Member States and WHO needed to learn from the Ebola virus disease outbreak and use it as an opportunity to create a stronger health security system. Establishing a contingency fund and a global health emergency workforce were important elements to ensure WHO's response capacity. He called for further discussion on the governance of a global health emergency workforce and encouraged Member States to provide flexible funding, the lack of which had been one of the main limitations in WHO's response to the outbreak. Prevention activities through the contingency fund should be focused on preventing grade two emergencies progressing to grade three emergencies. Normal prevention and preparedness activities should be funded through the programme budget. WHO's plans to work in partnership with other organizations highlighted the importance of finalizing the framework for engagement with non-State actors. He welcomed the Organization's commitment to strengthening medical staff evacuation processes.

Ms CABELLO SARUBBI (Paraguay) said that the declaration of the Ebola virus disease outbreak had prompted a review of her country's capacity to deal with health emergencies, which had highlighted limitations in timely investment of resources and equipment. She supported the establishment of a contingency fund. She requested WHO to develop a plan to monitor the International Health Regulations (2005) after 2016 to ensure the maintenance of previously achieved core capacities, and a flexible and adaptive response to emergencies.

Mr PUSP (India) expressed support for the Panel's recommendations. Consideration should be given to strengthening emergency preparedness by establishing three levels of alert at the national, regional and international levels, entailing clear responsibilities for Member States and the three levels of the Organization. He agreed with the Panel's conclusion that WHO needed to be strengthened both structurally and financially to improve its response capacities. His Government was committed to supporting the proposed contingency fund.

Dr YONGJUA LAOSIRITAWORN (Thailand) suggested that WHO should continue supporting research on the Ebola virus disease, focusing on epidemiology, the natural course of the disease, the mode of transmission and the strategy and model of prevention and control, covering scientific and cultural aspects and taking into account the new tools for diagnosis, prevention and treatment. He expressed broad support for the contingency fund, noting that adequate financing was essential in prevention and control activities. It was crucial to ensure good governance in managing such a fund, with regular reporting to Member States.

Ms ALARCÓN MAYORGA (Colombia) said that, considering that WHO already had a mandate to provide an operational response to public health emergencies, it would be much more efficient to integrate a full response capacity within its existing structure rather than creating a new

agency. Upgrading WHO's response capacity in this way would require profound institutional changes, and measures to ensure transparency and accountability. The Ebola outbreak had generated enormous pressure on national and international response capacities, highlighting the need to enhance surveillance and community engagement, to improve coordination with the UN system and to take national complexities into account, particularly in fragile states. The International Health Regulations (2005) provided the main framework for strengthening world health security. However, the means of integrating health emergency measures in the humanitarian system needed to be addressed. She called on WHO to take measures to improve its ability to participate in partnerships (which must be established before, not during, the emergency), and on Member States to strengthen their crisis response systems.

Dr LOGAN (Liberia) expressed his Government's support for the concept of a contingency fund for immediately addressing health emergencies, particularly since Liberia had been the victim of a gravely delayed response to the Ebola virus disease outbreak, resulting in the loss of thousands of lives, including those of almost 200 health care workers. It was crucial to close the gap between alert and response as the success of each system depended on the strength of the other; in the case of Ebola, the alert had come months too late.

Dr AYLWARD (Assistant Director-General) acknowledged Member States' expressions of encouragement to the Secretariat to build the capacity and cultures necessary to deliver large-scale humanitarian response, including work on capacity-building and verification of core capacities. He said that the Secretariat had also noted the firm call for a stronger WHO to operate as the cluster lead in large-scale humanitarian emergencies. He had taken note of the support for the contingency fund and the global health emergency workforce and the emphasis on the need to strengthen partnerships both with civil society and with bodies in the United Nations system. Above all, the discussion had highlighted strong agreement with the direction given to the Secretariat by the Interim Assessment Panel as to needed reforms.

The DIRECTOR-GENERAL expressed appreciation for the work of the Interim Assessment Panel, which had achieved a great deal in a short period. It would receive continuing support from the Secretariat to complete its activities by July, and its recommendations would be taken very seriously. Indeed, change had already started, notably in the area which was within the Director-General's managerial responsibility. The Interim Assessment Panel had further work to do, and Member States would undoubtedly wish to comment on the special resolution arising out of the January session of the Executive Board. All such comments would be considered, and the process of reform would continue.

DAME Barbara STOCKING (Chairman of the Ebola Interim Assessment Panel), thanked Member States for their support for the Panel's work; the Panel had taken note of their comments and reservations or requests for further information or evidence. She had been heartened by the commitment shown to strengthening the International Health Regulations (2005), particularly in the area of public health surveillance in-country, as well as by Member States' support for a strong, unifying WHO as a global leader, fit for purpose. Reforms could be made quickly now. The Panel would welcome the incorporation of its conclusions into other reviews worldwide, notably the United Nations Secretary-General's High-Level Panel on the Global Response to Health Crises.

The CHAIRMAN proposed that the remainder of the discussion should cover any or all of the outstanding Ebola-related sub-items.

Mr KONYNDYK (United States of America) said that the plan on the establishment of a global health emergency workforce was one of the most important ways of making WHO more fit for purpose and improving collective health security. Rather than creating a new entity, the workforce should be formed by building on, strengthening and expanding existing platforms, such as the Global

Outbreak Alert and Response Network and the Foreign Medical Teams system. The effort should also explore how better to engage the capacities of personnel from the global humanitarian system. The United States supported the plan, which responded to all of the elements requested by the Executive Board through its resolution EBSS3.R1, in particular the need for a strengthened and dedicated support structure at WHO headquarters. He was pleased to note that the plan provided for training and capacity-building, which over time would enlarge the workforce. Another important factor would be the trigger mechanisms, but he pointed out that a decision to deploy the workforce in emergencies with health consequences would not always rest solely under the Director-General's authority, for example in cases where the lead was taken by the United Nations cluster system. Early deployment in response to infectious disease outbreaks would improve surveillance and contribute to WHO risk assessments. While regional and country offices had a key role to play in WHO's emergency preparedness and response and must be strengthened accordingly, the effectiveness of a global health emergency workforce depended on the ability of WHO headquarters to mobilize it quickly and decisively, through a clear line of authority starting with the Director-General. Finally, while WHO had an important convening and coordination role to play in research and development, which required that it enhance its expertise in clinical trials and that it remain neutral, his Government was concerned that WHO had become a principal investigator in specific trials associated with the Ebola response.

Mr ROUSHDY (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed support for the contingency fund, which would give WHO the necessary capacity to mount a stronger and more vigorous response, especially during the early stages of an emergency or crisis. Two issues should, however, be addressed: namely, how to make such a fund sustainable, and how to ensure that it would be replenished quickly as money was disbursed. Since WHO often faced multiple emergencies simultaneously, money must be distributed quickly to wherever it was needed. In order to ensure accountability and transparency in the use of funds, an operational mechanism should be developed through broad-based consultation with WHO regional offices.

Ms RABOVICA (Latvia), speaking on behalf of the European Union and its Member States, hailed the plan for a global health emergency workforce as an ambitious step towards addressing current shortcomings in the global health system. The European Union assumed that the costs incurred would be included in the programme budget 2016–2017 and that the contingency fund, once established, could also be drawn on in emergencies. A clear and effective trigger mechanism would need to be designed as part of the operationalization of the global health emergency workforce. The European Union supported the broad scope of emergency response proposed by the Secretariat. Improved leadership and coordination within WHO would be key to raising the all-hazards surge capacity for rapid deployment. In addition, the European Union supported separate administrative and technological systems for ensuring rapid deployment in emergencies. Preparation should be enhanced, for example through advance agreements with partners on the main roles of teams on the ground. Existing networks and partnerships such as the medical evacuation system (MEDEVAC), established during the Ebola outbreak by the European Union and other partners in collaboration with WHO, needed to be strengthened. Under the European Union Civil Protection Mechanism, the European Union was also developing a voluntary pool of medical experts and response capacities which could be drawn on for fast emergency response. It welcomed the proposal for a steering committee to ensure coherence between networks and partners, and it was prepared to play a constructive role in that effort.

Mr LUTZOW STEINER (Mexico) stated that Mexico supported the creation of a global health emergency workforce and offered to share with WHO its experience and expertise. Mexico was also in favour of the creation of a WHO contingency fund for emergencies, which should be transparent and sustainable. The fund should draw on as many sources of voluntary financial support as possible and be deployed in conjunction with other regional funds.

Mr KUEMMEL (Germany), speaking on behalf of the European Union and its Member States, expressed support for the creation of the contingency fund financed by flexible voluntary contributions, which would complement other funds both inside and outside WHO. The fund should be merged with existing disused funds, as outlined in document A68/26. The contingency fund would serve as a first source of funds, filling the gap created before other resources became available, for example from appeals. A three-month period should provide enough time for appeal funding to be made available. Disbursement of the fund should be at the discretion of the Director-General, with minimal bureaucracy to ensure rapid deployment, including delivery through partners. The European Union agreed with the recommendation of the IHR Review Committee that the fund should contain US$ 100 million. In order to ensure transparent and accountable use of the fund, regular financial reporting would be required in addition to robust accountability structures, including full access to the fund's financial, implementation and performance data. The European Union proposed that the present Health Assembly should establish the fund on a pilot basis, with a review after two years.

Ms MOE (Norway) acknowledged that although the primary responsibility for preventing and responding to health emergencies remained with governments, sometimes external assistance was necessary. Norway supported many of the proposals presented in the Director-General's report on the global health emergency workforce, including improving early identification by Member States, providing regular training and simulations, developing a single emergency training system for WHO-driven deployments, and deepening partnerships with United Nations agencies and similar bodies. The draft decision presented in document A68/51 should acknowledge that the new emergency response programme would be directly accountable to the Director-General. Staff and resources must be flexible and mobile, not tied to specific country offices or regions, and under the direct control of the Director-General. Lastly, when establishing new emergency management structures, WHO should give qualified crisis managers the lead and be sure to consult them on the future direction of its emergency reform.

Ms GODIN (Canada), welcoming the plan to establish a global health emergency workforce, expressed support for the plan to strengthen pre-deployment and readiness though rosters and quality assurance measures, training and simulation exercises. She urged WHO to continue to address its weak operational platform as revealed in the Ebola outbreak, including in the areas of contracting mechanisms, insurance and medical evacuation methods. WHO should also implement its plan to identify a reserve corps of surge-ready staff members. Her Government supported all aspects of the plans for a contingency fund and echoed Germany's call for reports and evaluations to gauge its effectiveness. Regarding research and development, she recalled that the unprecedented speed in which potential Ebola vaccines and therapies had been brought to clinical testing had been a direct result of investment prior to the outbreak. Accordingly, Canada supported the very ambitious proposal for a blueprint for research and development in epidemics or health emergencies where preventative and curative solutions were lacking. The proactive establishment of target product profiles and the development of robust preclinical models would also help to better anticipate new drug development.

Ms PRICE (United Kingdom of Great Britain and Northern Ireland) said that the global health emergency workforce and the contingency fund would enable WHO and its partners to intervene more effectively in health crises and prevent them from escalating. It was vital that the triggers for the release of the contingency fund, which should only be used for a maximum of three months, be set at a level that both enabled action in order to avoid an emergency and prevented the use of the fund where

no risk of escalation had been detected. Work on setting the triggers should be done in partnership with the Office for the Coordination of Humanitarian Affairs. Under WHO's coordination, disbursement of the funds should be done by the best-placed partner. She reiterated her country's pledge to contribute up to US$ 10 million to the fund. She welcomed the priority afforded to strengthening the existing mechanisms within the Global Outbreak Alert and Response Network and the foreign medical teams as part of the ambitious plans for the global health emergency workforce.

Ms COOK (United States of America), while welcoming the contingency fund proposal, said that the main problem during the early Ebola outbreak response had been a lack not of resources, but of organizational structure. Consideration of WHO's initial performance had revealed that it needed to be able to make funds available early to improve the prospects of halting a health emergency, rather than delaying the activation of funds until an outbreak had become an epidemic. Thus it was essential to examine the triggers for the activation of such funds. In addition, the contingency fund should be reserved for the first phase of the response and available for up to three months from the onset of a health emergency. She commended the review of existing mechanisms in order to assess the fund's pertinence in relation to those and recommended that WHO report on the uses of the fund after two years so that Member States could evaluate its usefulness. In addition, the competent authorities for activating and distributing the funds should be specified, the more so as fragmentation of authority had hindered WHO's Ebola response. Sustainability was another important issue. The United States supported a replenishment model, and would also endorse the provision by WHO itself of flexible initial funding to help set up the contingency fund.

Mr KONG Insik (Republic of Korea) supported the establishment of the contingency fund as the outcome of a lesson learned from the tardy response to the outbreak. Mechanisms for its transparent use and for additional fundraising should also be considered. It was crucial to set up domestic and international surveillance systems with a view to preventing further outbreaks of infectious disease and providing a basis for research and risk assessment. The timely exchange of information with respect to quarantine and disease should also be promoted, in line with the International Health Regulations (2005). He expressed the hope that the global health security agenda would provide an effective policy platform applicable to both affected and non-affected countries.

Dr EVANS (World Bank) welcomed the probing analysis and practical recommendations of the Ebola Interim Assessment Panel and called for a well-funded Organization that could support countries as they prepared to meet the challenges of increased global interdependence and shared vulnerability. In the light of WHO's chronic underfinancing resulting from the zero-nominal growth policy, he urged all Member States to reconsider that policy which endangered all WHO's core functions in the long term. The establishment of a contingency fund constituted a critical element of rebuilding the financing architecture for pandemic risk management. The World Bank Group in cooperation with private sector partners was developing a global pandemic emergency financing facility which would swiftly disburse resources upon receipt of a trigger from WHO, to support the rapid deployment of personnel during outbreaks. The funding facility would thus complement the contingency fund. Lastly, he welcomed the plan to implement the global health emergency workforce. It would be vital to determine how the recommendations of the Interim Assessment Panel, the United Nations Secretary-General's High-Level Panel on the Global Response to Health Crises, and other review bodies, could be swiftly and sustainably financed through existing and new mechanisms. He drew attention to several upcoming forums on pandemic financing.

Dr Song-En HUANG (Chinese Taipei) supported the proposals for a contingency fund and the plan to expand and strengthen the global health emergency workforce to fight future outbreaks. Chinese Taipei would contribute to strengthening global preparedness for, and prevention of, emerging infectious diseases, and to rebuilding essential health systems in countries affected by the Ebola virus disease, by sharing its experiences in health communications and electronic disease

surveillance systems. Chinese Taipei would be hosting Ebola virus disease safety training courses to further strengthen skills of health care personnel in line with the International Health Regulations (2005).

Mr WEBB (United Nations Development Programme) said the Ebola virus disease outbreak had demonstrated the need for crisis prevention mechanisms in all health systems. The failure to pay salary and incentives to health care workers could have been prevented, had robust governance systems been in place, and the UNDP Payment of Ebola Workers Programme, set up to alleviate grave payment difficulties, would provide relevant lessons for future health and development crises. Epidemic preparedness must be focused on health systems, not health sectors, and should include health worker payment systems as a priority. To that end, WHO and other partners would be able to facilitate the appropriate inter-agency coordination, inter-institutional data creation and sharing protocols, country-based needs assessment protocols and technical assistance. Moreover, development gains made during the current Ebola virus disease crisis should not be lost, including banking and payment systems. He noted that the proposed contingency fund would emphasize preparedness, prevention and response, and provide funding for health care workers, including hazard pay and insurance. The response to future health crises required robust investment in social mobilization and community support; strengthened engagement and coordination across the health sector; and the inclusion of other sectors such as communication, banking and transport.

Ms VIVIANI (UNICEF), recalling UNICEF's long-standing collaboration with WHO, said that UNICEF had worked with WHO to mobilize, engage and educate communities with regard to the Ebola virus disease; and had provided water, sanitation, hygiene and nutrition, and had ensured the supply of key commodities and medicines. While lessons had been learned, further evaluations would help to inform future responses, and UNICEF looked forward to WHO's continued technical leadership and coordination in public health emergencies.

Dr BJORO (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that the falling number of cases of Ebola virus disease did not mean the end of the commitment to end the outbreak. She commended the work of WHO, with the support of others, in rebuilding and developing health systems. Adequate numbers of trained nurses were required for the prevention and control of infections and for ensuring patient safety, and she urged WHO to include longer-term health workforce planning and continuing education of health care professionals in efforts to strengthen health systems. Finally, she called on WHO and its Member States to take into account the long-term social impact of the Ebola virus disease outbreak, which included orphaned children of health care workers and stigmatization.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that the Ebola virus disease outbreak had revealed the vulnerability of health systems, and the need to prioritize education on hygiene and prevention strategies and the protection of health care professionals. The International Pharmaceutical Federation recommended the inclusion of pharmacists in crisis plans, to facilitate timely access to medicines and evidence-based information and to assist in first response, triage, immunization and first aid. It had developed tools for pharmacists to act against the Ebola virus disease or other infectious diseases and communicate medication instructions in situations where there was no common language. She welcomed ongoing research into new medicines, which would facilitate continuing progress.

Ms NWACHUCWU (GAVI Alliance), speaking at the invitation of the CHAIRMAN, said that according to preliminary estimates, immunization coverage had dropped by 20% to 40% in the three Ebola-affected countries, and outbreaks of diseases such as measles were being observed. Thousands of children were at risk due to disruption of routine immunization programmes. The GAVI Alliance was prepared to invest significantly in restoring confidence in the public health system and ensuring

availability of future Ebola vaccines, and would provide up to US$ 80 million to assist with health and immunization system recovery efforts, including the doubling of health system strengthening support to the affected countries. Immunization recovery plans should be rapidly implemented in each country to prevent further deaths and disability. The need to rebuild confidence in public health systems should not be underestimated. The Ebola crisis had highlighted the weaknesses of health systems and an effective global emergency response was needed for the future.

Mrs BURDET (Medicus Mundi International and the People's Health Movement), speaking at the invitation of the CHAIRMAN, said that if the Ebola outbreak did not trigger substantial investments in building resilient health systems, pre-existing deficiencies would be exacerbated. The emphasis in EBSS/3/INF./2 on the need to ground health systems in primary health care and universal health coverage principles, rather than create a vertical programme, was welcome. However, it was deplorable that the African Public Health Emergency Fund established by the WHO Regional Office for Africa had had no financing during the Ebola crisis, and that the African Development Bank had refused to support it. WHO's presence in the Region would be further undermined if the African Centre for Disease Control and Prevention was established without the involvement of the Regional Office. A concerted and coordinated effort among Region members was needed to properly address the health challenges revealed by the Ebola crisis. She did not share the Secretariat's appreciation of the pharmaceutical industry for its development and roll-out of Ebola vaccines, blood therapies, medicines and diagnostics. The prevailing model of profit-driven research and development had neglected Ebola since the isolation of the virus in 1976, and an alternative model that delinked research and development from profits and provided more affordable treatment was needed.

Ms DIJK (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that prior to establishing the global health emergency workforce, WHO should ensure that its deployment would be based on transparent and scientific mechanisms supported by concrete guidelines for its deployment, and consider whether it could be used in situations not involving communicable diseases. Clear and transparent financing mechanisms for the workforce were needed at global and local levels, and it was imperative to identify how they would support local organizations. WHO should determine how the workforce would be integrated with the International Health Regulations (2005) and previous World Health Assembly resolutions on human resources for health, to avoid duplication of efforts and waste of resources. It was important to tackle the most basic social determinants of health and invest in health literacy to proactively prevent outbreaks. She thanked WHO for recognizing the role of young people as first responders in the crisis, and said that the Kick Ebola Out campaign organized by members from Sierra Leone and Guinea was a prime example of how medical students could support the emergency workforce.

Dr KAMAL-YANNI (OXFAM), speaking at the invitation of the CHAIRMAN, welcomed the findings of the Ebola Interim Assessment Panel and the recommendation on strengthening WHO's role as the global lead agency in health emergencies. However, strong accountability mechanisms targeting WHO's performance needed to be established. To fulfil its role, WHO required full political and financial support, and its current funding model had to shift from voluntary but earmarked contributions to adequate, flexible and predictable contributions from Member States. Strengthening the role of communities was essential to successfully controlling outbreaks. Governments should recognize that long-term investment in building resilient health systems would protect national and international health, and would entail investment in an adequately-sized and trained health workforce; available medical supplies; robust health information systems; sufficient well-equipped health facilities; sufficient financing from domestic resources; and a strong public sector to deliver equitable quality services.

Ms DURLING (World Vision International), speaking at the invitation of the CHAIRMAN, said that further collaborative action was needed to get to zero cases and ensure recovery from the outbreak. Global surveillance, prevention and response mechanisms were ineffective without functioning health systems and active community participation. The Ebola outbreak had exposed the vulnerability of weak health systems and the significant risk they posed. But it was well-known that prevention was more effective than cure, certainly more effective than emergency response. Member States and the Secretariat should prioritize social mobilization and comprehensive support to weak health systems as part of preparedness plans to prevent future large-scale disease outbreaks and emergencies with health consequences.

Dr AYLWARD (Assistant Director-General), responding to the various comments, acknowledged the strong support expressed for the Director-General's plan for a global health emergency workforce, the options for a contingency fund, and the proposals for advancing research and development in the context of emergencies and outbreaks of infectious diseases. The Secretariat had noted the call that all of that needed to be part of a larger reform, in that all emergency work within the Organization needed to be coordinated, with all financial and human resources deployed in accordance with humanitarian principles, and that all such work needed to be aligned within the wider international emergency architecture, including the United Nations system, civil society and humanitarian organizations. It had also noted that support would be contingent on clear, unambiguous and professional emergency management and leadership under the Director-General, which should be informed by emergency management experts from other organizations. The Director-General was establishing an advisory group to guide the process in that regard.

Regarding the global health emergency workforce, he assured delegates that it would be built on existing structures, such as the GOARN Network, Global Health Cluster and the foreign medical teams that had played a vital role in the response to Ebola and other crises, and that the Director-General's plan would provide a more explicit focus on the need to build the capacity of national responders. Key groups would be appropriately represented on a workforce steering committee. In operationalizing the plan, the Secretariat would furthermore take into account the need to establish a common operational support platform; to increase the capacity of WHO, focusing in particular on its added value in coordination and technical support on the ground; and to ensure that staff were sufficiently flexible and geographically mobile to be utilized to best effect in the new emergency programme.

Turning to the contingency fund, he thanked the Member States that had made initial pledges and, responding to the specific question of triggers and the balance between early activation of the fund and its use to manage risks without its being rapidly depleted, he said that attention would be paid to the grading of risks and crises within the new emergency response framework currently being assembled for consideration by the Director-General and the Global Policy Group, which should provide a mechanism capable of ensuring that balance. As to interaction with other funds, the contingency fund had been carefully designed to complement those that facilitated the procurement of equipment and supplies for large-scale projects, for example, but which did not cover staffing needs for surge support. More details would be provided as the specifics of the fund's modus operandi were further developed. Meanwhile, the Secretariat would take into account the request that the fund be used for an initial three- to six-month period in order to allow enough time to launch appeals to bring other financing mechanisms into play. Regarding the call for the contingency fund to absorb other WHO funds, it was important to bear in mind that they covered critical gaps beyond the initial three- to six-month period, especially in protracted crises, and that any consolidation of funds must not result in a loss of flexibility in their utilization at the global and regional levels. He suggested that consolidation might be delayed until after the pilot period. As to the sustainability of the fund, the Secretariat had noted the suggestions made in regard to its capitalization from voluntary contributions, existing WHO funds and even the private sector, which would give rise to another set of issues, including those relating to replenishment.

Responding to the call for a blueprint for future research and development agendas, he said that having such blueprints was central to the Director-General's vision in regard to the Organization's work in infectious disease risk management. One delegate had expressed a strong preference for WHO to focus on coordinating rather than conducting research and that, too, was consistent with current thinking within the Organization. In the case of the Ebola crisis, however, WHO had been compelled to intervene as "trialler of last resort" to tackle critical gaps in the clinical trial agenda, when other agencies had been unwilling to step forward. While it might well have to do so again in the event of other outbreaks of infectious diseases, he assured delegates that it had not been seen as precedent-setting.

Dr SMITH (Executive Director, Office of the Director-General), responding to the question raised by the delegate of Egypt on the sustainability of the contingency fund, said that the fund would be financed through a replenishment model that drew on voluntary contributions, adding that multi-year agreements with Member States could help to ensure a measure of sustainability. Furthermore, the fund was to be established by the governing bodies and, hence, would be sustained by the political commitment reflected in that status; its replenishment would tie in with the financing dialogue for the biennial programme budget; and, in accordance with the prevailing accountability mechanism, there would be regular reports to the Member States on the current assets, expenditures and results achieved. As such, it had a strong chance of being able to continue, over time, to provide the Organization with adequate funding for its work in emergency situations.

The CHAIRMAN drew attention to the draft decision contained in document A68/51 and informed the Committee that the Programme, Budget and Administration Committee of the Executive Board had proposed that a drafting group, co-facilitated by the delegates of South Africa and the United States of America, be set up to finalize the text. Should the Committee agree to the proposal, the delegations that had commented on the draft decision would be invited to take up their comments in the drafting group and the Committee's consideration of the item would be suspended while the drafting group met.

It was so agreed.

(For continuation of the discussion and approval of the draft decision, see the summary record of the eleventh meeting, section 2.)

The meeting rose at 18:40.

FOURTH MEETING

Wednesday, 20 May 2015, at 09:25

Chairman: Dr E. JARAMILLO NAVARRETE (Mexico)

PROGRAMME AND BUDGET MATTERS: Item 12 of the Agenda

Implementation of Programme budget 2014–2015: mid-term review: Item 12.1 of the Agenda (Documents A68/6 and A68/54)

Mrs TYSON, speaking in her capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, reported on the Committee's consideration of Implementation of Programme budget 2014–2015: mid-term review, as reflected in document A68/54 and noted that the Committee, on behalf of the Executive Board, had recommended that the Health Assembly should take note of the report contained in document A68/6.

Ms RUIZ VARGAS (Mexico) said that future reports should include information on results, progress and challenges in the implementation of the leadership priorities set forth in the Twelfth General Programme of Work, 2014–2019. They should also report on progress made in regard to the achievement of outputs that were the joint responsibility of the Secretariat and Member States. Great strides had been made through the establishment of the financing dialogue, but misalignment of resources and priorities persisted. More needed to be done to bring the key principles of the dialogue into line with other elements of WHO reform, such as bottom-up planning, results-based management, costing and resource allocation. It would be useful to conduct an assessment, both during and at the end of the biennium, of the way in which the application of the financing dialogue principles affected the financing of the Programme budget 2014–2015.

Ms ZHANG Yang (China) said that future reports should contain more analysis, thus providing Member States with more comprehensive information and enabling them to offer targeted suggestions.

Ms GIROD (United Kingdom of Great Britain and Northern Ireland) said that, given the challenge the Ebola outbreak had presented to the Organization, it was not surprising that full delivery of programmes and results for the Programme budget 2014–2015 was at risk. She invited the Secretariat to share its strategy for improving delivery, and its plans to absorb any underspend into the 2016–2017 budget. Realistic and time-bound output indicators should be included in the Proposed programme budget 2016–2017.

Mr SVERSUT (Brazil) said that Member States should make every effort to meet the "90–90–90" targets for HIV and reduce vertical transmission. He also called on States to rise to persistent challenges in the fight against malnutrition and work towards meeting the Global Nutrition Targets for 2025. In the implementation of commitments undertaken under the International Health Regulations (2005), efforts should also be directed towards assessing and building core capacities to detect and respond to public health emergencies.

Professor SEMDE (Burkina Faso), speaking on behalf of the Member States of the African Region, noted that although the level of programme budget financing, excluding the emergency component, had stood at 87% as at 31 December 2014, overall resource availability had been

improved by additional funding for the Ebola outbreak response. However, the levels of financing for other programme areas had been affected by the crisis, resulting in a low overall programme budget implementation rate. Noting that the process of reprogramming of funds and the increase in flexible and voluntary funds should help improve absorption rates in the latter part of 2015, he stressed that the budget for strengthening health systems should be augmented. The efficient implementation of the budget would always be affected by natural and man-made disasters.

Mr KUEMMEL (Germany) said that it was important to adopt a realistic rather than an aspirational budget, and enquired about the level of funds currently available to support the programme budget. Member States should take account of the existing level when assessing the Secretariat's capacity to mobilize additional voluntary funding in the future. The amount of funding from non-traditional donors was impressive and he asked the Secretariat to elaborate further on the shifting profile of donors.

Dr TROEDSSON (Assistant Director-General) acknowledged that the report under consideration could be further improved. Future reports would establish better links to the results chain and indicators would be used more constructively to facilitate better analysis and clarify obstacles and areas needing improvement.

Efforts were under way to improve the alignment of resources to the programme budget. Resources were being mobilized from a broader donor base, earmarked funds were used to finance the programme budget, and flexible funds were set aside to close funding gaps. That new approach had made it possible to keep all programmes at all three levels of the Organization operational and secure resources for staffing and priority activities.

As at 30 April 2015, funds available to support the programme budget, including outbreak and crisis response, polio and additional funding received for the Ebola response, had amounted to US$ 5.3 billion. The redirection of resources to the Ebola crisis had resulted in some delays in other areas, and discussions were under way with all programmes and regional offices to identify options for accelerating implementation during the remainder of the biennium. The Programme budget 2014–2015 was a realistic one, requiring funding for its implementation of between US$ 4 billion and US$ 4.5 billion.

The Committee noted the reports.

Proposed programme budget 2016–2017: Item 12.2 of the Agenda (Documents A68/7 and A68/7 Add.1, A68/55 and A68/INF./7)

Mrs TYSON, speaking in her capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, reported on the Committee's consideration of the Proposed programme budget for 2016–2017, as reflected in document A68/55, and noted that the Committee, on behalf of the Executive Board, had recommended that the Health Assembly consider the Proposed programme budget 2016–2017 and the draft resolution proposed by the Secretariat in the light of the discussions in the Committee (document A68/7 Add.1).

Mr BOWLES (Australia), speaking on behalf of Cook Islands, Fiji, Malaysia, New Zealand, Papua New Guinea, Solomon Islands, Tonga and Vanuatu, welcomed the extensive consultations that had informed the work on the Proposed programme budget 2016–2017. Although WHO had broadly achieved resource mobilization and implementation targets in the 2014–2015 biennium, alignment remained an issue. In the light of the recent Ebola crisis, he welcomed the emphasis on strengthening the Organization's capacity to prepare for and respond to emergencies and on improving human resource development. He also commended the focus on strengthening WHO's capacity for compliance with financial controls. The request for a 5% increase in assessed contributions had not been communicated to Member States in adequate time or with sufficient preparatory work to allow

proper consultation. He urged the Secretariat to continue its dialogue with Member States on the issue of assessed contributions in the lead-up to the 2018–2019 biennium, noting that a substantial proportion of the budget should be financed by such contributions. In the context of the new whole-of-Organization approach to the budget and financing dialogue, he supported the proposal to mobilize resources through voluntary contributions in order to achieve the proposed 8% budget increase, but observed that not all Member States would be in a position to increase their voluntary contributions.

Mr KUEMMEL (Germany) said that approval of the Proposed programme budget 2016–2017 was closely linked to resolution EBSS3.R1, which was approved at the Special Session of the Executive Board on the Ebola Emergency. The assessment by the IHR Review Committee panel of experts had concluded that the level of resources required to underpin the Secretariat's capacity to monitor the International Health Regulations (2005) and provide related technical support was inadequate. He noted that the experience from the recent Ebola outbreak had been taken into account in the proposed programme budget, together with the costing of governing body resolutions and deliverables related to the work on antimicrobial resistance, as well as efficiency measures. The proposed 8% budget increase was realistic and would enable WHO to cope with the increased policy, technical and operational support required by Member States. Why should WHO be denied the right to accept potential funding for priorities agreed by the Health Assembly, if individual donors were willing to provide such resources? Highlighting the need to implement effective accountability and transparency measures, issues for which the Secretariat and Member States were both equally responsible, he noted that clear and decisive steps had been taken by the Secretariat to improve transparency and accountability in the context of the WHO reform process. Contributions and political will on the part of all Member States were required to ensure that WHO's emergency response was fit for purpose. Although Germany's support for the proposed programme budget was a sign of its trust in the Organization in the wake of the Ebola crisis, he observed that further work was needed to ensure that WHO was able to respond to the challenges of the 21st century, including by introducing the necessary operational and structural changes.

Ms LANTERI (Monaco) said that the adoption of the Twelfth General Programme of Work, 2014–2019 had led to greater responsibility, transparency and alignment across the Organization. Given that Member States were responsible for approval of the Proposed programme budget 2016–2017 in its entirety, greater scrutiny should be applied to proposed budget increases. She expressed concern that the proposed 8% budget increase was being explained, on the one hand, as a consequence of the lessons learnt from the recent Ebola epidemic, including the need to maintain services at the country level and, on the other, as an increase in the budget space. Proposed budget increases must be fully justified and assigned to precise programmatic areas. Although she did not oppose the proposed programme budget, she requested greater transparency, more timely communication of proposed increases in contributions and responses to Member States' questions.

Ms HARB (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed support for the proposed programme budget increase. The bottom-up planning process, conducted in consultation with Member States, had resulted in greater focus on noncommunicable diseases, health system strengthening, preparedness, surveillance and response, particularly with regard to emergency risk and crisis management, reflecting needs at the country and regional levels. In order to continue to develop and advance the WHO reform process, the Region advocated for a continued and substantial increase in country allocations. Continued support from WHO should be provided to strengthen country preparedness beyond meeting the core capacities required for implementation of the International Health Regulations (2005). Further work was needed to meet global commitments in relation to noncommunicable diseases and to sustain work on the unfinished Millennium Development Goals agenda. The Region's approach was strongly focused on strengthening country offices in terms of technical capacity, management and security. In the spirit of

the WHO reform process, the Region was proposing a 15% budget increase for country offices, but a 6% budget decrease for the Regional Office; she advocated continued and similar budgetary shifts across all WHO regions.

Ms CABALLERO ABRAHAM (Mexico) recognized the need for sufficient funding to enable WHO to continue to fulfil its mandate, but noted the importance of maintaining a prudent approach to the Organization's budget. Mexico favoured zero nominal growth. The proposed 8% budget increase did not reflect national forecasts of inflation or the financial challenges faced by many countries. She noted the detailed information on changes to the Proposed programme budget 2016–2017 by category and by region, but requested further explanation of the reallocation of funds for tuberculosis programmes. She expressed concern about the allocation of budget space to staff recruitment, noting the related short-, medium- and long-term commitments for the Organization. In that connection, she requested additional information on cost-effective measures. With regard to corporate services and enabling functions (category 6), the proposed funding should be directed to strengthening budget reviews and audits. An evaluation of the impact of the financing dialogue should be undertaken prior to approval of the proposed budget increase. Further work was necessary to align the resources received with the programmatic priorities approved by the governing bodies.

Mr BOISNEL (France) expressed support for the draft resolution contained in document A68/7 Add.1. The proposed programmes and priorities were realistic in view of the numerous current and emerging challenges faced by the Organization, including the need to learn from the experience of the recent Ebola crisis. The proposed budget was also realistic; it did not contain a request for an increase in assessed contributions, but rather requested an increase in budget space to allow the Organization to fulfil its functions and ensure an effective financing dialogue. Sufficient resources should be provided to ensure coherence between WHO's needs and challenges and the requests of Member States. Approval of the proposed programme budget would be a reflection of Member States' confidence in the Organization and in the leadership of the Director-General. However, Member States bore a shared responsibility for closely monitoring implementation of the budget. In that regard, WHO should continue to: provide detailed justification of the choice of programmatic priorities; implement the measures undertaken to improve the management and overall performance of the Organization; and improve monitoring of, among others, alignment and coherence between all three levels of the Organization.

Dr AXELROD (Russian Federation) expressed support for the Proposed programme budget 2016–2017, which reflected the ongoing WHO reform process and the need to ensure an effective response to emerging challenges. Greater transparency was required with regard to expenditure and funding in order to facilitate a comprehensive assessment of the progress made at all three levels of the Organization and to increase accountability. Her Government endorsed the six categories of programmatic priorities, including the proposed health-related sustainable development goals in the post-2015 agenda and, in particular, the prevention and treatment of noncommunicable diseases. Priority should be accorded to strengthening health system preparedness to respond to emerging diseases and disasters, antimicrobial resistance and measures to address inequities in health services. She acknowledged the need to increase the proposed programme budget space by 8%, particularly in the light of the recent Ebola crisis. The financing dialogue should be continued in order to increase transparency and accountability and inform donors about the overall financing process. Greater budgetary flexibility could be secured through an increase in voluntary contributions. She suggested introducing measures to enhance the accountability of Member States and ensure full implementation of their commitments.

Dr USHIO (Japan) expressed support for the Proposed programme budget 2016–2017, which was an important component of WHO reform. The proposed budget increase should be fully funded by voluntary contributions and would ensure that WHO continued to play a critical role in the global

health security architecture. He requested further information on the resource mobilization strategy, as well as on the additional benefits flowing from the proposed 8% budget increase and the elements of WHO's work that could not be undertaken without it. In order to ensure that the budget was fully funded, he asked whether there was room to moderate the increase proposed for the programmatic category of corporate services and enabling functions.

Mr ENGELS (Netherlands) said that the Netherlands advocated zero nominal growth as an effective instrument for efficiency gains and priority setting. His delegation was concerned about several budget-related issues: the balance of assessed and voluntary contributions, the need for further efficiency gains, the increase in WHO's reserves and insufficient internal controls; those issues should be resolved before any budget increase could be undertaken. Indeed, the idea of a budget increase was ambitious and would involve great responsibilities, and any increase in budget space would not encourage increased efficiency. He stressed that the current discussions should focus on programmatic reprioritization, in particular the need to strengthen country preparedness for future outbreaks of disease, and he welcomed the priorities defined in the report. Reform lay at the heart of the discussion on efficiency gains and reprioritization, and a closer analysis of the precise distribution of functions at all three levels of the Organization was therefore required. He urged the Secretariat to take firm steps in the corporate alignment of the Organization to ensure unified implementation.

Dr ROA RODRIGUEZ (Panama) said that her delegation supported the proposed budget increase. Future draft programme budgets should be made available to Member States well in advance of Health Assembly sessions, so that they could be considered in more detail. More efficient and transparent use of assessed contributions was essential and efforts should be made to strengthen the financing dialogue.

Mr DIKMEN (Turkey) said that his delegation welcomed the Proposed programme budget 2016–2017 and noted with satisfaction that governing bodies' discussions on strategic budget space allocation had been taken into account. He also welcomed the expression of commitment to strengthen country offices and the proposed budget increases for categories 4 (Health systems) and 5 (Preparedness, surveillance and response). While his delegation agreed that internal controls, efficiency measures and accountability mechanisms should be strengthened, that did not justify such a considerable increase in the budget allocation for category 6 (Corporate services/Enabling functions). Efforts to increase savings through efficient use of funds should be intensified. He drew attention to the increase in funding allocated to polio eradication, and said that care must be taken to avoid potential funding hardships and indemnity costs for those working to fight polio on the ground. Greater transparency in spending would be much appreciated, and to that end a programme budget implementation dashboard would be very useful. Turkey supported the proposal to finance the 8% budget increase through voluntary contributions.

Dr JESSAMINE (New Zealand) said that his delegation accepted the proposal to fund the proposed 8% budget space increase for 2016–2017 through voluntary contributions. That increase would be necessary to allow WHO to accelerate its reform process and increase its responsiveness. His delegation would, however, appreciate further explanation and justification for some of the adjustments made since the previous programme budget, such as the decrease in allocations for communicable diseases, in particular vaccine-preventable diseases, which appeared to contradict the Organization's wish to learn from the recent Ebola virus disease crisis. He wondered whether the proposed decrease in category 1 (Communicable diseases) could in fact be managed by a redistribution of some of the proposed increases for categories 2 (Noncommunicable diseases) and 3 (Promoting health through the life course).

Ms BLACKWOOD (United States of America) said that the Proposed programme budget 2016–2017 responded to WHO's need for increased investment in key strategic areas. Some improvements in transparency could be seen in respect of outputs, outcomes and results. While efforts to improve cost efficiency were welcome, greater commitment to identifying potential savings would be appreciated. Reform-based savings and reprioritization should also take into consideration the large proportion of the Organization's budget used at the country and regional levels. More information would be welcome about which priorities would be reduced in the event that not all of the increased voluntary contributions were forthcoming. Although there was a certain degree of flexibility to move resources between areas of work, redistribution must be done in a clear and strategic manner. If budget increases were to be funded through voluntary contributions, as was the case for the Proposed programme budget 2016–2017, WHO must broaden its donor base. Further justification for the 8% increase for 2016–2017 would be appreciated. She expressed concern that Member States had not received a breakdown of the proposed programme budget by funding source, or any indication of the underlying assumptions that had been used to adjust the budget.

Ms DUSSEY-CAVASSINI (Switzerland) said that, although WHO must be sufficiently well-resourced to fulfil its mandate, Member States were facing their own financial restrictions. Optimum use of the resources available was therefore essential. Quality of funding must be assured, as well as quantity. Greater flexibility was required in order to allow funds to be more clearly linked with the priorities set out in the programme budget. Future discussions in the Programme, Budget and Administration Committee of the Executive Board should be linked with the financing dialogue, to promote greater flexibility of funding. Switzerland expected the Programme budget 2016–2017 to be used to uphold the reform commitments undertaken.

Dr MUKENGESHAYI KUPA (Democratic Republic of the Congo), speaking on behalf of the Member States of the African Region, noted with appreciation that the Proposed programme budget 2016–2017 was in line with public finance reforms under way in many Member States. He commended the substantial allocation to the African Region, and the intention to concentrate activities in a limited number of spheres of particular concern. Although resources had been allocated on the basis of a bottom-up approach, in the past they had not been fully aligned with the budget. Nevertheless, there had been a significant improvement in financing and it was to be hoped that the financing dialogue would pay attention to the alignment of resources by focusing on funding gaps. The budget should take account of the lessons learnt from the Ebola virus disease crisis, which had demonstrated the importance of health system strengthening and ample resource allocation. Given the importance of equity and coherence between the priority areas of activity, the African Group strongly supported a budget increase, with 5% coming through assessed contributions and the rest via voluntary contributions. As certain Member States could not easily increase their assessed contributions, the discussions should be continued through the financing dialogue.

Dr HOLM (Sweden), speaking also on behalf of Finland, expressed support for an increased budget that would allow WHO to emerge from the Ebola virus disease crisis stronger, better and fit for purpose. WHO must, however, demonstrate clearly how those additional resources would be spent. An increased budget came with increased responsibility: WHO reform must continue and results-based management must be strengthened, with better programmatic and financial reporting. Weaknesses in internal controls and oversight were worrying, and should be rectified; strong internal oversight was essential for WHO to fulfil its mandate efficiently and effectively. While gender mainstreaming in the Proposed programme budget 2016–2017 was welcome, it must be accompanied by the requisite resources. In that regard, he noted with concern the proposed cuts in resources allocated for that purpose at headquarters and in the European Region. Indicators for gender mainstreaming, as proposed by the Executive Board, were required to measure progress, yet had not been included in the proposed programme budget. He hoped to see them reintroduced into the final draft. Lastly, the budget

resolution should include a reference to how the additional voluntary contributions would be sourced, namely, through the financing dialogue and coordinated resource mobilization.

Ms GODIN (Canada) commended ongoing efforts to increase harmonization and clarify roles and responsibilities across the three levels of the Organization, and expressed support for the proposed programme budget's emphasis on resilient and integrated health systems. She noted that while special attention would be given to enhancing civil registration and vital statistics, they were not identified in any of the outcomes, indicators or deliverables. Health information system strengthening, and its contribution to civil registration and vital statistics, should be monitored. The proposed increase in allocations to categories 4 (Health systems) and 5 (Preparedness, surveillance and response), in response to the lessons learnt from the Ebola virus disease crisis, was welcome. Efforts to increase flexibility and transparency and consider how to improve efficiency, including through partnerships with non-State actors, were laudable. Stable and predictable funding was essential. The proposed programme budget must meet WHO's operational needs while respecting the fiscal realities in Member States. Canada had a long-standing zero nominal growth position with regard to assessed contributions, and therefore welcomed the Director-General's proposal to fund the proposed budget increase through voluntary contributions. More information would, however, be welcome on priorities in the event that full funding was not secured. The financing dialogue must be given sufficient time to demonstrate its capabilities for mobilizing resources that were predictable, aligned and flexible.

Dr PHAAHLA (South Africa) said that the Proposed programme budget 2016–2017 was realistic, and he appreciated the increased allocations, in particular to health systems. Efforts to strengthen WHO's capacity to respond to crises and epidemics were welcome, as were measures to increase financial controls, accountability and transparency. His delegation supported the proposed budget increase, which would be funded through voluntary contributions. Sustainable and secure funding would contribute to better planning and results, and in that regard, assessed contributions would need to be increased in the near future. Discussions on minimal increases should be held in the financing dialogue. South Africa supported the draft resolution contained in document A68/7 Add.1.

Mr LOTHE (Norway) said that delivery of the reforms agreed at the special session of the Executive Board on Ebola in January 2015 would come at a cost to Member States and he thus supported the proposed increase in budget space. However, his delegation was not fully satisfied with the proposed programme budget, which lacked detailed costing information for outputs. Such a lack of transparency and clarity would undermine the budget's value as a governance tool and make it difficult to convince Member States of the need for greater resources. He noted with concern the findings of the Internal Auditor, and cautioned that unsatisfactory control would negatively affect Member States' willingness to invest in the Organization. Given that the Organization already relied heavily on voluntary contributions, future budget increases to secure global public goods on which the whole international community depended should be financed by assessed contributions.

Ms RATTANA SOOMBOONWIT (Thailand) welcomed the transparent and participatory bottom-up process used to draft the Proposed programme budget 2016–2017. WHO had faced a long period of zero nominal growth. Although a budget increase was necessary, it was ill-timed, given that economic constraints in many Member States would not allow for an increase in assessed contributions. Thailand therefore urged WHO's partners to increase their non-earmarked voluntary contributions. WHO must leverage financial resources from ministries of health and other partners through the financing dialogue.

Ms ZHANG Yang (China) supported the Proposed programme budget 2016–2017. WHO had reached a consensus with Member States on the need to better align the budget with resource mobilization. Stable, transparent and predictable assessed contributions were indispensable to the Organization as its core source of funding. For Member States to mobilize resources for the

programme budget, health departments needed to coordinate with other national government departments as well as with the Secretariat. They should therefore be given more time to prepare for budget discussions in the future.

Mr AKPO GNANDI (Togo), supported the Proposed programme budget 2016–2017, which had been drawn up in the wider context of WHO programmatic and management reforms and emphasized prioritization based on a bottom-up approach and lessons learnt during the Ebola outbreak. The structure of the proposed programme budget was similar to that of the previous biennium, except for the addition of specific budgetary lines on noncommunicable diseases and polio eradication, and the introduction of a fund for emerging epidemics. He commended the introduction of more rigorous procedures for the mid-term review, the strategic allocation of resources and internal audits to favour a more rational use of resources, and measures to reduce costs and optimize the use of contributions.

Professor ELIRA DOKEKIAS (Congo) said that Africa was facing the epidemiological impact of communicable and noncommunicable diseases. He supported the Proposed programme budget 2016–2017, especially the increase in voluntary contributions, but called for a sharper focus on HIV/AIDS under category 1 and on the alarming increase in cardiovascular diseases and cancer in Africa under category 2. The Director-General's proposals were realistic since they took account of the need to prioritize improvements in preparedness, prevention and response to public health emergencies. The Organization relied on the mobilization of voluntary resources and should step up its support to the country offices if it was to remain strong and transparent.

Dr PARIRENYATWA (Zimbabwe), commending the bottom-up approach of the Proposed programme budget 2016–2017, requested that under "other categories" the budget be further disaggregated to indicate the amount allocated to each component. Noting that assessed contributions had not increased in 8 years, he fully supported the proposed increase, which should be undertaken in line with the principles of shared responsibility and global solidarity. In anticipation of the financing dialogue later in 2015, he asked the Secretariat to estimate the amount that each country would be expected to contribute.

Ms SAMIYA (Maldives) supported the Proposed programme budget 2016–2017 and welcomed its timely focus on universal health coverage in the prevention and control of noncommunicable diseases and the emphasis placed on the global post-2015 development agenda and on strengthening health systems and the global emergency response work of the Organization. The high number of resolutions endorsed by Member States at governing body sessions, changes in inflation rates and health needs, and the complexity of global health issues made it impossible for the Organization to continue with the same budget space. She was concerned that the budgetary increase would be funded by voluntary contributions and questioned the potential impact on the predictability and prioritization of financing. The Organization should seek a better alignment of voluntary funding with WHO priorities.

Mr SASTRE (Bolivarian Republic of Venezuela) stressed the importance of adequately aligning the Organization's budget with health objectives and recommended that the financing dialogue should focus on continuity in programme implementation. WHO should continue to broaden its activities under existing budgetary guidelines, and seek to achieve greater effectiveness and efficiency through prioritization. The Ebola crisis had demonstrated the importance of flexibility, but budget management should remain results-based. The budgets of international organizations should continue to be guided by a policy of zero nominal growth until the global economy regained stability. Differences in economic conditions among Member States would require some countries to make greater budgetary sacrifices than others. The ongoing WHO reform process should prioritize internal monitoring to foster accountability and transparency. Conditions were currently not conducive to an increase in

assessed contributions, but the proposed overall increase of 8% in budget space was reasonable, provided Member States could reach consensus on the issue.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland) said that the United Kingdom was a leading contributor to WHO funding, mainly through voluntary contributions, and accepted, despite her Government's zero nominal growth position for United Nations agency budgets, that an increase in WHO budget space might be necessary, given the Organization's need to be prepared for future emergencies and new challenges. However, governments were accountable to their taxpayers, and she believed that an 8% increase, to be achieved through voluntary contributions, was unrealistic. She requested clarification on the destination of any unspent funds in the current programme budget and asked if they would be rolled over into the next biennium. Although the global economic situation was starting to improve, stability and sustained economic recovery required continued emphasis on efficiencies and reforms. The budget must reflect priorities and she wondered whether any aspects of the work plan could be reprioritized within a smaller budget increase. The increase should be preferably no more than zero real growth, which would be sufficient to implement the 2016–2017 biennium's priorities and work plan. Clear priorities and a realistic budget would help WHO raise enough money to carry out its work. She sought assurances that, if the budget were to be increased through voluntary contributions, priority work in areas such as emergency preparedness and action on antimicrobial resistance would be safeguarded.

Ms ALARCÓN MAYORGA (Colombia) stressed the importance of providing WHO with the tools it needed to carry out its work. She welcomed the inclusion in the Proposed programme budget 2016–2017 of many relevant health issues and supported its adoption as proposed, including the 8% increase to be raised through voluntary contributions. The financing dialogue should be used to promote dialogue-based management, timely access to information for decision-making purposes and cost efficiencies. Transparency and accountability were critical for ensuring the legitimacy of the Organization's actions.

Ms FINDSEN (Denmark) said that the proposed programme budget should be adopted at the current Health Assembly. The information note provided by the Secretariat did not address all the questions raised during the Programme, Budget and Administration Committee's discussion, particularly with regard to the total cost of the follow-up to the Executive Board special session resolution on Ebola. Denmark supported a strong WHO and was committed to the reform process. The programme budget should be realistic, aiming for zero growth while providing for the allocation of adequate resources. She supported the proposed shift towards a stronger focus on preparedness and crisis management, as well as antimicrobial resistance, but questioned whether that required an overall budget increase. Budget restraint was an important factor in driving the reform process forward. The drive for cost-efficiency and effectiveness meant that more discussion was needed on the proposed 8% increase in budget space.

Mr EMANUELE (Ecuador) said that a budget increase was acceptable provided that it was accompanied by an increase in responsibility, transparency and independence in accounting procedures, and that its impact was closely monitored by the governing bodies. Organizational strengthening was also required, together with a review of the distribution of funds to different programmatic areas. Adequate funding should be allocated to enhancing WHO's governance and leadership functions to ensure that a budget increase was translated into an effective response to the numerous challenges faced by the Organization, particularly in the area of health system strengthening.

Mr BENAMAR (Morocco) welcomed the bottom-up approach applied to the preparation of the Proposed programme budget 2016–2017 and supported the proposed budget increase, provided that it came from voluntary funding and that accounting procedures were strengthened given the existing gap between new sources of funding and needs.

Mr GHEBRETINSAE GHILAGABER (Eritrea), noting with satisfaction the significant portion of the proposed programme budget allocated to the African Region, nevertheless expressed concern over the distribution among programmes. In particular, the allocations to health system strengthening and emerging health challenges were inadequate. He supported the Proposed programme budget 2016–2017 and the Director-General's proposal for an 8% increase in voluntary contributions.

Mr REMON MIRANZO (Spain) said that Spain had adopted a strict position of support for zero nominal growth, but recognized the Organization's need to respond to current and emerging challenges and, on that basis, was prepared to consider an overall increase in the budget – although 8% was a substantial amount. Bearing in mind, however, that the impact of the financing dialogue remained to be evaluated, the reform process was ongoing, and the weaknesses brought to light by the Internal Auditor and other control mechanisms had yet to be corrected, he asked what the Secretariat's reaction would be to any proposal for a smaller increase.

Dr RASHID (United Republic of Tanzania) pointed out that a 3% decrease in the proposed budget allocation for communicable diseases, as reflected in Table 4 of the Proposed programme budget 2016–2017 (document A68/7), would have a profound impact on the African Region, where the burden of communicable diseases was heaviest. The proposed 19% decrease in funding for vaccine-preventable diseases was particularly alarming, as the gains accruing from immunization were well known. While the number of cases of poliomyelitis had decreased globally, he strongly advocated maintaining the budget level for poliomyelitis eradication to ensure the gains were sustained.

Mr SVERSUT (Brazil) said that he recognized the importance of strengthening the institutional capacities of WHO and appreciated that the budget was based on country needs, reflected in a bottom-up planning approach and lessons learnt from the emergency response to the Ebola outbreak. He agreed with other delegates on the importance of accountability and transparency and pointed out that budget documents should have been circulated earlier in order to allow more time for delegations to consult on the proposals.

With regard to the draft resolution in document A68/7 Add.1, he supported the proposal for an 8% increase in the budget, to be financed by voluntary contributions. His Government would be willing to discuss an increase in assessed contributions in the context of the financing dialogue. He emphasized the importance of early implementation in line with priorities defined in the WHO Twelfth General Programme of Work, 2014–2019.

Dr GUERRA (Italy) said that Italy was in favour of zero nominal growth and of no increase in assessed contributions. He wished to understand how the ongoing reform in governance would impact on improving efficiency. A transparent process should be put in place to trace the dollar trajectory and show how financial inputs were translated into deliverables and outcomes. He encouraged better and more innovative work on how Member States could share responsibilities and costs of missions and meetings. There was a contradiction between the emphasis placed on implementation of the International Health Regulations (2005) and the proposed decrease of funds allocated to communicable diseases. He encouraged the Secretariat to identify other financial options; in times of crisis it was mandatory for international organizations and financial institutions to align their priorities.

Dr GONZALEZ GONZALEZ (Nicaragua) supported the proposed budget increase of 8% based on voluntary contributions. As a small country, Nicaragua could appreciate the difficulties of responding to emergencies such as the Ebola virus disease outbreak, which had highlighted weaknesses in the Organization and in affected countries. While he understood the concerns expressed by some delegations about efficient use of resources, he stressed the need to strengthen the Organization and to combine economic efficiency with epidemiological efficiency through investment in the development of resilient health systems that would enable countries to deal with epidemics and natural disasters in the future.

Dr KREMER (Argentina) said that a budget increase of 8% was appropriate and realistic and he supported the proposal to fund it from voluntary contributions. He appreciated the need for increased transparency and accountability and welcomed the savings that had already been made. If the proposed increase in budget space were approved, the Organization should seek to define a framework for collaboration with non-State actors, with a view to ensuring that their contributions were managed in an appropriate manner, free from conflicts of interest and conditionalities.

Dr TROEDSSON (Assistant Director-General) thanked Member States for their constructive interventions; a majority had indicated their agreement to a budget increase although others had rightly indicated that the programme budget should be linked to accountability and improved transparency. Cost efficiencies and cost savings must be enhanced, a challenge that the Organization would continue to address. A background document had been provided, showing how prioritization had been carried out.

The Proposed programme budget 2016–2017 was realistic, based on bottom-up planning, country priorities, WHO's comparative advantage in public health and the regional and global commitments of WHO as defined in the resolutions approved by Member States. The budget reflected new and emerging priorities and he was confident that it could be financed and implemented. Without an increase, the Organization would not have the resources to fund new areas of activity in emergency preparedness and response, antimicrobial resistance and climate change and health or the unfinished work on maternal and child health. WHO required the capacity to deliver on the priorities at country level that had been identified in consultations with ministries of health. The full effects of cost savings and cost-efficiency measures would not be apparent in the short term, since they required investment.

The programme budget defined results and deliverables at the three levels of the Organization, which had been costed using human resource plans and activity cost estimates. The Organization would introduce indicators on which it could report back to Member States. With respect to the questions raised by the delegates of Mexico, New Zealand and the United Republic of Tanzania, he explained that the budget decrease shown under communicable diseases in Table 4 of document A68/7 did not represent a decrease across all regions: the budget for Africa had increased. The overall decrease was based on bottom-up planning and the priorities identified by countries themselves, taking into account the activities of actors such as the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria, which limited the need for WHO to make heavy financial investments. In response to the delegates of Canada and Japan he said that resource mobilization had been improved and the Organization had developed a strategy for building a broader donor base. It would be essential to improve reporting on the results of investments for donors. The Organization had strengthened resources in category 6 (Corporate services/Enabling functions), thus allowing it to improve accountability, internal control, risk management and transparency, which many Member States had highlighted as areas of concern. The strengthening of human resources was part of the WHO reform process. In response to the question about underspending from the delegate of the United Kingdom of Great Britain and Northern Ireland, he said that any unused funds would be carried over to the 2016–2017 biennium.

The DIRECTOR-GENERAL, thanking Member States for their comments, said that the Organization had embarked upon a process of reform that was reflected in the WHO Twelfth General Programme of Work, 2014–2019 which provided the framework for the current prioritization of activities. The Programme budget 2014–2015 had not been a bottom-up budget but the proposed budget for 2016–2017 had been prepared with the guidance of Member States and the new budget matched country programmes with the Twelfth General Programme of Work, 2014–2019. In the bottom-up planning process, the regional offices had reminded countries that whenever they introduced a priority into the programme budget, there must be a corresponding national budget line, indicating Government commitment to that priority. Furthermore, the priority must also be present in the programme of work. Once they had been received, some requests from countries had been set aside, while others had been aligned with the programme budget and the core capacities of WHO in relation to those of other programmes and organizations. One example of such alignment was the decrease in the allocation for communicable diseases, which reflected acknowledgement of the role of the GAVI Alliance in funding support for immunization. The regional directors had improved the internal controls, compliance and audit reports of the country offices and continued to look for efficiency and effectiveness savings.

She was particularly grateful to the Member States that had indicated their willingness to support an increase in both assessed and voluntary contributions, although she understood that many countries could not accept an increase in assessed contributions since they had adopted zero nominal growth policies. She proposed that discussions on the Proposed programme budget 2016–2017 should be suspended and resumed at the following meeting. It would be essential to achieve a consensus decision. The deliberations on the budget provided an opportunity for Member States to hold WHO to account but also an opportunity for them to show their commitment to the Organization.

The meeting rose at 12:15.

FIFTH MEETING

Wednesday, 20 May 2015, at 14:43

Chairman: Dr E. JARAMILLO NAVARRETE (Mexico)

1. PROGRAMME AND BUDGET MATTERS: Item 12 of the Agenda (continued)

Proposed programme budget 2016−2017: Item 12.2 of the Agenda (Documents A68/7, A68/7 Add.1, A68/55 and A68/INF./7) (continued from the fourth meeting)

The CHAIRMAN invited the Committee to resume its consideration of the item in the light of the consultations held during the lunch break.

The DIRECTOR-GENERAL expressed appreciation of the consultations held by Member States with a view to achieving consensus on the item under consideration. She was committed to delivering on the concerns that had been expressed and to that end counted on the trust and support of Member States. She would continue to lead the Organization in a way that reflected her commitment to WHO reform, specifically in the areas of implementation of the programme budget, including clarification of the roles of the three levels of the Organization; measures to increase transparency and accountability and improve internal controls; and efforts to find efficiency savings. She promised to provide regular evidence-based reports on those areas of concern.

Mr ENGELS (Netherlands) said that he did not believe that a move away from zero nominal growth was the right way forward; however, in a spirit of consensus he would not block the Proposed programme budget 2016−2017. It substantially increased the pressure on WHO. Concrete steps should be taken to overcome inefficiencies, increase prioritization and speed up reforms to ensure that the Organization was fit for purpose.

Mr KURI MORALES (Mexico), expressing appreciation of the Secretariat's clarifications and the Director-General's commitment to transparency, noted the general consensus on the need for an 8% budget increase based on voluntary contributions. He supported the proposal, although it was his understanding that the increase would not give rise to medium- or long-term commitments by the Organization or to automatic increases in assessed contributions in future bienniums.

Mr STAUR (Denmark) reiterated his strong support for WHO and his trust in the Director-General. Over the past few months, the Organization had shown its commitment to reform at all levels. He joined the consensus on the Proposed programme budget 2016–2017, which he would follow very closely. There needed to be continued reform, including of the Organization's financial mechanisms.

Mr REMON MIRANZO (Spain) reiterated that he was not convinced of the need for a budgetary increase in the proposed amount. However, in the interests of consensus, he would support the proposal.

The CHAIRMAN proposed that the following preambular paragraph be inserted in the draft resolution in document A68/7 Add.1:

> "Recognizing the exceptional circumstances relating to the Ebola crisis, the additional work that will be required to ensure that WHO is ready to respond effectively to health emergencies and to deliver reforms to enhance WHO's accountability, transparency, financial management, efficiency and results reporting,"

Dr TROEDSSON (Assistant Director-General) read out the three dollar amounts that were to be included in document A68/7 Add.1, flagged in that document as "to be determined". The figures were US$ 929 million in subparagraph 4(1), US$ 3456 million in subparagraph 4(2), and US$ 956 million in paragraph 5.

The draft resolution, as amended, was approved.[1]

2. COMMUNICABLE DISEASES: Item 16 of the Agenda (continued)

Malaria: draft global technical strategy: post 2015: Item 16.2 of the Agenda (continued) (Documents A68/28, A68/28 Add.1 and EB136/2015/REC/1, resolution EB136.R1) (continued from the second meeting)

Dr PONGTORN CHARTPITUCK (Thailand) suggested the following amended wording for subparagraph 4(3) of the draft resolution recommended by the Executive Board in resolution EB136.R1, which had been agreed in consultation with the delegates of the United States of America and the United Kingdom of Great Britain and Northern Ireland: "to harmonize and integrate the provision of support to national malaria programmes for adopting and implementing WHO-recommended policies and strategies and promoting the long-term sustainability of malaria responses".

The draft resolution, as amended, was approved.[2]

Global vaccine action plan: Item 16.4 of the Agenda (Document A68/30) (continued from the second meeting)

The CHAIRMAN invited the Committee to resume its consideration of the draft resolution proposed by Libya.

Mr DE ANDRADE FILHO (Brazil) said that poliomyelitis was an example of a disease that was beginning to present new challenges in places where it had been eradicated. He recognized the positive impact of good vaccination programmes and called for vaccination to be strengthened and made accessible to all populations. The cost of vaccines heightened the importance of coordination mechanisms, such as the Revolving Fund of the Pan American Health Organization (PAHO), for their purchase. He highlighted the importance of price assessment and tools that favoured transparency and fostered competition between producers to provide high-quality, safe and effective vaccines. Noting the advances made in vaccine coverage, he stressed the need to continue with initiatives, such as the global vaccine action plan, in order to avoid any setbacks.

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[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA68.1.

[2] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA68.2.

Dr GOUYA (Islamic Republic of Iran) recommended that countries delegate the responsibility of monitoring and evaluating their national vaccine action plans to the National Immunization Technical Advisory Groups. The role of the Regional Technical Advisory Groups should be strengthened to assist countries in verifying their national action plans and implementing monitoring and evaluation activities. Countries should reach out to vulnerable groups such as migrants and refugees to improve Expanded Programme on Immunization coverage. Rapid response vaccination campaigns were particularly needed for measles and polio virus, and it was essential that international agencies such as WHO and UNICEF provide support in complex emergencies.

Dr HINOSHITA (Japan) welcomed the ongoing introduction of new vaccines but was concerned about the possibility of not reaching the target level of routine vaccine coverage. It was essential to maintain a balance between the introduction of new vaccines and the steady implementation of routine vaccine activities. Further analysis was needed on whether intellectual property was really a barrier to the establishment of national immunization programmes, and in that connection he proposed deleting the phrase "and intellectual property barriers" from subparagraph 2(12) of the draft resolution under consideration. He drew attention to the fact that Japan had obtained measles elimination status in March 2015.

Mr TEGENE (Ethiopia), speaking on behalf of the Member States of the African Region, said that the regional strategic plan for immunization 2014−2020 aimed at increasing the number of children vaccinated in the Region, especially in hard-to-reach areas. The ultimate goal was to ensure that no child was left behind. The Ebola virus disease outbreak had shown the importance of ensuring that health systems were strong and resilient. Natural and man-made disasters impeded vaccine programmes. The Secretariat needed to work closely with Member States to strengthen immunization and make it affordable for developing countries. The issue of vaccine supply and affordability needed urgent review, in accordance with the recommendation of the Strategic Advisory Group of Experts on immunization. Noting the critical role played by the GAVI Alliance in improving the availability and accessibility of vaccines, he listed a number of concerns of the African Region: parallel vaccination campaigns should be promoted and strengthened for cross-border areas; the shortage of traditional vaccines needed to be addressed; efforts were needed to increase the number of producers of new vaccines; vaccination for women of reproductive age and pregnant women should be prioritized; supply chain management for vaccines should be improved; and the Secretariat should promote affordability of vaccines and access to pooled procurement arrangements as developing countries took more responsibility in financing immunization programmes. He reiterated the African Region's commitment to realization of the vision of the Decade of Vaccines.

Dr AZZOUZI SIDI (Morocco) supported the draft resolution. Describing the situation in his country, he said that the national immunization programme had led to more than 95% vaccine coverage for the 11 targeted diseases. The original targets of the global vaccine action plan should be reviewed in the light of the global economic, health and security situation. WHO support for group-buying mechanisms was essential to ensuring the affordability of new vaccines in particular. Technical and financial assistance should be provided to countries like Morocco in the following areas: implementing disease control, elimination and eradication through vaccination; introducing group-buying platforms for vaccine purchase; strengthening vaccination coordination mechanisms between the Regional Office for Africa and the Regional Office for the Eastern Mediterranean; strengthening epidemiological surveillance and monitoring of undesirable post-vaccine effects; evaluating the impact of new vaccines; and strengthening the national and international partnership for vaccine development and research.

Dr HASSAN (Egypt) noted that, as a self-procuring country with a central vaccine purchasing unit, Egypt avoided most of the problems faced by middle-income countries due to international vaccine shortages. A lack of sustainable vaccination funding, however, made it difficult to introduce

new vaccines into the Expanded Programme on Immunization, particularly given their high prices. Access to sustainable funding for vaccines should be maintained. She supported the global vaccine action plan. The provision of access to affordable and, in particular, high quality vaccines should be sustained, monitored and successfully implemented by WHO.

Dr YANG Taeun (Republic of Korea) said that the web-based integrated immunization information system operating in her country since 2002 could serve as a model of best practice for other countries facing the challenge of poor data quality and use. The system allowed vaccination providers to register vaccination records online and the data were monitored in real time by public health centres and governmental agencies in order to encourage vaccination where needed. Her country would be pleased to share its experience of the system with other Member States. She supported the draft resolution, which would contribute to maintaining high population immunity in all nations in the face of high global mobility.

Mr ZHANG Yong (China) attached great importance to the global vaccine action plan and highlighted the issue of funding and training for its implementation. Given the lengthy implementation period for the global vaccine action plan, WHO should review the progress made and challenges faced. International communication and exchange should be strengthened and every effort made to achieve the targeted results. Technical support and financial resources for the plan should be reinforced and assistance should be provided to help developing countries collect and manage data. The Organization should look at ways of strengthening the technology and capacity of regions that had not achieved measles elimination targets.

Ms LUNA (Ecuador), welcoming the draft resolution, said with regard to the invitation it contained to Member States to make economies of scale, that the PAHO Revolving Fund for Vaccine Procurement in the Region of the Americas provided an example for others to follow: it was based on the principles of equity, solidarity and pan-Americanism and had been a key factor in promoting immunization campaigns in the Region.

It was important to focus on price; countries should work together to counter commercial interests that undermined States' efforts to ensure the right to health. She therefore welcomed any mechanism that would make vaccine pricing more transparent and thus help to guarantee access to immunization. She reiterated her country's commitment to the global vaccine action plan and to improving surveillance and vaccination coverage in order to achieve or exceed the 95% target.

Dr BUGTI (Pakistan) said that affordable medical supplies were essential to providing optimal health care. Universal coverage could not be achieved until all countries, especially developing countries, had access to affordable vaccines. She supported the draft resolution, which marked an important step towards providing accessible and affordable health care for all.

Dr AMMAR (Lebanon) stressed the importance of maintaining vaccination activities despite disruptive situations such as wars and population displacements. The massive influx of Syrian refugees into his country had increased the number of children requiring vaccination by 30%, which was an onerous financial burden, particularly given the failure of international assistance, the fact that his country was not GAVI-eligible and the high price of vaccines. Armed conflict and political instability should be given more attention, since hampered immunity was only one example of their impact on health systems. In middle-income countries, where immunization relied to some extent on the private sector, the situation was complicated by sudden acute shortages in vaccines. He called on WHO to monitor more closely the global supply of vaccines and to strive to prevent developing middle-income countries from bearing the heaviest burden when shortfalls occurred. Lebanon supported and wished to cosponsor the draft resolution proposed by Libya.

Dr ISMAIL (Brunei Darussalam) noted with concern the lack of progress in implementing the global vaccine action plan. It was essential to continue immunization in light of the impact of disasters and epidemics of noncommunicable diseases, since low immunization coverage would increase the burden on all health systems. The important role of high-quality and accredited laboratories in providing timely and reliable laboratory information and virus identification should not be forgotten. He also emphasized the importance of understanding and accepting innovative community approaches to vaccination and the role of different stakeholders, such as schools, in the integration process. He supported the draft resolution.

Ms ADAMS (United States of America) said that implementation of the global vaccine action plan had been disappointing and noted that the so-called polio legacy could help provide for the needs of routine immunization programmes. The polio infrastructure and model could also be mobilized to control the Ebola outbreak, as had been seen in Nigeria. She supported the development of enhanced guidance on immunization in humanitarian emergencies. Such guidance could show how routine and other immunization services could be maintained despite the disruption of war, outbreaks of disease or the collapse of immunization systems. She stressed that, despite the complexities of vaccine pricing and the need to foster innovation in the vaccine industry, it was important to monitor global vaccine supply and pricing to ensure equity of access. She encouraged continued support for new vaccines and for expanding the global use of influenza vaccines through collaboration across relevant programmes. Member States and stakeholders should address vaccine hesitancy and refusals, understand the reasons for children missing vaccines or dropping out of programmes and address related misinformation. Her delegation requested at least one day to consider its position on the proposed draft resolution.

Ms SMIRNOVA (Russian Federation) said that the analysis of the systemic failings in implementation of the global vaccine action plan and the related recommendations must provide a basis for adjusting both national immunization plans and global efforts to achieve the goals of the Decade of Vaccines. Difficulties remained with regard to the insufficiency and instability of funding for national vaccination programmes. Her country was steadily expanding and increasing funding for its own programme, and also provided vaccine-related assistance to countries in the Commonwealth of Independent States in the fight against hepatitis A, measles, rubella and poliomyelitis. Special attention should be paid to emergency situations that interrupted access to immunization and increased the risk of infection spreading across borders. International support was needed in such situations and WHO should provide clear guidelines on appropriate measures. She therefore supported the recommendation of the Strategic Advisory Group of Experts on immunization to expand the leadership of WHO in that area.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland) supported the global vaccine action plan and the recommendations of the Strategic Advisory Group of Experts on immunization, particularly those relating to disruptive situations and how to integrate vaccines into all aspects of the health care system. Her country was the largest donor to the GAVI Alliance and fully supported the GAVI model of allowing countries progressively to increase their co-financing of new vaccines, which was a sustainable development model that encouraged full national ownership. Her country was also a major donor to the Global Polio Eradication Initiative, was expanding its seasonal influenza vaccination programme, and would be the first country in the world to introduce a centrally funded meningococcal B immunization programme later that year.

Mr ALVES DE SÓ VALDEZ (Cabo Verde) noted that certain African countries were not eligible for access to affordable vaccines, which made it difficult to expand the vaccine calendar, particularly to include new vaccines, in lower-middle-income countries. He therefore called on WHO to provide strong international leadership to facilitate access to vaccines at affordable prices for Member States.

Dr BOOSBUN CHUA-INTRA (Thailand) said that one of the most important platforms for the successful delivery of immunization was the effective and equitable distribution of health delivery systems, requiring policy and financial commitment. Accordingly, there was a need to develop a health service model that could be adapted to the specific needs of vulnerable groups, such as migrants. The capacity to produce vaccines in developing countries was a key strategy for supporting vaccine security and bringing down prices. To that end, vaccine licensing, procurement and distribution mechanisms needed to be strengthened to ensure availability. She fully supported the draft resolution proposed by Libya.

Dr GORGOLON (Philippines) said that an increased budget over the previous five years had enabled her country to introduce a number of new vaccines targeting the poorest economic quintile. Being a non-GAVI eligible country, it continued to face challenges relating to the affordability of new vaccines, staffing for monitoring under the Expanded Programme on Immunization, strengthening surveillance, improving data use, and cold chain management. She supported the draft resolution.

Dr MGHAMBA (United Republic of Tanzania) said that her country was implementing the global vaccine action plan to ensure that new and underused vaccines were introduced and reached marginalized groups. She outlined progress in the vaccination programme of the United Republic of Tanzania, which had achieved positive results, notably in the elimination of neonatal tetanus. Preparations were under way for an immunization programme review that would be used to produce a revised multi-year plan of action. At the same time, data quality assessment and management tools were being introduced. Immunization services were integrated in the health delivery system. She supported the global vaccine action plan.

Dr IHEBUZOR (Nigeria) said that her country had made progress towards achieving the global vaccine action plan objectives. The introduction of a number of new vaccines had provided useful lessons that could be applied to future introductions. Although progress had been made under the Expanded Programme on Immunization, obstacles remained to extending the reach of immunization. The importance of integrating vaccination into other health services was of particular relevance for her country, where work was under way to identify missed opportunities and create synergies between health initiatives. The crisis in northern Nigeria had hampered activities related to the Expanded Programme on Immunization, and she therefore welcomed the recommendation to expand WHO guidance on immunization in humanitarian emergencies. Continued and sustainable access to vaccines at an affordable price was crucial to the success of immunization programmes. Although Nigeria was still eligible for GAVI support, it was beginning the graduation process, which would have a significant impact on its health budget. Concrete steps were therefore needed to ensure the availability of more affordable vaccines. She supported the draft resolution proposed by Libya.

Dr A. PILLAY (South Africa) said that, considering the slow and patchy implementation of the global vaccine action plan, States should re-examine the level of their contributions. His country supported the proposals of the Strategic Advisory Group of Experts on immunization to get the global vaccine action plan back on track and he urged Member States and organizations to accept and implement the recommendations contained in the report. He emphasized the importance of vaccines in reducing morbidity and mortality in children under 5 years of age, and the benefits for herd immunity at community level. His country had, for example, recently introduced the pneumococcus and rotavirus vaccines with positive results.

He supported the draft resolution but wished to propose some amendments. In the ninth preambular paragraph, the words “developing and middle-income” should be replaced by “low- and middle-income Member States”. Likewise, in the tenth preambular paragraph, “low- and middle-income countries” should replace “developing countries”. He proposed adding a new sixteenth preambular paragraph to read: “Noting with concern the global shortage of certain traditional routine vaccines, for example BCG and MR”. In subparagraph 1(6) he proposed replacing “middle-income

countries" with "countries that request assistance". He proposed inserting a new subparagraph after subparagraph 2(12), which would read: "to assist in mobilizing resources for countries that request assistance in the introduction of new vaccines in line with the global vaccine action plan and in accordance with national priorities".

Ms NICHOLLS (Canada) expressed concern that implementation of the global vaccine action plan had gone off track. Her Government strongly supported the recommendations of the Strategic Advisory Group of Experts on immunization and would appreciate learning how the Secretariat intended to support stakeholders in implementing them. Future reports on the action plan should highlight priorities, risks and mitigation measures to ensure objectives and targets were reached within established time frames, and consider how to strengthen access to affordable medicines. Clarification was needed on how implementation efforts were linked to overall health system strengthening activities. She requested information on how the action plan could be used in the interests of tiered pricing, in order to secure the lowest possible vaccine prices; on the leadership roles of key stakeholders involved in implementing the plan; and on whether dedicated funds would be set aside to implement the recommendations. Her delegation welcomed the draft resolution proposed by Libya but wished to make comments on the text and sought direction on the best way to provide them.

Dr RUIZ GÓMEZ (Colombia) said that notable progress had been achieved in his country in terms of vaccination coverage and quality assessment. Particular achievements included the certification of the interruption of the endemic transmission of measles, rubella and congenital rubella syndrome. Those efforts had been financed by the national budget, in line with WHO recommendations under the global vaccine action plan. He expressed concern at the sustained rise in the price of vaccines and drew attention to the need for information systems on vaccine prices and supply mechanisms, and for strategies to make them effective. In view of the technological and financial challenges, faced by developing countries in particular, in the implementation of vaccination plans, he supported the draft resolution proposed by Libya. It was important to strengthen the Organization's work to provide universal access to vaccination, ensure transparency of information on vaccine prices, and implement effective research and development mechanisms.

Dr NARGIS (Bangladesh) said that her country had achieved most of the global targets for routine immunization and vaccine-preventable disease control, including 90% measles vaccination coverage. Its surveillance indicators and activities complied with international standards and were supported by WHO's Surveillance Medical Officer Network. A number of new vaccines had been introduced, including the pneumococcal and inactivated poliomyelitis vaccine in 2015. Her country frequently received recognition as a global example of success in routine immunization. Two national pharmaceutical companies were producing vaccines locally and efforts were being directed to strengthening the national regulatory authority's capacity to monitor domestic vaccine production. WHO should develop tools and support countries to review the supply chain situation and respond immediately to shortfalls. Along with other technical partners, it should also examine the transparency of vaccine pricing and supply information, closely monitoring country needs for measures to ensure production and supply. She supported the recommendations contained in the 2014 assessment report of the Strategic Advisory Group of Experts on immunization.

Dr JENYFA (Maldives) emphasized the need for accelerating concerted action to achieve some of the key immunization goals under the global vaccine action plan. Achieving sustainable worldwide access to vaccines, particularly newer vaccines, at affordable prices called for the development of collaborative mechanisms. She urged countries with low coverage to strengthen control of vaccine-preventable diseases. Even in countries with high coverage, the focus should shift to population groups that were not being vaccinated. Countries required support in the area of risk communication and effective public awareness programmes. She urged Member States to fully integrate vaccination into the operation of all aspects of their health care systems, and to invest in

improving data quality at the local level to promote accountability and understanding of the programmatic issues involved.

Dr ENNIS (Jamaica) said that, in view of the popularity of anti-vaccination groups, WHO needed to provide Member States with increased support on advocacy and social mobilization to build public confidence in vaccinations. The resources allocated to such activities should be increased, particularly with regard to the introduction of new vaccines. Although her country had benefited from procuring vaccines through the PAHO Revolving Fund, the prohibitive cost of newer vaccines prevented it from introducing them or making them available to the full birth cohort. The prices offered by the GAVI Alliance showed that it was possible to lower the prices of vaccines. Her country had never been GAVI-eligible but the criteria used to determine eligibility did not give sufficient weight to the burden of disease in Jamaica, or to the gap between rich and poor. With a view to maintaining equity and social justice, PAHO should advocate more strongly for manufacturers to offer the same prices as were offered to the GAVI Alliance. Greater advocacy was also needed for research on newer and more affordable vaccines. She supported the actions recommended by the Executive Board and the draft resolution.

Dr BENEBY (Bahamas) said that the 2014 assessment report by the Strategic Advisory Group of Experts on immunization showed that the global vaccine action plan had underachieved. WHO should take the lead in raising awareness among all stakeholders that immunization was for all, not just for some. Financing was critical, not only to provide immunization services but also to combat the growing vaccine refusal movement. Implementation of the global vaccine action plan had a direct impact on child mortality and adult morbidity. It was impossible to speak of equity when the international community failed to seize opportunities to immunize all children. The global vaccine action plan must be implemented.

Dr AL MOSAWI (Bahrain) expressed support for the recommendations and draft resolution relating to the global vaccine action plan, to which Bahrain was firmly committed. With coverage rates for routine vaccinations exceeding 95% since 1997 and neonatal tetanus, rubella and measles now eliminated, Bahrain had achieved ground-breaking progress through its own expanded programme on immunization. At the regional level, it had pioneered the use of new vaccines and had been one of the first countries to introduce one dose of inactivated poliovirus into routine immunization programmes and to register bivalent oral polio vaccine (bOPV) for routine use.

Bahrain was furthermore committed to improving data quality in the interests of communicable disease surveillance in general and immunization in particular. Data and statistical information on immunization coverage were assessed biennially for quality and accuracy, using WHO-recommended tools, and recommendations were made on the basis of the findings. Monitoring of vaccine side-effects had also been stepped up, together with the investigation and classification of cases, in order to promote public confidence in the expanded programme on immunization. In short, the country's immunization action plan and vaccine strategy were fully in keeping with global immunization goals.

Dr ASSIRI (Saudi Arabia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that immunization coverage remained low in several Member States and was even decreasing in some countries. He called for increased investment from Member States, partners and other stakeholders to improve the quality of immunization data under the guidance of national and regional technical advisory groups. The elimination target for measles and rubella had not received adequate attention in most countries; more partners and greater political commitment were needed. Since all the countries yet to achieve neonatal tetanus elimination were financially constrained, more financial support was needed for the vaccination campaigns required. In several countries of his Region, natural and man-made disasters had disrupted vaccine delivery, resulting in reduced vaccination coverage. Affected countries and those hosting refugees should be granted access to vaccines at lower prices. Cooperation with vaccine producers was vital to ensuring the availability

of affordable vaccines, especially those against measles and rubella. In order to implement the global vaccine action plan, countries needed to establish an optimal programme structure and appoint enough qualified personnel. Saudi Arabia supported the draft resolution.

Dr AL-ROMAIHI (Qatar), stressing the importance of commitment to achieving the goals of the global vaccine action plan, said that the newest vaccines were included in his country's national child immunization programme and that adults and travellers had access to all required immunizations, which were provided free of charge to all citizens and residents. A national advisory committee on immunization effectively discharged its supervisory and review functions, making recommendations and elaborating and following up on immunization strategies and plans accordingly. The already sophisticated database run by the country's expanded programme on immunization was constantly being developed, in order to enhance the quality of the available information with a view to achieving higher vaccination coverage. In addition to its efforts for the basic integration of immunization services into all health care systems, Qatar played its part in the poliomyelitis campaigns under way in various affected countries and would continue until 2020 its support to GAVI, amounting during the current year to US$ 10 million. He expressed support for the draft resolution.

Dr SALLEH (Malaysia) said that the current global shortage of certain vaccines posed a threat to immunization programmes. A register of available vaccines from all manufacturers would help to overcome that problem.

Dr KREMER (Argentina) said that Argentina was committed to prioritizing free immunization for its citizens and procured the majority of its vaccines through the PAHO Revolving Fund. Such centralized purchasing mechanisms were particularly valuable. Unfortunately, suppliers' inflexibility in negotiating reasonable prices with the Revolving Fund had caused stock-outs and pushed many countries to purchase vaccines in a decentralized fashion to avoid disrupting their vaccination campaigns. Not interrupting campaigns should be a priority. Affordability and supply should not be barriers to fair and equal access to vaccinations. The fact that more than 40% of low- and middle-income countries had experienced at least one stock-out in their vaccination campaigns in 2014 gave cause for concern. The Government of Argentina supported the proposed draft resolution.

Dr ALHUWAIDI (Kuwait) welcomed the emphasis placed in the report on the need to improve the quality and use of data and involve civil society organizations in sharing the responsibility of delivering and improving immunization services. Also commendable were the recommendations to integrate vaccination fully into the operation of all aspects of the health care system and to make pricing information publicly available for the sake of transparency. Uniform purchase alternatives should also be created on a regional basis, along the lines of the collective purchase system in place in the States of the Gulf Cooperation Council.

Dr AMBOURHOUET-BIGMANN (Gabon) said that, despite expenditure of more than US$ 1 million per year on vaccines and provision of free vaccines for infants aged under 11 months, the country's vaccination coverage remained below the targets set out in the global vaccine action plan. Since poliovirus was a public health emergency of international concern, additional mass vaccination campaigns were being conducted in cooperation with neighbouring countries. To meet the target of introducing the injectable poliovirus vaccine by the end of 2015, a considerable increase in funding under the Expanded Programme on Immunization would be required. Despite assistance from WHO and partners, Gabon was not eligible for GAVI Alliance support and was therefore struggling to achieve its vaccination targets. Nevertheless, it remained committed to working towards global vaccine action plan objectives and supported the draft resolution proposed by Libya.

Mr MISHRA (India), referring to measures taken in India to ensure surveillance of health coverage, including immunization, said that a new programme to protect children against seven

vaccine-preventable diseases was under way, and three new vaccines would be introduced. India agreed with the five priority areas for action identified by the Strategic Advisory Group of Experts on immunization and was committed to addressing any shortcomings in those areas. His delegation endorsed the draft resolution proposed by Libya, but proposed a minor amendment, namely that "low- and" be inserted before "middle-income countries" in paragraph 1(6).

Ms MORÓN DE PORRAS (Bolivarian Republic of Venezuela) said that although vaccines were playing an increasing role in reducing infant mortality in the Bolivarian Republic of Venezuela, in some remote areas or areas with porous borders with neighbouring countries, vaccination coverage remained below the optimal 95%. Those challenges must be faced through the provision of new services to enhance coverage in line with the principle of free and universal vaccination. It was essential to maintain agreements between WHO and PAHO to ensure a consistent and constant supply of vaccines to meet the immunization targets of the Expanded Programme on Immunization. The Strategic Advisory Group of Experts on immunization should encourage continued immunization training for health personnel in Member States and allow them to guide future debates and activities with a view to optimizing the effectiveness of the Programme.

Ms RABOVICA (Latvia), speaking on behalf of the European Union and its Member States, said that the European Union was still considering the draft resolution and requested more time to coordinate its position.

Dr AL-TAAE (Iraq) underscored the importance of maintaining a sustainable supply of vaccines during crisis situations. Particular consideration should be given to the situation in the Eastern Mediterranean Region. In Iraq, vast swathes of internally displaced persons, including more than 800 000 displaced children under the age of five years, meant that many additional immunization campaigns were needed. Countries in crisis situations required particular support to switch from the trivalent to bivalent oral poliovirus vaccine and to introduce the inactivated poliovirus vaccine. In such situations, vaccine availability must be uninterrupted. Coordinated surveillance of all communicable diseases of concern to prevent their resurgence was particularly important. Any future guidance on immunization in conflict situations should include a reference to administering vitamin A supplements alongside measles vaccines as a means of addressing micronutrient deficiencies.

Dr E.M. NDIAYE (Senegal), speaking on behalf of the Member States of the African Region, said that Senegal had introduced all the vaccines recommended in the global vaccine action plan. A national survey on vaccination coverage carried out in March 2012 had revealed 90% pentavalent vaccination coverage. Efforts were being made to maintain and improve coverage in all districts in partnership with civil society organizations. WHO had confirmed the elimination of maternal and neonatal tetanus in the country in 2011. In 2014, most districts had been assessed as low risk for tetanus. Efforts were also under way to eliminate measles, including through a combined measles and rubella catch-up vaccine for children under the age of 15 years. A surveillance system for congenital measles had also been established and no significant measles outbreaks had been reported in the country since 2010.

Mr DE ANDRADE FILHO (Brazil) expressed support for the draft resolution and proposed that the phrase "and universal access to health" should be added at the end of the second preambular paragraph. In addition, in subparagraph 1(4), the phrase "the standards required for" should be replaced by "national regulatory standards, including".

Professor MESBAH (Algeria) said that access to vaccines was a two-pronged issue. The cost of vaccines was of particular concern and was a substantial obstacle to the implementation of the global vaccine action plan, for both low- and middle-income countries. Transparency in price setting was therefore essential and WHO had a key role to play in that regard. Availability of vaccines in sufficient quantities was the other concern. Algeria supported the draft resolution.

Dr AL-MOKHTAR (Libya) read out the amendments to the draft resolution that had been proposed by Member States during the meeting. He further proposed that in subparagraph 2(12) the phrase "including regulatory and intellectual property barriers" should be deleted.

Ms NICHOLLS (Canada) proposed the deletion of the last phrase of the ninth preambular paragraph, which read "and that mechanisms which lower the price of vaccines are not accessible to developing and middle-income Member States". Moreover, the phrase "to secure funding" should be deleted from subparagraph 2(7).

Ms KEKEMPANOU (Greece) said that at a time when there were many competing health priorities, it was essential to strengthen vaccination programmes to prevent diseases that placed a heavy burden on health systems. At the regional and national levels, there should be increased focus on raising public awareness of the importance of vaccination and increasing vaccination coverage for vulnerable groups and groups that refused vaccination due to anti-vaccination sentiment.

Dr AL-MOKHTAR (Libya) agreed with the amendment to the ninth preambular paragraph proposed by the delegate of Canada and suggested that in subparagraph 2(7), the phrase "to explore ways" could be inserted prior to "to secure funding", instead of deleting the latter phrase. Some delegations had asked for more time to review the draft resolution and he was prepared to be flexible in that regard.

Ms An-Chi LAI (Chinese Taipei) said that the supply of vaccines containing acellular pertussis had been unstable in Chinese Taipei, leading to delays in vaccination. The shortage had affected overall vaccination coverage and disease prevention efforts and she encouraged all relevant stakeholders to commit to stabilizing vaccine supply. WHO should address supply shortfalls by providing support to Member States to enable them to meet target coverage rates and coordinating efforts to increase regional vaccine production capacity.

Mr WRIGHT (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that since the replenishment cycle for the GAVI Alliance had been completed, it was crucial to focus on reaching every child, addressing the inequity of coverage and building a sustainable vaccine market. In that regard, the GAVI Alliance should ensure that the indicators to measure progress were appropriate; those currently proposed fell short of what was needed and more time should be taken to develop them further. Although donor support was important, Member States should also play their role by implementing strong vaccination policies at the national level.

Ms ELDER (MSF International), speaking at the invitation of the CHAIRMAN, said that she shared the concerns of many Member States regarding the affordability of vaccines. More data and transparency were needed on vaccine prices and she urged all Member States to make public the prices they paid, through the WHO Vaccine Product, Price and Procurement project. MSF International had recently launched a campaign to secure a reduction in the price of the pneumococcal conjugate vaccine for children in developing and middle-income countries and she encouraged Member States to join that campaign.

Mrs BARRIA (Medicus Mundi International – International Organization for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, encouraged Member States to maintain the reference in the draft resolution to regulatory and intellectual property barriers that undermined the introduction of priority vaccines. Her organization strongly supported pooled regional procurement, which would be a key requirement for countries that became ineligible for GAVI Alliance support, and was concerned at the pressure placed on countries to introduce new vaccines despite an absence of surveillance and information systems covering epidemiology, delivery and evidence of safety and efficacy. WHO regional and country offices should provide support for countries to take informed decisions on the issue.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, agreed that vaccine affordability and supply were key issues. Opportunities to vaccinate continued to be missed; there was growing evidence that vaccination by pharmacists increased coverage rates for hard-to-reach groups and previously unvaccinated persons. As noted by the Strategic Advisory Group of Experts on immunization, disruptive situations, such as conflict, impeded vaccination delivery. Governments and nongovernmental organizations tackling such situations should be encouraged to include pharmacists in their plans, as they could help to ensure timely access to vaccines. Pharmacists should also play a role in educating the public to address vaccination hesitancy and resistance.

Ms NWACHUKWU (GAVI Alliance)[1] thanked donors that had pledged funding for the GAVI Alliance at the recent pledging conference for their generosity. Demand for vaccines in developing countries continued to increase; the GAVI Alliance continued to support many Member States in the provision of life-saving vaccines. In the coming year, more than one hundred new vaccine introductions were expected around the world, which was significant progress and demonstrated the commitment of Member States. Although Member States were on course to achieve targets in that regard, more needed to be done to achieve other goals on coverage and equity. Going forward, it would be important to recognize country ownership, the need for commitment at the highest levels of government, and differing country needs; and to take a long-term view with an emphasis on sustainability. One particular concern that was often raised by countries that were transitioning from GAVI Alliance support was related to the need to continue to access vaccines at affordable prices. The GAVI Alliance Board would soon consider an approach that would enable those countries to continue to access the GAVI Alliance prices for specific vaccines for a five-year period after direct support ceased.

Dr BUSTREO (Assistant Director-General), commending the foresight of Member States in requesting an annual substantive discussion on the implementation of the global vaccine action plan, said that it was clear that immediate and concerted action by all stakeholders was needed to correct the slow and patchy progress of the action plan and address the gaps in the indicators; WHO stood ready to play its role in the effort to get the plan back on track. It was also working with UNICEF and the GAVI Alliance to support those middle-income countries that were no longer eligible for GAVI Alliance funding, focusing on equitable coverage. A task force had been set up to address the issues faced by those countries, such as affordability and availability of a constant supply of vaccines, and it was hoped that the task force would be in a position to propose potential solutions to those issues at the next Health Assembly. The Secretariat was also continuing its work on guidelines for immunization in humanitarian and emergency settings and was collaborating with the Global Polio Eradication Initiative to learn from its experiences, in order to enhance the capacity of WHO to help Member States to strengthen routine immunization programmes.

The CHAIRMAN took it that the Committee wished to suspend its discussion of the item in order to allow delegations time to reach agreement on the text of the draft resolution.

It was so agreed.

(For continuation of the discussion and the draft resolution, see the summary record of the eleventh meeting, section 4)

The meeting rose at 17:25.

[1] The representative of the GAVI Alliance addressed Committee A under agenda item 16.4 by invitation of the Director-General.

SIXTH MEETING

Thursday, 21 May 2015, at 09:10

Chairman: Dr E. JARAMILLO NAVARRETE (Mexico)

1. FIRST REPORT OF COMMITTEE A (Document A68/65)

Dr ROOVÄLI (Estonia), Rapporteur, read out the draft first report of Committee A.

The report was adopted.[1]

2. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 14 of the Agenda

Health and the environment: addressing the health impact of air pollution: Item 14.6 of the Agenda (Documents A68/18 and EB136/2015/REC/1, decision EB136(14))

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Albania, Chile, Colombia, France, Germany, Monaco, Norway, Panama, Sweden, Switzerland, Ukraine, United States of America, Uruguay and Zambia, which read:

> The Sixty-eighth World Health Assembly,
>
> Having considered the report on Health and the environment: addressing the health impact of air pollution,
>
> (PP0) Reaffirming our commitment to the outcome document of the Rio+20 Conference "The future we want", in which all States Members of the United Nations committed to promoting sustainable development policies that support healthy air quality in the context of sustainable cities and human settlements, and recognized that reducing air pollution leads to positive effects on health; (= from UNEA resolution 1/7, PP6)
>
> (PP1) Noting with deep concern that indoor and outdoor air pollution are both among the leading avoidable causes of disease and death globally, and the world's largest single environmental health risk;[2]
>
> (PP2) Acknowledging that 4.3 million deaths occur each year from exposure to household (indoor) air pollution and that 3.7 million deaths each year are attributable to ambient (outdoor) air pollution, at a high cost to societies;[3]
>
> (PP3) Aware that exposure to air pollutants, including fine particulate matter, is a leading risk factor for noncommunicable diseases in adults, including ischemic heart disease, stroke, chronic obstructive pulmonary disease, asthma and cancer, and poses a considerable health threat to current and future generations;

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[1] See pages 364 and 365.

[2] Global Health Observatory http://www.who.int/gho/phe/en/ (accessed 18 March 2015).

[3] WHO. Burden of disease from ambient air pollution for 2012. http://www.who.int/phe/health_topics/outdoorair/databases/AAP_BoD_results_March2014.pdf?ua=1 (accessed 1 December 2014).

(PP4) Concerned that half of the deaths due to acute lower respiratory infections, including pneumonia in children aged less than five years, may be attributed to household air pollution, making it a leading risk factor for childhood mortality;

(PP5) Further concerned that ambient air pollution, including fine particulate matter, is classified as a cause of lung cancer by WHO's International Agency on Research for Cancer,[1]

[ADD FOOTNOTE 4 AND 5] (USA, Uruguay)

[which has classified emissions from diesel[2] and coal combustion[3]

[products]/[emissions] (Canada)

(major causes of household, work place and ambient air pollution)

[as] (Canada) carcinogenic in humans;]

(EU) (**DEL:** Egypt, Saudi Arabia)

(PP6) Aware that both short- and long-term exposure to air pollution has a negative impact on public health, with a much greater impact resulting from long-term exposure and exposure at high levels, causing chronic diseases such as cardiovascular diseases and respiratory diseases, including chronic obstructive pulmonary disease (COPD), and also that for many pollutants, such as particles, long-term exposure even at low levels (below WHO air quality guidelines proposed levels) could result in some adverse health effects;

(PP7) Noting the strong significance of air pollution and its health effects on the objectives and targets contained in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020;

(PP8) Noting that air pollution is a cause of global health inequities, affecting in particular women, children and old persons, as well as low-income populations who are often exposed to high levels of ambient air pollution as a result of living near busy roads or industrial sites, or in homes that have no choice but to rely on polluting fuels and technologies for cooking, heating and lighting, and that improving air quality is among the measures with the greatest potential impact on health equity;

(PP9) Cognizant that most air pollutants are emitted as a result of human activity in a range of sectors, with indoor air pollution typically [but not exclusively] (Colombia) being a result of home use of polluting fuels [;]/[,] (Canada) inefficient technologies for heating, cooking and lighting [;]/[,] (Canada) smoking; or emission of harmful chemicals[4] from building materials and household products [,] (**DEL:** Canada) exacerbated by poor ventilation systems [,]/[;] (Canada) with outdoor air pollution typically

[but not exclusively] (Colombia) being a result of

[nuclear detonation,] (Egypt) (**DEL:** France, Monaco, EU)

[unsustainable patterns of] (Uruguay)

energy production, motorized transportation, [patterns of] (**DEL:** Uruguay) industrial and urban development, waste disposal, agriculture and burning of biomass and other household sources of energy;

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[1] IARC Monographs Working Group on the Evaluation of Carcinogenic Risks to Humans. Outdoor Air Pollution. Lyon: International Agency for Research on Cancer; 2013 (IARC Monographs on the Evaluation of Carcinogenic Risks to Humans, Volume 109; http://www.iarc.fr/en/media-centre/pr/2013/pdfs/pr221_E.pdf, accessed 17 March 2015).

[2] IARC Monographs Working Group on the Evaluation of Carcinogenic Risks to Humans. Diesel and gasoline exhausts and some nitroarenes. Lyon: International Agency for Research on Cancer; 2012 (IARC Monographs on the Evaluation of Carcinogenic Risks to Humans, Volume 105; http://monographs.iarc.fr/ENG/Monographs/vol105 /mono105.pdf, accessed 17 March 2015).

[3] IARC Monographs Working Group on the Evaluation of Carcinogenic Risks to Humans. Household use of solid fuels and high-temperature frying. Lyon: International Agency for Research on Cancer; 2010 (IARC Monographs on the Evaluation of Carcinogenic Risks to Humans, Volume 95; http://monographs.iarc.fr/ENG/Monographs/vol95/index.php, accessed 17 March 2015).

[4] See resolution WHA59.15. (http://www.who.int/ipcs/publications/wha/saicm_resolution.pdf?ua=1 accessed 20 March 2015).

and noting also that there is a significant interrelation between outdoor and indoor air quality;
[taking also into account that other rare events, like nuclear detonation, not only results in air pollution but short and long-term environmental consequences as well] (Egypt) (= resolution WHA46.40)
OR
(DELETE PARAGRAPH: Saudi Arabia)

(PP9 bis) Cognizant that there are also other air pollutants not resulting from human activity which cause significant health threats, such as radon, that exposure to indoor radon is a cause of lung cancers in the general population and that this exposure can be substantially reduced by awareness raising programmes aimed at the general public and in particular property owners, as well as by prevention and remediation measures in buildings;

(PP9 bis bis)Cognizant that there are also naturally occurring phenomena that negatively affect air quality, such as dust- and sandstorms, volcanic eruptions and forest fires, taking into account the specific circumstances of each region, and also cognizant that, inter alia, regional and subregional cooperation frameworks may address this;

(PP9ter) *[Underscoring that the root causes of air pollution and its adverse impacts are predominantly socioeconomic in nature]* and cognizant of the need to address the social determinants of health related to development in urban and rural settings, including poverty eradication, as an indispensable element for sustainable development and for the reduction of the health impact of air pollution;

*(PP9ter.bis) [Recognizing that international cooperation is a key element to address challenges that countries encounter in addressing the health impact of air pollution;] (Iran, Egypt) (**RESERVE POSITION**: USA, EU, Switzerland)*

(PP9cinc) [Reaffirming the importance of facilitation of technology transfer
[and providing support for innovation for addressing indoor and outdoor air pollution] (India, Brazil) (**DEL**: USA)
[on mutually agreed terms] (Monaco, USA, France, Switzerland, EU)/[as appropriate] (India, Iran, Egypt, Ecuador, Brazil, Saudi Arabia, Indonesia)
between developed and developing countries, as well as among developing countries,
[as appropriate] (**DEL**: India)];
(= based on resolution WHA66.22)

(PP10) Acknowledging recent global efforts to promote air quality, in particular the 2014 United Nations Environment Assembly resolution on air quality as well as the many national and regional initiatives to mitigate the health impacts of indoor and outdoor air pollution, while noting the need for the health community to contribute to a coordinated global strategy to reduce outdoor and indoor air pollution, so as to prevent disease and ill-health, with reduced quality of life and life expectancy;

(PP11) Recognizing that the sources of air pollution, its impacts on health, and the policy options for tackling it, are place- and context-specific, and that outdoor air pollution may also be transported over long distances, thereby requiring cooperation across sectors at the local, subregional, regional, and global level for the identification and implementation of policies with maximum health and social benefits ("win-win actions"), and that in order to contribute to policy choices that protect health and reduce health inequities, the health sector will need to engage in cross-sectoral approaches to health, including adopting a health-in-all policies approach;

(PP12) Noting that WHO's air quality guidelines for both ambient air quality[1] (2005) and indoor air quality[2] (2014) provide guidance and recommendations for clean air that

[1] WHO air quality guidelines for particulate matter, ozone, nitrogen dioxide and sulfur dioxide – global update 2005: summary of risk assessment. Geneva: World Health Organization; 2006 (document WHO/SDE/PHE/OEH/06.02).

[2] WHO indoor air quality guidelines: household fuel combustion; 2014; (http://www.who.int/indoorair/guidelines/hhfc/en/).

protect human health and recognizing that these need to be supported by activities, such as the promotion and facilitation of implementation.

(PP13) Acknowledging that while many of the most important and cost-effective actions against outdoor and indoor air pollution require the involvement and leadership of national governments as well as regional and local authorities, cities are both particularly affected by the consequences of air pollution and well-placed to work alone or in partnership to reduce air pollution and its associated health impacts, and can complement national air quality measures and national [emission standards through policies and investments in more energy-efficient and healthy urban planning, more sustainable and healthy transport, building, housing and energy systems, and that the health sector can contribute to identifying, communicating and evaluating the healthiest policy options for indoor and outdoor air quality;

(PP14) [Aware that both established and expanding clean-energy technologies and renewable energy solutions can offer cost-effective opportunities to reduce energy poverty while contributing to improved health;] (USA) (**DEL**: Saudi Arabia)

(PP14bis) [Acknowledging that re-tooling household, urban [and agricultural] (Egypt) and industrial infrastructure which contribute to air pollution, [may] (France) [involves] [huge] (Egypt) (**DEL**: EU, Switzerland, France)/[substantial] (India) financial and technological investments, requiring mobilization of adequate and sustained resources at national, [and, as appropriate,] (EU) regional and international levels;]
(= based on IPCC report box 113 page 728)
(India, Saudi Arabia, Egypt, Iran, Brazil)
(**RESERVE POSITION**: EU, Switzerland, France, USA)

(PP15) [[Stressing]/[Aware] (India) that promoting air quality is a priority to protect health and provide co-benefits for the climate, ecosystem services, biodiversity, and food security[1],] [STOP HERE] (Indonesia, India)

[and that there are opportunities for synergies between air pollution and [climate change] (**DEL**: Saudi Arabia) (ADD FOOTNOTE UNFCCC) (Egypt) reduction strategies[9]]]

(France, USA, Canada, Monaco, EU, Switzerland)

(PP15bis) [Underscoring that the

[environmental changes] (**DEL**: Saudi Arabia)

[often] (USA)

[associated with climate change[2]] (**DEL**: Saudi Arabia) (ADD FOOTNOTE UNFCCC) (Egypt)

[, such as higher temperatures, more frequent heatwaves, dust- and sandstorms and forest fires, can also exacerbate the impact of air pollution on health[3]]]

[**RETAIN PARAGRAPH AS PROPOSED BY CHAIR**] (EU, Switzerland, Canada, Monaco, France);

(PP16) [Underscoring that air pollution-related health impacts can be a health-relevant indicator for sustainable development policies,]

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[1] United Nations Environment Assembly Resolution 1/7 (http://www.unep.org/unea/download.asp?ID=5171 accessed 20 March 2015). Smith, K.R., A. Woodward, et al, 2014: Human health: impacts, adaptation, and co-benefits. In: Climate Change 2014: Impacts, Adaptation, and Vulnerability. Part A: Global and Sectoral Aspects. Contribution of Working Group II to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change. Cambridge University Press, Cambridge, United Kingdom and New York, NY, USA, pp. 709–754.

[2] IPCC, 2013: Summary for Policymakers. In: Climate Change 2013: The Physical Science Basis. Contribution of Working Group I to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change. Cambridge University Press, Cambridge, United Kingdom and New York, NY, USA.

[3] Smith, K.R., A. Woodward, et al, 2014: Human health: impacts, adaptation, and co-benefits. In: Climate Change 2014: Impacts, Adaptation, and Vulnerability. Part A: Global and Sectoral Aspects. Contribution of Working Group II to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change. Cambridge University Press, Cambridge, United Kingdom and New York, NY, USA, pp. 709–754.

[MOVE FOOTNOTE 12 TO HERE AND STOP HERE] (USA)

[particularly with regard to sustainable energy, sustainable cities and clean and sustainable transport;[1]] (**DEL**: Saudi Arabia] (**RESERVE POSITION**: Uruguay, Switzerland, Monaco)

(OP1) URGES Member States[2] to: [, in accordance with national circumstances, priorities and needs,] (Saudi Arabia)

(OP1.1) Redouble their efforts to identify, address and prevent the health impacts of air pollution, by developing and strengthening, as appropriate, multisectoral cooperation on the international, regional and national levels, and through targeted, multisectoral measures in accordance with national priorities;

(OP1.1bis) Enhance international cooperation on air pollution

[, according to national context] (USA) AND (China)/ OR

[and on a voluntary basis,] (China, Egypt, Saudi Arabia) (**DEL:** EU, Monaco, Uruguay) by contributing to global data collection, monitoring, research, the development of normative standards, sharing of best practices and dissemination of good practices and lessons from implementation;

(OP1.2) Enable health systems, including health protection authorities, to take a leading role in raising awareness in the public and among all stakeholders of the impacts of air pollution on health and opportunities to reduce or avoid exposure, including by guiding preventive measures to help reduce these health effects, to interact effectively with the relevant sectors and other relevant public and private stakeholders to inform about sustainable solutions, and to ensure that health concerns are integrated into relevant national, regional and local policy, decision-making and evaluation processes, including public health prevention, preparedness and response measures, as well as health system strengthening;

(OP1.3) Facilitate relevant research, including developing and utilizing databases on morbidity and mortality, health impact assessment, the use and costs of health care services and the societal costs associated with ill health, supporting identification of research priorities and strategies, engaging with academia to address knowledge gaps, and supporting the strengthening of national research institutions and international cooperation in research to identify and implement sustainable solutions; (NOTE: SEPARATE LIST USING SEMICOLONS)

(OP1.4) Contribute, [as appropriate]/[in accordance with the national context] , to global and regional initiatives to address air pollution and its health effects, emphasizing in particular enhanced monitoring of the health effects of specific air pollutants, and other challenges to air quality, including [as appropriate,] [in accordance with the national context] [and on a voluntary basis,] (China, Egypt, Saudi Arabia) (**DEL:** EU, France, Monaco, Uruguay) by collecting, sharing and utilizing data on air pollution exposure and other challenges to air quality and relevant health outcomes, and by working towards harmonization of health-related indicators which could be used by decision makers;

(OP1.6) Improve the morbidity and mortality surveillance for all illnesses related to air pollution, and optimize the linkage with monitoring systems of air pollutants;

(OP1.7) Take into account the WHO Air Quality Guidelines and WHO Indoor Air Quality Guidelines and other relevant information in the development of a multisectoral national response to air pollution and carry out measures supporting the aims of those guidelines;

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[1] Dora, C et al. Indicators linking health and sustainability in the post-2015 development agenda. Lancet. 2015, 385: 9965. doi:10.1016/S0140-6736(14)60605-X.

[2] And, where applicable, regional economic integration organizations.

(OP1.8) Encourage and promote measures that will lead to meaningful progress in reducing levels of indoor air pollution such as clean cooking, heating and lighting practices and efficient energy use;

(OP1.9) Take effective steps, to address and to minimize as far as possible air pollution specifically associated with health care activities, including by implementing, as appropriate, relevant WHO guidelines;

(OP1.10) [Develop policy dialogue and information sharing between different sectors to facilitate a coordinated, multisectoral basis for future participation in regional and global processes to address the health effects of air pollution,

[taking into account the principle of Common But Differentiated Responsibility (CBDR)] (Saudi Arabia, Egypt) (**DEL**: France)

[including by securing close collaboration between health and other relevant sectors in the efforts [ADD FOOTNOTE: These efforts should be in line with the articles and provisions included in the UN Framework Convention on Climate Change] (Egypt) to fight climate change[1],[2]] (**DEL:** India, Saudi Arabia)]

(RETAIN ORIGINAL PARAGRAPH TEXT AS PROPOSED BY CHAIR: EU, France, Switzerland, Monaco)

[(OP1.10bis) Strengthen international cooperation, with a view to promoting health equity in all countries, through facilitating transfer [on mutually agreed terms] (Switzerland, EU, USA, Monaco)/[as appropriate] (India, Egypt, Iran) of expertise, technologies and scientific data in the field of air pollution, as well as exchanging good practices for managing intersectoral policy development;] (= based on OP3.2 in resolution WHA65.8)

OR

[Reaffirm commitment to promote, facilitate and finance, as appropriate, access to and the development, transfer and diffusion of environmentally sound technologies particularly clean air technologies, and corresponding know-how, in particular to developing countries] (India), [on favourable terms, including on concessional and preferential terms, as mutually agreed] (Egypt, Saudi Arabia)

OR

[BASE TEXT ON PARAGRAPHS 72 AND 73 OF RESOLUTION A/RES/66/288 (The Future We Want)]

(OP1.10ter) [Identify and prioritize [at the national level] (Saudi Arabia) actions by the health sector that reduce health inequities related to air pollution and work closely with the communities at risk who can gain the most from effective equitable and sustained actions] (India, Egypt, Saudi Arabia) [, so as to facilitate the full realization of the right to the enjoyment of the highest attainable standard of physical and mental health] (Egypt) (**DEL PARAGRAPH**: USA) (**RESERVE POSITION**: EU, Monaco)

(OP1.10quart) [Make use of the flexibilities contained in the agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the Doha Declaration on the TRIPS Agreement and Public Health to address the public health impacts of air pollution] (India, Egypt) (**DEL PARAGRAPH**: USA, EU, Norway, Switzerland, Monaco)

[1] Noting in this respect the outcome of the WHO Health and Climate Change Conference which states "there is a particular opportunity to reduce the roughly 7 million deaths a year associated with air pollution while also reducing climate warming." WHO Health and Climate Change Conference Report (http://www.who.int/globalchange/mediacentre/events/climate-health-conference/whoconferenceonhealthandclimatechangefinalreport.pdf?ua=1, accessed 20 March 2015).

[2] Noting that the Convention on Long-Range Transboundary Air Pollution established a Joint Task Force on Health Aspects of Air pollution to assess the health effects of long-range transboundary air pollution and provide supporting documentation. (http://www.unece.org/env/lrtap/workinggroups/wge/who.html, accessed 20 March 2015).

(OP1.11) Meet the commitments made at the 2011 UN High level meeting on non-communicable diseases and to use, as appropriate, the road map and policy options contained in the WHO global action plan for noncommunicable diseases;
(OP1.13) [Collaborate with regional and international organizations in developing partnerships to [promote] (USA) [and mobilize] (India, Iran, Egypt) adequate technical and financial resources
[so as to accomplish enhanced capacity building including by human resources development through training, exchange of experiences and expertise, knowledge transfer, and subsequent to that encourage sustained adoption of clean air technologies] (Egypt, India) (**RESERVE POSITION**: Switzerland, EU)
that can
[strengthen domestic absorptive capacity by, inter alia, encouraging wide scale and sustained adoption of clean air technologies and] (**DEL**: India, Egypt, Iran, Saudi Arabia) (**RETAIN**: USA, Switzerland, EU)
support wide scale and sustained adoption of clean air technologies, particularly in low- and middle-income settings];

2. REQUESTS the Director-General:
(OP2.1) To significantly strengthen WHO's capacities in the field of air pollution and health in order to provide:
(a) Support and guidance for Member States in implementing the WHO Air Quality Guidelines and WHO Indoor Air Quality Guidelines;
(b) Enhanced technical support and guidance to Member States, including through appropriate capacities in regional and country offices to support country activities;
(c) Further identification, development and regular updating of WHO air quality guidelines and cost-benefit tools, including monitoring systems, to support effective and efficient decision making;
(d.Alt):Enhanced technical capacity of WHO to collaborate, as appropriate, with relevant international, regional and national stakeholders, to collect [, in line with national laws and regulations,] and analyse data on air quality, with particular emphasis on health-related aspects of air quality;
(e) Assistance to Member States to increase awareness and communicate to the general public and stakeholders, in particular communities at risk, about the effects of air pollution and actions to reduce it;
(f) Dissemination of evidence-based best practices on effective indoor and ambient air quality interventions and policies related to health;
(g) Enhanced ability of WHO to convene, guide and influence research strategies in the field of air pollution and health, in conjunction with the WHO Global Health Observatory;
(h) appropriate advisory capacity and support tools to assist the health and other sectors at all levels of government, especially the local level and in urban areas, taking into account different sources of pollution in tackling air pollution and their health effects;
(i) appropriate advisory capacity and support tools at regional and subregional level to help Member States address the health effects of air pollution and other challenges to air quality with a cross-border impact, and to facilitate coordination among Member States in this respect;
(j) [To [create]/[enhance and update] (EU, Monaco, Uruguay) a [dedicated] (Egypt, Indonesia) public [database]/[information] (EU, Monaco, Uruguay) of available clean air technologies to address the prevention and control of [indoor

and ambient or outdoor] (Egypt) air pollution and its impacts on health, in cooperation with relevant UN agencies;] (India, Egypt, Iran, Indonesia)
[and to [report on] (Iran) / [address] (Egypt) the challenges to access those technologies by developing countries] (Iran, Egypt) (**DEL**: Monaco, Uruguay)
(**RESERVE POSITION**: EU, Monaco, Norway)
(k) [To provide technical assistance, upon request, to make use of the flexibilities contained in the agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the Doha Declaration on the TRIPS Agreement and Public Health to address the public health impacts of air pollution;] (India, Egypt)
(**DEL**: USA) (**RESERVE POSITION**: EU, Switzerland)

(OP2.2) To exercise global health leadership and maximize synergies, while avoiding duplication of efforts, with relevant global efforts that promote air quality, air pollution reduction and health improvements,
[particularly in areas such as climate change [ADD FOOTNOTE: All matters on climate change should be in line with the articles, principles and provisions of the UNFCC] (Egypt, Iran), sound management of chemicals and waste, sustainable energy and clean and sustainable transport]; (**DEL**: India)
(**DEL PARAGRAPH**: Saudi Arabia)
(OP2.2bis) To work with other United Nations partners, programmes and agencies, in particular with reference to the UN Environment Assembly resolution on Air Quality;
(OP2.2ter) [To raise awareness of the public health risks of air pollution and the multiple benefits of improved air quality, in particular in the context of the discussions on [sustainable development goals as part of] (**DEL**: India) the post-2015 development agenda]; (**RESERVE POSITION**: USA, EU)
(OP2.2quart)[To continue to exercise and enhance the leading role of WHO in the Strategic Approach to International Chemicals Management to foster the sound management of chemicals and waste with the objective of minimizing and, where possible, preventing significant adverse effects on health, including from air pollution;] (EU) (= based on resolution WHA59.15) (**RESERVE POSITION**: India, Egypt)
(OP2.3) To strengthen, and where applicable, forge links with existing global health initiatives that can benefit from air pollution reduction, including global efforts to reduce noncommunicable diseases (such as the WHO global action plan for noncommunicable diseases) and improve children's health.[1]
(OP2.3bis) To set aside adequate resources for the work in the Secretariat, in line with the Programme budget 2014–2015 and Proposed programme budget 2016–2017 and the Twelfth General Programme of Work 2014–2019;
(OP2.4) To report to the Sixty-ninth World Health Assembly on the implementation of this resolution and its progress in mitigating the health effects of air pollution;
and other challenges to air quality;
(OP2.5) To propose to the Sixty-ninth World Health Assembly a road map for an enhanced global response to the adverse health effects of air pollution.

The financial and administrative implications for the Secretariat of the resolution were it to be adopted were as follows:

[1] Examples of such efforts are the Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD), The Global Strategy for Women's, Children's and Adolescents' Health and the Every Woman Every Child Movement.

1. Resolution: Health and the environment: addressing the health impact of air pollution

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 3. Promoting health through the life course

Programme area: Health and the environment — Outcome: 3.5
Outputs: 3.5.1, 3.5.2, 3.5.3

How would this resolution contribute to the achievement of the outcome of the above programme area?

The resolution will strengthen capacity of the health sector and health systems to prevent diseases and the seven million deaths each year due to air pollution.

Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US$ 10 000).

(i) The initial estimate covers the period 2015–2019, in line with the period covered by the Twelfth General Programme of Work, 2014–2019. Work on air pollution and health is likely to continue beyond 2019. However, the next general programme of work will be developed and a review undertaken in parallel, which may result in modifications to the programme budget depending on changes to the Organization's wider priorities.

(ii) Total: US$ 35.49 million[1] (staff: US$ 12.41 million;[2] activities: US$ 23.08 million).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US$ 10 000).

Total: US$ 3.64 million (staff: US$ 1.31 million; activities: US$ 2.33 million).

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If "no", indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes, for the biennium 2014–2015. However, additional staff will be required to implement the resolution from 2016 onwards.

If "no", indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

As indicated, for the biennium 2014–2015, current staffing levels are adequate. However, from 2016 onwards it is expected that two additional technical staff at grade P.4 and one at grade G.5 will be needed at headquarters, and one additional technical staff at grade P.4 will be needed in each of the regional offices. One part-time national professional officer will also be needed in each of the six countries that are hosting pilot programmes on enhanced cooperation.

[1] Figures are inclusive of programme support costs (13%).

[2] Staff cost figures are based on post cost averages for the biennium 2016–2017 plus programme support costs.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)

Yes.

If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Mr AASLAND (Norway), commenting that informal consultations had already taken place, proposed the establishment of a working group in order to continue discussions on the text of the draft resolution.

It was so agreed.

(For continuation of the discussion and the approval of the draft resolution, see the summary record of the fourteenth meeting, sections 2 and 5)

3. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 15 of the Agenda

Poliomyelitis: Item 15.2 of the Agenda (Documents A68/21, A68/21 Add.1, A68/21 Add.2 and A68/21 Add.3)

The CHAIRMAN drew attention to the draft resolution contained in document A68/21 Add.1 and the draft decision contained in document A68/21 Add.3.

Ms LANTERI (Monaco), speaking on behalf of the Member States of the European Region, said that the successful coordinated withdrawal of the type 2 component from oral poliovirus vaccine, depended on the readiness of all Member States, sound political commitment, global solidarity and strong determination from all actors. The progress in introducing inactivated poliovirus vaccine was encouraging and developments in controlling outbreaks in the Middle East and Africa and reducing transmission in Pakistan were promising. However, the gains were fragile and demanded continued vigilance, as demonstrated by the exportations of wild poliovirus from Afghanistan in late 2014.

Noting the importance of population immunity and surveillance, she welcomed the recent decision to restart poliovirus and measles vaccination in Liberia and Sierra Leone after the outbreak of Ebola virus disease. She commended and further encouraged the efforts undertaken by countries endemic for poliomyelitis to improve the quality of supplementary immunization activities and increase access to enable vaccination of children in conflict-affected areas.

She urged national authorities, in collaboration with donors and partners, to give higher priority to legacy planning; efforts to eradicate poliomyelitis could help to build stronger national public health systems. She applauded front-line workers for their commitment in challenging circumstances and condemned in the strongest terms the attacks and threats they faced. Poliomyelitis eradication needed maintained urgency and focus, and a redoubling of efforts.

Mr DE RAEDT (Belgium) asked the Secretariat to confirm whether the financial and administrative implications of the draft resolution under consideration, as well as those of other draft resolutions being discussed at the current Health Assembly, had been accounted for in the Programme budget 2016–2017.

Ms PALMIER (Canada) commended the progress made in the previous year, including the approach to a polio-free Africa, but expressed concern at the remaining challenges and threats,

including cross-border transmission. In line with the recommendations of the International Health Regulations Emergency Committee at its fifth meeting regarding the international spread of wild poliovirus, she encouraged strengthened coordination between Afghanistan and Pakistan in order to maintain the progress they had made. Donors should continue to support poliomyelitis eradication activities, fulfil their pledges and fill the residual funding gap for the Polio Eradication and Endgame Strategic Plan 2013–2018. She looked forward to the recommendations of the mid-term review of the Strategic Plan.

Legacy planning was an essential part of the Global Polio Eradication Initiative and would inform future global health initiatives, in particular routine immunization and broader public health programmes. She strongly endorsed the draft resolution, and urged all Member States to contribute to efforts to withdraw type 2 components and the switch to bivalent vaccine.

Mr MICHAEL TENE (Indonesia) expressed deep concern at the recent outbreaks of poliomyelitis in several countries. He cautioned against complacency and called for efforts to be stepped up to support the countries affected. As poliomyelitis would only be eradicated through concerted global cooperation, it was crucial to ensure the availability of effective and affordable poliovirus vaccines, in particular for developing countries. Implementation of the Polio Eradication and Endgame Strategic Plan 2013–2018 must be cautious and gradual, taking into account national circumstances and individual countries' readiness and priorities. Indonesia was committed to contributing to the overall success of the eradication initiative through its continued and intensive national immunization programme and maintaining its polio-free status. However, his Government faced continuing logistical and geographical obstacles in ensuring full immunization coverage of its large population. The language of the draft resolution with its rigid timelines might be problematic and even jeopardize Indonesia's interruption of transmission. For that reason, he proposed replacing paragraph 2 with the following text: "URGES all Member States to consider the use of inactivated poliovirus vaccine in their national routine immunization programmes". In subparagraph 3(7), the references to deadlines should be deleted and the text read: "to implement appropriate containment of type 2 wild polioviruses in essential facilities and type 2 Sabin poliovirus following global withdrawal of the type 2 component in oral poliovirus vaccine". Similarly, the words "in April 2016" should be deleted from subparagraph 4(2).

Ms FAROOQ (Pakistan) said that major progress had been made in Pakistan over the previous seven months as a result of increased political commitment, resourcefulness and renewed determination. The major impediment of inaccessibility was being removed through an effective security strategy in sensitive areas and initiating immunization campaigns protected by the armed forces, in particular in the Federally Administered Tribal Areas. Her Government had accorded the highest priority to the security of health workers. Establishment of national and provincial emergency operations centres had led to improved monitoring and coordination; as a result, there had been a marked improvement in vaccination coverage, with a 70% decrease in the number of reported cases to 23 so far in 2015, compared with the corresponding period in the previous year and an accelerating decrease in the detection of poliovirus in environmental samples. The areas where outbreaks had been reported in 2013–2014 (North Waziristan and Karachi) had reported no case of poliomyelitis for more than six months. Eleven data support centres had been established to help record and track coverage of children who had not been immunized. Coverage of children in the most inaccessible and security-compromised areas had been improved as a consequence of the introduction of inactivated poliovirus vaccine and the establishment of health camps delivering primary health care interventions. The implementation of an effective communication strategy had resulted in a sharp decrease in vaccination refusals to the lowest-ever recorded level of 0.11%. Other successful strategies included the involvement of more than 1000 female community health workers in extremely high-risk areas, an initiative that was being expanded to other such areas; the initiation of a motivation programme for front-line health workers, which included improved training and timely payment; and the participation of more than 4000 paediatricians in promoting immunization. In line with the recommendations of the

International Health Regulations Emergency Committee, all travellers leaving Pakistan were being immunized and those not in possession of a valid vaccination certificate were being stopped at exit points. Pakistan had made efforts to strengthen collaboration with Afghanistan in order to reduce the risk of cross-border transmission. Aware of the need to vaccinate mobile populations within Pakistan, her Government had created 675 permanent transit vaccination points, with 19.2 million children vaccinated in 2014 and 7.96 million vaccinated thus far in 2015.

Nevertheless, much remained to be done. With strong political commitment, strengthened monitoring, effective coordination and the support of partners, further progress could be made. Cognizant of its obligations to children both within and beyond its borders, Pakistan remained fully committed to the eradication of poliomyelitis.

Dr ENNIS (Jamaica) urged WHO to increase its support to countries in dealing with groups opposed to vaccination and raising public awareness about vaccine safety. Support and technical guidance should also be provided on communicating risk and the benefits of immunization. Jamaica maintained a robust poliomyelitis surveillance system. Even though no confirmed cases had been detected since 1982, a single dose of inactivated poliovirus vaccine would be introduced in September 2015 and the recommended two-dose schedule in 2016. WHO and its international partners should continue to advocate lower prices for vaccines: Jamaica currently paid US$ 2.80 for a single dose of inactivated poliovirus vaccine, compared to US$ 0.13 for a single dose of oral poliovirus vaccine. Additional funds were also needed to close the funding gap in resources required to intensify global eradication efforts.

Dr USHIO (Japan), expressing appreciation for the ongoing global efforts to eradicate poliomyelitis, noted the difficulties in supplying vaccines to conflict-affected or politically-unstable regions. As with the eradication of other communicable diseases, the last phase – vaccinating hard-to-reach populations – required significant investment in both personnel and supplies. Close collaboration of all parties and national ownership were vital. Japan was committed to working with WHO and its partners to ensure full implementation of poliomyelitis eradication strategies in affected countries.

Dr MELNIKOVA (Russian Federation), speaking in the name of the members of the Council for Health Cooperation of the Commonwealth of Independent States, including Armenia, Belarus, Kazakhstan, Kyrgyzstan and Tajikistan, recognized the progress made in limiting the transmission of wild poliovirus, but expressed concern at its continued transmission in some countries, which threatened the attainment of the goal of polio eradication; in that connection, she welcomed the measures taken by Pakistan. The members of the Commonwealth of Independent States had implemented all the measures set out in the Polio Eradication and Endgame Strategic Plan 2013–2018 and WHO's temporary recommendations to reduce the risk of international spread of wild poliovirus. They endorsed the continued issuance of interim recommendations as a means of managing the emerging situation. They had robust routine immunization programmes and surveillance, which, in concert with other regional efforts, had enabled the Member States of the European Region to maintain poliomyelitis-free status. She called for prompt, full implementation of the Strategic Plan, including introduction of bivalent oral poliovirus vaccine and increased use of inactivated poliovirus vaccine. She welcomed the work of WHO and its partners to lower the price of vaccines, ensure supplies, and transfer the technology required to manufacture inactivated poliovirus vaccine to countries where it was lacking, and called for continued support from WHO. It was essential to establish both global and national stockpiles of monovalent oral poliovirus vaccine type 2, appropriately stored, and whose use would be governed by a transparent agreement with WHO. She expressed support for the draft resolution.

Mr PUSP (India) supported the proposal to withdraw the type 2 component of the oral poliovirus vaccine in April 2016 and to introduce inactivated poliovirus vaccine by the end of 2015, as timelines were important. He fully supported the draft resolution.

Dr JAMALUDIN (Malaysia) also supported the draft resolution. She noted the decisions of the International Health Regulations Emergency Committee at its fifth meeting and welcomed the initiative to expedite the prequalification of bivalent oral poliovirus vaccine.

Mr MAMACOS (United States of America) congratulated Nigeria on the results of its implementation of the polio eradication programme in 2014 and expressed support for continued strong programme implementation in Afghanistan and Pakistan. All Member States should sustain high levels of population immunity, strong routine immunization systems and certification-level surveillance. He endorsed the management of polio as a public health emergency of international concern through temporary recommendations issued under the International Health Regulations (2005). All Member States affected by poliomyelitis should implement fully both the Polio Eradication and Endgame Strategic Plan 2013–2018 and the Emergency Committee's temporary recommendations. By the end of 2015, all Member States should be ready for coordinated withdrawal of the type 2 component in the oral polio vaccine. His Government had increased financial support for the Global Polio Eradication Initiative and he urged Member States to help to close the funding gap for the implementation of the Endgame Strategic Plan.

He supported the draft resolution, but could not agree to the amendment proposed by the delegation of Indonesia, as timelines were important.

Mr RUIZ MATUS (Mexico) said that the main challenges faced by Member States in connection with the withdrawal of the oral polio vaccine type 2 were adequate and timely supplies of inactivated and bivalent oral vaccines; it was important to work with suppliers to ensure the availability of both. In Mexico, a nationally-produced trivalent oral vaccine had been used throughout the implementation of the universal vaccination programme. The manufacturer was currently preparing for registration of the bivalent vaccine by the national regulatory authority, but that would take time. Mexico would pay attention to the recommendations of WHO and the Strategic Advisory Group of Experts.

Mr PRUMMER (Austria) commended the relentless work of all stakeholders, in particular in countries that were still affected by polio, to bring polio eradication within reach. In the draft resolution, he proposed that, in paragraph 3(1), the words "to declare a new polio outbreak in a polio-free country a national public health emergency" be replaced by "to immediately put in place national public health emergency measures as appropriate, to respond to a new polio outbreak in a polio-free country" with the rest of the subparagraph unchanged.

Dr AL LAMKI (Oman), expressing support for the draft resolution, said that his Government had taken strenuous measures to maintain Oman's polio-free status and was preparing a national plan to respond to any outbreak. He underlined the importance of the International Health Regulations (2005) for limiting any transmission of poliovirus.

Professor BAGGOLEY (Australia) supported the draft resolution with its concrete actions. Its adoption would be timely, given that the spread of wild poliovirus remained a public health emergency of international concern. The actions taken by countries recently affected by polio outbreaks were commendable, and he particularly welcomed the report that no new case of wild poliovirus had been detected in Africa or the Middle East since mid-2014. He welcomed preparations for global readiness for the withdrawal of the type 2 component in oral poliovirus vaccines and expressed his Government's readiness to assist other countries in the Western Pacific Region to ensure its coordinated withdrawal.

Mr AL SHEHABI (Bahrain) commended WHO's efforts to expedite polio eradication and interrupt the transmission of wild poliovirus. Further work was needed in the regions still affected; international surveillance should be strengthened in order to ensure a swift response to new outbreaks. Concerted national efforts had resulted in more than 99% vaccination coverage of the population of Bahrain in 2014. He supported the draft resolution.

Dr ASSIRI (Saudi Arabia) welcomed efforts to stop poliovirus transmission, especially in those countries that had recently faced serious outbreaks of disease. WHO should adopt a standard operating procedure to respond to new outbreaks in polio-free countries. The introduction of at least one dose of inactivated poliovirus vaccine into immunization schedules was particularly important. The withdrawal of the type 2 component in oral poliovirus vaccines and the coordinated switch from trivalent to bivalent oral vaccines was the key to polio eradication. Clear timelines were required for vaccine procurement.

Ms DUSSEY-CAVASSINI (Switzerland) expressed support for the draft resolution and commended WHO and its partners for their efforts with regard to polio eradication during the biennium 2014–2015. Despite progress, problems remained, particularly with regard to coordinated immunization campaigns, owing to lack of access to populations in situations of insecurity. Other challenges include surveillance and the implementation of new standards. Given the substantial budgetary resources allocated to the eradication programme, inadequacies in internal monitoring, as reported by the Internal Auditor, could provoke programmatic, financial (in particular direct financial cooperation) and reputational damage to the Organization. The Secretariat should address that situation as a matter of priority.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland), acknowledging the commitment of the many partners to ensuring the successful implementation of the Polio Eradication and Endgame Strategic Plan 2013–2018, supported the temporary recommendations. Over the past year, considerable progress had been made and the concerted efforts in affected countries, in particular Afghanistan and Pakistan, were bearing fruit. Progress must not, however, lead to complacency. Surveillance efforts in Africa should be enhanced to ensure that no case was missed. Pakistan should continue to work with WHO to extend immunization coverage to reach children in conflict-affected areas. Polio eradication was within reach. Furthermore, national capacities designed to tackle polio could contribute to overcoming other health threats, as seen in Liberia, where the polio emergency operations centre had played a key role in coordinating activities during the Ebola virus disease outbreak.

Dr HASSAN (Egypt), speaking on behalf of the Member States in the Eastern Mediterranean Region, said that they were aware of the importance of eradicating polio globally. The progress in the Middle East and Horn of Africa was encouraging, but vigilance was still required. Member States in the Region were committed to supporting Afghanistan and Pakistan in their efforts to stop all poliovirus transmission and protecting polio-free countries from outbreaks following importation by strengthening immunization systems and enhancing surveillance for all wild and circulating vaccine-derived polioviruses, and by implementing the temporary recommendations under the International Health Regulations (2005) to ensure that travellers from infected areas were immunized before entry into polio-free countries. Member States were also committed to implementing the recommendations on global readiness for the coordinated withdrawal of the type 2 component in oral polio vaccines and switching from trivalent to bivalent oral poliovirus vaccines by April 2016. Given the particular importance of maintaining the momentum in progress towards eradication, a change in the agreed time frame for the globally coordinated eradication process would not be appropriate.

Mr LINDGREN (Norway), speaking on behalf of the Member States in the European Region, expressed support for the process and time frame for the withdrawal of the type 2 component in oral

poliovirus vaccines and the introduction of at least one dose of inactivated polio vaccine in 2016. He could not, therefore, support the amendment proposed by the delegate of Indonesia to the draft resolution.

Ms LANTERI (Monaco) proposed replacing the word "viruses" in the second line of paragraph 3(1) by "polioviruses". The text of paragraph 4(1) should start: "to continue in situations of humanitarian crisis to collaborate …."

Dr TILLUCKDHARRY (Trinidad and Tobago) said that, although his country had been polio-free since 1972, continuous efforts were being made to sustain that status. National surveillance strategies were operational and thus far there was no evidence of the presence of wild poliovirus. Steps were being taken to ensure maximum immunization coverage for including the administration of one dose of inactivated poliovirus vaccine to children with immunodeficiencies. He supported the draft resolution.

Dr JENYFA (Maldives) said that the Maldives had been polio-free for more than two decades and was committed to implementing the Polio Eradication and Endgame Strategic Plan 2013–2018. Its goal could only be achieved through global solidarity and international cooperation, and by the effective implementation of the temporary recommendations under the International Health Regulations (2005). Member States must have the support they needed, especially from vaccine manufacturers, to support the coordinated, phased withdrawal of oral poliovirus vaccines. They must strengthen their immunization and surveillance systems and build national capacities for programme planning and management, mobilizing communities and monitoring programme performance.

Ms MARTINEZ (Ecuador) said that, in response to the recommendation by the Strategic Advisory Group of Experts on immunization to introduce at least one dose of inactivated poliovirus vaccine into the routine immunization schedule, Ecuador had developed a plan for the introduction of the vaccine and taken steps to procure supplies through the PAHO Revolving Fund, in order to commence administration before December 2015. She supported the draft resolution.

Dr MUSAONBASIOGLU (Turkey) acknowledged recent progress in polio eradication, in particular in Pakistan, but urged vigilance in the Middle East, where the complex situation of conflict and instability demanded continued vaccination campaigns and effective surveillance. Turkey was pressing for political support within the Organisation of the Islamic Conference. In view of the high risk of reimportation of poliovirus, she supported the recommendations of the IHR Emergency Committee. Her Government was making every effort to prevent the transfer of poliovirus across its borders from the Syrian Arab Republic: all children under the age of 5 years in border cities and Syrian children inside and outside camps were being vaccinated. Global efforts to achieve eradication must continue.

Dr GOUYA (Islamic Republic of Iran) supported the draft resolution. His country was facing the challenge of maintaining its polio-free status in a region where the greatest number of polio cases had been reported in 2015 and several complex emergencies were occurring. Its action plan for integrating inactivated poliovirus vaccine had been implemented that year and domestic production of that vaccine was being finalized. The switch from trivalent to bivalent oral poliovirus vaccine was scheduled for April 2016. Clinical and environmental surveillance was being improved.

Eradication would need unprecedented coordinated international cooperation, cross-border collaboration, timelines and measurable targets. Surveillance systems must be enhanced in order to confirm interruption of circulation of vaccine-associated type 2 viruses, especially in countries that had reported cases of polio in recent years. Environmental surveillance must be implemented in countries where polio was endemic and in high-risk areas of neighbouring countries or countries at risk of reimportation of poliovirus, under WHO's supervision. Regional or intercountry cooperation

must be promoted for reporting and monitoring cross-border transmission, and he pledged his country's support to neighbouring countries to stop poliovirus transmission. Vaccine production capacity and manufacturing practices in developing countries had to be enhanced, with improved entry into global markets and lower price of vaccines.

Ms MORÓN de PORRAS (Bolivarian Republic of Venezuela) supported the draft resolution. Her Government planned to introduce inactivated poliovirus vaccine into the national immunization schedule in 2016, as set forth in the Polio Eradication and Endgame Strategic Plan 2013–2018. Although poliomyelitis had been eradicated in the Americas, poliovirus transmission continued in other parts of the world; her country had an effective surveillance and response system for cases of acute flaccid paralysis.

Professor DAGNAN N'CHO (Côte d'Ivoire) supported the draft resolution. His country had implemented all recommended measures and wild poliovirus had not been reported since mid-2011. However, the movement of persons, difficulty of accessing some areas, and resistance from some sectors of the population made it difficult to implement strategies, jeopardizing the country's polio-free status. Coordination of regional action was needed to strengthen surveillance measures, implement the Expanded Programme on Immunization and conduct supplementary immunization campaigns.

Mr ANDRIAMANARIVO (Madagascar) said that wild poliovirus had not been reported in Madagascar since 1997, although two cases of vaccine-associated paralytic poliomyelitis had been reported since October 2014. A national vaccination campaign of children under 5 years of age had been initiated in April 2015 with oral poliovirus vaccine but from May 2015 inactivated poliovirus vaccine would be used.

Dr DAKULALA (Papua New Guinea) outlined steps taken in his country to maintain its polio-free status, in particular development of an integrated surveillance system, laboratory testing, improvements in diagnostic capacities, health worker training and catch-up campaigns with multi-antigen supplementary immunization activities, although vaccination coverage remained about 70%. It planned to phase out oral poliovirus vaccine in 2015, replacing it with inactivated poliovirus vaccine at the time of measles-rubella vaccination. He supported the draft resolution, as amended by the delegate of Austria, and endorsed the comments by the delegates of Norway and Monaco.

Professor NAPO-KOURA (Togo), speaking on behalf of the Member States of the African Region, noted with satisfaction the implementation of the Polio Eradication and Endgame Strategic Plan 2013–2018 and welcomed progress in polio eradication, which remained a priority for the Region. He supported both the temporary recommendations and the draft resolution. Countries in the Region had noted the different strategies proposed, particularly those for strengthening surveillance and innovative approaches to vaccinating children in hard-to-reach areas, but were concerned by the difficulties health workers faced in efforts to eradicate polio, especially in conflict zones. Noting the guidance for introduction of bivalent and inactivated poliovirus vaccines, he proposed that the trivalent oral poliovirus vaccine be withdrawn in a way that minimized the risk of infection with the type 2 strain. Lessons should be learnt from the value of the infrastructure of the polio eradication programme to the overall health system in tackling other public health emergencies, as witnessed in Nigeria in its response to the outbreak of Ebola virus disease in 2014. He called on partners to continue their financial support for the Polio Eradication and Endgame Strategic Plan 2013–2018.

Mr ZHANG Yong (China) acknowledged WHO's leading role in global polio eradication. China had developed an inactivated poliovirus vaccine, which was gradually being introduced nationally, and a bivalent vaccine, which had been approved for clinical trials in the country and was expected to be integrated into the national immunization plan. China was willing to contribute these

vaccines to global stockpiles. The process of vaccine supply and production needed to be understood for Member States to implement the Polio Eradication and Endgame Strategic Plan 2013–2018 efficiently. Developing countries, especially those at high risk of imported poliovirus and those affected by conflicts, needed increased financial and technical support. Enhanced cooperation among countries and regions was needed to ensure polio eradication was synchronized.

Dr VIROLAINEN-JULKUNEN (Finland) supported the amendment proposed by the delegate of Austria.

Ms GODIN (Canada) echoed the concern of some Member States regarding the amendments proposed by the delegate of Indonesia. Although the switch to inactivated poliovirus vaccines presented challenges, the phased withdrawal of oral poliovirus vaccines was necessary to eliminate the risk of vaccine-associated paralytic poliomyelitis. The current target date of April 2016 and the agreed schedule must be maintained. She fully supported the draft resolution and encouraged the Global Polio Eradication Initiative to work with countries facing challenges.

Dr KREMER (Argentina) affirmed that his country was planning a sequential transition from trivalent oral poliovirus vaccine to a combination of inactivated and oral poliovirus vaccine. He supported the draft resolution but was concerned that supplies would be inadequate to support the introduction of even only one dose of the inactivated poliovirus vaccine, let alone a three-dose schedule. Protection against potential type 2 strain outbreaks needed an open and equitable mechanism for access to global stockpiles of monovalent type 2 vaccine. Vaccines with a type 2 component should only be withdrawn when sustained interruption of transmission of type 2 poliovirus is confirmed. The globally-coordinated switch from trivalent vaccines should be subject to assurance of sufficient stockpiles of the inactivated poliovirus vaccine, bivalent vaccines and monovalent type 2 vaccine during the transition period.

Dr SOE LWIN NYEIN (Myanmar) said that his country planned the introduction of inactivated poliovirus vaccine for July 2015, with the switch from trivalent to bivalent oral poliovirus vaccine in 2016. Myanmar would start planning for the transition to bivalent oral poliovirus vaccine by the end of July 2015, seeking to improve immunity among the population, laboratory standards, surveillance, and preparedness and response to imported poliovirus. He requested WHO's technical assistance in that matter.

Professor MESBAH (Algeria) said that, with WHO's support, his country had prepared and implemented a plan for the introduction of inactivated and bivalent poliovirus vaccines. He expressed serious concerns about the timely availability, supply and price of those vaccines. Every country with manufacturing capacity should produce sufficient affordable inactivated and bivalent poliovirus vaccine, prequalified by WHO, to meet demand. The Organization's credibility was at stake.

Dr AL-TAAE (Iraq) called for an exchange of expertise at regional and country levels, regardless of the magnitude of the problem in each region, to focus on routine immunization, immunization campaigns, vaccine procurement, the transition from trivalent to bivalent oral poliovirus vaccine and then to inactivated poliovirus vaccine, and monitoring and evaluation of that transition. The transition should be underpinned by studies and research, with an exchange of information on epidemiological and laboratory-based surveillance. Technical support was necessary to upgrade national laboratories, which should undergo regular accreditation assessments. Greater assistance should be offered to individual countries in difficult security situations. Despite high numbers of internally displaced persons and refugees, Iraq had carried out 13 national, subnational and mop-up immunization campaigns, which had reached every child in areas outside the Government's control. Iraq had also strengthened its surveillance and routine immunization systems. Community participation and mobilization, intersectoral collaboration, and use of non-State actors in areas outside

governmental control had helped to ensure that there had been no case of poliomyelitis since April 2014.

Dr AHMED (Bangladesh) supported the draft resolution. His country had been free of polio since 2011, and the challenge was to maintain that status. To ensure global eradication, he called for assured supplies of oral poliovirus vaccine, maintenance of immunization schedules in every country, and vaccination of travellers before travel to countries where the disease was present. Pakistan and Afghanistan should implement robust eradication programmes.

Dr ETSANO (Nigeria) fully supported the draft resolution, including its target date of 2016. Nigeria was on track to meet the four main objectives of the Polio Eradication and Endgame Strategic Plan 2013–2018, with one new case of poliomyelitis in the previous 10 months. Inactivated poliovirus vaccination was being phased into routine immunization programmes, with accelerated introduction in hard-to-reach, insecure areas. A task force on laboratory containment and a working group on legacy planning had been created. Emergency operations centres had been established throughout the country, transforming the quality of planning and data-driven decision-making, with improved coordination within the Government and between partner agencies. Nigeria had instituted several innovative approaches to vaccination, such as the "hit and run" strategy, efforts to vaccinate internally displaced persons, use of permanent health teams, and directly observed vaccination. The surveillance system was stronger and more integrated than previously, and accountability frameworks had been successfully enforced. Nigeria was working to fill the funding gap for 2016–2017, and he called on global partners to maintain funding for 2016–2017. In order to guard against the risks of complacency and political transition, an ambitious strategic advocacy plan had been produced, targeting new political office holders at all levels.

Dr RASHID (United Republic of Tanzania) said that routine trivalent oral poliovirus vaccination coverage had been maintained at high levels. A "reach every child" strategy had been implemented, and nongovernmental organizations had conducted door-to-door mobilization in districts with low coverage. One dose of inactivated poliovirus vaccine would be introduced into routine immunization programmes by October 2015, and the switch from trivalent to bivalent oral poliovirus vaccine, scheduled for April 2016, was being carefully planned.

Dr RAPEEPAN DEJPICHAI (Thailand) acknowledged the work of countries endemic for poliomyelitis towards its eradication but expressed concern that the schedules for introducing inactivated poliovirus vaccine and bivalent oral poliovirus vaccine would outrun supply. That shortfall could be mitigated by delaying the introduction of those vaccines in lower-risk countries. A long lead time was needed to expand production, as greater numbers of manufacturers would mean WHO's prequalification took longer. Limited supply combined with consistently high demand would result in high prices, necessitating concerted efforts to increase global supplies of inactivated poliovirus vaccine. Advanced technology and skills were needed to produce the vaccine, for which technology transfer was vital.

Dr FARAH (Ethiopia) said that the endgame strategies would need to be intensified in order to reach the goal of eradication. His Government had stepped up surveillance, especially in areas of potential importation and undetected poliovirus circulation, and accorded top priority to the Expanded Programme on Immunization. It had conducted four national and 10 subnational immunization days since a reported outbreak in the Horn of Africa in May 2013 although, for security reasons, there had been difficulties in synchronizing the cross-border campaign. He supported the actions set out in the draft resolution and requested the addition of a recommendation concerning the challenge of maintaining population immunity in situations of insecurity and conflict and the need to ensure that refugees and internally displaced persons received poliovirus vaccination as part of the routine health care services provided by humanitarian actors.

Mr SPRINGER (Barbados) said that, although Barbados had been polio-free since the 1960s, the Government remained committed to universal immunization coverage and from 2016 would move from the administration of the oral vaccine to the injectable vaccine. It was working on programmes to counter the impact of the growing anti-vaccine lobby. He expressed serious concern that the injectable vaccine was four times more expensive than the oral vaccine. He urged WHO to support small developing States in their quest to source vaccines at the best prices available.

Dr SAIZ MARTÍNEZ-ACITORES (Spain) expressed gratitude to the health workers who had risked their lives in combatting poliomyelitis. Spain had supported WHO's work to eradicate the disease from the outset; the success achieved thus far showed that cooperation between governments and the private sector could achieve excellent results. Her Government had introduced a national campaign to vaccinate the whole of its population with inactivated poliovirus vaccine and in its international cooperation programme eradication of poliomyelitis was a priority. She supported the draft resolution.

Dr E.M. NDIAYE (Senegal) said that, although transmission of wild poliovirus had been interrupted in Senegal since 1998, an imported case had been detected in 2010. Transmission had been interrupted within three months through an intensified campaign. Surveillance confirmed no further case subsequently. Inactivated poliovirus vaccine had been introduced in the routine immunization programme in December 2014 and the Polio Eradication and Endgame Strategic Plan 2013–2018 was being implemented.

Dr BEN SALEM (Tunisia) said that Tunisia had introduced a first dose of the inactivated poliovirus vaccine in 2014 and aimed to introduce a second dose into vaccination schedules in 2016. The Government planned to move from the use of trivalent to bivalent vaccines within the time frame recommended by WHO.

Dr PUKOSE (Kenya) said that, since eradication of endemic polio in 1986, four importations in recent years had resulted in 36 cases of disease due to wild poliovirus. The Government had improved surveillance and immunization, although insecurity in the north and north-east of the country made routine activities difficult. He agreed with the request that Member States should implement the eradication strategies and supported the temporary recommendations issued under the International Health Regulations (2005). He also agreed with the introduction of at least one dose of inactivated poliovirus vaccine by the end of 2015 in preparation for the withdrawal of the type 2 component in oral poliovirus vaccine. WHO should maintain the momentum towards eradication through continued technical and financial support for peer mechanisms in Member States with active transmission.

Dr TARAWNEH (Jordan), recalling that his country had been polio-free since 1992, said that the health ministry was working to deliver safe and effective vaccines, free of charge, to all children; to date, the coverage rate was greater than 95%. Five nationwide campaigns against wild poliovirus had also been conducted. The cost of the national immunization programme had spiralled by more than 40% since 2012 because of the country's substantial refugee burden, but the Government remained committed to free provision of immunization services, despite its limited financial resources and unsuccessful appeals for international assistance.

Dr DZABATOU-BABEAUX (Congo) praised the efforts of Pakistan, the multisectoral approach and especially the selfless endeavours of the health workers who combatted poliomyelitis. His Government continued to work with its partners in a multisectoral approach towards the eradication of the disease. He supported the draft resolution.

Dr RAJAPAKSA HEWAGEEGANA (Sri Lanka), speaking on behalf of the Member States of the South-East Asia Region, recalled that the Region had been certified as polio-free in March 2014.

Sri Lanka, which had been free of poliomyelitis since 1993, had maintained active surveillance of all cases of paralysis. Poliovirus vaccination was recommended for all travellers to endemic or infected countries. Sri Lanka planned to introduce the injectable vaccine as a single dose from July 2015 as the first step in withdrawing oral poliovirus vaccine.

Mr SKERRITT (Saint Kitts and Nevis) said that his country's Expanded Programme on Immunization provided free vaccination thanks to procurement arrangements through the PAHO Revolving Fund. The Government was in the process of introducing the inactivated poliovirus vaccine as well as other new vaccines but was concerned that the cost of inactivated poliovirus vaccine was four times higher than that of the oral vaccine. Affordability was the key to the success of the global vaccine plan and he therefore supported the continued strengthening of the Revolving Fund, which afforded protection to member countries of the Caribbean Community from vaccine-preventable diseases. He supported the draft resolution.

Dr Song-En HUANG (Chinese Taipei) applauded the proposed withdrawal of the type 2 component in the oral polio vaccine by 2016. Poliomyelitis had been eradicated in Chinese Taipei since 2000 and risk assessments conducted in 2013 and 2014 showed Chinese Taipei to be at low risk for wild poliovirus outbreaks. Preparations had been made for withdrawal of the type 2 component of the oral polio vaccine by 2016, and vaccine-derived polioviruses and Sabin vaccine strains stored in laboratories would be destroyed in September 2015. High vaccination coverage rates were maintained and excellent immunization information and disease surveillance systems were in place. She appealed to WHO to ensure the supply of inactivated poliovirus vaccine to support the sustainability of immunization programmes.

Dr MURT (The World Medical Association, Inc.), speaking at the invitation of the CHAIRMAN, paid tribute to all health workers who had lost their lives in service of a world free of polio. He urged the Secretariat and Member States to: ensure the safety of health workers so as to enable the effective implementation of immunization protocols; develop sensitive surveillance systems with immediate notification to WHO of any detected poliovirus transmission; provide adequate immunization training for health professionals; and increase public awareness to prevent and dispel myths. He also called on donors to fulfil outstanding pledges to close the funding gap for the implementation of the Polio Eradication and Endgame Strategic Plan 2013–2018.

Ms DIMENT (Rotary International), speaking at the invitation of the CHAIRMAN, said that the 1.2 million members of Rotary clubs in Member States remained committed to polio eradication. Progress had continued in Africa despite the outbreak of Ebola virus disease and the use of polio resources and infrastructure in combating the outbreak demonstrated the legacy of polio eradication in action; affected countries faced a tough challenge in ensuring continued high-quality immunization services and rigorous surveillance to ensure interruption of poliovirus transmission. She urged support for effective implementation of activities in Afghanistan and Pakistan with domestic ownership and commitment, and encouraged support of law enforcement authorities to protect health workers. She applauded those Member States that had already introduced inactivated poliovirus vaccine into their routine immunization programmes and looked forward to the successful switch from the oral to the injectable vaccine. As attainment of the goal approached, political and financial resolve by Member States, civil society and the private sector should grow.

Dr JAFARI (Polio, Emergencies and Country Collaboration) expressed appreciation for the comments and feedback provided during the extensive consultations on the draft resolution. The events of the year were defining: substantial progress in Africa, where no new case had been reported for more than nine months; three outbreaks in areas of conflict and humanitarian disaster in 2013 – the Horn of Africa, the Middle East and Central Africa – appeared to have been stopped; only Pakistan and Afghanistan had reported cases due to wild poliovirus in 2015; the immunization programme in

Pakistan had started to reach children who had not previously been vaccinated; wild poliovirus type 3 had not been detected anywhere in the world for two-and-a-half years; and, after 15 years, it was expected that the eradication of wild poliovirus type 2 would be certified in October 2015. The Strategic Advisory Group of Experts on immunization had established criteria for global readiness and recommended that countries should prepare for the withdrawal of the type 2 component of oral poliovirus vaccine by April 2016. The Group of Experts would monitor the availability of the bivalent and inactivated poliovirus vaccine to ensure that the switch could take place.

As not all the proposed amendments to the draft resolution had received support, he proposed that the Secretariat work with the delegation of Indonesia to resolve the problems it faced.

Implementation of the temporary recommendations under the International Health Regulations (2005) still varied between countries and he expected that the recommendations would be extended for a further three months if the draft decision contained in document A68/21 Add.3 was adopted.

He assured the delegate of Belgium that all programmes had been fully costed in the Programme budget although the budget ceiling for polio eradication, an emergency programme, was flexible. Steps taken by WHO and its partners to ensure that the inactivated poliovirus vaccine became increasingly affordable and available included: negotiation with vaccine manufacturers; technology transfer; WHO's recent endorsement of the open vial policy which avoided wastage; and supporting research into making the vaccine more affordable.

The CHAIRMAN noted the strong overall support for the draft resolution but that not all the proposed amendments were accepted by the Health Assembly as a whole. He encouraged interested parties to consult informally and proposed that a revised text, including the proposed amendments, be prepared for consideration at a subsequent meeting.

It was so agreed.

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

The CHAIRMAN drew attention to the draft decision on temporary recommendations regarding the international spread of wild poliovirus: considerations concerning their continuation in light of Article 15.3 of the International Health Regulations (2005) contained in document A68/21 Add.3.

The draft decision was approved.[1]

The meeting rose at 11:55.

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as decision WHA68(9).

SEVENTH MEETING

Thursday, 21 May 2015, at 14:30

Chairman: Dr E. JARAMILLO NAVARRETE (Mexico)

PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 15 of the Agenda (continued)

Antimicrobial resistance: Item 15.1 of the Agenda (Documents A68/19, A68/20 and A68/20 Corr.1)

The CHAIRMAN drew attention to a draft resolution on the global action plan on antimicrobial resistance submitted by Albania, Australia, Canada, Ghana, Iceland, Japan, Lebanon, Norway, Panama, South Africa, Switzerland, Thailand, Turkey, the United States of America, Zambia and the 28 Member States of the European Union, which read:

> The Sixty-eighth World Health Assembly,
>
> **PP1** Having considered the summary report on progress made in implementing resolution WHA67.25 on antimicrobial resistance and the report on the draft global action plan on antimicrobial resistance;[1]
>
> **PP2** Recalling resolutions WHA39.27 and WHA47.13 on the rational use of drugs, resolution WHA51.17 on emerging and other communicable diseases: antimicrobial resistance, resolution WHA54.14 on global health security: epidemic alert and response, resolution WHA58.27 on improving the containment of antimicrobial resistance, resolution WHA60.16 on progress in the rational use of medicines and resolution WHA66.22 on follow up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination and WHA67.25 on antimicrobial resistance;
>
> **PP3** Aware that access to effective antimicrobial agents constitutes a prerequisite for most modern medicine; that hard-won gains in health and development, in particular those brought about through the health-related Millennium Development Goals, are put at risk by increasing resistance to antimicrobials; and that antimicrobial resistance threatens the sustainability of the public health response to many communicable diseases, including tuberculosis, malaria and HIV/AIDS;
>
> **PP4** Recognizing that the main impact of antimicrobial resistance is on human health, but that the contributing factors and consequences, including economic and others, go beyond health, and that there is a need for a coherent, comprehensive and integrated approach at global, regional and national levels, in a "One Health" approach and beyond, involving different actors and sectors such as human and veterinary medicine, agriculture, finance, environment and consumers;
>
> **PP5** Aware that the inappropriate use of antimicrobial medicine continues to be an urgent and widespread problem in high-, middle- and low-income countries, with serious consequences for increasing antimicrobial resistance in a wide range of pathogens including bacteria, viruses and parasites;
>
> **PP6** Noting that despite sustained efforts over a number of decades by Member States, the Secretariat and partners, most developing countries are still facing a multitude of challenges

[1] Documents A68/19 and A68/20.

in improving the availability and affordability of quality, safe and effective antimicrobial medicines;

PP7 Recognizing that, although substantial investments have already been made to tackle antimicrobial resistance, significantly more resources need to be mobilized to support effective action at national, regional and global levels, including through the provision of technical assistance, particularly to low- and middle-income countries;

PP8 Reaffirming the critical importance of enhancing infection prevention and control, including good sanitation and hygiene, in both community and health care settings;

PP9 Recognizing the importance of immunization as one of the most cost-effective public health interventions, and that vaccines play an important role in reducing antimicrobial resistance;

PP10 Underlining the pressing need to develop new antimicrobial medicines as well as effective, rapid and low-cost diagnostic tools, vaccines and other interventions, and recalling the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property and resolution WHA66.22 on follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Co-ordination, which address drug market failure;

PP11 Acknowledging the urgent need for a more coordinated and harmonized surveillance system to monitor antimicrobial resistance at national, regional and global levels, including the need to develop internationally agreed standards for data collection and reporting across the human health, medical, veterinary and agricultural sectors;

PP12 Underscoring the need to improve awareness and understanding of antimicrobial resistance through effective public communication programmes, education and training as well as in the human health, veterinary and agricultural sectors,

(OP1) ADOPTS the global action plan on antimicrobial resistance;

(OP2) URGES Member States:[1]

(1) to implement the proposed actions for Member States in the global action plan on antimicrobial resistance, adapted to national priorities and specific contexts;

(2) to mobilize human and financial resources in order to implement plans and strategies to strengthen the containment of antimicrobial resistance;

(3) to have in place, by the Seventieth World Health Assembly, national action plans on antimicrobial resistance that are aligned with the global action plan on antimicrobial resistance;

(OP3) INVITES international, regional and national partners to implement the necessary actions in order to contribute to the accomplishment of the five objectives of the global action plan on antimicrobial resistance;

(OP4) REQUESTS the Director-General:

(1) to implement the actions for the Secretariat in the global action plan on antimicrobial resistance;

(2) to strengthen the tripartite collaboration between FAO, OIE and WHO for combating antimicrobial resistance in the spirit of the "One Health" approach;

(3) to work with the Strategic and Technical Advisory Group on antimicrobial resistance, Members States,[1] FAO and OIE, and other relevant partners to develop a framework for monitoring and evaluation, including the identification of measurable indicators of implementation and effectiveness of the global action plan on antimicrobial resistance;

[1] And, where applicable, regional economic integration organizations.

(4) to develop and implement, in consultation with Member States[1] and relevant stakeholders, a global programme for surveillance of antimicrobial resistance in human health, including surveillance and reporting standards and tools, case definitions, external quality assessment schemes, and to establish a network of WHO Collaborating Centres to support surveillance of antimicrobial resistance and external quality assessment in each WHO region;

(5) to explore with Member States[1] and relevant stakeholders, options for elaborating a global development and stewardship framework that aims to support the development, control, distribution and appropriate use of new antimicrobial medicines, diagnostic tools, vaccines and other interventions, while preserving existing antimicrobial medicines, taking into account the needs of all countries, and in line with the global action plan on antimicrobial resistance;

(6) to elaborate, in consultation with the United Nations Secretary-General, options for the conduct of a high-level meeting no later than 2016, in the margins of the United Nations General Assembly, including potential deliverables, which could include outcomes from work on paragraphs 4.3 and 4.4 in this resolution;

(7) to provide support and technical assistance to countries, with a specific focus on developing countries;

(8) to set aside adequate resources for the Secretariat, in line with the Programme budget 2016–2017 and the Twelfth General Programme of Work, 2014–2019 for implementing the draft global action plan on antimicrobial resistance;

(9) to submit biennual reports on progress achieved in implementing this resolution to the Seventieth, Seventy-second and Seventy-fourth World Health Assemblies, and to produce an interim report to the Sixty-ninth World Health Assembly.

The financial and administrative implications of the draft resolution for the Secretariat were:

1. Resolution: Global action plan on antimicrobial resistance

2. Linkage to the Programme budget 2014–2015 and the Proposed programme budget 2016–2017 (see documents: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf and http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_7-en.pdf)

Categories: 1, 3, 4 and 5

Programme areas: various (particularly in categories 4 and 5)	Outcome: 4.2, 4.3, 4.4, 5.2 and 5.4 Output: 5.2.3

How would this resolution contribute to the achievement of the outcomes of the above programme areas?

The development of this global action plan on antimicrobial resistance, requested in resolution WHA67.25, reflects a global consensus that antimicrobial resistance poses a profound threat to human health.

The goal of the global action plan is to ensure, for as long as possible, continuity of successful treatment and prevention of infectious diseases with effective and safe medicines that are quality-assured, used in a responsible way, and accessible to all who need them. It is expected that countries will develop their own national action plans on antimicrobial resistance, within the next two years, in line with the draft global action plan.

The adoption of this draft global action plan at the Sixty-eighth World Health Assembly will confirm the commitment from all Member States to address this threat to global public health, through the development of national action plans as set out in outcome 5.2 and output 5.2.3.

[1] And, where applicable, regional economic integration organizations.

Does the Proposed programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes. The Proposed programme budget 2016–2017 includes outputs and deliverables for all relevant programme areas, in line with the proposed actions for the Secretariat that are set out in the global action plan. Specific deliverables in the relevant programme areas that contribute to the implementation of the antimicrobial resistance global action plan have been included in the Proposed programme budget 2016–2017.

3. Estimated cost and staffing implications in relation to the Programme budget 2014–2015 and for the Proposed programme budget 2016–2017

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US$ 10 000).

(i) The global action plan is not time-bound.

(ii) The initial five-year implementation of the global action plan will require in total: US$ 115 million.

(b) (i) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US$ 10 000).

Total: US$ 15 million

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All three levels.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If "no", indicate how much is not included.

Not applicable.

(b) (ii) Cost for the biennium 2016–2017

Indicate how much of the cost indicated in 3(a) is for the biennium 2016–2017 (estimated to the nearest US$ 10 000).

The total cost of the Secretariat's work on the implementation of the global action plan has been estimated at US$ 53 million across the Organization, of which half is for activities and the other half for staff.

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All three levels.

Is the estimated cost fully included within the Proposed programme budget 2016–2017? (Yes/no)

Yes. The full costs of US$ 53 million for implementation by the Secretariat of the global action plan on antimicrobial resistance have been incorporated into the Proposed programme budget 2016–2017.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If "no", indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

The Secretariat currently has the equivalent of about 19 full-time staff members in the professional category. Based on initial estimates, about 40 staff members will be needed across the major offices, but this will be confirmed during operational planning for the biennium 2016–2017.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)

No, however, several activities that are being implemented during the current biennium that are relevant to the global action plan will continue, including its current financing.

If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Source of funds: the requirements will be financed through the regular Organization-wide resource mobilization process, including the financing dialogue.

Dr V. REDDY (India) said that his country gave high priority to antimicrobial resistance, and national and regional efforts to tackle it included action to promote the rational use of antibiotics and to improve surveillance and laboratory capacity. While the emphasis on multisectoral action in the draft global action plan was welcome, antimicrobial resistance should be viewed as a broader development challenge, rather than merely as a health security risk. Emphasis should also be placed on raising awareness, infection prevention, rational use of antibiotics, addressing the needs of developing countries and improving access to health care facilities and to new and existing antibiotics, diagnostics and vaccines. New mechanisms were needed to accelerate research and development for new antibiotics and to ensure that they were made available at affordable prices. The five objectives in the global action plan should be pursued simultaneously with equal priority. He supported the convening of a high-level meeting no later than 2016, in the margins of the United Nations General Assembly. It was important to maintain political will to ensure that the high-level meeting could deliver tangible results, including mechanisms to address the technical and financial needs of developing countries and promote innovative models for the development of new antibiotics. Work on the draft resolution should continue.

Ms RABOVICA (Latvia), speaking on behalf of the European Union and its Member States, said that Turkey, the former Yugoslav Republic of Macedonia, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova and Georgia aligned themselves with her statement. She was pleased that the draft global action plan was being presented to the Health Assembly but asked for confirmation from the Secretariat that, irrespective of the outcome of programme budget discussions, the draft resolution and the accompanying draft global action plan would be fully budgeted within the proposed programme budget 2016–2017. A framework for monitoring and evaluation of the draft global action plan needed to be developed by the Secretariat and the Strategic and Technical Advisory Group. Efforts to develop new antimicrobial medicines, diagnostic tools, vaccines and alternative therapies should be accelerated, while the effectiveness of existing antimicrobial medicines should be preserved through rational use. The European Union and its Member States were working to ensure public health interests through a "One Health" approach and had developed and were implementing a European Union action plan and national plans. The European Union stood ready to support WHO in areas such as the responsible use of antimicrobials and surveillance of antimicrobial resistance and to share its experience with other countries. She supported the call to convene a high-level meeting on antimicrobial resistance at the United Nations General Assembly in 2016.

Ms GYANSA-LUTTERODT (Ghana), speaking on behalf of the Member States of the African Region, highlighted some of the implementation challenges facing Member States in the Region. The lack of data required more capacity for data collection and strengthened information systems to ascertain the magnitude of antibiotic use and antimicrobial resistance. The lack of skills and well equipped laboratories called for more capacity for surveillance and pharmacovigilance and, where such systems existed, they should be enhanced to inform the health policy process. Infection prevention and control remained strategic in community and health care settings. Research and development facilities were weak, and a model for access to new medicines, diagnostics and vaccines

was needed. The rational use of antimicrobials and effective regulatory mechanisms were key, particularly in the private sector within the "One Health" approach, while public education involving nongovernmental organizations could help to contain antimicrobial resistance. The draft global action plan could only be successfully implemented if the financial implications for developing countries were addressed. She therefore proposed that the draft resolution should include a paragraph on financing the action plan. She endorsed the plan and looked forward to its implementation through partnerships and collaboration.

Dr GOMEZ (Bahamas), speaking on behalf of the member countries of the Caribbean Community, said that in his region the draft global action plan's five strategic objectives could be achieved only through significant investment and capacity-building in laboratory services. Health personnel should learn early in their training about the use and misuse of antibiotics. Agricultural management was critical to guiding the use of antibiotics in animals. Tripartite collaboration between WHO, FAO and OIE was essential to advancing the protection of the Caribbean region, which needed additional legislation to enforce prescribing practices and restrict imports of antibiotics used in animal feeding. His region increasingly depended on international research to determine the suitability of new vaccines and to guide national surveillance activities. His country wished to sponsor the draft resolution.

Mr MAMACOS (United States of America), speaking on behalf of the Member States of the Region of the Americas, said that in order to address antimicrobial resistance, low- and middle-income countries needed technical assistance and capacity-building. He expressed appreciation for the guidance on urgent action set out in the draft global action plan. His Region prioritized the development of programmes and dissemination of knowledge in priority public health areas such as microbiology and food safety and recognized the need for programmes to be technically feasible, economically viable and socially acceptable. Improved data were needed on the links between antibiotic use in animals and antimicrobial resistance in humans, but that should not reduce the focus on human health and behaviour change. Action to improve health in the Region included identifying best practices in infection control, ensuring that surveillance of resistant human infections conformed to WHO guidance and contributed to the global report on surveillance, strengthening laboratory capacity, heightening awareness of the problem and prioritizing improved access to antimicrobial medicines.

Speaking as the delegate for the United States of America, he supported the adoption of the draft resolution and the draft global action plan, which his country was committed to implementing. The National Action Plan for Combating Antibiotic-Resistant Bacteria included core elements of the draft global action plan and improved capacity for international collaboration, such as through the European Union–United States Transatlantic Taskforce on Antimicrobial Resistance (TATFAR). He encouraged other nations to incorporate mechanisms for international collaboration in their national action plans. The detection and prevention of antimicrobial resistance could not be achieved by only a few countries.

Professor CHANWIT TRIBUDDHARAT (Thailand), speaking on behalf of the Member States of the South-East Asia Region, said that in 2011 health ministers in the Region had agreed on the Jaipur Declaration on Antimicrobial Resistance and a related regional strategy. The draft global action plan should provide clear guidance on the use of antimicrobials in animals and crop plants, particularly under objective 4. The use of antimicrobials as growth promoters should be rapidly phased out and, in the absence of risk analysis, their use for crop protection should be terminated. With reference to objective 3, vaccination in food animals was a complex issue and should be guided by evidence such as vaccine efficacy and need and the extent of subclinical infection among vaccinated animals. Infection control, improved husbandry hygiene and farm biosecurity were equally important and less controversial actions. Under objective 2, attention should be paid to monitoring human consumption of antimicrobials, as measured by the defined daily dose per 1000 inhabitants per day. The Secretariat

should take those observations into account when implementing the draft global action plan, and they should be reflected in the biennial progress report. He supported the draft global action plan and urged all Member States to adopt it.

Ms JANELM (Sweden) said that action on antimicrobial resistance was urgently needed at all levels and urged the Health Assembly to adopt the global action plan. She expressed support for convening a high-level meeting on antimicrobial resistance associated with the United Nations General Assembly in 2016.

Dr HARVEY (United Kingdom of Great Britain and Northern Ireland) supported the draft global action plan, endorsed the need for a "One Health" approach and encouraged other Member States to develop national plans on antimicrobial resistance, which was a stepwise process that required political will rather than simply adding more resources. An independent review conducted in the United Kingdom had predicted a high cost of inaction in terms of mortality and lost economic productivity, especially in low- and middle-income countries, which was why her Government had launched the Fleming Fund to assist those countries to develop plans on antimicrobial resistance.

Dr KREMER (Argentina) said that his Government was working actively to tackle antimicrobial resistance through a national strategy that was aligned with the draft global action plan. The strategy was distinctive and innovative in that it had integrated health, economic, agriculture and food perspectives at the design stage. He supported the draft global action plan but wished to draw attention to the need to align the document with the commitments made in multilateral forums. He therefore supported the corrigendum to paragraph 11 which had been presented by the Secretariat.

Dr AARABI (Islamic Republic of Iran) commended WHO's initiative to engage with FAO, OIE, the World Bank and industry and hoped that it would encourage commitments from other sectors. He expressed concern at the fact that the high incidence of some antibiotic-resistant infectious diseases had received little attention, particularly in low- and middle-income countries. Measures to address the problem of antimicrobial resistance included developing multidisciplinary and multisectoral partnerships at government and industry level. Mechanisms should be established to control the use of antibiotics, over-the-counter sales should be banned, and problems of substandard medicines should be addressed. Behavioural studies should be conducted, and OIE support was needed to collect data on antibiotic usage in animals. Antimicrobial resistance and the International Health Regulations (2005) were closely interrelated topics, and Member States and the international community should support national regulatory authorities in tackling the issue. WHO could benefit from engaging with the Scientific and Technical Advisory Committee to develop new guidelines in that regard.

Mrs JARASCH (Germany) said that people had to be very clear about the potentially devastating consequences of antimicrobial resistance. The problem was not confined by borders and a global approach, based on joint international efforts and close collaboration across various sectors, was required. The draft global action plan would contribute to global awareness of antimicrobial resistance as an urgent public health problem. The "One Health" approach was an important element of the plan, but putting it into practice remained a challenge that required mutual assistance between countries. Member States had a global responsibility not only to adopt the action plan but also to start implementing it in national settings.

Professor BAGGOLEY (Australia) said that his Government supported the draft global action plan and was working closely with stakeholders across different sectors to develop its first national strategy on antimicrobial resistance. An implementation plan was already being drafted under the "One Health" approach, with specific actions, time frames, targets and indicators. He urged Member States to adopt the draft global action plan and commit themselves to implementing its priority actions.

Dr MUÑOZ PORRAS (Chile) said that his country had taken a number of measures to combat the problem of antimicrobial resistance, including regulation of the sale of antimicrobials and development of national guidelines and standards on the clinical treatment of diseases, which provided recommendations on the appropriate use of antibiotics. Future activities, which would be coordinated through a single national plan, would include: training for health workers; the introduction of controls in veterinary, livestock and fishery activities; strengthening the National Commission; raising awareness; and studying specific measures to prevent infectious diseases. He supported the draft resolution and called on the Director-General to ensure WHO's promotion and support of regional and national initiatives to that end.

Dr PHAAHLA (South Africa) said that WHO should consider developing a repository of evidence-based strategies that were likely to produce the best outcomes in terms of bringing about behaviour changes among prescribers, dispensers and patients. Considering the entrenched use of antimicrobials in agriculture, it was necessary to use demonstration projects to show how similar outcomes could be achieved through alternative means. He supported the draft global action plan.

Mr AL ABRI (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that empowering systems and structures at the national level would facilitate activities by WHO to coordinate implementation of the draft global action plan. Surveillance networks should be strengthened across all countries: the data on the burden of resistance thus generated should be shared and used to inform policies. Particular attention should be paid to fragile and conflict-affected countries. He fully supported the draft global action plan and requested the Secretariat and other partners to support countries in developing their national action plans within the requested time frame, with some of the proposed increase in the programme budget 2016–2017 allocated to that end. His country, in partnership with the Regional Office for the Eastern Mediterranean, would host a high-level meeting in September 2015 bringing together ministries of agriculture and health and other regional and global stakeholders. He supported the draft resolution.

Dr PUKOSE (Kenya) said that his Government supported the draft resolution and was committed to implementing the global action plan. The urgent need for action to combat antimicrobial resistance was consistent with a precautionary approach, and such action and collaboration at the national and international levels should not be impeded by knowledge gaps. His country continued to face challenges related to low levels of public awareness. It had taken a number of actions, including reviewing its regulatory and legislative framework and its infection prevention and control guidelines, in order to rationalize the use of antimicrobials through the promotion of evidence-based practices. A national medicines and therapeutics committee had been established to raise awareness of antimicrobial resistance, and a robust pharmacovigilance system had been developed. Translation of the draft global action plan into national action plans would have greater success if its financial implications were addressed in detail.

Dr YANG TAEUN (Republic of Korea) expressed full support for the work of WHO, OIE, FAO and other relevant partners and called on Member States to support and adopt the draft resolution. She also requested WHO support for a high-level meeting to be held at the United Nations General Assembly. Her Government planned to reform its national plan on antimicrobial resistance to bring it into line with the global action plan. It had supported WHO's activities by sending experts and providing project funding. Antimicrobial resistance was one of the main agenda items of the high-level meeting of the Global Health Security Agenda to be held in Korea in September 2015. The problem needed to be addressed through public and private multisectoral cooperation. She requested WHO to share best practices with all Member States towards achieving the goals of the draft global action plan.

Mrs PENEVEYRE (Switzerland) welcomed the cross-cutting approach that was being developed by WHO, FAO, OIE and others and said that her country attached great importance to responsible use of medicines. Combatting antimicrobial resistance required national, regional and global efforts, and Member States needed to develop strategies in a coordinated manner. Switzerland was developing a national multisectoral strategy to tackle antibiotic resistance based on the "One Health" approach. At international level, it had commissioned a comparative study on best practices for the Global Health Security Agenda established by the United States of America. Switzerland supported adoption of the draft global action plan.

Dr AL MOSAWI (Bahrain), while expressing support for the draft global action plan, called for the establishment of an effective monitoring and reporting mechanism aimed at measuring progress and ensuring the implementation of national plans in the area of antimicrobial resistance. Such implementation would be further assisted by the creation of a regional framework for action, as would capacity-building carried out in collaboration with FAO and OIE.

Bahrain had cooperated in the development of a standard guide on antimicrobial resistance for the Gulf region, which had then been introduced to environmental, health and animal health authorities in a workshop setting. At the national level, it had formed both a multistakeholder committee and local hospital committees for monitoring antimicrobial resistance. It was committed to working with partners for adoption of the global plan and the elaboration of a comprehensive national plan, in cooperation with the WHO Regional Office for the Eastern Mediterranean and Member States of the Gulf Cooperation Council.

Dr AL-TAAE (Iraq) said that the rational use of antimicrobials was crucial to health system modernization. Pharmacovigilance should be consolidated for the timely reporting of drug interactions, specifically those involving antimicrobials. Laboratories which investigated antimicrobial resistance should be strengthened and integrated with epidemiological surveillance. Training of health personnel in antimicrobial resistance needed to be an integral part of institutional capacity-building. All approaches to tackling antimicrobial resistance should be introduced in primary health care and included in secondary and tertiary care. There was a need for community participation and intersectoral collaboration on antimicrobial resistance, accompanied by public awareness-raising. Lastly, closer collaboration between academic institutions and health ministries was required. WHO should provide technical sponsorship of research into antimicrobial resistance and issue guidelines.

Mr SALAKHOV (Russian Federation), speaking also on behalf of Armenia, Belarus, Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan, fellow member countries of the Council for Health Cooperation of the Commonwealth of Independent States, welcomed the global action plan as an opportunity to adopt a common approach and combine efforts against antimicrobial resistance in WHO Member States. Countries that were members of the Commonwealth of Independent States were working on harmonizing maximum permissible levels of antibiotics in food products of animal origin, in order to ensure biosafety. Those countries had gained extensive experience in organizing and conducting research into antimicrobial resistance in hospitals and in making clinical and economic analyses of the use of antibiotics in medical establishments. It was planned to develop measures to prevent and control antimicrobial resistance in the health systems of countries in the Commonwealth of Independent States by: increasing access to microbiological laboratory tests; monitoring the main triggers of antibiotic resistance; establishing a policy on rational use of antimicrobials; and introducing new antimicrobial medicines and monitoring their quality. Antimicrobial resistance necessitated interdepartmental cooperation in each country and could only be addressed by a comprehensive approach that brought together all sectors in which antimicrobials were used. WHO should develop recommendations in each of those areas of work. He supported the draft global action plan.

Dr USHIO (Japan) said that antimicrobial resistance was an increasingly important issue that affected not only treatment itself but also its costs. Although numerous researchers had studied the issue, their findings had not been put into practice. The problem of antimicrobial resistance could not be solved by health care professionals alone: strong government commitment and collaboration between all relevant stakeholders, including WHO, FAO and OIE, was essential, as was increased surveillance. Every effort must be made to implement the measures set out in the global action plan at all levels, including in front-line health care services. His country wished to sponsor the resolution.

Ms HU XIANG (China) said that concerted international and multisectoral action was needed to combat antimicrobial resistance. Although countries had made efforts to tackle the issue, the situation remained serious. In China, the clinical application of antimicrobials was managed through surveillance and monitoring. Improved management systems had led to better results on indicators such as the antibacterial usage rate, use intensity, and prevalence of bacterial resistance. The health sector would continue to manage antimicrobials strictly in order to consolidate progress. China supported the draft global action plan and would actively implement it.

Miss SANTIAGO (Philippines) said that the global action plan would serve as a template on how to consolidate and prioritize government and private sector activities into a national antimicrobial resistance action plan. Collaboration between FAO, WHO and OIE would be essential for achieving efficient and coordinated policies, programmes and regulations across all sectors and from the international arena to the patient level. The Philippines was fully committed to the principles outlined in the draft global action plan; it had created an interagency committee on antimicrobial resistance and would hold a national summit on the subject. The Government pledged to have a national action plan in place within two years, in addition to pursuing current efforts to develop antibiotic guidelines, manage the use of antimicrobials in hospitals, strengthen the national infection prevention and control policy, and expand its antimicrobial resistance surveillance programme.

Mr MÜHLBACHER (Austria), expressing support for the draft resolution, said that the draft global action plan comprehensively identified areas for intervention, major problems and potential solutions, thereby offering guidance to Member States in the development of national action plans. The “one health” approach enabled common actions to be taken in the food, veterinary and health sectors and had been successfully employed in Austria. However, the key to behaviour change was understanding and awareness; greater efforts would therefore have to be made to reach key professionals through effective communication, education and training.

Mr SILLO (United Republic of Tanzania) welcomed the draft global action plan and the convening of the Strategic and Technical Advisory Group on antimicrobial resistance. A number of key factors contributed to antimicrobial resistance. Medicines were inappropriately prescribed and dispensed, self-medication was practised, and counterfeit and substandard medical products were used. Public awareness of the issue was generally low, and access to vital medicines was limited for some sectors of the population. Moreover, surveillance systems and laboratory facilities continued to be inadequate. Successful implementation of the draft action plan would depend on the commitment and engagement of all actors and sectors at all levels. While the extensive global collaboration between WHO, FAO and OIE was to be commended, similar coordination at regional and national levels was also essential. He supported adoption of the draft resolution and called for a mechanism to mobilize technical and financial resources for developing countries.

Mr DE ANDRADE FILHO (Brazil) appreciated the consultation process that had been undertaken for development of the draft global action plan, including a consultation that had been held in Brazil on the research agenda for antimicrobial resistance. At a side event held during the current Health Assembly, discussions had centred on the importance of regulation and the mandatory retention

of prescription slips as key components of a strategy to promote the rational use of antimicrobials. He supported adoption of the draft global action plan.

Mr KURI MORALES (Mexico) supported the "one health" approach advocated in the draft global action plan and emphasized the importance of coordinated action among the relevant agencies within the United Nations system and a coordinated global response. Significant efforts must be made to ensure appropriate prescribing practices for antimicrobials in both the health and veterinary sectors. Training of health personnel, community engagement, strong regulatory policies for rational and responsible use of antimicrobials, heightened pharmacovigilance and better monitoring of antimicrobial resistance were all of particular importance in that regard. In order to ensure the success of the draft global action plan, Member States should develop national plans as soon as possible, through collaboration by all relevant sectors. Support from WHO and its regional offices would be vital in those endeavours.

Dr KOUASSY (Côte d'Ivoire) expressed support for the development of national action plans, which should take into account the use of effective generic medicines as part of achieving universal health coverage. The fight against illicit and counterfeit medicines should also be strengthened, as should efforts to clean up the environment and improve surveillance laboratories in Member States.

Dr MUSAONBASIOGLU (Turkey), welcoming the draft global action plan, said that given the multifaceted nature of the issue, any response should also involve all relevant sectors, such as human health, animal health, food and agriculture, and education. Turkey had drawn up a national action plan on the rational use of medicines, including antibiotics; numerous activities had been undertaken, including field work in provinces with high rates of antibiotic use, training of health personnel and awareness-raising campaigns; as a result, the rate of antibiotic use was falling. There were a number of critical factors for success, including a well functioning health system, political will, data collection, a well prepared and implementable plan, coordination at the ministerial level, and a dedicated field team. WHO should play an active role in implementation of the global action plan through strengthened cooperation with FAO and OIE. Moreover, a high-level meeting on the antimicrobial resistance should be convened at the United Nations. She supported the draft resolution and asked for her country to be added to the list of sponsors.

Ms SARASWATI SITEPU (Indonesia) said that her country had established an intersectoral antimicrobial resistance control committee in August 2014 and developed national action plans and strategies. Health promotion and disease prevention efforts were being stepped up in health care facilities, and medical curricula had been amended to raise awareness among health personnel as early as possible. Increased attention was also being paid to furthering relevant research and reducing the incidence of infection through effective sanitation, hygiene and infection prevention measures. However, as a developing country, Indonesia had faced a number of challenges in respect of capacity and the availability of resources. Technical support from WHO would be crucial to build and sustain programmes to tackle antimicrobial resistance.

Ms BOGDAN (Republic of Moldova) expressed support for the draft global action plan, particularly the strategic objectives on improving awareness, strengthening knowledge and optimizing the use of antimicrobial medicines. Her country was committed to addressing and preventing antimicrobial resistance with the support and guidance of WHO and wished to be added to the list of sponsors of the draft resolution.

Mr GLASSIE (Cook Islands) said that the inappropriate use of antimicrobial medicines continued to be a significant challenge for his country, with medical staff lacking of up-to-date information, facing difficulties in identifying the type of infection and succumbing to patient pressure to prescribe antibiotics. Development and implementation of a comprehensive national action plan

was therefore crucial. However, more resources were needed at country level to ensure delivery of elements of the global action plan, such as improved diagnostic capacity and effective antimicrobial stewardship. He welcomed the proactive approach adopted by the Regional Office for the Western Pacific in developing a regional plan that was aligned with the draft global action plan.

Ms ESVELD (Netherlands) welcomed the rapid progress made in development of the draft global action plan. Having a plan was important, but action was also vital and had been taken in the Netherlands for many years. Using a "one health" approach, in which public health interests prevailed, her county had substantially reduced the use of antibiotics, especially in veterinary care. A precautionary approach had been implemented in partnership with the food production industry, ensuring that the industry itself took responsibility for effective measures; it was important to note that the measures had not affected the business of the sector. The message was simple: there were clear indications that the use of antibiotics in the veterinary sector were a threat to human health; Member States had acceptable and cost-effective tools to prevent that threat; and health ministries should take the lead. She therefore urged the Health Assembly to adopt the global action plan.

Ms CABELLO SARUBBI (Paraguay) welcomed the draft global action plan but said that it would be difficult for many countries to develop a national action plan within the period specified; WHO support would be vital in that regard and should be adapted to different country situations.

Mr IVERSEN (Norway) said that although his country supported the draft global action plan in its present form, Norway would have preferred stronger wording in some areas, particularly those pertaining to the importance of the environment and the role of the ecosystem in the spread of antibiotic resistance. He welcomed the reference in the plan to exploring the possibility of partnerships for financing and coordination of the development of new antibiotics; the European Parliament had recently adopted a resolution on delinking the volume of antibiotic sales from the reward paid for a new antibiotic, which would contribute to those endeavours. Member States should commit themselves to ensuring that all people had timely access to effective, appropriate and affordable antimicrobials. Use of antimicrobials had to be well regulated and based on medical need and appropriate diagnosis; a global development and stewardship framework would facilitate global collective action in that regard. Manufacturers and marketers of antimicrobial medicines should be involved as partners in ensuring appropriate use.

Ms SCHMITT (France) said that the international community had reacted quickly to the report on antimicrobial drug resistance presented at the previous World Health Assembly.[1] The draft global action plan took into consideration all aspects of the fight against antimicrobial resistance and the differences between countries. Antimicrobial drug resistance continued to increase, particularly in bacteria that caused nosocomial infections, and the re-emergence of diseases previously thought to be controlled (such as tuberculosis) was a cause for concern. The "one health" approach to tackling antimicrobial resistance was essential, and she welcomed the input of FAO and OIE to development of the draft global action plan. That approach should also be implemented at national level. To ensure that the action plan was rapidly put into effect, the Secretariat should provide Member States with the necessary support for implementing simple measures to strengthen hygiene in hospitals and elsewhere and prevent the transmission of resistant bacteria. Her country believed that research into new antibiotics, better preservation of the effectiveness of existing antibiotics and their proper usage were three key priorities.

DR HASSAN (Egypt) supported the establishment of a unified global action plan on antimicrobial drug resistance. However, the draft global action plan did not address the undeniable link between the abuse of antiseptic agents and antimicrobial drug resistance. The specific action

[1] Document A67/39.

points related to antimicrobial agents used by farmers, animal husbandry and the food industry were not detailed in the plan. And it was not clear how WHO and its partners would address access to and affordability of new, higher-priced antimicrobial medicines in low- and middle-income countries.

Dr TAVÁREZ (Dominican Republic) said that the draft global action plan was very pertinent to her country as it represented continuity in cooperation aimed at strengthening responses under the International Health Regulations (2005). The National Public Health Laboratory had a role in improving the provision of services for analysis of drug sensitivity and surveillance of antimicrobial resistance. Despite the results achieved, tuberculosis and HIV infection, as well as the high incidence of nosocomial infections, were causes of concern for the Government. The draft global action plan would establish a framework for implementing a national action plan, in line with the technical priorities set, and had synergies in terms of the basic capacities required to implement the Regulations. It would also constitute technical support for countries with similar health problems.

Ms HARMSTON (Canada) said that her Government also wished to sponsor the draft resolution. Canada had taken important steps to address the issue, including releasing a federal framework for action and a complementary action plan which provided the basis for development of a national plan, as called for by the global plan. The draft global action plan had received broad support from stakeholders.

Mr QURESHI (Pakistan) said that a national antimicrobial resistance network had been launched in 2008, and a draft national action plan was under consideration with the same objectives as the draft global action plan. Adequate financial and technical support was needed to ensure that developing countries could carry out the activities described in the draft global action plan. Research leading to the development of new, accessible and affordable antibiotics was essential. His Government wished to sponsor the draft resolution.

Mr KRANIAS (Greece) said that a "one health" approach to antimicrobial resistance was essential. In Greece, there was a high frequency of antibiotic resistance in gram-negative bacteria. The prevalence of hospital-acquired infections in Greece was high compared to other European countries. The Ministry of Health had recognized the situation as a public health priority and had issued a circular to hospitals with specific instructions for combating antibiotic resistance. The Hellenic Centre for Disease Prevention and Control had also established a specific plan of action. Effective communication, education and training were of the utmost importance for altering the public's attitude to antibiotics and fostering public awareness and understanding of antimicrobial drug resistance.

Dr J. JAMALUDIN (Malaysia) supported the draft global action plan and its five strategic objectives. Her Government had introduced a national antimicrobial stewardship programme in 2014. In 2015, it would establish a multisectoral task force and a national action plan.

Mr HAMILTON (Saint Kitts and Nevis) said that the rising tide of drug resistance could eliminate the medical progress that had been made. The battle against antimicrobial resistance was thus an urgent health and development issue. His Government had increased both surveillance of resistance patterns and educational activities related to antimicrobial resistance. He called on WHO and global partners to provide support for the Caribbean regulatory system for pharmaceuticals.

Mrs JABLONICKA (Slovakia) noted that the draft global action plan recognized that there were no internationally agreed standards for the collection of data and reporting on antibacterial resistance in human health, while surveillance and monitoring programmes for animal health had been adopted by OIE in 2012. With reference to objective 3 in the draft global action plan, she wished to draw attention to the issue of active screening for multidrug-resistant bacteria in potentially colonized patients, contact persons or carriers, and the development of internationally standardized

epidemiological measures to control the spread of multidrug-resistant bacteria by such carriers. Her Government wished to sponsor the draft resolution.

Mr ALEMNEH (Ethiopia) said that a multi-institution and multidisciplinary advisory committee had been established in his country with the aim of making antimicrobial resistance containment a priority and coordinating surveillance. A baseline survey had been conducted in 2009, and a strategic framework had been developed in 2011. A national plan of action intended to guide all stakeholders, health service directives and standards had been prepared and endorsed. A national surveillance reference laboratory with regional branches had been established. Work was being done on a mass media campaign. His country was committed to adopting the draft global action plan. He urged the Secretariat to increase support in terms of strengthening laboratory networks, supporting the accreditation of laboratories and gathering evidence.

Dr PAUVADAY (Mauritius) endorsed the draft global action plan. Successful implementation of the plan would require a multisectoral, integrated approach and technical support from the Secretariat.

Ms ANDIA (Colombia), recognizing that antimicrobial resistance was a serious threat to human health, commended the draft global action plan. Progress had been made in Colombia to reduce the incidence of infections, particularly in hospitals, and a policy had been implemented on the rational use of drugs which was in line with the draft global action plan. She emphasized the role played by other actors, including the industries involved, in the prevention and monitoring of antimicrobial resistance events. Pharmaceutical companies influenced the use of drugs through their promotional and educational activities. It was essential to create incentives for innovation with regard to products of public health interest for which there was an insufficient market. Mechanisms needed to be put in place so that existing medicines were preserved and did not become artificially or prematurely obsolete. She supported the draft global action plan.

(For continuation of the discussion and approval of the draft resolution, see the summary record of the eighth meeting, section 2)

The meeting rose at 16:45.

EIGHTH MEETING

Friday, 22 May 2015, at 09:45

Chairman: Dr E. JARAMILLO NAVARRETE (Mexico)

1. SECOND REPORT OF COMMITTEE A (Document A68/67)

Dr ROOVÄLI (Estonia), Rapporteur, read out the draft second report of Committee A.

The report was adopted.[1]

2. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 15 of the Agenda (continued)

Poliomyelitis: Item 15.2 of the Agenda (Documents A68/21, A68/21 Add.1 and A68/21 Add.2) (continued from the sixth meeting, section 3)

The CHAIRMAN invited the Committee to resume its consideration of the draft resolution proposed by the Secretariat, contained in document A68/21 Add.1. Following informal consultations, subparagraph 3(1) had been amended as follows: "… respond fully to polioviruses detected from any source; to immediately put in place national public health emergency measures, as appropriate, to respond to a new polio outbreak in a polio-free country following confirmation …". Subparagraph 4(1) had been amended as follows: "to continue to collaborate with all relevant actors, governments and administrators, in partnership with other organizations in the United Nations system and local and international nongovernmental organizations, to support national efforts for polio eradication to benefit children in all areas".

Mr TENE (Indonesia) expressed his delegation's appreciation to all those involved in the informal discussions on Indonesia's proposed amendments to the draft resolution. Although those discussions had not succeeded in resolving Indonesia's main reservations, his country would not stand in the way if it was decided to adopt the draft resolution.

Ms STRESINA (Romania), speaking on behalf of the Member States of the European Region, expressed support for the draft resolution as amended, which reflected Member States' collective commitment to the eradication of one of the world's most serious vaccine-preventable diseases.

The draft resolution, as amended, was approved.[2]

Mr TENE (Indonesia) reiterated the importance his delegation attached to having a flexible time frame for the withdrawal of the type 2 component from the oral poliovirus vaccine and the introduction of the inactivated poliovirus vaccine, based on national and local readiness as well as

[1] See page 365.

[2] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA68.3.

availability and affordability of the vaccines. His delegation considered that such a flexible time frame was already reflected in the last preambular paragraph of the draft resolution. Indonesia therefore dissociated itself from paragraph 2 of the draft resolution, as well as from the timelines specified in subparagraphs 3(7) and 4(2).

Antimicrobial resistance: Item 15.1 of the Agenda (Documents A68/19 and A68/20 (continued from the seventh meeting)

The CHAIRMAN invited the Committee to resume its consideration of the draft resolution submitted by Member States at the previous meeting.

Ms KIPIANI (Georgia) expressed her support for the draft global action plan on antimicrobial resistance and the draft resolution, and requested that Georgia be added to the list of sponsors.

Professor NAPO-KOURA (Togo) underscored the importance of collaboration between WHO, FAO and OIE, including the compilation of a database on antimicrobial resistance and suggested that an international high-level meeting should be convened on the subject. Although Togo had data on antimicrobial resistance, it had still to establish a multisectoral committee to exchange information and improve the use of antibiotics in human and animal medicine. Considerable challenges persisted with regard to awareness-raising about the misuse of antimicrobial agents, counterfeit products and the need to strengthen national, subregional and international policies to take account of the global action plan. Togo supported the draft global action plan on antimicrobial resistance contained in document A68/20.

Dr TILLUCKDHARRY (Trinidad and Tobago) expressed his support for the draft action plan. Efforts to mitigate antimicrobial resistance required a cross-sectoral approach to ensure that all stakeholders in human medicine, veterinary medicine and agriculture used antimicrobial agents rationally and responsibly. Surveillance in health-care settings was crucial, alongside national oversight, quality assurance and local policy-making. Trinidad and Tobago had developed an antimicrobial resistance policy that would guide the appropriate use of antimicrobial agents, strengthen research through population-based health studies and studies on the economic impact of antimicrobial resistance, and raise public awareness.

Dr DZABATOU-BABEAUX (Congo) expressed support for the draft resolution and the draft action plan, particularly the provisions on prevention of communicable diseases, which would considerably reduce the number of people needing antimicrobial agents, and on the quality of diagnostic tools. Education and public awareness-raising were essential, particularly for children, to make the new generation aware of the dangers of the misuse of antimicrobial agents. Efforts to tackle antimicrobial resistance must prevent the loss of patients to follow-up, ensure that supplies reached remote areas and promote rational prescribing and stock management.

Dr HENG (Singapore) welcomed the draft action plan. Singapore had made efforts to overcome antimicrobial resistance through its national antimicrobial resistance committee, and was continuing to focus on surveillance, research, training, infection control and antibiotic stewardship, with support from WHO, FAO, OIE and partner countries. Singapore supported the draft resolution and wished to be included in the list of sponsors.

Dr BANDARA (Sri Lanka) said that to ensure universal health coverage in his country, most pharmaceuticals had to be imported at high cost. Sri Lanka and other Member States in similar situations could not afford essential laboratory supplies. He therefore suggested the inclusion in the draft resolution of a new subparagraph 4(10), calling upon the Director-General "to review regularly with the pharmaceutical industry associations for the free availability of common first- and second-line antibiotic discs in the market for Member States to fulfil the requirements with regard to the objective 4 of the framework for action on antimicrobial resistance".

Dr Song-en HUANG (Chinese Taipei) expressed support for the draft action plan. Chinese Taipei had implemented an effective antibiotic stewardship programme to promote education and training of health-care providers, conduct surveillance and research on antibiotic use and outcomes, monitor infection prevention and control in health-care facilities and ensure rational use of antibiotics. She urged WHO to intensify its work with partners, including FAO, OIE, the World Bank and industry associations and foundations, to counter antimicrobial resistance in animals. Chinese Taipei welcomed any opportunity to cooperate in global efforts to address antimicrobial resistance.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, welcomed the draft action plan. Under objective 1 (see document A68/20, paragraphs. 30–31), she suggested that a reference should be added highlighting the importance of adherence to treatment and an understanding of the responsible use of antibiotics. The failure of patients to adhere to long-term treatment plans, particularly for tuberculosis, was leading to drug resistance: empowering pharmacists to supervise treatment could help to resolve that problem. With reference to objective 4 (paragraphs 40–44) she noted that diagnostic tools could be integrated into pharmacy practice to increase access to testing. Prescribers should be given feedback, which would be facilitated if treatment indications were included on prescriptions. Antibiotics should only be distributed through authorized channels.

Ms MACINTYRE (Water Aid), speaking at the invitation of the CHAIRMAN, welcomed the draft action plan's emphasis on the importance of good sanitation, hygiene and infection prevention, particularly in health-care facilities. To meet the objectives set out in the action plan, universal access to water, sanitation and hygiene facilities in households, health-care facilities and schools was essential. Greater investment in wastewater management systems was particularly important. Member States should take action at national level to enforce the WHO Essential Environmental Health Standards in Health Care and monitor the incidence of health-care-associated infections.

Dr RODITIS (The World Medical Association), speaking at the invitation of the CHAIRMAN, said that it was essential to ensure the financial sustainability of interventions in low- and middle-income countries. The action plan must be accompanied by health systems strengthening, with a focus on access to primary health care, availability of diagnostic laboratories and surveillance. Research was required on infection prevention in resource-poor settings and the role of international travel and international trade agreements in antimicrobial resistance. Monitoring the prescription of antibiotics in veterinary medicine was particularly important; a multisectoral approach to antimicrobial resistance was essential. Training for health professionals on the appropriate use of antimicrobial agents was required.

Mr RIVALAN (Global Health Council), speaking at the invitation of the CHAIRMAN, welcomed the draft action plan and said that antimicrobial resistance was a major threat, not only to health but also to global security. Studies in the United Kingdom of Great Britain and Northern Ireland had concluded that, by 2050, antimicrobial resistance would cause 10 million deaths per year, with considerable economic impact. Drug-resistant tuberculosis, which also placed health-care personnel at serious risk, was not adequately acknowledged in the draft action plan: drug-resistant strains of the

disease already caused 210 000 deaths per year. Urgent action was required, or decades of progress in global health would be undone.

Ds CHIARELLA (International Council of Nurses), speaking at the invitation of the CHAIRMAN, expressed support for the draft action plan and said that health-care workers had a key role to play in preventing misuse of antimicrobial medicines. The involvement of nurses in drafting the action plan was therefore particularly welcome. She commended the first three objectives and emphasized that treatment adherence was critical in order to fulfil objective 4. Nurses had a key role to play in helping patients to take the correct dose of antibiotics for the correct period of time. She welcomed the move in some countries to authorize nurses to prescribe medicines, particularly since the relationship of trust between nurses and patients could improve treatment adherence. The success of global efforts to counter antimicrobial resistance would depend largely on the mobilization of millions of nurses around the world: governments should involve them in the relevant policy planning and strategy development.

Ms GUMPERT (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, urged Member States to adopt the draft action plan, although she noted that it did not mention how the development and implementation of national plans to tackle antimicrobial resistance would be financed. If the draft action plan were to be successfully implemented, the Secretariat must strengthen resources for technical and financial support for country stakeholders, establish monitoring, evaluation and accountability frameworks and work with other United Nations agencies to provide guidance on antimicrobial use in animals, environmental contamination and other issues. Stakeholders should commit themselves to multisectoral action against antimicrobial resistance and set measurable targets. Global standards were needed for surveillance, infection control and prevention of overuse of antimicrobial agents, and new innovation models should delink profits from volume-based sales and ensure that people in need had affordable access to antibiotics. She urged WHO to take into account the key principles of the Antibiotic Resistance Coalition's Declaration on Antibiotic Resistance. Effective antibiotics would be essential for the success of the post-2015 development agenda.

Mr GAD (Medicus Mundi International), speaking at the invitation of the CHAIRMAN, urged Member States to phase out the nontherapeutic use of antimicrobial agents in animals. Environmental pollution from animal and hospital waste contributed to the spread of resistance and should be monitored and controlled. Health systems should be strengthened to ensure the appropriate use of antimicrobial agents. Member States and the Secretariat should develop robust standards and accountability mechanisms for national action plans, since the provisions of the draft action plan relating to accountability were weak. Many developing countries would require financial and technical assistance in that regard. Research into and development of new antibiotics should be accelerated and, since profit-driven priority-setting had failed to drive innovation, research funding should be delinked from monopoly pricing and anticipated profits.

Dr CHUA (MSF International), speaking at the invitation of the CHAIRMAN, urged Member States and the Secretariat to provide the resources needed to implement the global action plan and coordinate efforts to combat antimicrobial resistance, including mechanisms for accountability and evaluation. She called for the allocation of sufficient resources to implement infection control measures at all levels of health care; to monitor the appropriate and inappropriate use of antibiotics; and to guarantee access to key vaccines for all low- and middle-income countries to reduce the need for antibiotics. Registration policies for older antibiotics which were being revived to combat multidrug-resistant bacteria must be revised. Diagnostic tests should be developed for resource-limited settings, along with innovative mechanisms for research into and development of new antibiotics.

Mr MELLO (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that health professionals must have a sound evidence base for the medicines they prescribed. Emerging resistance trends, empirical treatment regimens and diagnostic protocols must be incorporated into continuing medical education materials in order to raise awareness of polypharmacy and self-medication with antimicrobial agents. Member States should regulate unofficial channels of antimicrobial drug distribution in order to prevent suboptimal medicines reaching hospitals. Failure to act would risk exposing new generations to health consequences from previously treatable diseases.

Ms GRUNDMANN (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that a globally coordinated policy approach and consistent regulation were required. Her organization's members were currently working on 34 antibacterial compounds, eight of which were in the final stages of development. The slowdown in approval of new antibiotic agents was only the tip of the iceberg: action was needed in areas such as basic research, regulation, good clinical practice and public awareness-raising. Antibiotics held a high societal value, and their development should be rewarded through a combination of incentives. Her organization supported the draft action plan and stood ready to provide expertise.

Dr FUKUDA (Assistant Director-General) welcomed participants' endorsement of the draft action plan and briefly summarized the consultative process which had led to its creation. The development of the draft action plan was a positive start but challenges remained, such as surveillance, prevention of disease through vaccination which would reduce the use of antimicrobial agents, improved hygiene and sanitation, the need for a sound funding base for financing in-country work and the development of new medicines and diagnostic tools. He noted the requests for detailed guidance on the implementation of the draft action plan as well as examples of best practice. The draft action plan built on the work done by agencies such as FAO and OIE and fitted in with existing WHO work in areas such as HIV, malaria and tuberculosis control, which would be strengthened as a result. The Secretariat would continue to discuss with Member States the possibility of convening a high-level meeting in the margins of the United Nations General Assembly. The top priority of the Organization would be to work with Member States on national implementation plans. The draft action plan provided a strong basis for future work.

Dr PANDA (India) proposed that consideration of the draft resolution should be deferred to allow for further consultations between Member States.

It was so agreed.

(For continuation of the discussion and approval of the draft resolution, see the summary record of the thirteenth meeting, section 1.)

Implementation of the International Health Regulations (2005): Item 15.3 of the Agenda (Documents A68/22, A68/22 Add.1 and EB136/2015/REC/1, resolutions EB136.R5 and EB136.R6)

Dr AMMAR (Lebanon, representative of the Executive Board) said that, at its 136th session, the Executive Board had adopted resolution EB136.R5 on yellow fever risk mapping and recommended vaccination for travellers and resolution EB136.R6 on the report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation. Many speakers had drawn parallels between the Review Committee's recommendations and the ongoing response to Ebola virus disease. Members had taken particular note of the recommendations concerning the relationship between the International Health Regulations (2005) and health systems strengthening, as well as the need to study options on how to best monitor and assess implementation by States Parties.

Mr RUIZ MATUS (Mexico), speaking on behalf of the Member States of the Region of the Americas, said that compliance with the International Health Regulations (2005) was the shared responsibility of WHO and States Parties. The latter should establish and maintain minimum core capacities at national and regional level to identify, assess and report on events. National public health risks and emergencies should be tackled through preparedness, monitoring and response. Given the obstacles States Parties faced in applying the Regulations at national level, granting second extensions to the States Parties which had requested them should contribute to collective global compliance. The universal development and maintenance of core capacities should be viewed from a more long-term perspective. A new assessment method was needed in addition to self-assessment and should be supported by WHO and the States Parties which had succeeded in establishing their core capacities. Collaboration between States Parties and WHO should take into account the sustainability of those core capacities.

Ms RABOVICA (Latvia), speaking on behalf of the European Union and its Member States, said that it was essential to bear in mind the relationship between the Regulations and health systems strengthening, in which the health workers who prevented, detected and responded to outbreaks played a central role. There should be a recognition of the specific needs of countries with weak health systems and governance structures, where implementation would require additional support. The high costs of the Ebola crisis demonstrated the advantages of investing in capacities to improve the response to public health events.

The European Union supported the recommendations of the Review Committee, including acceleration of implementation in the short term and investment in longer-term sustainable objectives. The key role of the Secretariat and its partners in providing States Parties with expertise and guidance to support implementation should be further enhanced. Transparent and reliable assessment tools, such as external assessment and certification processes, would provide a more accurate view on the level of implementation in countries. States Parties should prepare for the 2016 deadline by defining a road map and time frame for implementation, including regional meetings.

Dr KAN TUN (Myanmar), speaking on behalf of the Member States of the South-East Asia Region, said that all States Parties to the Regulations in the Region had established National IHR Focal Points and improved their reporting of events, early warning systems, communication between the animal and human health sectors, emergency response and coordination structures and international information-sharing systems. The status of core capacities was regularly reported by countries in the Region. No Ebola virus disease cases had been reported.

Major challenges had been identified in capacity of National IHR Focal Points, legislative capacity, limited coordination with other sectors, international cooperation and limited investment in financial and human resources. An established financing mechanism was essential to enable independent self-assessment and monitoring. Effective horizontal collaboration was required for workshops on medical preparedness for radiation emergencies and Ebola virus disease, strengthening point-of-entry capacities and emergency operation centres and providing training on quality management systems and risk management in laboratories.

Dr AARABI (Islamic Republic of Iran) said that the Ebola virus disease outbreak and other public health events had demonstrated the importance of strong International Health Regulation capacities and of a response system to deal with outbreaks of infectious diseases. In order to rectify the limited involvement of sectors other than human health, National IHR Focal Points should be coordinated by both ministries of the interior and ministries of health. More legal powers could be given to subregional plans of action such as the one established by the G5 countries in his Region (Afghanistan, Islamic Republic of Iran, Iraq and Pakistan, with the support of the WHO Regional Office for the Eastern Mediterranean). His country stood ready to share its experience of integrated laboratory-based surveillance and epidemiological investigation.

Dr NARGIS (Bangladesh) said that the experience of the Ebola virus disease outbreak had highlighted the importance of implementing the Regulations and the need to prepare for more complex health emergencies. Bangladesh had made substantial progress in implementation, but weaknesses persisted in the areas of multisectoral public health response and points of entry, and there was a lack of skilled human resources.

Turning to the report of the Review Committee, contained in document A68/22 Add.1, she proposed that the technical working group on data management capacities and practices, mentioned in recommendation 6, should be made permanent and that it should develop a standard methodology for assessment of implementation progress by State Parties. Under recommendation 7, she emphasized the need to prioritize building basic core capacities and publication of an annual scorecard of progress in implementation. An indicator might be included in the health-related sustainable development goals. Under recommendation 8 she urged that capacity building should be linked with health system strengthening and that, under recommendation 9, consideration should be given to creating a global fund to support Member States in building capacity.

Ms HARB (Lebanon) said that most States Parties which were requesting an extension of the deadline to establish their core capacities were facing serious institutional and resource constraints. For countries such as Lebanon, civil unrest and political instability remained the main obstacles to implementing core capacities, with mass migration impeding enforcement at points of entry and complicating further the chronic shortage in human resources and high turnover among health professionals. Since there was little hope that the situation would improve in the near future, it was all the more important to strengthen capacities and to invest in building resilient health systems through the proposed adoption of a continuous process with improved coordination for health systems and at the political level. She also supported the proposal to conduct an external independent assessment in order to detect national weaknesses and provide support to help countries to meet the requirements of the Regulations.

Dr AL-TAAE (Iraq) said the consolidation of approaches to the Regulations might include: testing their response to epidemics and events-based epidemiology, starting at points of entry; testing their capability to prevent the occurrence of communicable diseases; more capacity building at the personnel and institutional level to deal with disease outbreaks; more capacity-building opportunities for countries such as Iraq that faced specific security situations; and exchanges of practice within WHO regions and intersectoral cooperation with ministries other than health and international organizations. Such approaches to the Regulations should be an important indicator to evaluate collaboration with non-State partners. The G5 initiative in the Eastern Mediterranean Region was another pragmatic application of the Regulations.

Mr ROLLE (Bahamas) said that, although only one third of States Parties had been able to fulfil the core capacities outlined in the Regulations, the standards should not be changed to facilitate compliance. The Bahamas was working diligently towards achieving compliance with the Regulations by its extended deadline of June 2016 and had already enhanced capacity in the area of chemical events. Membership of the International Atomic Energy Agency had helped small island countries to obtain technical cooperation and financial streams for establishing radiation-related legislative frameworks, infrastructure strengthening and capacity building.

Ms GBANYA (Liberia), speaking on behalf of the Member States of the African Region, said that countries should be supported and engage with the WHO Secretariat on the building of core capacities without the imposition of sanctions, restrictions or incentives; the Secretariat should provide technical assistance to support implementation of the Regulations and ongoing monitoring and evaluation; countries should build core capacities within their health systems to strengthen health security; and countries should use experiences and lessons learned from recent outbreaks, especially the Ebola virus disease outbreak, to fast-track the support needed to build minimum public health

capacities. The African Region supported the draft resolution recommended in Executive Board resolution EB136.R6, with the proposed amendments.

Dr AL HAJERI (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, supported the recommendations of the Review Committee and the draft resolution recommended to the Health Assembly in Executive Board resolution EB136.R6. She suggested the following action points: establishing an independent group of experts to work closely with countries in assessing capacities and implementing the recommendations of the Review Committee; strengthening the human and financial capacity of the Secretariat at country and regional levels to support the development of national capacities; establishing a mechanism to monitor the progress and development of capacities and their maintenance beyond 2016; facilitating experience-sharing and documentation of best practices by States Parties, academic institutions and other stakeholders; and establishing a mechanism to strengthen cross-border collaboration for surveillance and response.

Mrs FORTALEZA (Philippines) said her country was committed to implementation of the Regulations and viewed its adherence to the Asia Pacific Strategy for Emerging Diseases (APSED, 2010) as a tool to that end. Her Government intended to further improve its national systems and infrastructure, especially with regard to surveillance and the provision of preventive and quarantine measures at points of entry since the Philippines was an international hub for travellers and for returning expatriate workers. The Government recognized the usefulness of the Regulations, together with the "One Health" approach, as an essential tool for national and global health security.

Mr ZHANG Guoxin (China) commended WHO for its work to promote implementation of the Regulations. He gave a brief overview of measures China had taken to achieve national core capacity requirements by 2014, and of recent successes in tackling major epidemics and other public health-related incidents. He encouraged WHO to continue providing guidance and relevant tools to help countries overcome problems in the implementation of the Regulations and thus improve the global response capacity to public health incidents. His delegation supported the two draft resolutions.

Ms MARTINEZ (Ecuador) said that, despite the progress made, owing to new and complex challenges at national, regional and global levels Ecuador had been unable to fulfil its core capacity requirements within the set time frame and would welcome feedback on its National IHR Action Plan in order to guide further work. It would be useful to compile best practices from different countries and regions from which others could learn. The assistance afforded by both WHO and PAHO was greatly appreciated, although technical cooperation at all three levels of the Organization should be strengthened further. She welcomed the idea of exploring new, country-led options for assessing the robustness of States Parties' core capacities in addition to the current system of self-assessment. Her delegation fully supported the recommendations made by the Review Committee.

Professor VALLET (France) supported the recommendations of the Review Committee. Secretariat input was essential to ensure the availability of effective tools in support of the implementation of the Regulations on the ground: he hoped that the Secretariat would contribute to the development of peer review mechanisms and guarantee exchanges of information about national capacities beyond 2016. During its term on the Executive Board, France would work to enhance the visibility and legitimacy of the Regulations in the global health agenda. The regional offices should be the driving force behind the implementation of the recommendations of the Review Committee, the coordination of national pandemic preparedness and the assessment of preparedness by means of innovative techniques. Regional and global consultations should be held, with a view to developing concrete action. France would be willing to host an international conference on the Regulations in early 2016.

Dr VIROLAINEN-JULKUNEN (Finland) said that a large number of countries had failed to fulfil the core capacity requirements within the prescribed time frame. On the other hand, the success in preventing Ebola from growing into a pandemic showed that effective action on the local, national and global level was possible. The diversity of social and natural environments in different countries and regions largely determined their vulnerability to disasters and their capacity to respond. Twinning and networking were useful tools to promote the international solidarity advocated by the Review Committee. She called on all States Parties to integrate the Regulations into their national legislation and develop well-functioning health systems, using the recommendations of the Review Committee as guidance.

Ms SMIRNOVA (Russian Federation), speaking also on behalf of Armenia, Belarus, Kazakhstan, Kyrgyzstan and Tajikistan, fellow member countries of the Council for Health Cooperation of the Commonwealth of Independent States, said that the Ebola outbreak had highlighted the need to strengthen and improve the Regulations. They needed WHO assistance to draw up clear plans for future action and the mobilization of national resources. She called on countries that had fulfilled their own core capacity requirements to assist others that were lagging behind. The Russian Federation provided financial assistance to countries in eastern Europe and central Asia to that end, and had made targeted contributions to WHO. Her delegation supported the two draft resolutions.

Dr ASSIRI (Saudi Arabia) expressed support for the two draft resolutions. Technical expertise was needed to support States Parties in the implementation of the Review Committee's recommendations. It was important to promote awareness of the Regulations among senior officials in key sectors in order to build up political commitment. Closer links must be established with international and regional institutions and bodies, and States Parties must engage in dialogue to enhance cross-border surveillance and response. He called for a closer link between the Regulations and key programmes on patient safety, health-related human resource development, legislation and information systems. Country-level preparedness and stronger links with national disaster and emergency preparedness and response mechanisms was also crucial. He suggested the establishment of independent regional groups of experts that could assist countries in the assessment and development of core capacities.

Dr TILLUCKDHARRY (Trinidad and Tobago) expressed support for the recommendations of the Review Committee. Trinidad and Tobago had been unable to meet its core capacity requirements, owing to human resource constraints affecting its national implementation plan. It had nevertheless been possible to strengthen national capacities to detect and respond to public health emergencies of international concern, especially with regard to preparedness for biological, chemical and nuclear emergencies. Current efforts focused on strengthening the national disease surveillance system and scaling up core capacities at points of entry. His country was acutely aware of the interdependence of the Caribbean islands, which lived mainly from tourism.

Dr AL ATTAR (United Arab Emirates), reiterating her country's commitment to implementation of the Regulations, said that it had achieved qualitative progress in all core areas and fulfilled the necessary requirements in 2014. Among other achievements, it had developed a highly effective national surveillance and control mechanism and substantially strengthened infection control measures, laboratory capacities, food safety and biosecurity. It hoped for technical support and regional cooperation in training in the interests of reinforcing its core capacities at points of entry, looking forward also to a practical structure for periodic self-assessment that would enhance the annual reporting exercise.

Dr HARVEY (United Kingdom of Great Britain and Northern Ireland) said that the Ebola outbreak had been a chilling reminder of the importance of strong health systems capable of compliance with the Regulations. It was thus crucial to develop detailed plans to prepare for the 2016 deadline and to develop longer-term preparedness to prevent, detect and respond to public health threats. She expressed support for the recommendation to move implementation of the Regulations beyond a "checklist" approach. Improved assessment tools, including external validation, were vital.

Mr ALAM (Indonesia) stressed the importance of National IHR Focal Point entities and called on States Parties to publish or inform the Secretariat of their international communication mechanism, using a format accessible to all States Parties.

Ms ALVEBERG (Norway) supported WHO's call for countries to avoid excessively restrictive measures that influenced international travel and trade. She welcomed the prospect of new approaches to assessing core capacities, as recommended by the Review Committee. Sustainable implementation of the Regulations could be achieved only through long-term commitment to building resilient health systems. Norway supported the establishment of a country-twinning programme for the exchange of best practices in the implementation of the Regulations, and also supported the Global Health Security Agenda. Such initiatives should be consistent with the principles of the Regulations and underpin WHO efforts to improve core capacities. Cooperation on infectious disease control also had great potential.

Mr ISMAIL (Malaysia) expressed support for the recommendations of the Review Committee and the draft resolutions. Countries should shift the focus from mere compliance to seeing core capacity building as a continuous process that contributed to global health security. States Parties would require WHO support in implementing the recommendations of the Review Committee and building capacities for the implementation of the Regulations.

Dr KEITA (Mali) said that her country's response to the Ebola crisis had been consistent with the Regulations, and had required considerable human resources to monitor designated entry points and border areas. An interministerial epidemic management group had been set up for that purpose. Countries relied on WHO support for the effective implementation of the Regulations; her country was currently in the process of developing its own national action plan to facilitate implementation.

Dr ENNIS (Jamaica) commended the quality of the Review Committee's membership, which illustrated the importance WHO accorded to the exercise. Her country had adopted various policies and plans in order to develop core capacities for the implementation of the Regulations. Countries with significant human, financial and material resource deficits urgently needed increased support from the Secretariat to boost their national capacities. The countries of the Caribbean needed special assistance to strengthen their surveillance systems and develop preparedness and response capacity, especially in regard to radionuclear emergencies. Jamaica fully supported the action recommended in Executive Board resolution EB136.R6, and the recommendation on the changeover to a single dose of yellow fever vaccine in Executive Board resolution EB136.R5. Jamaica would adopt the updated Annex 7 of the Regulations immediately rather than waiting for the July 2016 deadline.

Dr AHMED SIDAHMED MOHAMMED (Sudan) said that her country faced considerable challenges in regard to health technology procurement and training of health-care personnel. Like most countries that had requested a second extension of the deadline, Sudan was in dire need of technical and financial assistance. Such assistance could only be effective if the capacity of national health systems and WHO country offices was strengthened.

Dr ATEBA ETOUNDI (Cameroon) said that multisectoral activities to ensure country preparedness for a potential Ebola virus disease outbreak, together with the support provided by the recent WHO preparedness missions in the most at-risk countries in Africa, had helped Cameroon to strengthen its core capacities under the Regulations. Work undertaken with partners from the Global Health Security Agenda had enabled Cameroon to accelerate implementation of the Regulations to the extent that, with continued support from WHO, his country would be able to implement the Regulations fully by 2016, thereby obviating the need for a further extension.

Ms GÓMEZ GÓMEZ (Colombia) said that one of the most important aspects of the Regulations was the need for all States Parties to establish basic core capacities to detect, assess and communicate events in order to ensure an effective response to public health risks and emergencies. The recommendations of the Review Committee would guide efforts to overcome existing challenges in implementation, especially at the national level. She endorsed the recommendation that extensions should be granted to those countries requesting them. It was essential to ensure both comprehensive professional, technological and technical training at the local level and the sustainability of the core capacities for community surveillance. The monitoring process should be continued and support should be provided to enable States Parties to deal effectively with public health threats and bridge existing gaps in capacity.

Ms WOOD (United States of America) said that, although significant progress had been made in the fight against Ebola virus disease, essential health security infrastructure and resources were still lacking in western Africa and many other at-risk areas. Over the course of the previous year, the partners engaged in the Global Health Security Agenda had worked to develop multilateral and multisectoral collaborations and measurable targets to accelerate implementation of the Regulations. External evaluations would enable countries to better understand their gaps and needs, seek partnerships and build sustainable country capacities. She expressed support for the proposal to establish peer reviews or external evaluations as a core element of the assessment of national core capacities under the Regulations. Her Government noted with satisfaction the commitments made to support at-risk countries to achieve full implementation of the Regulations by 2019: it had committed itself to supporting 30 countries to meet all the targets of the Global Health Security Agenda, and called on other countries to synchronize their efforts in a collective approach. The United States welcomed the decision to establish the African Centres for Disease Control and Prevention to prevent and respond to future health emergencies.

Dr DAKULALA (Papua New Guinea) said that his country was fully committed to implementation of the Regulations before its extended deadline of 2016. He described a number of measures taken in his country to support implementation, including an integrated disease surveillance and response policy and a work plan on emerging infectious diseases and health. A National IHR Focal Point had been designated. The national experience from the recent outbreaks of pandemic avian influenza A(H1N1) and cholera would inform the future response to public health emergencies and had highlighted the need to strengthen human resources capacity. He supported the two draft resolutions.

Mr DE ANDRADE FILHO (Brazil) said that recent public health events worldwide, including the Ebola virus disease outbreak, illustrated the need to ensure a rapid response and organize health services to protect vulnerable groups. The Regulations played an important role in guaranteeing transparency and solidarity in the response to global public health threats. However, he expressed concern at the introduction of restrictions by some countries in response to the outbreak of Ebola virus disease. Health system strengthening would promote and protect public health. It was imperative that all States Parties should stand by their commitments to implement and assess basic core surveillance and response capacities: WHO played a central role in that regard by promoting exchange of good practices. Brazil supported the draft resolution recommended to the Health Assembly in Executive

Board resolution EB136.R6, and congratulated Argentina on its initiative on yellow fever which had led to the draft resolution contained in Executive Board resolution EB136.R5.

Mr BOYCE (Barbados) affirmed his country's commitment to achieving full compliance with the Regulations by 2016. The recent Ebola virus epidemic in Western Africa and outbreak of chikungunya in the Caribbean had demonstrated the importance of scaling up national capacities and ensuring robust regional and international surveillance measures. His country had worked to improve chemical, biological, radiological and nuclear surveillance and management, food and water surveillance and port health, and was constructing a new public health laboratory to strengthen its national capacity and assist other countries of the Organization of Eastern Caribbean States in monitoring public health issues.

Dr HAUFIKU (Namibia) said that many countries had introduced stricter controls and surveillance measures at points of entry in response to the recent outbreak of Ebola virus disease rather than as a result of their commitment to implementation of the Regulations: there was a need for proactive, rather than reactive, implementation. The challenges highlighted by the Review Committee must be addressed, including the need for multisectoral action. It was imperative to invest in preventive measures and strengthen detection capacities and preparedness. He called on States Parties to respond to the Secretariat's efforts to strengthen the current system of self-assessment of core capacities. He supported the draft resolution recommended in Executive Board resolution EB136.R6.

Mr SKERRITT (Saint Kitts and Nevis) said that his country, as a small island State, would require additional support to enable it to achieve its core capacities. Regional action was needed to ensure that member countries of the Caribbean Community could guarantee radionuclear and chemical preparedness. However, notable progress had been made in relation to the core capacities to address infections. Preparedness activities to combat the Ebola virus and chikungunya virus had provided valuable lessons in areas such as regional rapid response, port health services and contingency funding. His Government looked forward to collaboration with neighbouring countries in the implementation of the Regulations: regional health organizations such as PAHO and the Caribbean Public Health Agency had played a pivotal role in resource mobilization. He supported the draft resolution recommended in Executive Board resolution EB136.R6.

Dr YONGJUA LAOSIRITAWORN (Thailand) underscored the importance of strengthening laboratory services, especially collaboration between animal and human health laboratories. Whole-of-government and multisectoral engagement were essential, in addition to increased cooperation between the animal, environment and human health sectors. His Government fully supported the recommendation of the Review Committee that self-assessment should be supplemented by further measures in order to improve transparency and validity. He drew attention to the vital role of human resources, including scientists, information technology specialists and front-line workers at primary care level, in responding to public health events: however, internal migration of well-trained personnel to the private sector was a matter of concern. Additional support should be provided by the Secretariat and its partners for countries that had not yet met the minimum core capacity requirements. Thailand had met its core capacity requirements and would welcome joint expert assessments. He supported the two draft resolutions.

Mr TEGENE (Ethiopia) said that considerable efforts were being made in Ethiopia to meet the required core capacities, including the establishment of the Ethiopian Public Health Institute and appointment of a National IHR Focal Point, training and countrywide deployment of public health emergency officers and a new reporting system. His Government had adopted the Integrated Disease Surveillance and Response guidelines and updated its legislation, and believed that it would soon be fully compliant with the Regulations. He supported the establishment of the African Centres for Disease Control and Prevention and the provision of additional support for developing countries with

limited system capacities, but objected to the proposed introduction of sanctions for countries failing to abide by the Regulations.

Dr E.M. NDIAYE (Senegal) said that Senegal was on course to fulfil its core capacity requirements by the extended deadline of 2016. An assessment of core capacities of points of entry at airports, ports and ground-crossings, conducted in his country in October 2014, had exposed weaknesses in several capacities, including coordination, communication and response to potential public health emergencies of international concern. He noted the difficulties in mobilizing the resources required to bridge the current funding gap and the importance of conducting risk assessments and strengthening the capacities of National IHR Focal Points in order to improve coordination with other sectors.

Mr SEGARD (Canada) said that the recent outbreak of Ebola virus disease had highlighted the critical importance of full implementation of the Regulations by all States Parties, as well as the need for a monitoring process to identify gaps in capacities. He called for a strengthening of collaboration between States Parties, including the conduct of external evaluations. As an active participant in the work of the Global Health Security Agenda, Canada supported the five-year timeline to achieve the Agenda's targets. He endorsed the recommendations of the Review Committee and urged the Secretariat to provide further technical support for States Parties in implementing them. His Government also supported the development of a renewed monitoring framework to evaluate implementation of the Regulations before the extension deadline of 2016. He endorsed the draft resolution recommended in resolution EB136.R6.

The meeting rose at 12:45.

NINTH MEETING

Friday, 22 May 2015, at 14:40

Chairman: Dr E. JARAMILLO NAVARRETE (Mexico)

1. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 15 of the Agenda (continued)

Implementation of the International Health Regulations (2005): Item 15.3 of the Agenda (Documents A68/22, A68/22 Add.1 and EB136/2015/REC/1, resolutions EB136.R5 and EB136.R6) (continued from the eighth meeting)

Mr SASTRE (Bolivarian Republic of Venezuela) said that his country had achieved good results in the implementation of the International Health Regulations (2005). The additional extensions of the deadline for meeting core capacity requirements were of great relevance and importance to facilitate progressive compliance with the Regulations. To establish and maintain core capacities, the Member States required increased financial and human resources. Accordingly, the time frames for implementation needed to be extended, or where that was not possible, funds and technical assistance should be provided via WHO cooperation mechanisms. Member States should regard implementation as a continuous process.

Dr MHANDO (United Republic of Tanzania) said that various large-scale epidemics had highlighted the role of the International Health Regulations (2005) and had led to the implementation of core capacities in her country. Activities had included the development of community-based surveillance, which was crucial for the early detection of diseases. Strengthening core capacities was of paramount importance and she welcomed the recommendation by the IHR Review Committee that it should be seen as a continuous process, which required local and global leadership. She also welcomed the recommendation to carry out an independent peer review and said that her country would be willing to participate in the first phase. WHO and other partners should adopt a multisectoral approach to support countries in areas where gaps were identified. She endorsed the recommendations of the IHR Review Committee and supported the adoption of the draft resolutions recommended for adoption in resolutions EB136.R5 and EB136.R6.

Professor MESBAH (Algeria) said that the implementation of the Regulations, which were being incorporated into national legislation, was a priority in his country. A committee on the International Health Regulations (2005) had been established and a plan of action had been developed with WHO support. As a result, an emergency funding mechanism had been set up separately from the health budget. Notwithstanding, his country continued to require WHO technical support on aspects related to the strengthening of staff and laboratory capacities, the implementation of cross-border cooperation and sharing of best practices.

Dr HINOSHITA (Japan) noted that, despite the time that had elapsed since the start of the implementation period of the revised International Health Regulations (2005), the time frame was being extended by another two years for a number of reasons. He expressed the hope that no other public health emergency would occur before implementation was completed and he called on Member States to set implementation as a priority in order to move forward.

Ms PRETORIUS (South Africa) said that it was crucial for States to establish core capacities in order to detect, assess, notify and report events and to respond to public health emergencies. The end of the second extension time frame was a good opportunity to remind Member States that developing, strengthening, and maintaining the Regulations formed a continuous process. The advancement and maintenance of core capacities required extensive and sustained financial and human resources. It was imperative to adopt a more action-oriented approach to the Regulations by evaluating functional capacities instead of simply relying on implementation checklists. The principles and key themes of the Regulations provided an essential foundation for the construction of a long-term approach. She commended draft resolution EB136.R6 for adoption.

Dr CARBONE (Argentina) endorsed the requests to the Director-General, contained in subparagraphs 2(1) and 2(2) of resolution EB136.R5, to publish, and update in real time, an online list of countries accepting a certificate of vaccination against yellow fever for the life of the person vaccinated, and to establish a formal scientific and technical advisory group on geographical yellow fever mapping, with the participation of countries with areas at risk of the disease. She furthermore called on countries to agree to waive requirements for a booster dose of the yellow fever vaccine. A large and expanding area of her country was free of yellow fever, and the territory as a whole should not be classified as a risk area. In order to protect other countries in similar situations, she called on Member States to adopt resolution EB136.R5. Low core capacity levels reported in relation to the implementation of the International Health Regulations (2005) highlighted a deficit in support mechanisms and her Government called for the Sixty-ninth World Health Assembly in 2016 to establish a monitoring mechanism, which should not consider self-assessments of core capacities alone but also operational evaluations of the Regulations as a whole, including responses to international health emergencies. She encouraged the three levels of WHO to continue cooperating to achieve results in that regard.

Ms BARROS (Timor-Leste) said that, although her country was on track to meet objectives on core capacities under the International Health Regulations (2005), much remained to be done. In particular, the control of disease at border crossing points required a multi-agency approach and strong partnerships. Working in close collaboration with WHO, progress had been made in her country towards the implementation of the Regulations in a number of areas, including through the review of public health legislation and the development of coordination with the relevant departments of the Ministry of Health and across a number of technical sectors. Other outstanding issues and challenges included the development of a public health core and emergency preparedness plan, the lack of trained staff and equipment, and the need to strengthen laboratory capacities. Accordingly, she called on WHO to continue supporting her country in its efforts to overcome implementation problems.

Dr BOKENGE BOSUA (Democratic Republic of the Congo) said that, by the end of the first extension period, his country had made good progress in several areas, including indicator- and community-based surveillance and preparedness and response capacities. Challenges that warranted a second extension included the need to strengthen capacities at points of entry for the detection of chemical and radiological events. He supported the draft resolution recommended for adoption in resolution EB136.R6.

Ms An-Chi LAI (Chinese Taipei) said that Chinese Taipei had met the core capacity requirements of the International Health Regulations (2005) without an extension. The Framework of National IHR Focal Points served a useful purpose, and access to the IHR Event Information Site, which provided timely information on public health events, had enabled her Government to work closely with global and local public health partners to prepare for threats. She urged countries to continue complying with the Regulations, in particular regarding the timely notification of public health risks to WHO. Chemical and radiological disasters, which could have global ramifications, should be included in the Regulations and reported using the same mechanism.

Dr HOEMEKE (Global Health Council, Inc.), speaking at the invitation of the CHAIRMAN, said that the Ebola virus disease had underscored the need for a global framework to prevent and control the spread of infectious diseases, highlighting the dangers of weak health systems. In particular, the implementation of the Regulations should be directed at overcoming the global deficit in trained health workers, who were crucial to achieving health goals. Some of the countries that had been hardest hit by the Ebola outbreak had previously identified shortfalls in their health workforce. She urged the Secretariat and Member States to institutionalize and support reporting under the Regulations and to finalize a robust strategy on global human resources for health by 2016.

Dr FUKUDA (Assistant Director-General) said that the recommendations made by the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation identified a need to examine how core capacities were being assessed. Implementation of the Regulations could be progressed by accelerating and reinforcing support to strengthen core capacities, through technical assistance and enhanced strategic approaches, and by creating synergies with existing initiatives, such as the global health security agenda. A long-term perspective should be adopted, recognizing that, once they were achieved, core capacities needed to be maintained over time. Core capacity monitoring should move away from a checklist approach to more active and interactive methods, incorporating voluntary and external evaluation. In that light, the means of improving assistance should be the subject of further discussion in the regions. Referring to issues raised by the delegate of Argentina, he indicated that updated real-time information on countries that had adopted the yellow-fever guidelines would be placed online in a few weeks' time. Subject to the adoption of the draft resolution contained in resolution EB136.R5, he expected that a formal scientific and technical advisory group would be established; one of the issues that the working group would need to address would be the status of countries that were only partially affected by yellow fever.

The draft resolutions recommended for adoption in resolutions EB136.R5 and EB136.R6 were approved.[1]

WHO response in severe, large-scale emergencies: Item 15.4 of the Agenda (Document A68/23)

Dr CHAND (Nepal), speaking on behalf of the Member States of the South-East Asia Region, said that his Region was one of the most disaster-prone regions in the world, to which the two recent earthquakes in Nepal bore witness. He expressed appreciation for the efforts made by WHO and the Regional Office in their immediate response to the disaster, and for their collaboration with the Ministry of Health and the Nepalese population. The disaster had severely damaged Nepal's health system and the immediate priority was to revive and resume health services in the affected districts. He requested WHO to provide technical assistance in rebuilding health infrastructures, training staff, and most importantly, setting up prefabricated medical facilities. In the context of the Sendai Framework for Disaster Risk Reduction 2015–2030,[2] the same importance was attached to preparedness and surveillance as to emergency response. Accordingly, he called on the international community and agencies to support economically vulnerable and disaster-prone countries in building resilient health systems. The countries of his Region looked forward to receiving continued support from WHO in preparing for and recovering from disasters.

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA68.4 and resolution WHA68.5, respectively.

[2] Adopted at the Third United Nations World Conference on Disaster Risk Reduction (Sendai, Japan, 14–18 March 2015).

Ms RABOVICA (Latvia), speaking on behalf of the European Union and its Member States, said that Turkey, the former Yugoslav Republic of Macedonia, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova and Georgia aligned themselves with her statement. The Ebola virus outbreak had shown the importance of timely, efficient response and of prevention, preparedness and early action at national level in order to save lives. In that regard, she underlined the urgent need to implement the International Health Regulations (2005). Given its mandate, extensive expertise and presence around the world, WHO should continue to coordinate health emergency responses and be the lead agency of the global health cluster in humanitarian emergencies. She welcomed the five changes announced by the Director-General in her opening statement to make WHO fit for purpose. In addition, an enhanced WHO response required clear operational leadership by the Director-General, advised by the Global Policy Group. Those improvements should be submitted for consideration to the Sixty-ninth World Health Assembly through the Executive Board. She reiterated the importance of a standing item on emergencies being placed on the agenda of the governing bodies and suggested that the Secretariat should report under that item on improvements made to WHO's emergency work, including with regard to work on preparedness.

Dr RANDRIANTSIMANIRY (Madagascar), speaking on behalf of the Member States of the African Region, said that, regrettably, the disasters and emergencies to which the Region was prone often had serious political, economic, social and health consequences for vulnerable populations. Governments in the Region were concerned that public health emergencies were placing a heavy burden on their humanitarian, social and economic projects. Nevertheless, ensuring that national health systems were efficient and resilient remained a priority. All Member States should implement the International Health Regulations (2005) and continue to improve their capacity for dealing with disasters and epidemics. The Members in the Region urged the Secretariat, WHO's partners and donors to act together to help African countries to strengthen their risk management capacities. The regional health sector disaster risk management strategy needed to be implemented. Member States should collaborate with the Secretariat by notifying events liable to become public health emergencies in a timely manner, and responding appropriately.

Dr ZWANE (Swaziland) said that all nations, communities and families affected by disease outbreaks and other emergencies faced acute health needs. Given that emergency response was not an end in itself, the Secretariat should step up its collaboration with stakeholders to enable States to build strong national emergency programmes and minimize the after-effects of disasters. He commended all parties that had assisted in emergency efforts, particularly Chinese Taipei, which had contributed greatly to emergency response efforts. The Health Assembly should consider harnessing the knowledge and expertise of Chinese Taipei through broader participation in WHO processes and organs, for the benefit of the whole Organization.

Dr ASSIRI (Saudi Arabia) said that the major challenges to WHO's emergency response included insufficient resource capacity, lack of rapid response funding, insecurity, increasing field costs, and inefficient internal administrative, financial and human resource processes. The weaknesses revealed during the Ebola outbreak in systems, capacities and structures needed to be remedied in the proposed reform of WHO emergency capacities. Given that WHO's capacity to respond to emergencies was limited, Member States needed to ensure sufficient national capacity and trained experts who could work with their WHO counterparts. Major emergencies should not overshadow or impede responses to protracted emergencies.

Mr TEGENE (Ethiopia) said that WHO country offices in the African Region were overwhelmed by outbreak response, which pointed to shortcomings in preparedness, capacities and technical expertise in Member States. The situation had been worsened by very limited capacity-building for disaster risk management in the health sector. Notwithstanding the facts reported in document A68/23, there had been delays in WHO's leadership, information sharing and assessment

and grading of emergencies, despite the existence of the Emergency Response Framework. Health systems at the country level should be future-proofed against severe and large-scale emergencies caused by man-made and natural disasters. The Government of Ethiopia was keen to support WHO emergency operations requiring large-scale response.

Mr MANUELLA (Tuvalu) said that climate change was a serious threat that required collective global action. In Tuvalu, natural disasters had increased vulnerabilities and destroyed health facilities. He acknowledged WHO's swift response during Tropical Cyclone Pam in March 2015. His Government would continue to depend on technical and financial support from its health partnership with WHO, as well as with other international and regional development partners, in particular Chinese Taipei.

Ms GREPSTAD (Norway) noted with dissatisfaction that the report had been issued on 15 May 2015, which was too late to allow for proper preparation. For that reason, she had no substantive comment to make, despite considering the item being discussed to be one of the most important on the agenda.

Dr ZEIDAN (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, emphasized that the Region had more than half the world's refugees and hosted the largest number of internally displaced persons globally. Complex emergencies had affected the stability of the entire Region, jeopardizing the health of thousands of patients suffering from long-term noncommunicable diseases and other conditions, increasing the risk of communicable diseases spreading across borders, and overburdening already weak health systems. Countries experiencing political conflict had endured barriers to humanitarian aid, including blocked roads and points of access, as well as repeated and targeted attacks on health care workers and health facilities.

In order to ensure a streamlined and coordinated response in severe and large-scale emergencies, WHO should give top priority to: training, hiring, retaining and maintaining emergency public health experts for rapid deployment; establishing dedicated logistics hubs for crisis response and stockpiling critical medical supplies; and speeding up the establishment of the contingency fund to ensure a more predictable and reliable funding mechanism for response. He called on countries and donors to provide urgent financial support to the fund.

WHO should reinforce its preparedness and response capacities across its three levels. Country offices should be equipped to detect and notify any public health event that could constitute a threat to public health security. Regional offices should be equipped to provide rapid technical and logistical support to contain or mitigate the impact of any country emergency. Strengthening country presence was crucial. WHO headquarters should have the capacity to monitor and access any public health emergency and mobilize the international community by using the various provisions of the International Health Regulations (2005).

Mr DIKMEN (Turkey), welcoming the efforts to reform the emergency response capacity of WHO, drew attention to the humanitarian assistance provided by Turkey to countries around the world. He reiterated the call made by the delegate of Latvia for a standing item on emergencies to be included in the provisional agenda of future Health Assemblies; the Secretariat should use that item as an opportunity to report on improvements to the emergency preparedness and response of WHO.

Dr AL-TAEE (Iraq) said that the Secretariat should support Member States in the development and strengthening of surveillance systems, which would facilitate an early warning approach. In addition, WHO should collaborate closely with other relevant international organizations and donors to ensure the best investment of all available resources, and with affected Member States to evenly distribute the roles and costs of response. As a conflict-affected country, Iraq faced numerous challenges, including large numbers of both internally displaced persons and refugees fleeing from the Syrian conflict; as well as difficulties in maintaining the progress it had made towards attaining the

Millennium Development Goals and in providing preventive and curative care in areas outside the control of the Government. WHO and other partners had an important role to play in that regard. There should also be increased emphasis on interregional and intraregional cooperation in response to emergency situations. Furthermore, studies of past emergencies should be undertaken to analyse how best to use all available resources in the future. During emergencies, evidence-based practices for family health should be consolidated, with increased intersectoral collaboration and community participation in the aftermath of such events.

Dr TARAWNEH (Jordan) thanked WHO for its support to his country's health system in shouldering the burden of the Syrian refugees with whom Jordanian citizens shared their resources and amenities, including the free quality health services now adversely affected by the growing weight of that burden. Bearing in mind the pressure on those limited resources, he expressed the hope that WHO could expand its role even further by scaling up its collaboration, coordination and consultation with other international bodies in order to provide Jordan with financial and other support.

Miss RAMIRO (Philippines) said that health gains could be wiped out by severe, large-scale emergencies; rapid emergency response to such events, including attending to the injured, distribution of essential medical supplies and deployment of local and foreign medical teams, was a significant challenge for affected countries. In addition, environmental concerns, unsafe water supplies and poor sanitation, among other things, raised the risk of disease outbreaks. Her country strongly supported WHO's Emergency Response Framework and considered it important for the Secretariat to support disaster-prone Member States and to cooperate closely with other United Nations bodies and relevant international organizations to maximize resources for emergency preparedness and response.

Mr RUIZ MATUS (Mexico) said that, as the lead agency in the global health cluster for emergency response, WHO should ensure that actions to increase the local response capacities of countries and facilitate the delivery of international aid were a priority. Accordingly, capacity-building for Member States at the regional and subregional levels was vital. An overall organizational and coordination framework was needed to ensure an agile cooperation mechanism, together with changes to regulations and budgetary provisions to permit the establishment of strategic reserves, whether at Member State, regional or subregional level.

Dr RAPEEPAN DECHPIJAI (Thailand), expressing appreciation for the aid provided by Member States to Nepal in the wake of the recent earthquake, observed that, given the multifaceted nature of humanitarian emergencies, it was crucial that the roles and responsibilities of WHO and all partners at the international level were clearly defined and harmonized with the United Nations system. Moreover, assistance should be driven by demand rather than the decisions of donors. Better coordination and dialogue between those providing assistance and the affected countries would be essential in that regard. The Secretariat should support Member States in the development of disaster preparedness strategies and risk assessment.

Dr AHMED (Bangladesh), acknowledging WHO's key role in responding to the six current level 3 emergencies in the world, said that the outbreak of Ebola virus disease had highlighted the importance of rapid, timely and efficient action. An emergency fund should be established to facilitate such action. It was also essential to build Member States' capacity under the International Health Regulations (2005) and emergency risk management programmes. WHO should also continue to play a leadership role in relation to health-care delivery in emergency situations.

Dr OYEMAKINDE (Nigeria), expressing appreciation for the coordinating role played by WHO in response to severe, large-scale emergencies, said that such situations not only affected society and the economy, but also national security. Consequently, the issue should be a key priority for all Member States. Preparedness was the key to mitigating impact. Appropriate infrastructure to support risk detection, communication and response was also needed, together with strengthened health systems.

Ms KYLOH (United States of America), recognizing the unprecedented simultaneous demands to which WHO was responding, expressed support for the Organization's continuing work as the lead agency in the health cluster at both global and country levels; in that capacity, WHO had a key role in coordinating health-related assistance and responding to the needs of affected countries. The Organization should therefore take the necessary steps to ensure that it could continue to fulfil that role; the ongoing institutional reforms would contribute to that goal.

Ms FUKUDA (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, welcomed efforts to strengthen the emergency structures, systems and surge capacity of WHO, particularly the discussions regarding a global health emergency workforce to provide high-quality humanitarian assistance in a timely and predictable manner. Civil society organizations, such as the national Red Cross and Red Crescent societies, played an important complementary role to that of WHO, by providing the capacity to implement policy and technical decisions, and information about their effects. Her organization was therefore keen to work with WHO on the design of the global health emergency workforce.

The Foreign Medical Teams initiative had largely proven to be successful, but it was important to establish global standards for humanitarian health assistance. However, the main area of action for the initiative was in sudden-onset events. Further development of the approach was needed to tackle issues such as noncommunicable diseases, mental health, and sexual and reproductive health, without neglecting the role played by national civil society organizations in emergencies. Global surge capacity should be developed in such a way as to build local capacity, sustain trust among communities and underpin the role of community health workers.

Dr AYLWARD (Assistant Director-General) apologized for the late submission of the report; the Secretariat would endeavour to issue reports in a more timely manner in the future. The large number of crises in the previous year had overstretched all levels of the Organization and its partners. Acknowledging the leading role that Member States expected WHO to play in emergency response, he said that the focus of the Director-General's five-point reform programme was on disaster preparedness and prevention, in addition to disaster response. Member States had also emphasized the need for increased support from WHO on comprehensive disaster risk management guidance in the wake of the Third United Nations World Conference on Disaster Risk Reduction. During that Conference, WHO had launched a new policy framework for all levels of the Organization regarding disaster risk reduction, to enable the Secretariat to provide support to Member States in areas such as risk identification and assessment, the building of core capacities under the International Health Regulations (2005), and safe hospitals. With respect to enhancing the readiness of WHO to respond to emergency situations, the Secretariat was also in the process of developing a country office readiness checklist. Although there was currently significant emphasis on acute crises, countries suffering from protracted crises remained a priority and the Secretariat was developing a standard planning framework for those countries, based on proper needs assessment. He acknowledged the call from Member States for the Secretariat to enhance its coordination, leadership and management of the resources that were available through WHO partners. The global health emergency workforce was a key concept in that regard.

The Committee noted the report.

2. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 14 of the Agenda (continued)

Monitoring the achievement of the health-related Millennium Development Goals: Item 14.1 of the Agenda (Document A68/13)

Professor MBU ENOW (Cameroon), speaking on behalf of the Member States of the African Region, said that they had made considerable progress in achieving the health-related Millennium Development Goals, particularly with regard to reducing maternal, newborn and child mortality. Nevertheless, 29 States in the Region had been classified as either having achieved "insufficient progress" or as having experienced "setbacks" by UNDP in its 2014 review of progress in achieving Goal 4 (Reduce child mortality). Other areas of progress included reducing the prevalence of and deaths associated with HIV/AIDS; nonetheless, distribution of that progress had been uneven and remained below global levels. The incidence of malaria and tuberculosis had reduced, as had tuberculosis and HIV comorbidity. However, numerous challenges remained, including epidemics of diseases such as poliomyelitis, meningitis and Ebola virus disease. Moreover, reaching end users with life-saving commodities was hampered by poor road infrastructure and geographical barriers, and health systems continued to be weak. Given the differing levels of development across the world, he questioned why achievement of the Millennium Development Goals in African countries should be compared against other, more developed, regions. As more remained to be done, elements of the Millennium Development Goals should be included in the sustainable development goals in order to sustain the progress made.

Ms HARB (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that it was important to draw on lessons learnt from the Millennium Development Goals in discussions of the post-2015 development agenda; detailed analysis would be needed to take stock of the experiences of different countries. High-level political commitment and international support had been instrumental to the progress made, but significant challenges remained in many countries, particularly in terms of achieving universal health coverage while optimizing investments to improve the health of women, children and vulnerable groups in the face of resource constraints and public sector reform policies. Cross-cutting issues such as health system strengthening, equitable access to health care and social determinants of health also required consideration. Health in emergency and conflict situations should also be a priority area for action. Given the multisectoral nature of development goals, the Director-General should support coordination within the United Nations system and across key development partners and harness the necessary political commitment and financial support for the post-2015 development agenda.

Dr AL HAJERI (Bahrain) said that, despite challenges, her country had made notable progress towards the Millennium Development Goals; it was on track to achieve the targets relating to child mortality and maternal health. Innovative measures were needed at the regional and country levels in order to accelerate progress and harness political and financial support for achievement of the health-related goals and targets. Such measures included those aimed at promoting close coordination, especially in cases of conflict, insecurity or complex emergencies, with a view to sustaining political commitment, financial support and investment levels; reducing health risks from all disasters and emergencies and preserving gains won; effectively guiding the expansion of interventions to prevent mother-to-child transmission of HIV; strictly enforcing compliance with national malaria surveillance policies; improving access to second-line medicines for multidrug-resistant tuberculosis; assessing prices of medicines in terms of accessibility and affordability; and providing assistance for implementation of the new WHO guideline on country pharmaceutical pricing policies.

Dr AL-TAAE (Iraq) said that, in view of the situation in certain countries, specifically in the Eastern Mediterranean and African regions, the Millennium Development Goals should be reprioritized on the basis of their effectiveness. Indicators needed to be more pragmatic and in line with epidemiological and demographic variables. The work plans for the Millennium Development Goals to reduce child mortality and improve maternal health should be maintained in the post-2015 context. The number of proposed sustainable development goals should be increased on the basis of previous experience in fulfilling the Millennium Development Goals, and a review of partnership development, quality management approaches and adherence to primary health care concepts should be undertaken.

Mrs VALLINI (Brazil) said that the global effort to achieve the Millennium Development Goals reflected a concrete exercise in strengthening health system capacity, leadership and the intersectoral dialogue. Strategies for ensuring universal health access to all citizens were an important basis for achieving global health targets. A solid post-2015 development agenda was needed in order to guarantee principles of equity, gender equality, sustainability, human rights and access to universal health care.

Miss RAMIRO (Philippines) said that her country had achieved the target of sustainable access to safe drinking water and had made considerable progress in reducing under-5 child mortality, reducing infant mortality rates and reducing the prevalence of malaria deaths. There had also been an increase in tuberculosis case detections and cure rates. However, the country still lagged behind in reducing neonatal and maternal deaths, improving access to reproductive health services, and halting the spread of HIV. The natural disasters that had plagued the Philippines were an added burden because they affected the livelihoods of Filipinos and the health structures in the affected areas. The continuing threat of emerging and re-emerging infectious diseases also affected progress. The Government was pursuing a high-impact strategy to make high-quality affordable health services a reality for all Filipinos.

Dr M.C. NDIAYE (Senegal) supported the statement made by the delegate of Cameroon.

Ms PRETORIUS (South Africa) expressed concern about those areas where little or no progress had been made in meeting the targets set in the Millennium Development Goals. Many low-income countries had struggled to meet the maternal and child health targets and child mortality remained high. Countries in Africa had a long way to go before reaching the mortality levels reported in developed countries. The decline in neonatal mortality was slow, and globally the stillbirth rate remained high. She welcomed the neonatal action plan and urged WHO to support countries in its implementation. WHO, UNAIDS and the Stop TB Partnership should collaborate closely to accelerate progress in combating HIV/AIDS and tuberculosis. All countries should adopt the “90-90-90” targets for both diseases. She urged the Secretariat to provide additional support to Member States in the area of adolescent health.

Mr JAISINGH (Trinidad and Tobago) said that his country had taken several initiatives, including protecting patients’ rights, construction and upgrading of public health-care facilities, integrating sexual reproductive health services at primary care level, and improving mental health services. It was also taking steps to improve health sector responsiveness to the Millennium Development Goals, for example, by remedying internal gaps in data collection, formalizing a modern institutional information technology structure, and updating policies and procedures to ensure that high-quality health care was provided in all health care institutions.

Dr USHIO (Japan) commended the improvements made in various indicators of the health-related Millennium Development Goals but laid stress on the need to resolve disparities between regions and between rural and urban areas within countries. Universal health coverage would enable every citizen to access basic health services. Japan supported the inclusion in the post-2015 development agenda of Millennium Development Goals that had not yet been fully attained.

Mr RUIZ MATUS (Mexico) agreed that more action was needed to promote health measures to decrease the under-5 mortality rate, with an emphasis on actions related to children under one year old, particularly in relation to neonatal deaths. The latter could be prevented by stepping up investment in prenatal care and care during birth as well as during the 24-hour period after birth when 25% to 45% of neonatal deaths occurred. Mexico had adopted many measures to reduce under-5 mortality, including vaccination, promotion of breastfeeding, proper use of antibiotics, and environmental hygiene. Treatment of tuberculosis had yielded an 87.1% success rate. Regarding HIV transmission, Mexico had in place a multisectoral strategy to combat discrimination and promote gender equality.

Dr KESKİNKILIÇ (Turkey) said that data collection errors had resulted in gaps and inaccuracies in published statistics on maternal mortality in Turkey. Authorities had taken steps to reduce maternal and infant mortality rates, and yet the World Health Statistics report incomprehensibly showed an increase of nearly 50% in infant mortality rates for Turkey in 2013; moreover, the Global Health Observatory database and the European Health for All database reported widely diverging numbers for the same variable. Such inaccuracies could only give rise to a lack of trust in WHO's statistical reporting.

Ms CORLUKA (Canada) said that Canada had long championed the Millennium Development Goals and would continue to advocate for maternal, newborn and child health. She was concerned about the lack of country data for the indicators recommended by the Commission on Information and Accountability for Women's and Children's Health. If progress could not be measured and monitored, it would not be possible to determine the areas where global health was failing. Member States, United Nations organizations, the private sector and civil society partners had to collaborate on strengthening national health systems in order to provide integrated and comprehensive health services, particularly at the local level. Canada was a founding member of the Global Financing Facility for Every Woman Every Child, which aimed to bring an end to preventable maternal and child deaths by 2030. The post-2015 development agenda should focus on realistic, achievable and measurable goals and targets along with a strong global monitoring framework that leveraged existing mechanisms. Credible monitoring systems based on timely, reliable, disaggregated data were needed. Furthermore, maternal, newborn and child health should be an essential component of the post-2015 development agenda.

Mr BLACK (United Kingdom of Great Britain and Northern Ireland) said that his country had fulfilled its commitment to spending 0.7% of gross domestic product on international development over the previous two years. He was concerned that further acceleration of progress was still needed in regard to maternal and child health, particularly newborn health.

Dr AL LAMKI (Oman) said that the Millennium Development Goals were a major priority for his country's health system and that Oman had made great progress towards their attainment through the sharing of responsibility between the health sector and other relevant sectors. The objective of attaining the sustainable development goals in addition to the Millennium Development Goals called for the Secretariat to provide support to Member States for the creation of mechanisms for partnership with other organizations involved in the relevant national sectors.

Ms CAO Bin (China) commended WHO's global efforts to realize the Millennium Development Goals. Impressive progress had been made in lowering malnutrition and underdevelopment among children and in reducing newborn and maternal mortality rates. Many developing countries had great difficulty in achieving the Millennium Development Goal targets. WHO should play a lead role and countries needed to mobilize their resources and increase international cooperation. The Secretariat should incorporate health into all policies and relevant indicators, and develop health targets for the post-2015 development agenda. Surveillance and regular updates were also required. The Secretariat should systematically collate best practices used for realizing the Millennium Development Goals in order to provide evidence for the development and implementation of the post-2015 development agenda.

Ms STEVENS (United States of America) noted the existence of considerable agreement on the targets and indicators for ending child and maternal deaths, providing access to family planning, improving nutrition and reducing the burden of infectious diseases such as HIV/AIDS, tuberculosis and malaria. To ensure that those topics were reflected in the post-2015 development agenda and the sustainable development goals, WHO's leadership and the continued engagement of Member States were essential. Furthermore, activities to strengthen health systems were integral to achieving health goals.

Mr PUSP (India) said that his country had made substantial progress in reducing mortality in children under 5 years of age. The maternal mortality rate was also declining, and the prevalence of tuberculosis had been substantially reduced. India had launched a strategic initiative aimed at strengthening the capacity of health care providers. It aimed to extend several components of universal health care, particularly focusing on marginalized populations. Noting with concern that low- and middle-income countries continued to face a scarcity of medicines, he called for renewed international action with the strong support of WHO and other stakeholders.

Dr CHAIRUL RADJAB NASUTION (Indonesia) said that Indonesia faced challenges such as geographical and socioeconomic disparities in achieving the Millennium Development Goal targets. Universal health coverage was essential to attaining those targets. All Indonesian citizens needed to have access to health care services in order for universal health coverage to be possible. Maternal, neonatal and child deaths could be prevented by ensuring quality of care in primary and referral care facilities. Progress in achieving targets should be tracked at the subnational level and accountability needed to be assured. Commitment from the health sector was also required, and multiple global initiatives should be harmonized with and adapted to the national context. Indonesia was working towards strengthening its capacity to use data on health inequalities in order to move forward with universal health coverage, which in turn would ensure equity in progress towards attainment of the Millennium Development Goals and sustainable development goals.

Professor KULZHANOV (Kazakhstan) said that his country's progress in achieving the health-related Millennium Development Goals had been facilitated by health system strengthening and coordination between United Nations bodies, with WHO playing a leading role. Skilled specialists were a further guarantee of success. There was a need to reduce the disparities in the quality of public health care between urban and rural areas, provide continuous training for health professionals and expand the role of nurses. He supported proposals to monitor and control the costs of medicines and medical technology, since high costs were a problem faced by his country. The European Region was the only one where the incidence of diseases such as HIV and tuberculosis, including multidrug-resistant tuberculosis, was growing. He expressed support for the drafting of the proposed sustainable development goals.

Dr AARABI (Islamic Republic of Iran) emphasized the need to analyse the factors impeding the achievement of the health-related Millennium Development Goals, one of which was the failure to achieve a substantial decrease in neonatal mortality, a problem which could be remedied by increasing the budget for neonatal intensive care units and promoting breastfeeding. In order to decrease high rates of caesarean sections in some Member States, natural vaginal delivery should be incentivized, as had been done in his country. Social determinants of health were particularly important in attaining the targets related to pregnancy and neonatal mortality. In that regard, he highlighted the impact of factors including violence against women, physical and mental stress and substance addiction. Environmental factors, such as air pollution and chemical contamination, could lead to miscarriage and preterm birth. Social protection laws that mandated the physical and emotional evaluation of pregnant women by social workers were crucial, alongside government support for pregnant women that went beyond basic maternity leave. Easy and convenient pregnancy should be highlighted as a basic human right in the post-2015 debate on the Millennium Development Goals.

Dr TESFAZION (Eritrea) said that his country's development strategy had focused on developing basic socioeconomic, political, legal and administrative infrastructure and preparing the ground for productive investment and sustainable development. That development strategy had had an impact on health determinants and his country had made significant progress on the three health-related Millennium Development Goals. As a low-income country, Eritrea had achieved success in primary health care through innovative approaches that were low-cost but high-impact. Increased support from WHO and other international organizations was expected in the run-up to the introduction of the proposed sustainable development goals.

Dr PATTARAWALAI TALUNGCHIT (Thailand) requested WHO and other relevant partners to continue to work on the health-related Millennium Development Goals that had not been achieved and to integrate them in the post-2015 development agenda. Given that the Millennium Development Goals had suffered from a lack of attention in the second half of the implementation period, a sustained effort was needed throughout the time frame for the proposed sustainable development goals. A jointly agreed mechanism was needed to promote sustainability and progress on the Millennium Development Goals, which should be comprehensively and systematically reviewed and the results made available to the public. Initial success was relatively easy, but multiple approaches were needed to have an impact on hard-to-reach groups, and external support was needed to achieve difficult targets. The targets for the Millennium Development Goals had been set without related targets for improving health systems. The proposed target for universal health coverage of the sustainable development goal on health would be essential to completing the unfinished agenda.

Dr N'GORAN-THECKLY (Côte d'Ivoire) drew attention to malnutrition, an issue that should be given more prominence in the context of work on the health-related Millennium Development Goals.

Dr BOKENGE BOSUA (Democratic Republic of the Congo) said that, despite good progress to date, the maternal mortality ratio in his country remained high. Accordingly, an acceleration framework had been established to mobilize the resources needed to achieve Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health).

Mr HEGAZY (Egypt) said that, even though much progress had been made towards the Millennium Development Goals, concerted efforts were needed to ensure that outstanding targets were met in the run-up to the United Nations summit for the adoption of the post-2015 development agenda in September 2015. Health should be made central to those efforts, given its inestimable value to humanity. However, one of the main challenges faced by his country – hepatitis C – had not been covered by the Millennium Development Goals and should therefore be included in the proposed

sustainable development goals. The latter should focus on health equity and social justice, and prioritize the most vulnerable sections of the population.

Dr CARBONE (Argentina) said that health should be looked at through the prism of social determinants, which meant that all the Millennium Development Goals were health-related and had a bearing on WHO's promotion of intersectoral policies. Her country was committed to establishing a post-2015 development agenda that incorporated universal access to health care based on the social determinants of health and the reduction of inequities. She therefore requested the Secretariat to carry out a comprehensive final assessment of the Millennium Development Goals strategy and its impact on health that took into account the social determinants of health and identified the main achievements and challenges.

Dr BEN SALEM (Tunisia) expressed regret that his country had not achieved the target for maternal mortality, the continuing high rate of which was due to a failure to convince specialists in gynaecology and obstetrics to work in unattractive regions. Tunisia was therefore developing an acceleration strategy in cooperation with WHO and other organizations in the United Nations system.

Ms PEARCE (Nauru) noted that significant progress had been made in her country in areas such as infant and maternal mortality and access to water and adequate sanitation. There was still room for improvement, especially in terms of skilled health personnel, as members of the workforce in Nauru tended to exercise multiple responsibilities. She expressed concern about the large number of goals and indicators proposed for the post-2015 development agenda, but said that Nauru was committed to strengthening its health system through a whole-of-government, whole-of-community, whole-of-family approach that ensured universal access to health care.

Ms Yi-Ching WANG (Chinese Taipei) said that significant progress had been made in Chinese Taipei towards achieving the Millennium Development Goals, notably through improved nutrition, reduced child and maternal mortality and lower HIV infection rates. Preventive health-care services had been scaled up and tuberculosis morbidity had declined for seven consecutive years. Chinese Taipei was committed to promoting global targets.

Ms GABELNICK (Global Health Council, Inc.), speaking at the invitation of the CHAIRMAN, noted that, despite significant progress on Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases), it could not be said that the HIV/AIDS epidemic had been halted, as was claimed in paragraph 2 of the report. HIV funding and programmes should be maintained to prevent the virus rebounding owing to complacency. Indeed, ending the epidemic by 2030 would require an increase in resources. The report had not reflected the fact that young children and adolescents, particularly girls, were disproportionately affected by HIV, and adolescents were the only group globally experiencing an increase in deaths from AIDS. She encouraged delegates to intensify action on HIV/AIDS, particularly with regard to children, adolescents and young women.

Dr BUSTREO (Assistant Director-General) commended Member States on the considerable progress that had been made towards achieving the health-related Millennium Development Goals over the previous 15 years. More money had been allocated to health, and unprecedented improvements had been seen in maternal and child health and in combating HIV/AIDS, malaria and tuberculosis. Nonetheless, work in several critical areas had fallen behind, including maternal and neonatal mortality, sexual and reproductive health and rights, HIV infection, particularly in young girls, and adolescent health. Efforts should be accelerated in the remaining six months of the implementation period and it should be ensured that health remained central to the proposed sustainable development goals. Referring to comments on the estimates for maternal and child mortality, she said that the Secretariat was committed to working with Member States to improve the data underlying those estimates and strengthen the capacity of countries to analyse data and make their

own estimates. In response to the requests for an assessment to be made of the lessons learnt from implementation of the Millennium Development Goals, she said that the *Bulletin of the World Health Organization* had recently included a call for papers[1] on lessons learnt and progress made in the health of women, children and adolescents. It was clear that unfinished business from the Millennium Development Goals should be a key element of the new sustainable development agenda. She assured the delegates of Lebanon and the United States of America that the vision of ending preventable maternal, newborn and child deaths was at the centre of the United Nations Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health.

The Committee noted the report.

The meeting rose at 17:40.

[1] Bustreo F, Gorna R. Knowledge for effective action to improve the health of women, children and adolescents in the post-2015 era: a call for papers. Bulletin of the World Health Organization, 2015; 93(5):285-360, available at http://www.who.int/bulletin/volumes/93/5/15-156521.pdf?ua=1 (accessed 25 June 2015).

TENTH MEETING

Friday, 22 May 2015, at 18:00

Chairman: Dr E. JARAMILLO NAVARRETE (Mexico)

PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 14 of the Agenda (continued)

Health in the post-2015 development agenda: Item 14.2 of the Agenda (Document A68/14)

Mr DE SANTIS (Switzerland) recalled the difficulties experienced with the tools and data for monitoring progress towards the Millennium Development Goals. With regard to the proposed sustainable development goals, he supported the overarching health goal proposed by the Open Working Group on Sustainable Development Goals, which promoted global engagement in achieving universal health coverage. By offering primary health care, including high-quality sexual and reproductive services, universal health coverage was crucial for fulfilling the right to health. Such a goal would also encourage a multidimensional response to the broad-ranging determinants of health. The health goal should encourage efforts to achieve and surpass the Millennium Development Goals.

Within the United Nations Statistical Commission, WHO should take a lead role in drawing up appropriate indicators for not only the health goal but also other goals that had a direct impact on health. It should also oversee follow-up and dialogue at country level, and periodically review progress through the High-level Political Forum on Sustainable Development. Member States should be informed of progress and obstacles through the Health Assembly.

Ms RABOVICA (Latvia), speaking on behalf of the European Union and its Member States, said that the following countries aligned themselves with her statement: Serbia, Albania, Bosnia and Herzegovina, Ukraine and Republic of Moldova. She highlighted the importance of health as an integral part of the post-2015 development agenda, including its contribution to poverty eradication, and, hence, the need to ensure universal health coverage and social protection for all, especially the poorest and most vulnerable. The European Union was committed to integrating a human rights-based approach into all development activities, including those connected with sexual and reproductive health. Prevention and control of communicable and noncommunicable diseases (including outbreak preparedness) should also be emphasized in the post-2015 development agenda, in order to alleviate the burden that disproportionately affected low- and middle-income countries. She affirmed WHO's leading role in developing the monitoring framework and supported the ongoing discussion on the means of implementation.

Mr USAMATE (Fiji), speaking on behalf of 14 Pacific island nations, said that the Eleventh Pacific Health Ministers' Meeting (Yanuca, Fiji, 15–17 April 2015) had recognized that most of the post-2015 development agenda was aligned with their vision for guiding health development in the Pacific. In particular, he supported proposed sustainable development goal 3 and welcomed the focus that was being placed on noncommunicable diseases and the integration of health in other proposed sustainable development goals, such as those relating to poverty, nutrition and water, sanitation, climate change and the oceans – the latter having particular significance for Pacific island States as some of them were already in danger of being submerged. He appreciated the scope of the proposed sustainable development goals, but noted with concern the proposal to draw up a short list of indicators. He appealed for those relating to the areas he had mentioned to be retained.

Ms ELLIOTT (Australia) commented that her country was active in the negotiations on the post-2015 development agenda, aiming for a simple, concise and compelling document that focused global efforts towards economic growth and poverty reduction. She had noted with satisfaction that the Open Working Group's proposed health goal and targets carried forward the unfinished business of the Millennium Development Goals, and welcomed the focus on noncommunicable diseases, sexual and reproductive health, and universal health coverage. Designing a robust and fit-for-purpose accountability framework that supported development outcomes without diverting resources from delivering results was crucial.

Mrs NDLELA-SIMELANE (Swaziland), speaking on behalf of the Member States of the African Region, welcomed the inclusion of health as a separate proposed sustainable development goal, but underlined the need for national and international partnerships to mobilize adequate resources for implementing the post-2015 development agenda. Member States had noted the need to review the number of proposed targets and indicators and she affirmed their commitment to continue contributing to the work, including alignment and harmonization with existing systems for monitoring and evaluation. Given that the outbreak of Ebola virus disease in West Africa had brought national economies to a halt, technical support from WHO and other partners was essential in order to ensure adequate surveillance for early detection of possible future disease outbreaks. The gains stemming from work towards the Millennium Development Goals should be extended through community ownership of primary health care strategies and universal health coverage. The Africa Agenda 2063, adopted in January 2015, placed emphasis on investment in human capital through education and health. She called for continued advocacy to consolidate the position of health in the post-2015 development agenda.

Dr AL-TAAE (Iraq) said that all indicators and standards that had been elaborated for the Millennium Development Goals should be reviewed during the development of a strategic work plan for the post-2015 development agenda. Similarly, the lessons learnt from the difficulties encountered should be applied in the work plan, which should focus on all epidemiological and demographic variables. It should also pay more attention to: the need for better monitoring and evaluation, and more partnerships; reducing maternal morbidity and mortality through establishment of early warning and response systems, with greater emphasis on preventing birth defects and improving perinatal health; combating communicable diseases, including through raising awareness of risk factors and promoting disease prevention; social, environmental and economic determinants of health; intersectoral collaboration; gender issues; and health security.

Mr MAGNÚSSON (Iceland) welcomed the content of the proposals and WHO's participation in the negotiations in the interests of ensuring the centrality of health in all relevant processes. Work should continue to focus on noncommunicable diseases, injuries, universal health coverage, and social and environmental determinants of health. With particular reference to proposed target 3.4 on reducing by one third premature mortality from noncommunicable diseases through prevention and treatment and promoting mental health and well-being, and target 3.6 on halving global deaths and injuries from road traffic accidents by 2020, he stressed prevention, treatment and the well-being of those living with noncommunicable diseases or suffering from injuries. In that regard, he urged Member States to continue their efforts to increase existing knowledge on, and find treatment for, diseases of the nervous system and spinal cord injuries.

Dr GRECH (Malta) said that the post-2015 development agenda process should be based on a single comprehensive and coherent framework in order to ensure significant results at all levels. He reiterated his Government's position that any recommendation or commitment by the European Union related to health in the post-2015 agenda should not create an obligation on any party to consider abortion as a legitimate form of reproductive health, right or commodity.

Dr TAKIAN (Islamic Republic of Iran) expressed the hope that the Third International Conference on Financing and Development, due to be held in Addis Ababa on 13–16 July 2015, would successfully address the main challenge of the availability of adequate financing and experienced human resources for implementing the proposed sustainable development goals. Care should be taken to ensure that valuable new work was not sacrificed, but indicators should be consistent with those already agreed by the Health Assembly and United Nations General Assembly, and overlaps should be avoided. The proposed sustainable development goals should take sufficient account of health in emergency and conflict situations. Health information systems must include the relevant data, as health statistics were the essential metrics of progress towards sustainable development and because good health and well-being in the fullest sense were a reflection of economic, environmental and social improvement. National health information systems needed strengthening in order to enable countries to report on identified indicators. The health sector should actively engage in multisectoral partnerships for coordinated action through a health-in-all policies approach. In addition, cross-cutting issues, including health system strengthening, increasing resources, and access to health care and functional infrastructures, needed to be considered.

Dr CORLUKA (Canada) commended WHO's valuable technical work in the post-2015 development agenda process and urged continued collaboration with the United Nations Statistical Commission. The indicators used to measure progress by all protagonists should be consistent.

In order to take advantage of the opportunity to end the preventable deaths of women and children within a generation, Canada sought to ensure that maternal, newborn and child health remained a central global priority on the post-2015 agenda; that meant realistic, achievable and measurable goals and targets, and a strong global monitoring framework, underpinned by reliable data and supported by strengthened civil registration and vital statistics systems. To that end, Canada continued to promote greater accountability for results and resources for maternal, newborn and child health through its engagement in the renewed global strategy for women's, children's and adolescents' health, and support for the Global Financing Facility in Support of Every Woman Every Child.

Ms HARB (Lebanon) recalled that her country had long since achieved Millennium Development Goals 4 and 5 and was focusing on discrepancies in areas affected by the Syrian crisis. All 17 proposed sustainable development goals could be related to health, but they could not be achieved through single-sector actions. WHO should promote the inclusion of health in any international sustainable development framework through the integration therein of health targets and indicators. The outcome should be a political declaration, with monitoring and evaluation tools to facilitate its implementation. Indicators should build on achievements in the area of noncommunicable diseases, injuries, universal health coverage, and the social and environmental determinants of health. There should be consistency between existing and new indicators, and health information systems should be strengthened to ensure reporting on new indicators.

Dr AL MOSAWI (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that noncommunicable diseases, injuries and mental health should be included in the post-2015 development agenda, and urged consideration of the social determinants of health and intersectoral action. Lessons had to be learnt, particularly those concerning resourcing, from how the work towards the Millennium Development Goals had been affected by national contexts and determinants, in order to facilitate the global attainment of the proposed sustainable development goals. Appropriate consideration had to be given to emergency and conflict situations.

Multisectoral actions were required on the social, environmental and economic determinants of health. As health often depended on economic and social conditions, health-related issues should remain on the shortened list of indicators. The Director-General should coordinate more closely with the United Nations and development partners to sustain political commitment and advocate investment in the health-related sustainable development goals. She urged WHO to hold a high-level meeting following the adoption of the proposed sustainable development goals in order to establish steps towards their attainment.

Mr B.A. MOHAMED (Egypt) emphasized the importance of health in the attainment of all 17 proposed sustainable development goals, and the need for multisectoral action. The related targets and indicators should be clear and include the promotion, prevention and treatment of communicable and noncommunicable diseases. He seconded the proposal by Switzerland for WHO's role with the United Nations Statistical Commission to ensure comprehensive health-related indicators. He encouraged health-related investment, particularly in universal health coverage. Expressing concern about the global burden of hepatitis C, he called for the inclusion of an indicator on hepatitis C in the proposed list of targets under sustainable development goal 3.

Ms CAO Bin (China) said that a comprehensive evaluation of international development and cooperation would facilitate further discussions and decisions on the proposed sustainable development goals. Different national conditions, development paths and development stages should be taken into account and the principle of common but differentiated responsibilities upheld. The Secretariat should strengthen its support to developing countries, in particular the least developed countries, and developing countries should harness national resources to build national capacity.

Mr LA Ki-tae (Republic of Korea) argued that, even if health itself was one of the 17 proposed sustainable development goals, it was inherent in the other 16 goals. The nine targets for proposed goal 3 should include all those already identified by the Health Assembly as essential, in particular universal health coverage. Indicators had to be measurable and affordable, and the Secretariat and Member States must collaborate to ensure that the right tools existed for implementing the post-2015 health-related development agenda. Advocacy for health had to take place at the national, regional and international levels.

Ms MARTINEZ (Ecuador), speaking on behalf of the Member States of the Union of South American Nations, noted the progress made towards the health-related Millennium Development Goals but recognized the remaining challenges, particularly relating to health. She commended the work on the nine health-related targets under proposed goal 3 and the momentum towards universal health coverage. Intersectoral action would be needed to attain the proposed sustainable development goals, and progress indicators had to reflect that approach as well as the social determinants of health.

Dr PATTARAWALAI TALUNGCHIT (Thailand) expressed support for the comprehensive proposed goal 3 on health. Although the nine targets were broad-ranging, those on access to sexual and reproductive health and universal health coverage (targets 3.7 and 3.8) should be clearer and more specific with defined indicators.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) urged both Member States and the Secretariat to continue developing indicators and monitoring frameworks to ensure alignment with other mechanisms, such as WHO's global monitoring framework for noncommunicable diseases. Further, Member States and the Secretariat must continue to press for the inclusion of references to antimicrobial resistance in the proposed sustainable development goals; without such references the agenda would be neither credible nor coherent.

Ms KATJIVENA (Namibia) welcomed the cross-cutting approach of the sustainable development goals and the continued focus in proposed goal 3 on maternal and child health and noncommunicable diseases. Proposed goal 5 on gender equality and empowerment of women and girls should be expanded to cover all vulnerable groups. The experience of the Millennium Development Goals showed that good governance and strong national leadership, resilient health systems, adequate resources, stable economic policies, good statistical capacity, and peace and political stability would be vital to the success of the post-2015 development agenda. Broad partnerships built on intersectoral civil society cooperation and community participation would therefore be essential to the achievement of the proposed sustainable development goals.

Dr OGAJA (Kenya) recognized the efforts to ensure the centrality of health in the post-2015 development agenda and to complement the health-related Millennium Development Goals. Having failed to achieve all the Millennium Development Goals, Kenya had identified health as a human right in its new Constitution, thereby establishing an obligation to achieve the health-related Goals. She urged all Member States to advocate health as the central pillar of the future development agenda. The gains achieved thus far could only be sustained by adopting context-specific universal health coverage policies that built on the progress made over the past decade in promoting maternal child health and the control of HIV, malaria and tuberculosis. Kenya was creating strategic partnerships to realize the aims of proposed goal 3 on health. She encouraged WHO and other organizations in the United Nations system to use their collective strengths within the development agenda to help developing countries to mitigate the impact of noncommunicable diseases.

Mr KPEGBA (Togo), expressing the hope that the United Nations summit on the post-2015 development agenda would adopt an ambitious work plan for the next 15 years, encouraged Member States to ensure that funding was directed to the attainment of the proposed sustainable development goals at both the global and national levels. For efficient management of data related to the sustainable development goals, the United Nations Statistical Commission should produce a list of key indicators that was shorter but included noncommunicable diseases, universal health coverage, and social and environmental determinants of health.

Mr DE ANDRADE FILHO (Brazil) acknowledged the challenge of the post-2015 development agenda, which had to remain relevant, and the inclusion of the three pillars of sustainability: economic development, environmental protection and social justice. Member States should review their national plans to incorporate intersectoral action, as health was an issue that cut across all the proposed sustainable development goals. A large number of indicators would not limit effectiveness, but they had to be carefully chosen to facilitate implementation of the post-2015 development agenda and ensure a more inclusive and sustainable development model.

Dr WILLSON (Panama) said that, although progress had been made in the attainment of the Millennium Development Goals, progress in areas such as reducing maternal mortality rates, improving the water supply in rural areas and decreasing the number of people living in slums had slowed in recent years. Hunger, gender inequality and gender-based violence continued to be challenges. The focus of health-related goals in the post-2015 development agenda should be on reducing the burden of communicable and noncommunicable diseases and injuries. Multisectoral measures to address the social, economic and environmental determinants of health would be vital to achieve universal health coverage and promote physical and mental well-being. The epidemic of noncommunicable diseases was especially burdensome for low- and middle-income countries, with devastating consequences for economies and society, particularly the poorest populations. Health education, community organization and the participation of other sectors, civil society and industry were all useful strategies in that regard. Tackling the social determinants of health, particularly poverty and malnutrition, should be a central priority of the post-2015 development agenda. The economic and

social development of countries was not possible without health and it was time to move from discussions to action to fight inequality in all its forms.

Ms GÓMEZ GÓMEZ (Colombia) stressed the centrality of health in the post-2015 development agenda, and urged the Secretariat and Member States to continue work towards the attainment of the Millennium Development Goals and to prepare for the health-related sustainable development goals. Colombia had decided to include the latter in a national development plan and policies. An intersectoral committee had been established to monitor follow-up of progress towards those goals. Cooperation among all bodies in the health sector should be promoted in order to work towards the attainment of other proposed sustainable development goals.

Dr DAKULALA (Papua New Guinea) said that his country could more actively engage with the post-2015 development agenda than with the Millennium Development Goals, which remained an unfinished agenda. As universal health coverage constituted an overarching framework in the proposed post-2015 development agenda, his country would use that approach to strengthen its health system and provide equitable access to quality health services.

Ms RUIZ VARGAS (Mexico) said that all efforts should be made to accelerate the achievement of the health-related Millennium Development Goals, reduce the burden of noncommunicable disease and guarantee universal health coverage. The primary objectives of equality and sustainability should be incorporated into the post-2015 development agenda. The proposed agenda should be disseminated among civil society, the education sector and private partners, each of which had a fundamental role to play in the formulation of the agenda. Although the proposed goals were commendably universal, the targets should be adapted to each national situation. Furthermore, it would be crucial to monitor progress towards the targets and the results of public policy in that area.

Ms Li-Ying LAI (Chinese Taipei) welcomed the emphasis on equity, rights, maternal and child health, noncommunicable disease control and universal health coverage in the discussion of the health targets of the post-2015 sustainable development goals. Indicators on noncommunicable disease risk factors should, however, be included, as progress in that area depended on political will and a health-in-all-policies approach. In the reform of its health system, which included merging health and social welfare departments, Chinese Taipei was fostering intersectoral cooperation and developing strategies to reduce noncommunicable diseases and promote mental health. Health was vital for social development and the public sector and civil society shared a joint responsibility for health and welfare.

Mr SIMPSON (World Dental Federation), speaking at the invitation of the CHAIRMAN, noted that many of the targets under proposed goal 3 on health were of direct concern to oral health professionals. The Tokyo Declaration on Dental Care and Oral Health for Healthy Longevity called for recognition that oral health was fundamental to quality of life, helped to protect against noncommunicable diseases and contributed to a longer life expectancy. Dental and other health professionals should encourage collaborative practice across all professions and sectors. Oral health should be included in the consideration of indicators to monitor progress towards the proposed sustainable development goals and in the drafting of policies and guidelines.

Dr KEENAN (International Pediatric Association), speaking at the invitation of the CHAIRMAN, said that, despite progress towards the Millennium Development Goals, 7700 newborns died every day and thousands were left with disabilities as a result of their birth; much of this morbidity and mortality was preventable. The following principles should underlie the sustainable development goals: each country must have a plan for human and financial resources to reduce neonatal deaths; maternal health must be improved; equity and access to health care were vital; the relationship between maternal and child health and other determinants of health must be recognized;

good statistics were essential; and paediatricians, obstetricians and midwives should be included in advocacy and policy planning.

Dr COPELAND (World Federation for Mental Health), speaking at the invitation of the CHAIRMAN, urged WHO to ensure that mental health was specified in proposed goal 3, which should be entitled "Ensure healthy lives and promote *physical and mental health and* well-being …". Target 3.4 should read "by 2030 reduce by one third preventable mortality from noncommunicable diseases through prevention and treatment … in full accordance with the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020 … and promote mental health and well-being in full accordance with the WHO mental health action plan 2013–2020". Target 3.8 should read "Achieve universal health coverage for physical and mental disorders". Indicator 23 should include the reduction of suicide rates and indicator 28 should read "to increase the proportion of persons with severe mental disorder (psychosis, bipolar affective disorder, or moderate-severe depression) who are using services". He called for support for those amendments, which had been endorsed by hundreds of organizations in many countries, in order to raise the profile of mental health.

Dr HOEMEKE (IntraHealth International Inc.), speaking at the invitation of the CHAIRMAN, argued for the proposed sustainable development goals to prioritize access to health workers for all people. The shortage in the global health care workforce undermined every aspect of health care delivery. Universal health coverage and resilient health systems were not attainable without the necessary staff. The post-2015 development agenda must include a specific health workforce target to ensure that all persons had access to a health worker. She urged the Secretariat and Member States, as requested in resolution WHA67.24, to finalize by 2016 a new global strategy for human resources for health, which should be taken into account in the post-2015 development agenda.

Ms LEONG Wai Yee (World Vision International), speaking at the invitation of the CHAIRMAN, underlined that the success of the post-2015 development agenda would be measured by its ability to reach the most disadvantaged children in the most remote areas. The negotiations on the proposed sustainable development goals should encompass measures for implementation of and monitoring progress towards the goals. Moreover, accountability mechanisms at all levels should be promoted. In order to ensure that the goals brought about real change, it was crucial to involve citizens, including children and young people, in data gathering, planning, monitoring and reviewing. Her organization was mobilizing people to urge the adoption of an ambitious post-2015 development agenda that included goals to end preventable child deaths, malnutrition and violence against children.

Mr LUCHESI (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that the sustainable development goals should retain the focus of the Millennium Development Goals on reducing maternal, newborn and child mortality and welcomed the inclusion of universal health coverage and the more ambitious proposed targets. Progress must be measurable in all socioeconomic groups rather than being subsumed in national averages. The overall goals process required multistakeholder accountability mechanisms at all levels of the world community. The weaknesses in the health systems of the countries affected by Ebola virus disease in 2014 and 2015 were also present in the health systems of other countries: policies at global and national levels must change to ensure sufficient funding for comprehensive primary health care.

Ms MATZKE (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN, called on Member States to ensure that all elements of the post-2015 development agenda included references to health; to make specific commitments at the Third International Conference on Financing for Development to providing the maximum possible allocation of resources to prevention and control of noncommunicable diseases; to define and promote a clear role for civil society in the review mechanisms of the post-2015 development agenda; and to prioritize the reduction of noncommunicable diseases in national-level health planning.

Ms BATTELLO (Handicap International Federation), speaking at the invitation of the CHAIRMAN, recommended that: universal health coverage should be central to the proposed sustainable development goal 3; health-related action at the global level should be comprehensive across the health continuum; health information systems should be strengthened; a financing framework should be developed for inclusive health, including rehabilitation services and assistive devices; and persons with disabilities, who had been poorly served by the Millennium Development Goals, should be consulted in the planning and implementation of disability-related policy.

Ms NALUBANGA (International Baby Food Action Network), speaking at the invitation of the CHAIRMAN, said that the Millennium Development Goals process had not paid enough attention to malnutrition: almost a quarter of all children were still not adequately nourished. The sustainable development goals would only succeed if people became active participants in the process rather than recipients of charity, if governments and international organizations were accountable to those they served, if public policy-making was protected from conflicts of interest, and if the right indicators were chosen, one of which should relate to exclusive breastfeeding for the first six months of life. WHO should act in line with the recommendations on conflict of interest set out in the framework for action of the second International Conference on Nutrition, and she urged the Secretariat to conclude its work on such safeguards for nutrition.

Mr SOUSA (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, urged WHO to concentrate on supporting the elaboration of targets and indicators before the adoption of the proposed sustainable development goals, in particular those for goal 3; the ambitious targets, such as ending the epidemics of AIDS and malaria by 2030, would need WHO's full commitment.

Health should be seen as relevant to all the proposed goals, whose implementation would need application of Health in All Policies, recognition of health as a cross-cutting issue, and consideration of social determinants of health. Cross-sectoral targets would be vital for measuring progress. He called for independent targets for several important health areas that were absent, such as primary health care, health literacy and patient empowerment, and further discussion on some proposed targets, such as target 3.c, which should refer to education rather than training of the health workforce globally.

Dr KIENY (Assistant Director-General) thanked speakers for their comments. The Secretariat would continue to contribute technical advice in the different debates on the proposed goals, including those on financing for development and indicator frameworks. The financing framework was scheduled to be ready for September 2015 following the Third International Conference on Financing for Development (Addis Ababa, 13–16 July 2015), and the indicator framework would be submitted to the United Nations Statistical Commission by March 2016. WHO had been designated an observer in an interagency and expert group on the proposed indicators that had been established with representatives from 28 national statistical offices, and was continuing to provide technical advice. She recognized the need to continue to engage in discussions on the development and implications for the health sector of goals, targets, financing and monitoring of the post-2015 framework at all levels.

The Committee noted the report.

Adolescent health: Item 14.3 of the Agenda (Document A68/15)

Dr AL-TAAE (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the proposal to develop a framework for accelerated action for adolescent health. Global efforts to adopt a comprehensive approach on adolescent health urgently needed intensification. The involvement of various sectors and stakeholders, including adolescents, in addition to multisectoral collaboration led by health ministries and anticipation of the constraints of

coordination mechanisms were necessary for effective support for adolescent health and development. The framework should be flexible so as to accommodate culturally and religiously sensitive health issues, especially those relating to sexual and reproductive health and use of psychoactive substances, and allow for adaptation at country level. Adequate financial and human resources should be allocated to provide appropriate and friendly health services for adolescents. He welcomed the proposed consultative process with Member States in the development of the framework, with the participation of adolescents.

Dr KALANTARI (Islamic Republic of Iran) said that the third phase of the framework development should take into account the involvement of countries with diverse communities to ensure applicability to different sociocultural contexts. Universal health coverage, with intersectoral engagement, integrated services and appropriate resources, was the most comprehensive approach to adolescent health. The approach could incorporate the following components: measurable indicators of service provision and health; annual student health-screening programmes; adolescent health service packages for primary health care professionals; high-risk behaviour surveillance systems; self-care programmes, through training in healthy lifestyles; morbidity and mortality surveillance systems for injuries and diseases; parenting and life skills education; and puberty and pre-puberty consultation services.

Dr KABIRU (Kenya), speaking on behalf of the Member States of the African Region, said that accelerated action for adolescent health was essential to reduce the unacceptably high mortality rate, largely due to preventable causes, among young people. In the Region, the leading causes of adolescent deaths were injuries from accidents and violence, HIV/AIDS, and reproductive and maternal health problems. Substance abuse, including tobacco and alcohol use, mental health, physical inactivity and noncommunicable diseases were also growing concerns. Health policies were essential in order to protect adolescents who were key assets for their families, communities and countries. The efforts to develop a framework that was aligned with the updated Global Strategy for Women's, Children's and Adolescents' Health were welcome. The framework should build on and reinforce relevant existing global and regional strategies and action plans, and should be practical and comprehensive. Its development should involve adolescents in an all-inclusive process, in order to take into account their perspectives and provide the necessary grassroots support. The draft framework should be submitted to the regional committees for further input beyond the proposed web-based engagements. The Member States of the Region would engage fully in its development.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) supported the proposed framework and the efforts to raise the profile of adolescent health, but stressed that the framework and its development should be aligned with other global and international initiatives. She asked for further details of such alignment. She strongly supported both the inclusion of interventions that tackled the common determinants of major health problems and the focus on youth participation. Policies and programmes that empowered adolescents to realize the right to control their own health and bodies were central to the success of the framework. Investing in adolescent health and well-being was important for the recognition of their rights and global development.

Dr JENYFA (Maldives), speaking on behalf of the Member States of the South-East Asia Region, highlighted some of the public health issues facing more than 350 million adolescents living in the Region. Numerous regional and national actions had been undertaken to improve the health and well-being of adolescents and young people, including support by the South-East Asia Regional Office for Member States to strengthen policies and develop national adolescent health programmes. Provision of comprehensive adolescent health services, however, remained a challenge owing to cultural norms and restrictive policies. For programmes to succeed, it was vital to strengthen adolescent health-related information for evidence-based policies and guidelines, improve regulatory frameworks to increase access to youth health services, and boost multisectoral responses. The five

domains of the proposed framework would meet adolescent health concerns and improve the health and well-being of young people. Further work on the proposed framework was needed.

Dr ROY (Bangladesh) welcomed the development of a framework for accelerated action for adolescent health. Bangladesh needed to expand adolescent-friendly health services. It appreciated the support of the Regional Office in strengthening national strategies and plans but needed further support in the following priority areas: nutritional awareness and services; raising the age of marriage and first pregnancy; eliminating discrimination against and enhancing the social protection of female adolescents; and institutionalizing a results framework for monitoring and evaluation. He urged WHO to mobilize rapidly more technical and financial resources for adolescent health.

Mr BEDFORD (Australia) said that WHO was the natural leader for work at the global level on meeting the needs for adolescent health, and he encouraged the Secretariat to fully integrate adolescent health into its programme planning, particularly in the areas of reproductive, maternal, newborn and child health, HIV/AIDS and mental health. He supported the approach proposed to develop the draft framework, and called for a joint WHO/United Nations approach that took into account the areas of mutual expertise and avoided duplication and fragmentation of effort.

Dr HINOSHITA (Japan) said that, as the lifestyle of adolescents had major consequences for the subsequent onset of noncommunicable diseases, WHO's work on prevention were important. Collaboration with other relevant organizations and across sectors was vital. The draft framework should be consistent with the renewed Global Strategy for Women's, Children's and Adolescents' Health.

Dr ENNIS (Jamaica) said that her country had a very high adolescent fertility rate, with legislation that prohibited health care workers from providing reproductive services to minors. To remedy that situation, the Government was drafting a policy on access to medical information, advice, health and health-related services at public health facilities to sexually active persons below the age of majority (18 years). She welcomed the proposed framework.

Dr ELSOBKY (Egypt) said that his country, recognizing adolescent health as a public health challenge, had taken a primary health care approach in adopting several policies. Its programme had established sustainable youth-friendly primary health care services and units; included the topic in medical and nursing training; developed adolescent health interventions; and introduced a system for monitoring service provision. The mortality due to road traffic injuries was recognized and multidisciplinary teams provided services for mental health issues. Legislation and constitutional changes had been introduced to ban early marriage and female genital mutilation. He welcomed the Secretariat's programme on adolescent health, which needed to be addressed in a way that was not in contradiction to his country's culture, ethics or norms.

Dr MSEMO (United Republic of Tanzania), highlighting some of the health problems and needs facing the young people in her country who constituted nearly one third of the population, recognized that the health sector must respond to the problems affecting the reproductive health of adolescents and youth, such as unmet contraceptive needs. Young people bore a disproportionate share of the burden of disease, including new HIV infections. Her Government had set in place policies, strategies and guidelines to support adolescent health. She welcomed the proposal to develop a framework for accelerated action for adolescent health that was aligned with an updated Global Strategy for Women's, Children's and Adolescents' Health; it would enable adolescents to enjoy the highest attainable standard of health and lay the foundations for a positive transition to adulthood.

Dr YOUBI (Morocco) said that his Government recognized the need to provide adequate health services, support and life-skills training to its considerable population of young people. He supported

the proposed action but urged the Secretariat to provide support for research on increasing problems among adolescents, particularly suicide and compulsive information and communication technology use, and for developing sexual education programmes that were adapted to their national social and cultural contexts.

Ms ST. LAWRENCE (Canada), recognizing that outreach to population groups such as adolescents, especially adolescent girls, was crucial to achieving global health targets, welcomed the intended alignment of the proposed framework with existing strategies and other initiatives such as the renewed Global Strategy for Women's, Children's and Adolescents' Health and the linkages with other sectors. She strongly encouraged the active participation of young people in the development of the framework. Countries should define their own strategies within the context of universal health coverage, taking into account social and economic contexts. Prevention of noncommunicable diseases, many of whose risk factors young people experienced, needed leadership, coordinated multistakeholder and multisectoral engagement, and action, encompassing all levels of government, civil society and the private sector. The framework should fully integrate the principles of gender equality, with gender-sensitive indicators, and collected data should be disaggregated for sex, age and other relevant factors.

Mr DE ANDRADE FILHO (Brazil) commented that discussions to accelerate action for adolescent health must take place at national, regional and global levels. Brazil had made progress within its multidisciplinary, multisectoral, approach to policy-making, which was aligned with PAHO's Adolescent and Youth Regional Strategy and Plan of Action, and guidance for health professionals, but it recognized that much remained to be done to ensure universal and equitable access to health services.

Dr ALGARNI (Saudi Arabia) stated that the fifth main domain of the proposed framework, on "safe sexual debut, when ready and wanted", was unacceptable from the viewpoint of his country's cultural and religious sensitivities. He urged the Secretariat to consider either deleting or amending the text to reflect national development plans and priorities.

Mrs JABLONICKA (Slovakia) welcomed the development of a framework for accelerating action for adolescent health, but said that, in view of the risk factors associated with premature sexual relations, the fifth programmatic guideline on "safe sexual debut, when ready and wanted" should be amended to include reference to maturity. Adolescent girls in some countries were marginalized and vulnerable to forced marriage and sexual violence. HIV/AIDS, self-harm and interpersonal violence were among the leading causes of adolescent and youth mortality. Endorsing the emphasis on the supportive and protective role of families, communities and policies, she proposed that the framework should also include, as a core strategy, improving education on parenting and partnership skills, especially for vulnerable groups.

Ms BIN Cao (China) underlined the importance for adolescents' health of a protective and supportive environment. In addition to ensuring access to regulated and well-equipped family planning services for young people of child-bearing age, her Government, in the interest of social development, was piloting an integrated, sustainable, service model in medical centres, universities, private institutions and local communities with an emphasis on changing health-compromising behaviours. China was keen to work and exchange experience with others to improve adolescent health globally.

Dr BENJAWAN TAWATSUPA (Thailand) observed that the greatest harm to adolescents came from the social determinants of health and the consequences of health-compromising behaviours continued through adulthood, also affecting the next generation. A multisectoral approach with more attention to interventions that address the determinants of multiple risk behaviours was therefore crucial. Priority should be given to alcohol use, teenage pregnancy, physical inactivity and, in

particular, mental disorders, most cases of which went unrecognized and untreated, with serious consequences.

Mr SPANGLER (United States of America) applauded WHO's leadership in developing a draft framework, with collection of specific and disaggregated data, and ensuring the involvement of adolescents and youth in the decision-making process. The framework should comprise strategies that were developmentally appropriate and promoted a positive transition into adulthood, backed by measurable objectives and indicators to evaluate progress and multistakeholder engagement in producing, testing and disseminating evidence-based policies and programmes. Key considerations included sexual and reproductive health needs, HIV/AIDS, mental health needs, an understanding of cultural and faith-based contexts, and the prevention of interpersonal violence and human trafficking, with a particular focus on the needs of the victims.

Ms FIERRO (Mexico) said that the increasing public health challenge of adolescent health required urgent measures to improve the quality and coverage of services and interventions. She supported the alignment of the proposed framework with the renewal of the Global Strategy for Women's, Children's and Adolescents' Health. Mexico accepted the three stages of development of the framework, and welcomed the inclusion of both experts and adolescents in the drafting process.

Dr AHMED BASHIR ABUKARAIG (Sudan) recognized that addressing the needs of adolescents was a real challenge in some national contexts. She welcomed the proposed framework, which would facilitate progress at the country level, but proposed adding a seventh element to the list of common determinants, namely partnership, which would be crucial for a comprehensive and coordinated approach to adolescent health. The three-stage development process should ensure that diverse cultural contexts were taken into account in the pilot phase. She supported the five proposed domains for programmatic action, but expressed serious concern about "safe sexual debut, when ready and wanted". She acknowledged the need to advocate against early marriage, unwanted or early pregnancy and unwanted abortion, but warned that the text could be viewed as critical and therefore hinder action. "Safe" sex could not always be guaranteed in areas where adolescents did not access health services, and "ready" and "wanted" were not clearly measurable or defined. That domain needed an innovative, culturally-sensitive approach if it were to protect adolescents from risky behaviours.

Mr SALAKHOV (Russian Federation) supported the development of the proposed framework. As a result of his Government's recent legislation to protect citizens from the consequences of tobacco use, smoking among children and adolescents had fallen, and a law classifying beer as an alcoholic product had reduced sales to minors and resulted in a sharp fall in adolescent consumption of alcohol and more than halved the rate of appearance of signs of alcoholism in adolescents. He also drew attention to the problems related to physical inactivity and poor nutrition. His country strongly supported WHO's work on improving adolescent health and approved the planned consultation process.

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

The meeting rose at 21:00.

ELEVENTH MEETING

Saturday, 23 May 2015, at 09:35

Chairman: Dr E. JARAMILLO NAVARRETE (Mexico)

1. THIRD REPORT OF COMMITTEE A (Document A68/69)

Dr ROOVÄLI (Estonia), Rapporteur, read out the draft third report of Committee A.

The report was adopted.[1]

2. COMMUNICABLE DISEASES: Item 16 of the Agenda (continued)

2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on the Ebola Emergency: Item 16.1 of the Agenda (Documents A68/24, A68/25, A68/26, A68/27, A68/56 and A68/51 Rev.1) (continued from the third meeting)

The CHAIRMAN drew attention to the amended draft decision on the 2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on the Ebola Emergency, which read:

The Sixty-eighth World Health Assembly, having recalled the resolution adopted by the Executive Board in its Special Session of 25 January 2015;

Interim assessment

1. Welcomed the preliminary report of the Ebola Interim Assessment Panel appearing in document A68/25;

2. Thanked the Ebola Interim Assessment Panel for its work to date;

3. Requested the Ebola Interim Assessment Panel to continue its work as mandated by the Executive Board Special Session resolution on Ebola,[2] and to issue a final report to be made available to the Director-General not later than 31 July 2015.

International Health Regulations (2005)

1. Requested the Director-General to establish a Review Committee under the International Health Regulations (2005) to examine the role of the International Health Regulations (2005) in the Ebola outbreak and response, with the following objectives:

[1] See page 365.

[2] See EBSS3.R1.

(a) to assess the effectiveness of the International Health Regulations (2005) with regard to the prevention, preparedness and response to the Ebola outbreak, with a particular focus on notification and related incentives, temporary recommendations, additional measures, declaration of a public health emergency of international concern, national core capacities, and context and links to the Emergency Response Framework[1] and other humanitarian responsibilities of the Organization;

(b) to assess the status of implementation of recommendations from the previous Review Committee in 2011[2] and related impact on the current Ebola outbreak;

(c) to recommend steps to improve the functioning, transparency, effectiveness and efficiency of the International Health Regulations (2005), including WHO response, and to strengthen preparedness and response for future emergencies with health consequences, with proposed timelines for any such steps;

2. Requested the Director-General to convene the International Health Regulations (2005) Review Committee as provided by the International Health Regulations (2005) in August 2015, and to report on its progress to the Sixty-ninth World Health Assembly in May 2016;

3. Agreed to support west and central African States and other at risk States to achieve full implementation of the International Health Regulations (2005), including meeting the requirements of the core capacities, by June 2019;

4. Noted the recommendation of the Ebola Interim Assessment Panel for WHO to propose a plan with resourcing requirements to be shared with Member States and other relevant stakeholders to develop the core public health capacities for all countries in respect of the International Health Regulations (2005), and further to explore mechanisms and options for objective analysis through self-assessment and, on a voluntary basis, peer-review and/or external evaluation for the requesting Member States.

Global health emergency workforce

1. Welcomed the Director-General's efforts to provide an initial conceptual plan for a global health emergency workforce to respond to outbreaks and emergencies with health consequences, as part of the dedicated structure and functions of the wider emergency response programme, which would unite and direct all WHO outbreak and emergency response operations within the WHO mandate, across the three levels of the Organization, and under the direct supervision of the Director-General, in support of countries' own response;[3]

2. Reiterated that WHO emergency response at all levels shall be exercised according to international law, in particular with Article 2(d) of the WHO constitution and in a manner consistent with the principles and objectives of the Emergency Response Framework, and the International Health Regulations (2005), and be guided by an all-hazards health emergency approach, emphasizing adaptability, flexibility and accountability; humanitarian principles of neutrality, humanity, impartiality, and independence; and predictability, timeliness, and country ownership;

[1] See resolution WHA65.20.

[2] See document A64/10.

[3] See paragraph 44 of document A68/27.

3. Emphasized the importance of WHO building capacity in its areas of comparative advantage and drawing extensively on the capacities of other United Nation agencies, funds and programmes, the Global Outbreak Alert and Response Network, foreign medical teams and stand-by partners[1] and the lead role of WHO in the Global Health Cluster;

4. Requested the Director-General to report on progress on the establishment, coordination and management of the emergency response programme, including the global health emergency workforce, to the Sixty-ninth World Health Assembly through the 138th Executive Board in January 2016.

Contingency fund

1. Welcomed the parameters described in document A68/26, which include the guiding principles that must govern the fund, such as: size, scope, sustainability, operations, voluntary sources of financing and accountability mechanisms;

2. Decided to create a specific, replenishable contingency fund to rapidly scale up WHO's initial response to outbreaks and emergencies with health consequences, that merges the existing two WHO funds,[2] with a target capitalization of US$ 100 million fully funded by voluntary contributions, flexible within the fund's scope;

3. Agreed that the contingency fund will reliably and transparently, including with regard to financial reporting and accountability, provide financing, for a period of up to three months, emphasizing predictability, timeliness, and country ownership; humanitarian principles of neutrality, humanity, impartiality, and independence; and practices of good humanitarian donorship;[3]

4. Decided that the contingency fund would be under the authority of the Director-General, with disbursement at his or her discretion;

5. Requested the Director-General to review the scope and criteria of the contingency fund after two years of implementation, and include, in a report to be presented at the Seventieth World Health Assembly in May 2017, proposals to improve the fund's performance and sustainability;

6. Thanked Member States for contributions already committed to the contingency fund;

7. Requested the Director-General to approach donors to encourage contribution to the contingency fund, including through the next round of the Financing Dialogue;

8. Requested the Director-General to report on the performance of the contingency fund, including amount raised and spent, value added and for what purpose, to the Sixty-ninth World Health Assembly in May 2016, through the Executive Board at its 138th session in January 2016;

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[1] See paragraph 15 of document A68/27.

[2] WHO's Rapid Response Account and WHO-Nuclear Threat Initiative Emergency Outbreak Response Fund.

[3] This may be extended by the Director-General if needed, for an additional period of up to 3 months to support continuity, only if other funding cannot be mobilized by that time.

9. Requested the Director-General to prioritize in-field operations in affected countries when using the contingency fund.[1]

Research and development

1. Appreciated the key coordination role played by WHO for ongoing work in development of vaccines, diagnostics and drugs for the Ebola virus disease;

2. Welcomed the development of a blueprint, in consultation with Member States and relevant stakeholders, for accelerating research and development in epidemics or health emergency situations where there are no, or insufficient, preventive, and curative solutions, taking into account other relevant work streams within WHO;

3. Reaffirmed the global strategy and plan of action on public health, innovation and intellectual property.

Health systems strengthening

1. Welcomed the development of the robust, costed national health system recovery plans for Guinea, Liberia and Sierra Leone, which were presented at the World Bank Spring Meetings on 17 April 2015, as the basis for donor coordination and strategic investments;

2. Requested WHO to continue its coordination role in support of national administrations as they prepare for the United Nations Secretary General's high level pledging conference on Ebola, to be held on 10 July 2015;

3. Acknowledged the leadership shown by the Ministries of Health of the three countries in focusing, with support of WHO country offices, on early recovery through emphases on infection prevention and control, reactivation of essential services, immediate health workforce priorities and integrated disease surveillance;

4. Requested the Director-General to continue and enhance the work of the Organization in supporting Member States to be better prepared to respond to emergencies with health consequences by strengthening national health systems.

Way forward

1. Welcomed the Director-General's commitment to reform the work and culture of WHO in emergencies with health consequences, and in particular to establish effective, clear command and control across the three levels of the Organization;

2. Welcomed the Director-General's proposal to establish a small, focused expert advisory group to guide and support the further development of reform of WHO's work in emergencies with health consequences;

[1] See A/58/59/-E/2003/94, annex II.

3. Requested the Director-General to report on progress on these reforms, and on the other decisions taken herein, to the Sixty-ninth World Health Assembly in May 2016, through the Executive Board at its 138th session in January 2016, and reiterated the request to the Director-General to report annually to the World Health Assembly on all Grade 3 and United Nations Inter-Agency Standing Committee Level 3 emergencies where WHO has taken action.

The financial and administrative implications for the Secretariat of adoption of the draft decision were:

1. Decision: 2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on the Ebola Emergency

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Programme areas: Health systems information and evidence; alert and response capacities; outbreak and crisis response

Outcomes: 4.4, 5.1, 5.6
Outputs: 4.4.1, 4.4.4, 5.1.1, 5.6.1

How would this decision contribute to the achievement of the outcomes of the above programme areas?

This decision implements the requests of the Executive Board in the resolution it adopted in its Special Session on the Ebola Emergency, held on 25 January 2015. The foundation for building WHO's capacity to respond to emergencies with health consequences will be in: (a) the work of the Ebola Interim Assessment Panel; (b) the creation of a contingency fund; (c) the establishment, coordination and management of the Global Health Emergency Workforce; (d) the evaluation provided by an IHR Review Committee focused on the International Health Regulations (2005) in the context of the Ebola response; (e) a framework for advancing research and development of medical products for infectious diseases of epidemic potential; and (f) enhancing the work of the Organization in supporting Member States to be better prepared to respond to emergencies with health consequences by strengthening national health systems.

Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the decision during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US$ 10 000).

(i) The elements of the decision cover varying time frames (in order of date of completion):

a. WHO support to national administrations as they prepare for the United Nations Secretary General's 10 July 2015 high-level pledging conference on Ebola will be completed in the 2014–2015 biennium;
b. The Ebola Interim Assessment Panel's work will be concluded in the 2014–2015 biennium;
c. The IHR Review Committee under the International Health Regulations (2005) will begin its work in the 2014–2015 biennium, and complete its work in the 2016–2017 biennium;
d. Development of a framework for advancing research and development of medical products for other infectious diseases of epidemic potential will begin in the 2014–2015 biennium, and continue into the 2016–2017 biennium;
e. Support to west and central African States and other at-risk States to achieve full implementation of the International Health Regulations (2005) by 2019 will take place in three bienniums: 2014–2015, 2016–2017 and 2018–2019;
f. Continuation and enhancement of WHO's support to Member States to be better prepared to respond to emergencies with health consequences by strengthening national health systems will continue indefinitely;
g. Establishment, coordination and management of the Global Health Emergency Workforce will be initiated in the 2014–2015 biennium and will continue indefinitely;

h. Establishment, management and maintenance of the contingency fund will be initiated in the 2014–2015 biennium and will continue indefinitely.

(ii) The costs of implementing the decision

The costs of the outcomes and outputs in Categories 4 and 5 will fall within the Programme budget 2016–2017, as approved by the Health Assembly in resolution WHA68.1. A thorough operational planning exercise will be undertaken in the last half of 2015 and the results, including staffing and budget implications, will be reported.

The work taking place in the 2014–2015 biennium under outcomes 4.4 and 5.1 fall within the Programme budget 2014–2015. Under outcome 4.4, the costs are minimal; under outcome 5.1, the work supporting west and central African States and other at-risk States to achieve full implementation of the International Health Regulations (2005) will cost US$ 1 000 000.

The total cost for 2014–2015 is as follows:

- Supporting Member States to prepare for the July 2015 pledging conference: US$ 1 000 000
- The remainder of the Ebola Interim Assessment Panel's work: US$ 500 000
- Establishing the contingency fund and developing the report on its performance for consideration by the Executive Board at its 138th session in January 2016: US$ 300 000
- Establishing and staffing the secretariat of the Global Health Emergency Workforce: US$ 1 000 000
- Establishing and supporting the IHR Review Committee under the International Health Regulations (2005): US$ 500 000.

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US$ 10 000).

Total: US$ 4.3 million (staff: US$ 2.7 million; activities: US$ 1.6 million).

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All three levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If "no", indicate how much is not included.

(c) Staffing implications

Could the decision be implemented by existing staff?

Though much of the decision will be implemented by existing staff, starting in biennium 2014–2015, four additional staff positions will be required for the secretariat of the Global Health Emergency Workforce.

For the remainder of the decision, additional staffing will be required for next biennium. The number of positions is to be determined as part of the operational planning exercise mentioned above.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded?

No.

If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The funding gap is US$ 4.3 million, which will be mobilized from those donors who: have contributed to WHO's work in outbreaks and emergencies with health consequences; have expressed interest in doing; and are yet to be identified through concerted resource mobilization efforts.

Capitalizing the contingency fund will also require resource mobilization, to an initial US$ 100 000 000 with continuous mobilization to replenish the fund when monies have been drawn down to support emergency response. Two Member States have announced pledges that amount to US$ 11 000 000.

Mr McIFF (United States of America) said that the outcome of the drafting group had been reached through an inclusive and consultative process. The work accomplished by the drafting group would take forward some of the far-reaching and bold elements of WHO reform, to ensure that the world would be better prepared for future outbreaks and emergencies with health consequences.

The draft decision, as amended, was approved.[1]

3. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 14 of the Agenda (continued)

Adolescent health: Item 14.3 of the Agenda (Document A68/15) (continued from the tenth meeting)

Dr AL MOSAWI (Bahrain) said that all sectors concerned with adolescents, such as those dealing with education, social affairs and youth, should be involved alongside the health sector in developing the proposed framework for accelerated action for adolescent health, in order to ensure that it allowed for cultural and religious diversity and took into account country-specific features. Countries with diverse communities must also be involved in the third stage of piloting the draft framework, so as to test its applicability to their social and cultural contexts. The positive initiative of preparing such a comprehensive framework for action would promote regional efforts for adolescent health, guide the development of national strategies and underpin their implementation.

Dr CHAIRUL RADJAB NASUTION (Indonesia) said that, in order to promote adolescent health and improve financial investments and human resources, an integrated, multisectoral approach involving several stakeholders and taking into account the social context of health was necessary. Adolescent health intervention programmes should target school-age children. He agreed with the proposal to develop a framework for accelerated action for adolescent health and highlighted the importance of a comprehensive approach that took into account the individual, family, schools and the environment. Efforts had been made by the Government of Indonesia to promote adolescent health, in particular the implementation of health programmes in schools. A gender-based approach to adolescent health was important, and gender-disaggregated data were therefore required. The issue of adolescent health was linked to the issues of HIV/AIDS, contraception and sexual violence against adolescents.

Dr MADDALENO (Chile) described her Government's efforts to promote a rights-based approach to adolescent health. National policy and strategies for adolescent health focused on well-being, equity and personal development, and multisectoral initiatives had been implemented to promote children's health, reduce the adolescent pregnancy rate and combat the use of alcohol and drugs by adolescents. She supported WHO's work on the proposed framework for accelerated action on adolescent health.

Dr BAYUGO (Philippines) highlighted four points for consideration. Paragraph 4 of the report should cover adolescent health in humanitarian emergencies such as natural disasters. The wording of the fifth domain in paragraph 10 should be amended to read "safe and responsible sexual activities, when ready and wanted". Regarding paragraph 14, his Government had recently passed a law requiring minors to obtain parental consent before accessing services. To ensure inclusivity, future reports should include details of the health status of adolescents with disabilities, lesbian, gay, bisexual and transgender adolescents, adolescent sex workers and injecting drug users. Government agencies,

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as decision WHA68(10).

civil society organizations, parents, inter-faith groups, community leaders and adolescents themselves should collaborate to ensure that adolescents were well informed, empowered, responsible and healthy.

Dr ASSIRI (Saudi Arabia) asked for the wording in the proposed framework of the fifth main domain, paragraph 10, to be amended to "safe sexual debut, when ready and appropriate", in order to take account of religious and cultural considerations.

Dr ZAKARIAH (Ghana) supported the proposal to develop a framework for accelerated action. His Ministry of Health was working closely with the Ministry of Education to promote adolescent health. Ghana had implemented a national health insurance scheme under which adolescents were able to access adolescent-focused health services free of charge at the point of use and without an adult present.

Mr ALAKHDER (Libya), in response to the amendment proposed by the delegate of Saudi Arabia, recommended that the wording should be amended to "safe sexual debut, when ready and where appropriate".

Dr Shu-Ti CHIOU (Chinese Taipei) said that the five important domains proposed in paragraph 10 of the report were appropriate but insufficient. She therefore proposed the addition of three domains: mental well-being and resilience; injury prevention; and digital literacy. Adolescent health was a priority for Chinese Taipei and authorities had implemented several initiatives to promote adolescent health, in particular an accreditation programme for health-promoting schools. As a result, declines in adolescent smoking rates and in the prevalence of overweight and obesity had been observed in recent years.

Ms EARDLEY (World Vision International), speaking at the invitation of the CHAIRMAN, called on Member States to actively support the proposed framework for accelerated action. She advocated its timely, comprehensive development and implementation, which should involve and empower adolescents, families, communities and vulnerable groups, with supportive and protective environments fostered by faith groups. Member States should sharpen coherent national plans for adolescent health aligned with the proposed framework, and incorporate adolescent-sensitive policies and programmes in numerous other sectors. Multisectoral policies and programmes should pay close attention to the health of adolescents in situations of conflict. Adolescent health should be prioritized in the intergovernmental dialogue on the post-2015 development agenda.

Ms MARKBREITER (World Heart Federation), speaking at the invitation of the CHAIRMAN, said that she supported the proposed framework, in particular the five important domains and the fresh impetus given to locating adolescent health services within the context of universal health coverage. She called on countries and regions with endemic rheumatic heart disease to support early detection, prevention and control of the disease.

Ms HIGGINS (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN, supported the proposed framework. She requested the Organization to ensure that the full scope of midwifery practice was included in the proposed framework, so that preventive, supportive and respectful midwifery care could be understood and made accessible. The International Confederation of Midwives and its Young Midwifery Leaders should be invited to participate in all three stages of development of the proposed framework. Her organization would encourage its member associations to participate in the web-based consultation. She urged Member States to ensure that all young people had access to a midwife and other services providing high-quality sexual and reproductive health care, including family planning services.

Ms MATZKE (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN, underlined a life-course approach and integrated services for noncommunicable disease prevention. She looked forward to working with Member States and the Secretariat on developing a framework that would be closely aligned with the updated Global Strategy for Women's, Children's and Adolescents' Health.

Dr BUSTREO (Assistant Director-General) said that it had been evident, since the beginning of moves to update the Global Strategy for Women's, Children's and Adolescents' Health, that further input on adolescent health was needed from Member States and young people. Consultations in India and South Africa had underscored the commitment to adolescents' health needs and rights. A group of young people had been convened before the Health Assembly in order to identify key health issues and ascertain in which areas they could take the lead. The message from that group, "Nothing about us without us", would be a guiding principle in future work. The Secretariat was also working with young members of parliament, who would be discussing the proposed framework at the second Inter-Parliamentary Union Global Conference of Young Parliamentarians that same weekend. She assured Member States that their suggestions regarding the five domains, and particularly the fifth domain of safe sexual debut, had been noted. The Secretariat would continue to consult Member States on how to incorporate social and cultural factors into the framework. The Secretariat was collaborating with other organizations of the United Nations system to develop the framework and to ensure its alignment with the Global Strategy, into which WHO was, in turn, providing input.

The Committee noted the report.

4. COMMUNICABLE DISEASES: Item 16 of the Agenda (continued)

Global vaccine action plan: Item 16.4 of the Agenda (Document A68/30) (continued from the fifth meeting, section 2)

At the invitation of the CHAIRMAN, Dr AL-MOKHTAR (Libya) summarized the discussions that had taken place on the draft resolution on the global vaccine action plan proposed by the delegations of Algeria, Egypt, Libya, Morocco, Nigeria, Pakistan, Qatar, Saudi Arabia, Thailand and Tunisia. The resulting amended draft resolution read:

The Sixty-eighth World Health Assembly,

PP1 Having considered the report on the Global vaccine action plan;

PP2 Emphasizing the importance of immunization as one of the most effective interventions in public health and access to immunization as a key step towards access to health and universal health coverage;

PP3 Acknowledging the progress made in global immunization and the commitment under the 2011–2020 Decade of Vaccines to achieve immunization goals and milestones;

PP4 Recalling resolutions WHA58.15 and WHA61.15 on the global immunization strategy, resolution WHA65.17 on the global vaccine action plan, resolution WHA61.21 on the global strategy and plan of action on public health, innovation and intellectual property and resolution WHA54.11on the WHO medicines strategy;

PP5 Noting with concern that globally immunization coverage has increased only marginally since the late 2000s; and that in 2013 more than 21 million children under one year of age did not complete the three-dose series of diphtheria-tetanus-pertussis (DTP) vaccine;

PP6 Recognizing that the availability of new vaccines against important causes of vaccine preventable diseases such as pneumonia, diarrhoea and cervical cancer can prevent leading causes of childhood and women's death;

PP7 Acknowledging that successful national immunization programmes require sustainable political and financial support of Member States;

PP8 Appreciating the contributions of WHO, UNICEF, Gavi, the Vaccine Alliance, and all partners in their efforts to support the introduction of new vaccines in developing countries and strengthen immunization services;

PP9 Concerned that inequities between Member States are growing, inter alia, due to the increased financial burden of new vaccines and based upon those that are eligible or ineligible for financial and technical support from global partners;

PP10 Concerned that many low and middle-income countries may not have the opportunity to access newer and improved vaccines particularly because of the costs related to procurement and introduction of these vaccines; and concerned of the increase of costs of overall immunization programmes because of increase in price of the WHO recommended vaccines;

PP11 Recognizing that publicly available data on vaccine prices is scarce, and that availability of price information is important for facilitating Member States' efforts towards introduction of new vaccines;

PP12 Recalling many Member States' interventions on the WHA immunization agenda item each year expressing concern over the unaffordable cost of new vaccines and appealing to the global community to support strategies that will reduce prices;

PP13 Recalling the WHO global framework for expanding access to essential drugs, and its four components: the rational selection and use of medicines, reliable health and supply systems, sustainable financing, and affordable prices;

PP14 Taking into account the importance of competition to reduce prices and the need to expand the number of manufacturers, particularly in developing countries, that can produce WHO-prequalified vaccines and create a competitive market;

PP15 Stressing the critical life-saving role of vaccines and immunization programmes and striving to make immunization available to all;

PP16 Noting with concern the global shortage of certain traditional routine vaccines, for example BCG, measles-rubella;

PP17 Acknowledging that shortages of vaccines are quite often an important cause of disruption of vaccination schedules and that therefore the establishment of effective and sustainable vaccine production, supply, procurement and delivery systems is essential to ensure access to all the necessary vaccines of assured quality at the right time;

PP18 Concerned that scepticism against vaccination is continuing to grow in society despite the proven efficacy and safety of modern vaccines, and that many children do not receive life-saving vaccines as a result of insufficient information to parents or health care workers or even of active anti-vaccination propaganda,

(OP1) URGES Member States:

(1) to allocate adequate financial and human resources for introduction of vaccines into national immunization schedules and sustaining strong immunization programmes in accordance with national priorities;

(2) to strengthen efforts, as and where appropriate, for pooling vaccine procurement volumes in regional and interregional or other groupings as appropriate that will increase affordability by leveraging economies of scale;

(3) to provide, where possible, timely vaccine price data to WHO for publication, with the goal of increasing affordability through improved price transparency, particularly for the new vaccines;

(4) to seek opportunities for establishing national and regional vaccine manufacturing capacity, in accordance with national priorities, that can produce to national regulatory standards, including WHO-prequalification;

(5) to create mechanisms to increase the availability of comparable information on government funding to vaccine development and work towards strategies that enhance public health benefit from government investments in vaccine development;
(6) to support the ongoing efforts of various partners coordinated by WHO to design and implement the strategies to address the vaccines and immunization gaps faced by the low and middle-income countries that request assistance;
(7) to improve and sustain vaccine purchasing and delivery systems in order to promote the uninterrupted and affordable safe supply of all the necessary vaccines and its availability to all immunization service providers;
(8) to strengthen immunization advocacy and provide training to health professionals and information to the public regarding immunization issues to achieve a clear understanding of the benefits and risks of immunization;

(OP2) REQUESTS the Director-General:
(1) to explore ways to mobilize funding to fully support collaborative efforts with international partners, donors, and vaccine manufacturers to support low- and middle-income countries in accessing affordable vaccines of assured-quality in adequate supply;
(2) to continue developing and adequately managing publically-available vaccine price databases, like the WHO Vaccine Product, Price and Procurement project, working with Member States to increase availability of price information;
(3) to monitor vaccine prices through annual reporting of the Global Vaccine Action Plan;
(4) to provide technical support and facilitate financial resources for establishing pooled procurement mechanisms where appropriate for use by Member States;
(5) to strengthen the WHO prequalification programme and provide technical assistance to support developing countries in capacity building for research and development, technology transfer, and other upstream to downstream vaccine development and manufacturing strategies that foster proper competition for a healthy vaccine market;
(6) to report upon technical and legal barriers that may undermine robust competition that can enable price reductions for new vaccines;
(7) to assist in mobilizing resources for countries that request assistance in the introduction of new vaccines in line with the Global Vaccine Action Plan and in accordance with national priorities;
(8) to continue to assist Member States to improve and sustain their vaccine delivery systems and to continue to provide technical support to Member States to strengthen the knowledge and skills of their health care professionals in vaccination programmes;
(9) to report back on progress in implementing this resolution to the World Health Assembly through the Executive Board in the annual report on the basic document.

The financial and administrative implications for the Secretariat of adoption of the draft resolution were:

1. Resolution: Global vaccine action plan	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)	
Category: 1 Communicable diseases	
Programme area: Vaccine preventable diseases	Outcome: 1.5 Outputs: 1.5.1 and 1.5.3

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

This resolution would contribute to accelerating progress towards the targets set in the global vaccine action plan by facilitating access to reliable supplies of affordable vaccines to all Member States. In particular, this resolution will address challenges faced by many middle-income countries in securing reliable supplies of the newer, more expensive, vaccines at prices they can afford.

Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US$ 10 000).

(i) 5.5 years (covering the period 2015–2020)

(ii) Total (2015–2020): US$ 107.80 million (staff: US$ 31.63 million; activities: US$ 76.18 million)

(iii) The total cost of the resolution assumes additional funding and the Programme budget of US$ 5.12 million per year for 2016–2020 (total additional for 2016–2020 staff: US$ 4.00 million; activities: US$ 21.60 million).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US$ 10 000).

Total: US$ 13.80 million (staff: US$ 2.88 million; activities: US$ 10.92 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If "no", indicate how much is not included.

Not applicable.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If "no", indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

Additional staff would be required in 2016–2020 at global and regional levels to support the activities (estimated full-time equivalents: one global staff member and two regional staff members).

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)

Yes.

If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Not applicable.

In the amended draft resolution, the customary footnote should be added to the introductory phrase in paragraph 1, to read: "And, where applicable, regional economic integration organizations." In subparagraph 1(3), the word "possible" should be replaced with "available". The draft resolution responded to the recommendations concerning vaccine affordability and supply in the 2014

assessment report of the global vaccine action plan, as well as to the concerns of Member States in those respects.

Ms ST. LAWRENCE (Canada), reiterating her support for immunization as a key component of maternal, newborn and child health, expressed her concern that insufficient time had been allowed for discussion of the draft resolution. Given calls by Member States for organizational reform, it was appropriate for them to behave in a manner conducive to good governance. She therefore proposed that discussion of the draft resolution be transferred to the Executive Board at its 137th session, and requested the Secretariat to clarify whether that postponement would affect the work of the Organization. Noting that the draft resolution would require an additional US$ 5.12 million per year for the following five years, she enquired whether allowance had been made in the Programme budget 2016–2017.

Dr BEN SALEM (Tunisia) said that, despite the increasing cost of vaccination, the status of Tunisia as a middle-income country meant that it did not receive any financial assistance. The draft resolution promoted two essential principles: price transparency and equal access by low- and middle-income countries to an adequate supply of high-quality vaccines at affordable prices. He therefore supported it.

Dr BUGTI (Pakistan) affirmed that effective immunization was critical to optimal health care delivery but was often hampered by financial constraints in developing countries. She therefore supported the draft resolution as a step towards ensuring the affordability and accessibility of vaccines for all.

Dr CHAIRUL RADJAB NASUTION (Indonesia) also supported the draft resolution. In order to ensure its full implementation, there should be consideration of follow-up mechanisms, including one for establishing pooled procurement.

Dr WOLDEMARIAM (Ethiopia), speaking on behalf of the Member States of the African Region, and Dr PANDA (India), supported the draft resolution.

Dr TAKIAN (Islamic Republic of Iran) and Dr ALI YAHIA ELABBASSI (Sudan) asked for their countries to be added to the list of sponsors of the draft resolution.

Professor ELIRA DOKEKIAS (Congo) said that several African countries, such as Congo, would soon become ineligible for assistance from The GAVI Alliance, owing to the estimated size of their economies. It was therefore unreasonable to delay adoption of the draft resolution.

Mrs VALLINI (Brazil) supported the adoption of the draft resolution at the current Health Assembly.

Dr AL-MOKHTAR (Libya), making a procedural point, said that it was his understanding that draft resolutions could be accepted until the date on which the Health Assembly commenced; his delegation had submitted the draft resolution on the global vaccine action plan in the week before the Health Assembly. All the amendments received to date had been incorporated in the draft. The Health Assembly was a sovereign body that had the right to consider resolutions submitted to it.

Mr MAMACOS (United States of America) said that the draft resolution contained some valuable elements, including the proposal to promote reporting of publicly available vaccine prices. His delegation had circulated some late amendments which had not yet been included in the draft and he could not support the resolution in its present form. He acknowledged that the submission of the resolution had not violated the rules of the Health Assembly but, in light of the ongoing discussion on

best practices of the governing bodies, it would have been correct procedure to submit the resolution first to the Executive Board. The United States of America would have been better placed to support the document if it had been circulated at least two weeks before the Health Assembly. He therefore supported the proposal to move discussion to the Board at its 137th session.

Dr TARAWNEH (Jordan) said that his country was all too well aware of the need for the timely supply of affordable vaccines to low-income countries and reiterated his earlier caution of the dire global consequences that would result from any complacency in the implementation of immunization programmes in conflict-ridden countries of the Eastern Mediterranean Region. He expressed support for the draft resolution.

Dr BAKASWA NTAMBWE (Democratic Republic of the Congo) said that vaccination of children had a significant impact on infant mortality and was a priority for his country. He therefore supported adoption of the draft resolution.

Ms HARB (Lebanon) asked for Lebanon to be added to the list of sponsors of the draft resolution. The latter could increase the affordability and accessibility of vaccines, particularly for developing countries.

Ms RABOVICA (Latvia) wished to verify that subparagraph 1(3) would begin: "to provide, where possible …" and not "to provide, where available …".

Dr REYES (Plurinational State of Bolivia) expressed full support for the draft resolution and emphasized the importance of continuing to develop and adequately manage "publicly available vaccine price databases" as set out in subparagraph 2(2).

Mr ZHANG Yong (China) said that the draft resolution presented the main issues in the global vaccine action plan in a manner that was comprehensive and feasible to implement. China hoped that the resolution would be adopted by the present Health Assembly.

Dr THAKSAPHON THAMARANGSI (Thailand) supported the proposal that subparagraph 1(3) should begin: "to provide, where available…". Having consulted with his capital, he preferred to reinstate the words "including regulatory and intellectual property barriers" in subparagraph 2(6).

Dr GUTERRES CORREIA (Timor-Leste) fully supported the amended draft resolution.

Dr MADZIMA (Zimbabwe) noted with concern that the health gains of immunization programmes were negatively affected in African countries that were no longer eligible for support from The GAVI Alliance. Affordability and supply were major concerns for emerging economies, especially with respect to the time lag between high- and low-income countries for the introduction of new vaccines. Zimbabwe wished to be added to the list of sponsors of the draft resolution.

Ms SAMIYAH (Maldives) said that, although the Maldives maintained high immunization coverage, it continued to experience challenges in ensuring timely access to an affordable supply of vaccines and in reaching vulnerable groups. She therefore supported adoption of the draft resolution at the current Health Assembly.

Ms MARTINEZ (Ecuador) said that, in the interests of flexibility, she could agree to the revised draft resolution, with the addition of the amendments to subparagraphs 1(3) and 2(6) proposed by the delegate of Thailand.

Dr KAN TUN (Myanmar) strongly supported the draft resolution.

Dr ZAKARIAH (Ghana) also supported the draft resolution, as immunization was one of the most cost-effective interventions in preventing morbidity and mortality. Ghana had made tremendous gains through its vaccination programmes but, as it moved to middle-income status, it would lose the support of The GAVI Alliance; affordability and availability were therefore key issues for Ghana and other low- and middle-income countries.

Professor NAPO-KOURA (Togo) said that affordability and supply of new vaccines were problematic for low- and middle-income countries, and he was therefore in favour of adoption of the draft resolution by the current Health Assembly. Togo wished to be added to the list of sponsors of the resolution.

Dr ASMA GALI (Niger) said that, although her country benefited from the support of The GAVI Alliance, affordability and availability of vaccines were still a major concern. During a recent outbreak of meningococcal meningitis, the price of vaccine in Niger had risen from US$ 2.5 to US$ 32 in the space of one month, an increase that could not be borne by most African countries. She therefore called for adoption of the draft resolution by the current Health Assembly.

Dr MOKGWEETSINYANA (Botswana) said that Botswana had been obliged to buy vaccines without the support of The GAVI Alliance for a considerable time and had found the process very difficult. He asked whether the phrase "price data" in subparagraph 1(3) of the draft resolution referred to a price that was negotiated by a Member State with one manufacturer or whether it was a standard price set in the country where a vaccine was manufactured. He fully supported the draft resolution.

Dr GHEBRETINSAE GHILAGABER (Eritrea) also fully supported the draft resolution and appealed for its adoption by the Health Assembly.

Dr HINOSHITA (Japan) supported the draft resolution but could not agree to reinsertion of the phrase "including regulatory and intellectual property barriers", as proposed by the delegate of Thailand.

Mr BOWLES (Australia) said that the draft resolution would help to improve affordable access to vaccines in developing countries as well as countering the anti-vaccination movement. He was also concerned at the late introduction of the resolution; however, given the large amount of time and good will that had been spent on negotiating the text, it would be preferable for it to be adopted.

Dr AL LAMKI (Oman), underscoring the importance of the supply and affordability of vaccines in view of their effectiveness in reducing child mortality and lowering morbidity, said that his country not only supported the draft resolution but also wished to be added to the list of sponsors.

Dr DAKULALA (Papua New Guinea) said that his country's national health plan was being updated in line with the global vaccine action plan. Measles-rubella combined vaccine, pneumococcal conjugate vaccine, inactivated poliomyelitis vaccine and human papillomavirus vaccine were being introduced or piloted in 2015. He strongly supported adoption of the draft resolution by the current Health Assembly.

Dr DIARRA (Mali) strongly supported the draft resolution. His country purchased all its routine vaccines out of the State budget and benefited from the support of The GAVI Alliance with respect to new vaccines and strengthening of its health system.

Dr AMBOURHOUET-BIGMANN (Gabon) called on Member States to work towards a consensus that would allow the Health Assembly to adopt the draft resolution. Gabon was particularly concerned that the draft resolution should be adopted at the current Health Assembly as its

Government did not benefit from support from The GAVI Alliance, was entirely responsible for the purchase of vaccines and would thus find it difficult to implement the global vaccine action plan.

Dr STANEKZAI (Afghanistan) and Ms AKINOCHO (Benin), aware of the importance of immunization as a means of reducing maternal and infant mortality, supported the draft resolution and wished to see it adopted by the current Health Assembly.

Ms MORÓN DE PORRAS (Bolivarian Republic of Venezuela) supported the draft resolution and the amendments proposed, particularly with regard to affordability. Her country was operating a vaccine production facility in order to strengthen immunization and reduce maternal and infant mortality. She asked for her country to be added to the list of sponsors of the draft resolution.

Ms GURBANOVA (Azerbaijan) said that the global vaccine action plan would enable the Organization to respond to the priority of combating communicable diseases. Member States should combine their efforts to ensure the affordability and accessibility of vaccines at global and national levels.

Dr KREMER (Argentina) said that it was unacceptable that countries were forced to interrupt national campaigns because vaccines had become unaffordable or inaccessible. As a result of recent negotiations with vaccine manufacturers, countries in the Region of the Americas had been able to continue their campaigns. He supported the adoption of the draft resolution at the current Health Assembly, as amended by the delegate of Thailand.

Mr ALAOUI (Morocco) said that the national vaccination plan had played a role in increasing life expectancy in Morocco. Adoption of the draft resolution would undoubtedly contribute to improving the health of populations in developing countries.

Dr MADDALENO (Chile) and Professor L'HADJ (Algeria) supported adoption of the draft resolution at the current Health Assembly.

Ms MATSOSO (South Africa) expressed support for the draft resolution and called on Member States to reach agreement on the proposed amendments so that it could be adopted at the current Health Assembly. The importance of the draft resolution had been demonstrated by the successful results achieved following inclusion of rotavirus and pneumococcal conjugate vaccines in the Expanded Programme on Immunization. However, the availability of measles vaccine and the affordability of human papillomavirus vaccine were causes for concern.

Dr HAUFIKU (Namibia) expressed support for the amended draft resolution and called for its adoption at the current Health Assembly. He drew attention to the importance of an uninterrupted manufacturing and supply chain, as well as access to vaccines and transparent pricing structures, especially for low- and middle-income countries.

Professor AZAD (Bangladesh) said that Bangladesh's consistently high coverage rate of routine immunization had contributed to its achievement of Millennium Development Goal 4. With a view to sustaining and building upon the progress achieved, he strongly supported the draft resolution and called for its adoption at the current Health Assembly. The amendment proposed by the delegate of Thailand should be accepted, given the importance of identifying the factors responsible for creating barriers to sustained immunization coverage. However, he suggested rephrasing the amendment to subparagraph 2(6) to read: "to report upon technical, intellectual property and legal barriers …".

Dr ATEBA ETOUNDI (Cameroon) expressed concern at the possible future removal of Cameroon from the list of countries benefiting from the support of The GAVI Alliance for vaccine procurement, owing to the sudden and prohibitive increase in the financial burden. His Government therefore strongly supported the amended version of the draft resolution and called for its adoption at the current Health Assembly.

Ms DUSSEY-CAVASSINI (Switzerland) underlined the importance of implementing the global vaccine action plan. Her Government had put in place a range of measures to increase vaccination coverage. She echoed the concerns expressed about the late submission of the draft resolution to the Health Assembly. Several amendments under discussion had not been included in the current version of the draft resolution, and it had become difficult to keep track of them all. She expressed concern also about the amendment proposed by the delegate of Thailand and supported the statement made by the delegate of Japan in that regard. However, in view of the level of support among Member States for the draft resolution, she called for the current Health Assembly to reach consensus.

Mrs VALLINI (Brazil) fully supported the amendment proposed by the delegate of Thailand and agreed with the procedure through which the draft resolution had been submitted. It was important to finalize the text of the draft resolution at the current Health Assembly.

The DIRECTOR-GENERAL said that the number of comments made by delegates clearly demonstrated the importance they accorded the item. There appeared to be consensus that immunization was extremely important to public health. However, there was a wide range of opinion about the draft resolution: many supported the current version, calling for its immediate adoption, whereas others were requesting additional time in which to discuss the item, either by moving consideration of the topic to the Executive Board at its session the following week, or by reaching consensus by the end of the current Health Assembly. With that in mind, she proposed that those countries seeking to finalize the text at the current session should work together to find a solution. She would continue to support Member States in reaching consensus.

The CHAIRMAN took it that the Committee wished to suspend discussion of the item.

It was so agreed.

(For continuation of the discussion and approval of the resolution, see the summary record of the twelfth meeting, section 3.)

5. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 14 of the Agenda (continued)

Women and health: 20 years of the Beijing Declaration and Platform for Action: Item 14.4 of the Agenda (Document A68/16)

Ms GÓMEZ GÓMEZ (Colombia), speaking on behalf of the Member States of the Region of the Americas, noted the uneven progress made in implementing the Beijing Declaration and Platform for Action. Opportunities to advance the unfinished agenda of women's and girls' health, including through the updated Global Strategy for Women's, Children's and Adolescents' Health and the post-2015 development agenda, must be urgently seized. It was essential to strengthen health systems and remove the gender-related and socioeconomic barriers that prevented women from accessing health services and information. Women's health and empowerment would be further advanced by

addressing the broader determinants of health, such as poverty reduction, education and increased participation in economic, social and political activities.

She noted with concern the continued widespread violence against women and girls, and affirmed the Region's commitment to promoting and developing an effective, comprehensive, multisectoral response. Many challenges remained in the areas of sexual and reproductive health. In the light of the shifting global health burden of noncommunicable diseases towards women, it was imperative to address the associated risk factors. An improvement of timely, reliable and disaggregated gender-specific data on the major health challenges faced by women and girls was critical for national, regional and global decision-making processes. In that connection, she called on WHO to sustain its efforts regarding the use of disaggregated data and robust gender analysis.

Mr MAGNÚSSON (Iceland), speaking also on behalf of the Nordic countries, Denmark, Finland, Norway and Sweden, and the Baltic countries, Estonia, Latvia and Lithuania, said that sexual and reproductive health and rights were central to Nordic and Baltic development policies and affirmed their commitment to the Beijing Declaration and Platform for Action. Investment in women's and girls' rights should form the cornerstone of inclusive and sustainable development in the post-2015 development agenda. Women and adolescent girls still had inequitable access to good-quality health services and prevention. Despite the fact that violence against women, sexual abuse and forced marriage constituted serious human rights violations, efforts to promote sexual and reproductive health and rights continued to meet strong resistance. Full participation of women and girls in society would only occur if they possessed the necessary knowledge and rights. Consideration of women's health should encompass issues relating to their whole life course. He emphasized the importance of changing the attitudes and behaviours of men and boys that negatively impacted on women and girls, noting the crucial role of comprehensive sexual education in that regard.

Mr DE CONINCK (Netherlands) welcomed the development of the updated Global Strategy for Women's, Children's and Adolescents' Health. Further work was needed to address the root causes of poor health outcomes; the updated Global Strategy should therefore address gender inequality through concrete action points. He welcomed the Global Strategy's emphasis on investment in universal access to sexual and reproductive health and human rights, and on establishing shared goals with health-enhancing sectors, but called for the issue of women and health in humanitarian situations to be included in the Strategy. He stressed the need for sustained efforts and investment in order to address the unfinished agenda of the Millennium Development Goals, and in particular to attain the target of universal access to reproductive health. He expressed satisfaction at the inclusion of the problem of violence against women and girls in the post-2015 development agenda, as well as the continued efforts by WHO to address the problem.

Dr ASSIRI (Saudi Arabia) said that elaboration of the post-2015 development agenda and the updated Global Strategy for Women's, Children's and Adolescents' Health provided an opportunity to strengthen Member States' commitment and translate it into measurable actions to reduce maternal and child mortality and morbidity. The Secretariat should continue to support countries in generating health indicators disaggregated by gender and by measuring progress in the context of the monitoring framework for women's and children's health, noting in that regard the need to establish a culture of accountability. Innovative approaches were required to ensure that women's health was considered as part of a broad agenda. Culturally and religiously sensitive adolescent health issues, especially with respect to sexual and reproductive health, needed to be adapted to the national and local context.

Dr ZEIDAN (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, noted the slow and uneven progress made in core areas of the Beijing Declaration and Platform for Action, including reproductive health, nutrition, HIV/AIDS, violence against women and female genital mutilation. The progress made in reducing maternal morbidity and mortality was not sufficient to achieve the target of Millennium Development Goal 5; in that connection, a thorough

analysis should be made of the large increase in births by caesarean section. Women's continued inequitable access to good-quality health care services, including health promotion and prevention, reflected weaknesses in health systems that could not be resolved solely by targeting interventions at women. A well-functioning monitoring and accountability framework was therefore essential, with clearly defined responsibilities of stakeholders. WHO should coordinate more closely with other organizations of the United Nations system and key development partners, sustain the necessary political commitment and financial support to countries, and support implementation of innovative approaches.

Mr BOWLES (Australia) said that his Government was firmly committed to full and effective implementation of the Beijing Declaration and Platform for Action and the Programme of Action of the International Conference on Population and Development. He welcomed the progress made in a number of areas but expressed concern at continuing health inequities and the global burden of disease borne by women in the poorest countries. The Secretariat should ensure that gender equality and health issues were fully integrated into programme planning; strong health systems were needed to ensure comprehensive and sustainable results. He strongly supported inclusion of women's health issues in the post-2015 development agenda. His Government would continue to advocate strongly for action to address violence against women; for the women, peace and security agenda; and for the importance of gender equality; and strongly supported the Political Declaration adopted at the fifty-ninth session of the Commission on the Status of Women.

Dr MOSAWI (Bahrain) said that important measures had been taken in her country in accordance with the Beijing Platform for Action, particularly in the field of health. Accessible and free of charge to all, the country's health services also included women-specific components that had contributed significantly to the improvement of maternal and infant mortality rates, life expectancy and the achievement of the Millennium Development Goals. Women also benefited from the numerous government programmes and initiatives in place for health promotion and disease prevention, some of which likewise included women-specific components. Bahrain looked to WHO for leadership in meeting the challenges and emerging priorities in relation to women's health within a broader strategy for women's and children's health that was rooted in the post-2015 development agenda and addressed such issues as inequality and noncommunicable diseases.

Mr BOYCE (Barbados) said that national policy on gender equality and access to health and social services for all was in line with the Beijing Declaration and Platform for Action. Efforts were being made to adopt the principles set out in the updated Global Strategy on Women's, Children's and Adolescents' Health. Barbados remained committed to investing in universal health coverage and strategies for integrated sexual and reproductive health, and was fostering a multisectoral approach, which was the key to promoting women's health.

Mr RUNGSUN MUNKONG (Thailand) said that 20 years after the adoption of the Beijing Declaration and Platform for Action, progress had been made with regard to women's health. Challenges remained, however, on several fronts, which could only be overcome through a "women-in-all-policies" approach, with particular consideration for the social and cultural determinants of women's health. Universal health coverage should be the main driver for extending health services to women in remote settings. Health services that were gender-sensitive and specifically tailored to the needs of women should be developed and enhanced. Improvements in women's health would benefit not only women themselves but also the health and well-being of their families and communities, and the health system as a whole, particularly since women accounted for a large proportion of health care personnel.

Mrs VALLINI (Brazil) underscored the importance of continuous dialogue on women's health issues. Discrimination against women persisted, particularly with regard to their opportunities and access to services. Efforts must be made to ensure that the momentum that had culminated in the adoption of the Beijing Declaration and Platform for Action was not lost, and that new challenges were taken up. Renewed commitment was urgently required: women's health should be taken into account in all priority areas, in particular nutrition, sexual and reproductive health, HIV/AIDS and domestic violence. All activities and policies to do with women's, children's and adolescents' health should focus on improving the quality of life and should take an intersectoral approach, while remaining rights-based.

Dr CHILD (Chile) said that women's health was a priority issue for Chile. Although progress had been made since the adoption of the Beijing Declaration and Platform for Action, much remained to be done. With regard to sexual and reproductive health, she acknowledged the challenges referred to in the report, but it was also important to include programmes aimed at meeting men's health needs. Action must be evidence-based and driven by up-to-date information and gender-disaggregated statistics. The Government had presented a draft law on abortion, which decriminalized abortion in the event of major health risk to the mother, non-viability of the fetus, or rape. She hoped that the information in the report would be taken into account in the updated Global Strategy on Women's, Children's and Adolescents' Health.

Ms CAO Bin (China) said that China had taken measures to incorporate women's and children's health into its social development plans. Enhanced public health services, including for maternal and child health, had been rolled out nationwide through the health care reform in 2009. Cancer, HIV/AIDS and domestic violence were the greatest threats to women's health in China. She hoped that lessons learnt and the experiences of Member States could be taken into account when setting the priorities in the updated Global Strategy on Women's, Children's and Adolescents' Health.

Dr JENYFA (Maldives) said that, despite overall progress in reducing maternal and infant mortality rates, much remained to be done, especially to improve nutrition and sexual and reproductive health, and to counter HIV/AIDS and violence against women. Availability of good quality data was essential to assess the reasons for uneven progress. An impartial, transparent and participatory review was required, with clear recommendations for future action. Women's and children's health should be tackled through an integrated approach. She called for a universal, transformative post-2015 development agenda, with a gender-sensitive approach mainstreamed throughout all goals and targets.

Ms GONZÁLEZ (Uruguay) said that Uruguay had made progress in the implementation of the Beijing Declaration and Platform for Action, and had reached Millennium Development Goal 5 on maternal health. The reduction in maternal mortality had been achieved by improving sexual and reproductive health services, including family planning and counselling before and after abortions. Health checks during pregnancy were also crucial. New legislation on protection of the right to sexual and reproductive health had been adopted and integrated into Uruguay's national health system. Nonetheless, barriers to access to health care remained. A comprehensive approach to women's health throughout the life course was particularly important. In that regard, rights-based health policies had a key role to play.

Dr KESKİNKILIÇ (Turkey) said that women's health must be considered from the perspective of social determinants and addressed through multisectoral action and coordinated responses with relevant international agencies. Gender equality and women's empowerment would pave the way to a brighter future. Turkey had initiated a first-line human papillomavirus DNA screening programme for cervical cancer, to avoid the delays that could occur with cytological examinations. The new test had proven to be a good alternative, which would improve cervical cancer screening and have a positive impact on women's health.

Ms LEWIS (Trinidad and Tobago) said that women's right to the highest attainable standard of health was a matter of national priority for her country. Since the establishment of the Ministry of Gender, Youth and Child Development, gender mainstreaming was being done in all sectors, with the involvement of civil society. The Beijing Declaration and Platform for Action had shaped the approach to women's issues, including the transition from focusing on family planning to drawing up policy on sexual and reproductive health, and the provision of training for gender mainstreaming focal points in all ministries. Antenatal, postnatal and sexual and reproductive health services had been integrated into primary health care. Despite that progress, challenges remained: although HIV testing was free of charge, some populations, such as sex workers, experienced difficulties in accessing it, owing to stigmatization. Trinidad and Tobago supported WHO in its leadership in responding to women's health needs in the context of the post-2015 development agenda and its sustainable development goals.

Dr ROY (Bangladesh) said that, with support from the Regional Office for South-East Asia, Bangladesh had made good progress in implementing the Beijing Declaration and Platform for Action. The maternal mortality rate had decreased considerably, and antenatal and postnatal care, skilled birth attendance, and family planning had all been improved. Efforts were being made to foster women's empowerment through their participation in politics, education and involvement in the health care sector. Despite progress, challenges remained with regard to underage marriage and adolescent pregnancy. Measures were being taken to rectify that situation.

Dr MHANDO (United Republic of Tanzania), speaking on behalf of the Member States of the African Region, said that the progress made in the Region had proven that under-5 mortality could be significantly reduced in low- and middle-income countries. Neonatal mortality rates had not improved, however, and maternal mortality remained unacceptably high, particularly in sub-Saharan Africa. The launch of the Global Strategy for Women's and Children's Health in 2010 had accelerated progress: investment for health infrastructure had been mobilized and health information systems had been established. Gender-based violence had consequences for women's health, which should be addressed in the updated strategy. Efforts were being made in the African Region to disaggregate health data by gender and age. Measures were being taken to end child marriage, with action at both national and regional levels to support and strengthen education for girls. Emerging priorities for women's health included noncommunicable diseases and the harmful use of alcohol, illicit drugs and other psychoactive substances, while breast and cervical cancer were recognized as being the leading causes of cancer-related deaths among women.

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

The meeting rose at 12.30.

TWELFTH MEETING

Monday, 25 May 2015, at 09:10

Chairman: Dr E. JARAMILLO NAVARRETE (Mexico)

1. FOURTH REPORT OF COMMITTEE A (Document A68/71)

Dr ROOVÄLI (Estonia), Rapporteur, read out the draft fourth report of Committee A.

The report was adopted.[1]

2. Promoting health through the life course: Item 14 of the Agenda (continued)

Women and health: 20 years of the Beijing Declaration and Platform for Action: Item 14.4 of the Agenda (Document A68/16) (continued from the eleventh meeting, section 5)

Dr CHAIRUL RADJAB NASUTION (Indonesia) said that major health issues affecting women in his country included violence and early marriage and pregnancy. Government action targeted the age group 10–24 years, which accounted for about one quarter of the population. The concept of the maternal and child health handbook, containing health advice and family health records, had been shared with other countries in South–South cooperation programmes. In the light of uneven progress in core areas and the high maternal mortality ratio, maternal and newborn health should be a focus of the sustainable development goals. Partnerships with civil society, professional organizations, academia, research institutions and the private sector must be strengthened to ensure accelerated implementation, monitoring and evaluation of the Beijing Declaration and Platform for Action.

Ms GARCÍA ARREOLA (Mexico) called for more gender mainstreaming in WHO's programmes; the Secretariat should incorporate it into epidemiological analysis, analysis of risk factors and the design and organization of health strategies and services, and promote it in country programmes. Health promotion programmes should include gender as a social determinant of health, a factor for analysis, and a consideration in the development, implementation and evaluation of health interventions. Specific strategies were needed to counteract the effects of living conditions that put women at risk of noncommunicable diseases and conditions such as obesity. Action tailored to the mental health needs of women, who were more likely to suffer from anxiety and depression, was also required.

Dr SHEIKH (Pakistan) said that his country planned to introduce gender-sensitive budgeting to analyse the extent to which federal and provincial budgets allocated resources to reducing gender inequality. He commended the Organization's efforts to ensure that maternal health was central to the post-2015 development agenda. Prevention was important, but financial and technical assistance was

[1] See page 366.

needed in order to treat and manage existing noncommunicable diseases in resource-constrained countries.

Dr TARAWNEH (Jordan) said that the key indicators for women's health in Jordan had greatly improved as a result of strategies on safe pregnancy, breastfeeding and family planning. Further measures included a 90-day period of maternity leave and breastfeeding time for working mothers, a women's health database and a national maternal mortality register. All health care services were also provided free of charge to non-Jordanian women.

Mr AL ABRI (Oman) said that the poor provision of integrated reproductive health services in many countries gave rise to high reproductive morbidity and increased maternal and child mortality. In Oman, reproductive health was a leading element of primary health care and a vital part of maternal health policies, as socioeconomic development depended on the involvement of women and their enjoyment of good health. The sensitivity surrounding the subject of reproductive health in some cultures was clearly to blame, however, for the lack of integrated reproductive health services in the countries concerned.

Dr MAKUBALO (South Africa) said that global progress in improving women's health had been slower than expected owing to structural barriers, inadequate resources and a lack of action on gender equality. Realization of universal health coverage and strengthening of health systems would help to accelerate progress, along with the implementation of Health Assembly resolutions on adolescent health, the health of older women and noncommunicable diseases.

Professor KULZHANOV (Kazakhstan) said that health indicators relating to women and children in his country had improved, although challenges still remained. Legal barriers prevented female migrants from accessing health care. Efforts to raise reproductive health awareness among all members of the family, a cost-effective intervention, must continue, as should work to ensure that all women of reproductive age and pregnant women were covered by health care and health monitoring systems. Scientific research, data and recommendations were required, taking into account the social determinants of health, and intersectoral cooperation was essential at global, national and local levels.

Dr ASMA GALI (Niger) said that, although her country had achieved its targets under Millennium Development Goal 4 (Reduce child mortality), maternal mortality remained a concern. Her country had given priority to mothers and children and to measures to reduce early marriage rates and was working towards universal health coverage.

Dr ZAKARIAH (Ghana) said that her country had put in place an ambitious health-care system that included free maternal health services, coverage of family planning by health insurance, the implementation of an adolescent health strategy and the establishment of a ministry of gender, children and social protection. As a result, Ghana had made good progress in reducing morbidity and mortality among mothers and children aged under 5 years.

Dr AL-TAAE (Iraq) underscored the importance of the empowerment of women within the community; the relationship between women's health and human rights and the reduction of violence against women; raising women's awareness of primary health care programmes, particularly in rural areas; intersectoral collaboration and community participation; and the reduction of maternal mortality. He called on WHO to denounce Daesh (also known as the Islamic State in Iraq and the Levant) for preventing women from accessing health care.

Dr AHMED ELBASHIR (Sudan) said that, despite progress in maternal and child health care, including a training programme to redress the shortage of midwives, her country continued to face the critical challenges of war and instability, as well as emigration of health-care professionals, lack of

reliable, sex-disaggregated data and quality of service provision. The updated Global Strategy for Women's, Children's and Adolescents' Health would form a practical platform for action.

Ms PEARCE (Nauru) gave details of the services for women provided by her country's universal free health-care system, including provision of a safe house for victims of domestic violence and employment of a gender-based violence specialist.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) called for greater efforts to reduce maternal deaths, maternal morbidity and inequalities in health outcomes, especially for the poorest people and for adolescent girls; to ensure that comprehensive sexual and reproductive health rights were realized for women and girls; to support the positive role of health workers in the growing Africa-led movement to end female genital mutilation within a generation; and to ensure an approach that considered the full continuum of care for reproductive, maternal, newborn, child and adolescent health, recognizing the prevention of stillbirths as part of that continuum.

Dr ASUNCION (Philippines) said that her country was committed to substantially reducing maternal and under-5 mortality and to providing social health insurance coverage for at least 80% of poor people in the country. The adoption of a law on responsible parenthood and reproductive health was expected to lead to better health outcomes for women and children.

Dr RAJAPAKSA HEWAGEEGANA (Sri Lanka) said that Sri Lanka was on track to meet Millennium Development Goal 5 (Improve maternal health). The infant mortality rate had dropped to nine per 1000 live births, and a similar reduction had been experienced in the under-5 mortality rate.

Dr Miao-Ching CHEN (Chinese Taipei) said that, although women in Chinese Taipei lived longer than men, they spent a higher proportion of their lives living with disability and were at higher cardiovascular risk. Despite ranking favourably in terms of the gender inequality index, Chinese Taipei still had a biased sex ratio at birth. It was estimated that the interventions launched in 2010 in response to the "missing girls" phenomenon, including a ban on prenatal sex screening and on sex-selective abortion, had saved more than 5600 baby girls. She suggested two additions to the information on health systems response in the report (from paragraph 26 onwards): capacity-building relating to gender sensitivity and gender competencies for health professionals; and stronger regulation of ethical practices to prevent health professionals from imposing any form of violence or discrimination on women and girls, such as sex-selective abortion or genital mutilation.

Dr DE BERNIS (UNFPA) observed that the United Nations International Conference on Population and Development (Cairo, 5–13 September 1994) had been a milestone in advancing sexual, reproductive, maternal, child and adolescent health, but the review held in 2014 had revealed persistent inequalities. The recommendations of the review had provided an important contribution to the renewing of the Global Strategy for Women's, Children's and Adolescents' Health; UNFPA welcomed the inclusion of adolescent health and the focus on health in humanitarian and fragile contexts. Investment in girls' education and comprehensive sexuality education for young people should be encouraged, with free access to sexual and reproductive health services: the current generation of girls must be empowered to avoid early marriage, early pregnancy and deaths from maternal causes. Yet that investment would be in vain if ways could not be found to strengthen basic health systems and ensure that they were resilient enough to protect the most vulnerable.

Ms STAAB (UN-Women) said that women's and girls' health was a critical concern for gender equality, women's empowerment and sustainable development. She highlighted several action points requiring collaboration among organizations of the United Nations system, the private sector and civil society, particularly focusing on the promotion of a rights-based approach to women's and girl's health and women's empowerment. The Beijing Declaration and Platform for Action remained a

normative motherboard that must continue to serve as a guide in moves towards the sustainable development goals in the post-2015 development agenda.

Ms UPLEKAR (International Alliance of Women), speaking at the invitation of the CHAIRMAN, said that women in rural areas still had limited access to health education and services, emergency and non-emergency contraception and emergency obstetric care. They were still affected by mistaken ideas about modern contraceptive methods and by moral and religious norms detrimental to gender equality. Abortion laws were the responsibility of individual Member States, and appeals to revise abortion bans on health and human rights grounds had shown mixed results. Men continued to be unaware of their responsibility in ensuring smaller families, and sexualized violence continued to undermine women's health and human rights.

Mr MWANGI (World Heart Federation), speaking at the invitation of the CHAIRMAN, said that, despite some progress, cardiovascular disease was still the leading cause of death of women worldwide and morbidity was often worse in women than in men. Yet women were more likely than men to be underdiagnosed and undertreated, partly because the presentation, progression and outcomes were different in women, but also because male-oriented research had limited the understanding of heart disease in women. In order to redress those imbalances, health systems should support the inclusion of women in clinical trials; provide sex-specific data; train health workers to provide sex-specific care; provide screening and lifestyle counselling for low-income and post-menopausal women; and disaggregate health-care data by gender, race, ethnicity and income.

Dr BUSTREO (Assistant Director-General) said that she had noted the importance given to gender-disaggregated data and analysis in underpinning public health actions. WHO had recently published a report on inequalities in reproductive, maternal, newborn and child health,[1] which measured reproductive, maternal, newborn and child health against equity stratifiers such as wealth, age and geographical location. The Organization stood ready to train health workers and statisticians to use the relevant methodologies in planning basic health services. Member States had demonstrated their will to continue to address women's health through the updated Global Strategy for Women's, Children's and Adolescents' Health, which would build on the unfinished Millennium Development Goals related to women's health, particularly the target of ending preventable maternal deaths. The Strategy would highlight new challenges, including the need for universal access to integrated services for women within the context of universal health coverage, and would deal with new and emerging issues concerning women's health, such as noncommunicable diseases, violence against women and the needs of adolescent women. It would focus particularly on emergencies and humanitarian settings, in which there were still many maternal deaths. She appreciated the consultations that had been conducted with many countries on the development of a global action plan on violence against women and girls, which would be discussed and, it was to be hoped, adopted by the Health Assembly in 2016.

The Committee noted the report.

[1] WHO. State of inequality: reproductive, maternal, newborn and child health. Geneva: World Health Organization; 2015, available at http://apps.who.int/iris/bitstream/10665/164590/1/9789241564908_eng.pdf?ua=1&ua=1 (accessed 26 June 2015).

Contributing to social and economic development: sustainable action across sectors to improve health and health equity (follow-up of the 8th Global Conference on Health Promotion): Item 14.5 of the Agenda (Document A68/17)

The CHAIRMAN invited the Committee to consider the draft framework for country action across sectors for health and health equity (document A68/17, Annex), prepared in consultation with Member States and with reference to the Helsinki Statement on Health in All Policies, endorsed by the 8th Global Conference on Health Promotion (Helsinki, 10–14 June 2013).

Dr AL-TAAE (Iraq) said that the draft framework for country action across sectors should focus on sustainable development as a means to community development and rehabilitation, taking into account the social, environmental and economic determinants of health and community-based initiatives as an impetus for sustainability, and also on intersectoral collaboration within primary health care, as the paramount approach for economic and social development. Health promotion should be the responsibility of all sectors, including non-State actors. In Iraq, in spite of the difficult security circumstances, committees had been set up within the ministries of planning and health to promote sustainable development, and health promotion activities that focused on social and economic development had been introduced in primary health care services.

Ms CAO Bin (China) supported the draft framework. In order to take action across sectors for health and health equity, it was critical to enhance capacity building and equip the health sector with the human resources, knowledge and skills it needed to promote active dialogue with other sectors. Since the draft framework referred principally to action at country level, she asked whether resources had been made available for follow-up to action at that level. As a mark of its support, China would host the 9th Global Conference on Health Promotion in November 2016, on the theme of health promotion and the sustainable development goals.

Professor ELIRA DOKEKIAS (Congo), speaking on behalf of the Member States of the African Region, welcomed the progress achieved within the Health Promotion Strategy for the African Region and the inclusion of representatives of African countries in training on the use of the *Health in all policies training manual*, although it would be helpful to widen African participation with a view to improving health and health equity in the Region. He drew attention to the challenges they faced, including the lack of resources and data, and of coordination with other sectors in implementing the health-in-all-policies approach.

The Member States intended to establish viable policies and structures for coordinating intersectoral measures within countries, promoting good governance in health and monitoring trends in health equity. They recommended that the Secretariat and its partners strengthen the leadership role of WHO and health ministers in order to advocate intersectoral measures and coordinate them with guidelines, policies and strategies intended to influence the social determinants of health in all sectors; support national and regional research on the risk factors and social, cultural and behavioural determinants that might hinder implementation of health policies and programmes, and affect health outcomes.

Ms KOIVISTO (Finland), speaking also on behalf of the Nordic countries Denmark, Iceland, Norway and Sweden and the Baltic countries Estonia, Latvia and Lithuania, said that the draft framework did not do enough to ensure that public health was placed at the forefront of multisectoral policies, nor did it recognize the fact that other sectors were sometimes able to work in isolation to enhance health, without the need for intersectoral collaboration. The draft framework should acknowledge the need, where necessary, to manage policies where few or no synergies could be determined. The draft framework and WHO's *Health in all policies training manual* could be used as tools to support capacity building at the country level. With a view to facilitating and advancing work at the forthcoming 9th Global Conference on Health Promotion (Shanghai, China, 2016), she called

for approval of the draft framework at the current Health Assembly, and requested WHO to support its dissemination and implementation worldwide. Noting the need to improve intersectoral links within the Secretariat, she looked forward to collaborating with all relevant WHO offices, departments and programmes.

Ms DAESCHLER (France) said that public health was influenced by factors that lay beyond the health sector, thereby highlighting the need for a multisectoral approach in order to influence the social, economic and environmental determinants of health. WHO should guide the effective implementation of intersectoral action; in that connection, she drew attention to the work undertaken by the Regional Office for Europe and the Member States of the European Region. Her Government had recently created an interministerial health committee to promote the integration of health into all public policies, and would be hosting a high-level meeting on the subject of health-in-all-policies in early 2016.

Ms FIERRO SEDAS (Mexico) said that intersectoral action and a health-in-all-policies approach were essential for tackling public health challenges. The Mexican national strategy for the prevention and control of weight, obesity and diabetes reflected the country's focus on shared responsibility and on intersectoral and horizontal measures bringing together government sectors, the private sector and civil society. Regional workshops on social determinants and health-in-all-policies were also being held to identify experiences at the local and national levels and inform good practices.

Professor NONGNUT BOONYOUNG (Thailand) supported the draft framework but expressed three concerns. Firstly, it was essential to ensure a transparent approach and manage conflicts of interest effectively. Consultation across sectors and between the public and private sectors was required in the formulation of policies in order to enhance policy compliance and avoid delays. Private sector actors with conflicts of interest should be encouraged to focus on their roles in producing, marketing, distributing and selling products, and should play a major role in monitoring their own products, practices and policies. Secondly, it was imperative to identify priority areas and establish monitoring milestones and mechanisms, using data disaggregated by population group, to identify unmet needs and monitor policy demand. Thirdly, the health-in-all-policies approach must also be observed at the international level in order to respond effectively to global threats to health and health equity, including international trade and economic treaties. It was important to promote international collaboration and partnerships and coordinated resource mobilization.

Dr ESIN (Russian Federation) expressed support for the draft framework, but noted that the reference to mesothelioma in connection with exposure to asbestos (document A68/17, Annex, paragraph 8) was too narrow in scope. Malignant mesothelioma could be caused by long-term exposure to many different natural or artificial mineral fibres: analysis of the causes of the disease was far from complete. However, the wording in the draft framework might lead to a false sense of security and mean that some risk factors for mesothelioma were not taken into account. Indeed, malignant mesothelioma was not the only example of asbestos-related disease. He therefore suggested that the phrase "decline in mesothelioma as a result of regulations against the use of asbestos" should be replaced by "reduction in the incidence of asbestos-related diseases through the introduction of national programmes for their elimination". Alternatively, his Government would be prepared to approve the current version of the draft framework provided that it was expressly placed on record that the Russian Federation considered that the reduction in asbestos-related diseases, specifically mesothelioma, was achieved by means of a set of measures and standards that were reflected in national programmes to eliminate asbestos-related diseases.

Mr SPRINGER (Barbados) welcomed the emphasis on follow-up action in the implementation of the health-in-all-policies approach, including development of the draft framework and capacity-building activities to support contributions to health outcomes by non-health sectors. The member

countries of the Caribbean Community had been at the forefront of advocacy campaigns to include noncommunicable diseases in the post-2015 development agenda. Leadership at the highest level was required to bring about an intersectoral response to noncommunicable diseases. He requested the Secretariat and PAHO to provide more evidence on the economic, developmental and social benefits of the health-in-all-policies approach, and to provide technical support and practical tools for its implementation.

Ms LEWIS (Trinidad and Tobago) said that effective policies must be based on socially and scientifically sound evidence collected in an inclusive, cross-cutting manner. The Secretariat and regional offices should expand their efforts to build capacity at the national level in a multisectoral approach in order to enable Member States to use health impact assessments as a tool for generating the data required to assess health inequities. She welcomed PAHO's support in developing a regional plan of action on implementation of the health-in-all-policies approach, and commended WHO's continued leadership in health promotion and its continued focus on the social determinants of health and the importance of multisectoral involvement. She endorsed the draft framework.

Mr MOHAMED (Egypt) said that it was essential to implement action across all sectors through a health-in-all-policies approach in order to address the social, economic and environmental determinants of health and optimize the co-benefits. The challenges and opportunities related to universal health coverage were common to all countries, to a greater or lesser extent. His country was preparing legislation to prioritize health equity and universal health coverage; to strengthen the Government's role in providing public health services; to ensure effective governance to address the multisectoral aspects of health; ensure accountability and transparency; and to involve all stakeholders in the national health policy, including civil society and the private sector. Health equity was the most important driver of public health and should be viewed as a human right.

Ms PEARCE (Nauru) said that work to address noncommunicable diseases and their related risk factors was a priority area on her country's health agenda. Incorporating the relevant aspects of global strategies and their indicators into national action was a challenging task in a small country such as Nauru where the workforce was small. As Nauru imported almost all its food, the health sector was planning to work with key importers to address "smart" food imports. The health sector was leading actions across government sectors and the community, with clearly defined roles and responsibilities for all stakeholders. The Pacific island countries faced unique challenges in relation to noncommunicable diseases, environmental health, food security and climate change, as recognized by the Yanuca Island Declaration on Health in the Pacific in the 21st Century. Achieving universal health coverage while building a sustainable, holistic health system with strong levels of primary care services and trained personnel was therefore difficult. Noting the support provided to her Government by Chinese Taipei, she urged WHO to facilitate Chinese Taipei's broader participation in its meetings and activities.

Ms Miao-Ching CHEN (Chinese Taipei) said that Chinese Taipei was committed to the health-in-all-policies approach, which it had applied in respect of obesity prevention, cancer control, healthy ageing and tobacco control. A recent report on health inequalities in Chinese Taipei called for improved surveillance, a whole-of-government approach to addressing the social determinants of health, and an "equity-in-all-policies" approach to update Chinese Taipei's sustainable development framework. The draft framework should include a clear statement to the effect that social inequity could kill and that reducing it would lead to economic growth.

Mr TARLTON (United Nations Development Programme) welcomed WHO's emphasis on social determinants of health and health equity. The joint initiatives undertaken by UNDP and WHO would help to implement the draft framework at country level; both organizations had worked to ensure that multisectoral action was central to the efforts of the United Nations Interagency Task

Force on Noncommunicable Diseases. Other joint initiatives included work to create an integrated approach to funding in order to realize health and development co-benefits across sectors, as well as collaboration with the Government of Japan and other partners to build country capacity in co-financing systems for health. Funding of key interventions related to noncommunicable diseases should not be the sole responsibility of the health sector. By jointly negotiating each sector's willingness to provide funding, countries would be able to fund more interventions with co-benefits across multiple sectors.

Mrs KOCH (Alliance for Health Promotion), speaking at the invitation of the CHAIRMAN, commended the draft framework. Efforts to rectify health inequities should begin at the community level, since communities were in a key position to identify their own health issues and seek solutions using local wisdom. Her organization was working to catalyse community opinion and action. Cooperation across sectors would contribute to sustainable good health and would be essential to the success of the health-in-all-policies approach. She urged WHO to scale up its support to local nongovernmental organizations and communities in order to improve health.

Dr DOEBBLER (Global Health Council, Inc.), speaking at the invitation of the CHAIRMAN, noted with satisfaction that several States Parties to the United Nations Framework Convention on Climate Change had proposed a reference to health in the new climate change agreement, due to be finalized by the end of 2015. He urged WHO to strengthen its engagement in the Climate and Health Summit held during sessions of the Conference of the Parties to that Framework Convention. He commended efforts to develop a new work plan on climate change and health. The *Atlas of health and climate* published in 2012 had been particularly useful; the exercise should be repeated. He urged WHO to engage in the discussion on climate finance with the Green Climate Fund and its members, particularly on the creation of a spending stream on health under the category "adaptation".

Dr CHESTNOV (Assistant Director-General) said that the Helsinki Statement on Health in All Policies, the outcome document of the 8th Global Conference on Health Promotion, had emphasized the need to move from commitment to action. The Secretariat's report demonstrated that the transition to action was under way, but health and health equity could not be addressed by the health sector alone. The Secretariat could only lead the process if mandated to do so by the Member States; it stood ready to help Member States to resolve the important issues that speakers had raised, including conflicts of interest between government and the private sector, and would move forward with Member States' guidance. The next Global Conference provided an opportunity to discuss the way to move forward. There was much cause for optimism: Member States were committed to the process, and WHO had competent staff and the requisite technical capacity. Financial resources were, however, limited.

The CHAIRMAN said that it would not be possible to amend the Secretariat report but the Secretariat had taken note of the statement made by the delegate of the Russian Federation.

The Committee noted the report and approved the draft framework for country action across sectors for health and health equity.

3. COMMUNICABLE DISEASES: Item 16 of the Agenda (continued)

Global vaccine action plan: Item 16.4 of the Agenda (Document A68/30) (continued from the eleventh meeting, section 4)

The CHAIRMAN announced that, following informal consultations, the draft resolution on the global vaccine action plan had been revised. The financial and administrative implications for the Secretariat were unchanged. The revisions were as follows.

> The fourth preambular paragraph should read: "... public health, innovation and intellectual property, resolution WHA54.11 on the WHO medicines strategy and resolution WHA67.20 on Regulatory System Strengthening". The tenth preambular paragraph should read: "… concerned at the increase …".
>
> The introduction of paragraph 1 should read: "URGES Member States", with the addition of a footnote reading "And, where applicable, regional economic integration organizations". Subparagraph 1(3) should read: "to provide, where possible and available …". Subparagraph 1(7) should read: "… all the necessary vaccines and their availability …".
>
> Subparagraph 2(2) should read: "… adequately managing publicly available vaccine price databases …". Subparagraph 2(6) should read: "to report upon technical, procedural and legal barriers that may undermine robust competition that can enable price reductions for new vaccines, and address other factors that can adversely affect the availability of vaccines".

Dr AL-MOKHTAR (Libya), thanking all Member States that had participated in the informal consultations, said that the revised draft resolution was an example of the spirit of goodwill and constructive dialogue in which they had worked.

Mrs VALLINI (Brazil) expressed support for the revised draft resolution and said Brazil wished to be added to the list of sponsors.

Mr MAMACOS (United States of America), expressing appreciation for the informal discussions, stressed the importance of maintaining the good practice of submitting draft resolutions in the November or December before the Health Assembly in order to give the Executive Board time to consider them at its January sessions.

Ms ST. LAWRENCE (Canada) welcomed the progress made in reaching a compromise on the draft resolution. She emphasized the need for Member States to have sufficient time to consider draft resolutions on serious public health issues.

The draft resolution, as amended, was approved.[1]

[1] Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA68.6.

4. PROGRESS REPORTS: Item 18 of the Agenda (Document A68/36)

Communicable diseases

D. Eradication of dracunculiasis (resolution WHA64.16)
E. Elimination of schistosomiasis (resolution WHA65.21)
F. Neglected tropical diseases (resolution WHA66.12)
G. Prevention and control of sexually transmitted infections: global strategy (resolution WHA59.19)

Dr AL-TAAE (Iraq) urged caution when applying the term "neglected", as all tropical diseases should be paid adequate attention and taken into account in surveillance systems. Health security was closely linked to effective surveillance, particularly with regard to diseases that were on the verge of eradication. Progress was being made in Iraq towards the elimination of schistosomiasis, despite challenges posed by the security situation in the country. Mycetoma had been added to the list of diseases monitored by the surveillance system. The prevention and control of sexually transmitted infections was particularly important, and could only be achieved through enhanced primary health care and evidence-based family health interventions. Iraq had allocated resources to the prevention and treatment of sexually transmitted infections, and was fostering community involvement to promote early detection and treatment.

Professor NAPO-KOURA (Togo) welcomed the inclusion of data on dracunculiasis in surveillance of diseases of epidemic potential. Challenges remained with regard to its eradication in conflict-affected countries. Further research was required into the sporadic cases that persisted in some countries and in particular the appearance of nontraditional hosts, such as dogs. Togo had been certified as having eliminated dracunculiasis in 2011 and a post-certification plan was being implemented with technical support from WHO. The schistosomiasis elimination programme in Togo was yielding encouraging results. Mass administration programmes also allowed treatments for other neglected tropical diseases to be administered.

Mr WOLFE (United States of America) commended Member States' progress in eliminating dracunculiasis, which demonstrated the effectiveness of basic interventions. Member States should sustain surveillance and case containment in endemic areas and surrounding areas: WHO should help to enhance detection and prevention activities, including the provision of safe water supplies for at-risk communities. The increased availability of praziquantel and donations from partners had advanced schistosomiasis control: WHO should contribute to the development of specific guidelines to help countries to switch from control to elimination programmes. Regarding neglected tropical diseases generally, he said that, despite WHO's success in coordinating the delivery of treatments, only one third of people in need had received preventive chemotherapy in 2013. Sustained political will was required to mitigate the global impact of those diseases, along with a greater focus on country-level capacity building and implementation.

He strongly supported the development of a new global strategy for the prevention and control of sexually transmitted infections, which should include clearly specified, achievable targets to measure success and define challenges. WHO should update the *Guidelines for the management of sexually transmitted infections* issued in 2003 with new information on the use and quality assurance of point-of-care diagnostic tests, syphilis testing and treatment algorithms. WHO should promote primary prevention interventions, such as vaccination against human papillomavirus infection, where feasible.

Ms ELVIEDA SARIWATI (Indonesia) described her country's efforts to eliminate schistosomiasis, paying particular attention to target-setting, surveillance measures and programmes for prevention and control. Other supposedly neglected tropical diseases, including yaws and leprosy, were in fact priorities in the country's health programme.

Mr GORI MOMOLU (Equatorial Guinea), speaking on behalf of the Member States of the African Region, said that, to achieve their aims, they must implement the Regional Strategic Plan for Neglected Tropical Diseases in the African Region 2014–2020. Neglected tropical diseases programmes in the Region focused on large-scale preventive chemotherapy, legal documents on coordination, and operational programmes and plans. He described the progress made by some Member States of the Region. He called upon WHO and partners to provide technical and financial support for Member States in their elimination efforts.

Mr MORIKO (Côte d'Ivoire), also speaking on behalf of the Member States of the African Region, said that 39 African countries had achieved dracunculiasis-free certification since 1998. Partners should continue to provide support as the final stage of the eradication campaign would be the most difficult. Eradication could be achieved by restoring peace to endemic countries in crisis, strengthening surveillance through detection and case containment, providing uncontaminated drinking water, enhancing communication for behavioural change, and treating surface water. Countries in the Region would follow with interest future working group meetings on dracunculiasis. Endemic countries and partners should strive to eradicate dracunculiasis in the next five years.

Although global supplies of praziquantel for the treatment of schistosomiasis had increased and most countries in the Region had implemented preventive chemotherapy programmes, coverage in endemic zones was poor, especially among children. Most countries had fully or partially mapped the disease, and Burundi, Rwanda and the United Republic of Tanzania had launched a joint elimination project. The Secretariat should help all endemic countries to increase treatment of school-age children and at-risk populations by coordinating mass administration of treatment. He encouraged Member States, the international community and donors to mobilize the resources needed.

Dr YOUBI (Morocco) said that no active focus of schistosomiasis transmission had been detected in his country since 2005, although precautionary measures were still being taken. Morocco called upon WHO to consider procedures for evaluating the elimination of schistosomiasis and certifying elimination. He further asked the Secretariat to provide support for a second serological study to confirm the elimination of schistosomiasis in Morocco.

Dr SHEIKH (Pakistan) said that his country had been declared dracunculiasis-free in 1996. However, some neglected tropical diseases, such as leishmaniasis, were still endemic. He therefore urged the global community to ensure a continuous supply of the necessary medicines. More research and development were needed, particularly for the development of new vaccines.

Dr GORGOLON (Philippines) described her Government's campaign to eliminate schistosomiasis by 2025. The progress report would help the Philippines to advocate for mass treatment administration campaigns and build political commitment among local government units for schistosomiasis elimination activities.

She commended the Global strategy for the prevention and control of sexually transmitted infections, 2006–2015, particularly the provisions on the elimination of congenital syphilis, screening of donated blood and the implementation of the Gonococcal Antimicrobial Surveillance Programme.

Ms FIERRO SEDAS (Mexico) reported on the outcome of a regional consultation on the draft future global health sector strategy on sexually transmitted infections for 2016–2021, which had agreed on the need for greater integration and visibility of activities. She described recent efforts to

tackle sexually transmitted infections in Mexico, particularly noting the implementation of action plans to tackle HIV/AIDS, syphilis and other sexually transmitted infections.

Ms WANG Rongrong (China), noting that the elimination of schistosomiasis depended on large-scale treatment with praziquantel, said that only one country had obtained WHO prequalification status for its manufacture. The Secretariat and Member States should therefore help manufacturers to obtain prequalification status. Given the complex nature of schistosomiasis transmission, the disease could return, and continued surveillance would be required.

Although she supported the Global strategy for the prevention and control of sexually transmitted infections 2006–2015, she asked the Secretariat to evaluate it, particularly the proposal to include HIV/AIDS. More interventions were needed among target populations. Member States which had achieved the goals outlined in the Global strategy should share successes and best practices.

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

The meeting rose at 12:00.

THIRTEENTH MEETING

Monday, 25 May 2015, at 14:40

Chairman: Dr E. JARAMILLO NAVARRETE (Mexico)

1. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 15 of the Agenda (continued)

Antimicrobial resistance: Item 15.1 of the Agenda (Documents A68/19, A68/20 and A68/20 Corr.1, A68/A/CONF./1 Rev.1 and A68/A/CONF./1 Add.1) (continued from the eighth meeting, section 2)

The CHAIRMAN drew attention to the following revised version of the draft resolution on the global action plan on antimicrobial resistance, with amendments resulting from informal consultations.

The Sixty-eighth World Health Assembly,

PP1 Having considered the summary report on progress made in implementing resolution WHA67.25 on antimicrobial resistance and the report on the draft global action plan on antimicrobial resistance;[1]

PP2 Recalling resolutions WHA39.27 and WHA47.13 on the rational use of drugs, resolution WHA51.17 on emerging and other communicable diseases: antimicrobial resistance, resolution WHA54.14 on global health security: epidemic alert and response, resolution WHA58.27 on improving the containment of antimicrobial resistance, resolution WHA60.16 on progress in the rational use of medicines and resolution WHA66.22 on follow up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination and WHA67.25 on antimicrobial resistance;

PP3 Aware that access to effective antimicrobial agents constitutes a prerequisite for most modern medicine; that hard-won gains in health and development, in particular those brought about through the health-related Millennium Development Goals, are put at risk by increasing resistance to antimicrobials; and that antimicrobial resistance threatens the sustainability of the public health response to many communicable diseases, including tuberculosis, malaria and HIV/AIDS;

PP4 Aware that the health and economic consequences of antimicrobial resistance constitute a heavy and growing burden on high-, middle- and low-income countries, requiring urgent action at national, regional and global levels, particularly in view of the limited development of new antimicrobial agents;

PP5 Recognizing that the main impact of antimicrobial resistance is on human health, but that the contributing factors and consequences, including economic and others, go beyond health, and that there is a need for a coherent, comprehensive and integrated approach at global, regional and national levels, in a "One Health" approach and beyond, involving different actors and sectors such as human and veterinary medicine, agriculture, finance, environment and consumers;

PP6 Aware that the inappropriate use of antimicrobial medicines in all relevant sectors continues to be an urgent and widespread problem in high-, middle- and low-income countries,

[1] Documents A68/19, A68/20 and A68/A/CONF./1.

with serious consequences for increasing antimicrobial resistance in a wide range of pathogens including bacteria, viruses and parasites;

PP7 Noting that despite sustained efforts over a number of decades by Member States, the Secretariat and partners, most developing countries are still facing a multitude of challenges in improving affordability and universal access to quality, safe and effective antimicrobial medicines and diagnostic tools;

PP8 Recognizing that, although substantial investments have already been made to tackle antimicrobial resistance, significantly more resources need to be mobilized to support effective action at national, regional and global levels, including through the provision of technical and financial assistance, particularly to low- and middle-income countries;

PP9 Reaffirming the critical importance of enhancing infection prevention and control, including good sanitation and hygiene, in both community and health care settings;

PP10 Recognizing the importance of immunization as one of the most cost-effective public health interventions, and that vaccines play an important role in reducing antimicrobial resistance;

PP11 Underlining the pressing need to develop new antimicrobial medicines as well as effective, rapid and low-cost diagnostic tools, vaccines and other interventions, and recalling the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property and resolution WHA66.22 on follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, which address drug market failure;

PP12 Acknowledging the urgent need for a more coordinated and harmonized surveillance system to monitor antimicrobial resistance at national, regional and global levels, including the need to develop internationally agreed standards for data collection and reporting across the human health, medical, veterinary and agricultural sectors;

PP13 Underscoring the need to improve awareness and understanding of antimicrobial resistance through effective public communication programmes, education and training as well as in the human health, veterinary and agricultural sectors,

(OP1) ADOPTS the global action plan on antimicrobial resistance;

(OP2) URGES Member States:[1]

(1) to implement the proposed actions for Member States in the global action plan on antimicrobial resistance, adapted to national priorities and specific contexts;

(2) to mobilize human and financial resources through domestic, bilateral and multilateral channels in order to implement plans and strategies in line with the global action plan;

(3) to have in place, by the Seventieth World Health Assembly, national action plans on antimicrobial resistance that are aligned with the global action plan on antimicrobial resistance and with standards and guidelines established by relevant intergovernmental bodies;

(OP3) INVITES international, regional and national partners to implement the necessary actions in order to contribute to the accomplishment of the five objectives of the global action plan on antimicrobial resistance;

(OP4) REQUESTS the Director-General:

(1) to implement the actions for the Secretariat in the global action plan on antimicrobial resistance;

[1] And, where applicable, regional economic integration organizations.

(2) to ensure that all relevant parts of the Organization, at headquarters, regional and country levels, are actively engaged and coordinated in promoting work on containing antimicrobial resistance, including through the tracking of resource flows for research and development on antimicrobial resistance in the new global health research and development observatory;

(3) to strengthen the tripartite collaboration between FAO, OIE and WHO for combating antimicrobial resistance in the spirit of the "One Health" approach;

(4) to work with the Strategic and Technical Advisory Group on antimicrobial resistance, Members States,[1] FAO and OIE, and other relevant partners to develop a framework for monitoring and evaluation in line with principle five of the global action plan;

(5) to develop and implement, in consultation with Member States[1] and relevant partners, an integrated global programme for surveillance of antimicrobial resistance across all sectors in line with the global action plan;

(6) to establish a network of WHO Collaborating Centres to support surveillance of antimicrobial resistance and quality assessment in each WHO region;

(7) to develop, in consultation with Member States[1] and relevant partners, options for establishing a global development and stewardship framework to support the development, control, distribution and appropriate use of new antimicrobial medicines, diagnostic tools, vaccines and other interventions, while preserving existing antimicrobial medicines, and promoting affordable access to existing and new antimicrobial medicines and diagnostic tools, taking into account the needs of all countries, and in line with the global action plan on antimicrobial resistance, and to report to the sixty-ninth World Health Assembly;

(8) to work with the United Nations Secretary-General and bodies in the United Nations system to identify the best mechanism(s) to realize the investment needed to implement the global action plan on antimicrobial resistance, particularly with regard to the needs of developing countries;

(9) to elaborate, in consultation with the United Nations Secretary-General, options for the conduct of a high-level meeting in 2016, in the margins of the United Nations General Assembly, including potential deliverables, and to report to the sixty-ninth World Health Assembly through the 138th Executive Board;

(10) to provide support and technical assistance to countries, with a specific focus on low and middle income countries;

(11) to set aside adequate resources for the Secretariat, in line with the Programme budget 2016–2017 and the Twelfth General Programme of Work, 2014–2019 for implementing the draft global action plan on antimicrobial resistance;

(12) to submit biennial reports on progress achieved in implementing this resolution to the Seventieth, Seventy-second and Seventy-fourth World Health Assemblies, and to produce an interim report to the Sixty-ninth World Health Assembly.

The financial and administrative implications of the draft resolution for the Secretariat remained unchanged.

Ms HALÉN (Sweden), speaking on behalf of the participants in the informal consultations on the draft resolution, which had been led by her own delegation and that of the United Kingdom of Great Britain and Northern Ireland, said that consensus had been reached on a new text which reflected the specific needs of low- and middle-income countries regarding financial assistance and

[1] And, where applicable, regional economic integration organizations.

universal access to medicines. She commended the revised draft resolution, which was sponsored by more than 60 countries, for adoption by the Health Assembly.

The draft resolution, as amended, was approved.[1]

Mrs GYANSA-LUTTERODT (Ghana) welcomed the amended text just approved and urged the Secretariat to support countries in developing policies and regulatory regimes to facilitate the implementation of the global action plan on antimicrobial resistance.

Dr JAYASUNDARA (Sri Lanka) said that Sri Lanka was committed to making the contents of the action plan a reality. He welcomed WHO's commitment to promoting affordable access to not only new and expensive antimicrobials but also existing antimicrobial medicines and diagnostic tools. That was a prerequisite to achieving a rational use of antimicrobials and tackling the issue of antimicrobial resistance.

Dr PANDA (India) said that the amended resolution reflected the collective priorities defined by Member States, including India's desire for a holistic and comprehensive strategy. Antimicrobial resistance was a development challenge as well as a health challenge, especially for low- and middle-income countries. For that reason, strategies should incorporate contributions from sectors in addition to that of health. The need to ensure access to affordable antimicrobials, diagnostics and vaccines was also critical. He expressed satisfaction that the amended text assigned significant responsibilities to the Secretariat while providing Member States with a clear course of action and a timeline for implementation.

Dr KONG INSIK (Republic of Korea) welcomed the amended resolution, which provided greater clarity with regard to financial responsibility. The Republic of Korea wished to be added to the list of cosponsors. He would particularly welcome the organization of a high-level meeting on the sidelines of the United Nations General Assembly in 2016.

Miss SANTIAGO (Philippines), expressing strong support for the global action plan on antimicrobial resistance, asked for her country to be included as a cosponsor of the resolution.

Dr MAKUBALO (South Africa) strongly supported the global action plan, and hailed the approval of the draft resolution a landmark event.

Dr BAKASWA NTAMBWE (Democratic Republic of the Congo) said that his country took the problem of antimicrobial resistance very seriously; it currently faced resistance to first- and second-line medicines for tuberculosis as well as the problem of self-medication. His country wished to be added to the list of cosponsors.

Ms FIERRO SEDAS (Mexico) expressed satisfaction that the environmental sector had been consulted in the elaboration of the global action plan. The same approach should be taken to developing national plans on antimicrobial resistance. Mexico welcomed the proposed multisectoral implementation of the action plan.

Mr BRAITHWAITE (United Kingdom of Great Britain and Northern Ireland) said that the adoption of the first-ever global action plan to combat antimicrobial resistance marked an important step towards tackling a grave threat. He recalled that the Fleming Fund had been launched by his Government for the purpose of improving surveillance networks and laboratories for the detection and

[1] Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA68.7.

diagnosis of deadly diseases in countries with limited existing capacity. Furthermore, it would be releasing up to £3 million of funding and support to the Secretariat to support developing countries in establishing their own national action plans on antimicrobial resistance and identifying gaps in capacity. The goal was to help all Member States to move quickly from words to action.

The DIRECTOR-GENERAL said that the approval of the draft resolution was a cause for celebration. She thanked all Member States for taking a historic step towards combating antimicrobial resistance, and assured the Health Assembly that WHO would work closely with OIE, FAO, the academic sector and civil society to guide implementation of the global action plan.

2. PROGRESS REPORTS: Item 18 of the Agenda (Document A68/36) (continued)

Communicable diseases (continued from the twelfth meeting, section 4)

D. Eradication of dracunculiasis (resolution WHA64.16) **(**continued**)**
E. Elimination of schistosomiasis (resolution WHA65.21) (continued)
F. Neglected tropical diseases (resolution WHA66.12) (continued)
G. Prevention and control of sexually transmitted infections: global strategy (resolution WHA59.19) (continued)

Dr DAKULALA (Papua New Guinea) said that, despite the heavy burden of communicable diseases in Papua New Guinea, WHO had certified the country free of dracunculiasis, and cases of schistosomiasis were rare. Thanks to international support, progress had been made on elimination of lymphatic filariasis and a country-wide mass medicine administration programme was under way. Further support would be needed to ensure its success. Challenges remained with regard to other tropical diseases. Yaws was re-emerging, with the number of cases increasing rapidly; microbial confirmation remained a challenge. For soil-transmitted helminthiases, joint efforts were being made with the education sector to run deworming programmes in schools, but progress remained slow. Papua New Guinea required support to accelerate progress towards the elimination of neglected tropical diseases.

Sexually transmitted infection rates in Papua New Guinea were particularly high and had been increasing steadily in recent years, especially among women. In an effort to rectify the situation, a range of sexual health services had been established in the country, with the support of various international partners. Nonetheless, the country was experiencing a concentrated HIV epidemic. Although antiretroviral treatment coverage had increased and mortality had decreased in the major treatment centres, data gaps persisted and better surveillance was urgently needed. A few instances of resistance to antiretroviral medicines had been reported.

Mr BLACK (United Kingdom of Great Britain and Northern Ireland) said that his Government had committed a further £195 million to neglected tropical disease control. Pointing out that the populations worst affected by those diseases were often those with the most limited resources, he stressed the need for programmes to foster economic development and job creation. Resources were required from international partners to bridge the significant funding gap with respect to programme implementation in the countries affected.

Dr JENYFA (Maldives) highlighted the need to strengthen disease surveillance systems and ensure appropriate programme management. Neglected tropical disease control programmes should be integrated into public health-care services, vaccination campaigns, or existing programmes, in order to achieve greater coverage and reduce operational costs. The Secretariat should support Member States in their efforts to collect, validate and analyse data on neglected tropical diseases from national

surveillance systems. Despite declining rates of syphilis in Maldives, sexually transmitted infections remained a serious public health problem, with adolescents and young people increasingly affected. A new strategy for the post-2015 period was essential.

Mr BARROS (Cabo Verde), speaking on behalf of the Member States of the African Region, said that ongoing efforts to control sexually transmitted infections included updating national guidelines and recommendations. Despite the progress made, a lack of financial and human resources was hindering efforts to provide more accessible services. Surveillance of sexually transmitted infection should be improved in the context of health system strengthening. He urged WHO to draw on lessons learnt during the implementation of the Global strategy for the prevention and control of sexually transmitted infections: 2006–2015, in order to develop the new global strategy without delay, in line with the post-2015 development agenda and the principle of universal health coverage. Member States should mobilize all necessary resources to guarantee universal access to prevention and control services for sexually transmitted diseases. Such efforts should uphold human rights, equality of the sexes, and equity in health care.

Ms Szu-Pei WU (Chinese Taipei), welcoming the efforts of WHO to prevent and control sexually transmitted infections, particularly the call for a new global strategy on the matter, said that health care providers in both the public and the private sector in Chinese Taipei had been encouraged to offer effective treatment, voluntary HIV counselling and testing services, and education on risk behaviours and prevention methods to patients with sexually transmitted infections. Emphasis had also been given to encouraging patients to notify their partners, although experience had shown that many patients were willing but unsure of how to do so. Difficulties had also been experienced by clinicians in the notification of sexual partners of index patients. The capacity of patients and clinicians should be strengthened in that regard, and WHO should provide guidance and continue to work with partners on those issues.

Dr NAKATANI (Assistant Director-General) welcomed the comments made on eradication of dracunculiasis, elimination of schistosomiasis, and neglected tropical diseases, and emphasized the importance of breaking the cycle of poverty and disease. He acknowledged that some neglected tropical diseases, such as human African trypanosomiasis and dracunculiasis, were approaching the so-called “last mile” before eradication; the number of patients was declining and, although there was a risk of diminishing political and donor commitment, that had not occurred. Industry was also playing a key role through increasing the number of medicines donated to affected countries. With regard to dracunculiasis, thus far in 2015, incidence had been low. Although the high season was approaching, it was expected that further reductions compared to the previous year would be observed. Regarding the elimination of schistosomiasis, industry was again playing a key role by expanding its donation programme to enable 100 million school-aged children to be treated in 2016. Nevertheless, more remained to be done and WHO stood ready to provide support in that regard. Responding to comments by the delegate of Morocco regarding the need for procedures to monitor and evaluate the interruption of schistosomiasis, he said that WHO was working on such procedures and would soon produce guidelines on the matter.

Dr BUSTREO (Assistant Director-General) said that WHO was in the process of developing a new global strategy on sexually transmitted infections, which would also incorporate action on HIV/AIDS and hepatitis B. Regional consultations were ongoing in that regard and it was expected that the Health Assembly would discuss and agree upon the strategy in 2016. Sexually transmitted infections remained an important public health issue, particularly the elimination of mother-to-child transmission of HIV and syphilis.

Promoting health through the life course

H. Newborn health (resolution WHA67.10)
I. Working towards universal coverage of maternal, newborn and child health interventions (resolution WHA58.31)
J. Implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children (resolution WHA66.7)

Ms GREPSTAD (Norway) said that it was important to build on the progress made in reducing maternal and child mortality and keep up the momentum in the post-2015 era. In that connection, Norway welcomed the development of the United Nations Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health and the Global Financing Facility that was being established to support implementation efforts. Her country intended to make substantial investments in that Fund in the coming years and saw it as an important tool to consolidate health financing through rights-based and results-focused approaches. In addition, she encouraged partners to continue to increase the availability and use of the 13 life-saving commodities and related services identified by the United Nations Commission on Life-Saving Commodities for Women and Children. The year 2014 had seen significant progress in efforts to shape markets, with the Implant Access Program helping to improve access to contraceptive implants at lower-than-market price in the poorest countries, and the local manufacture of zinc and oral rehydration salts for childhood diarrhoea generating competition in local markets, improving availability, boosting local economies and saving lives. She underscored the importance of synergies between education and health, particularly in terms of education for young people on sexual and reproductive health.

Dr SAID ALI (Comoros), speaking on behalf of the Member States of the African Region on the issue of newborn health, said that, although the under-5 mortality rate in the Region had decreased significantly, it remained the highest in the world. Many newborn deaths could be avoided if the measures contained in the Every Newborn action plan were properly implemented. To date, Member States had achieved varying degrees of progress in the development of national action plans to implement that plan. He requested WHO and all partners to provide increased support to Member States in the Region for the development of national action plans.

Dr AL-TAAE (Iraq) said that all issues related to maternal, newborn and child health should be addressed through a single strategic work plan. Iraq had developed such a strategy. Improving neonatal health, through neonatal screening, early detection and prevention of birth defects, neonatal resuscitation, and efforts to improve maternal and perinatal health as well as availability of life-saving commodities were of particular importance. Primary and secondary health care initiatives should be combined, taking into account the main causes of child mortality, and efforts should be decentralized and undertaken at the district level. More attention should be given to family planning issues.

Ms VOETMANN (Denmark) said that supporting women's and children's health rights, including sexual reproductive rights, had been a key aspect of her country's development cooperation for many years. In recognition of that focus, the organization Women Deliver had decided that its next global conference would be held in Copenhagen, in 2016.

Ms EL-HALABI (Botswana), speaking on behalf of the Member States of the African Region on progress report I, Working towards universal coverage of maternal, newborn and child health interventions, said that the Millennium Development Goals Report 2014 by UNDP had stated that living standards were improving across the African Region, but that countries in sub-Saharan Africa continued to lag behind. The Ebola virus disease outbreak had also highlighted how weak health systems could increase the negative impact of epidemics. Universal coverage of essential health care services in countries in the Region remained low and no country in the Region had achieved universal

access to reproductive health. Moreover, despite global progress in reducing maternal and child mortality, rates remained high in developing regions compared with developed regions, with rates in sub-Saharan Africa particularly high. She expressed concern at the slow progress, particularly as the causes of deaths and the interventions required to prevent them were well known and could be applied in resource-limited settings. Key challenges included inadequate health information systems, limited access to good-quality health services, inadequate financial and human resources, insufficient community involvement, and a lack of coherence between policies and programme implementation. A regional action plan on the issue was being drafted and she requested the support of WHO and other development partners in the facilitation of dialogue between relevant ministries and other key partners in that regard. Equitable distribution of financial and human resources would also be vital.

Ms CAO Bin (China) said that in her country, a review of baby-friendly hospitals had been undertaken with a focus on improving breastfeeding rates, controlling non-medically necessary caesarean sections and enhancing paediatric services. Folic acid was provided free of charge in rural areas and the availability of screening services was increasing, with those services being free of charge for some women. China intended to formulate a national action plan on newborn health in line with the Every Newborn action plan and would take measures to end preventable maternal and newborn deaths, and improve maternal and neonatal care.

Ms WOOD (United States of America) said that access to life-saving commodities across maternal, newborn and child health and family planning was an essential component of efforts to end preventable child and maternal deaths. Support was needed for the continuation and completion of the work of the United Nations Commission on Life-Saving Commodities for Women and Children and for addressing the remaining barriers to implementing its recommendations.

Dr ASMA GALI (Niger) said that the continued high maternal mortality rates in some countries were a social injustice, as many deaths could be prevented. Emphasizing the importance of meeting the health needs of children and adolescents, she said that her country had developed a programme to support the education and reproductive health needs of adolescents and the improvement of their socioeconomic status. Neonatal and perinatal health and the reduction of preventable maternal deaths were other important areas, with community-based actions being a vital tool in that regard.

Dr BENJAWAN TAWATSUPA (Thailand) urged the Secretariat to support Member States in the development and implementation of national action plans on newborn health, which should focus particularly on high-risk target groups, such as pregnant teenagers and migrants. Thailand was endeavouring to achieve universal health coverage for maternal and child health. Although progress had been made, more needed to be done to improve the accuracy of registration of data on health status and utilization of health services, including reliable data on maternal and infant mortality. The Secretariat should therefore support Member States in improving their health information systems. In addition to focusing on treatment, emphasis should also be placed on understanding patients' individual situations and backgrounds, and ensuring that pregnant women attended antenatal clinics.

Dr JENYFA (Maldives) said that newborn mortality and stillbirths required greater visibility in the post-2015 sustainable development agenda in order to reduce the overall under-five mortality rate. Noting that, in Maldives and globally, neonatal deaths accounted for the highest percentage of child deaths, and, recognizing that newborn survival had been lagging behind in the context of efforts to end preventable child mortality, she said that the Every Newborn action plan was aimed at achieving equitable and high-quality health care coverage for all women and newborns. She stressed, moreover, that countries bore primary responsibility for establishing good governance and providing effective and good-quality reproductive, maternal and newborn health services, and that coordinated health system approaches involving multiple stakeholders were therefore essential.

Ms SCAMMEL (United Kingdom of Great Britain and Northern Ireland) welcomed the fact that an increasing number of countries had developed newborn health action plans, which had been integrated into the full continuum of reproductive, maternal, newborn and child health. The focus on stillbirths should be maintained under the Every Newborn action plan.

Dr GORGOLON (Philippines) said that her country's newborn action plan aimed to reduce neonatal mortality through evidence-based interventions on the management of premature birth complications, intrapartum-related deaths, neonatal infections and low birth weight. Centres of excellence had also been established in hospitals. It was imperative that newborn survival be improved by enforcing health regulations in health facilities. The results of a 2013 national survey showed that the Philippines had been able to reduce neonatal mortality.

Ms KAWAPURO (Papua New Guinea) said that her Government had developed a newborn management policy that provided context and direction for newborn care strategies and activities to be implemented by stakeholders, government service providers, nongovernmental organizations and pre-service training institutions. Using WHO's *Early Essential Newborn Care: Clinical Practice Pocket Guide*, guidelines had been developed for health care workers. A newborn care centre of excellence and capacity building for health care workers were being established. The neonatal mortality rate was beginning to decline.

Ms Szu-Pei WU (Chinese Taipei) said that Chinese Taipei had considerable experience in providing overlooked yet life-saving commodities and products to women and children, and its health insurance system especially protected disadvantaged groups. Internationally, Chinese Taipei was willing to continue assisting countries in their efforts to improve maternal, newborn and child health.

Ms BOLAN (World Vision International), speaking at the invitation of the CHAIRMAN, urged Member States to finalize action plans on newborn health and translate them into action at both national and subnational level, placing emphasis on robust monitoring and evaluation, together with strong accountability mechanisms. To accelerate progress towards ending preventable newborn deaths, the focus should be on better targeting resources for the benefit of the most vulnerable mothers and children, expanding birth registration and vital statistics systems, and improving the coverage of essential maternal, newborn and child health services. Particular attention should be paid to mothers and babies in fragile, conflict-affected and emergency settings. World Vision International was committed to the Every Newborn action plan.

Mr BONDIONI (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, emphasized the commitment of the oral health community to reducing oral health-related inequalities and promoting oral health in all policies. Only about two thirds of the world's population had access to adequate oral health care, and the social gradient in oral health was significant, both within and across countries. Thus, in order to improve oral health – and therefore general health – globally, particular attention should be paid to the relevant social determinants. The Ottowa Charter for Health Promotion, 1986, provided an appropriate framework for bringing about tangible change.

Mr LUCHESI (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, commended Member States for taking forward the newborn health action plan, which provided a road map for improving the quality of care for women and children at the start of the life cycle. He urged the inclusion of the newborn, child, maternal and stillbirth mortality targets endorsed at the Sixty-seventh World Health Assembly in national and subnational plans. Challenges to progress included maternal death surveillance and response, prioritization of research and development, and the costing of action plans. All stakeholders must be dedicated to fulfilling the more than 50 new commitments for newborn health under the Every Woman, Every Child initiative.

Dr BUSTREO (Assistant Director-General) acknowledged the impressive progress made in the area of maternal, newborn and child health in the 10 years since WHO had issued *The world health report 2005. Making every mother and child count*, followed by resolution WHA58.31 on universal coverage of maternal, newborn and child health interventions. However, much more remained to be done. The newborn health action plan focused on the continuum of care that had lagged the most. Although under-5 mortality rates had declined, the proportion of neonatal deaths in the under-5 segment continued to increase. The quality of care during and after delivery was a marker demonstrating how much work still needed to be done to prevent maternal and neonatal deaths and newborn complications. She commended the work being done by many countries to strengthen the newborn components in their existing health plans and the specific commitments made by many countries and organizations in the area of newborn health. The question of how to measure and track those commitments would be taken up by the Executive Board at its next session.

Turning to the progress report on implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children (resolution WHA66.7), she noted that there had been some improvement in that area since 2013, particularly regarding access to long-lasting contraceptives. In particular, the 13 life-saving commodities had been included in the WHO Model List of Essential Medicines. The Global Financing Facility to be launched in Ethiopia in July 2015 would be a vehicle for further procurement, shaping the market, and enhancing the availability of those commodities.

Health systems

K. Social determinants of health (resolution WHA65.8)
L. Sustainable health financing structures and universal coverage (resolution WHA64.9)
M. Strategy for integrating gender analysis and actions into the work of WHO (resolution WHA60.25)
N. Progress in the rational use of medicines (resolution WHA60.16)

Dr AL-TAAE (Iraq) said that Iraq had adopted several approaches to consolidate, modernize and develop its health system, including capacity building to streamline the work of health personnel at all levels of health care; making use of evidence-based practices to deal with the social determinants of health; strengthening the private sector to fit it for full collaboration with the public health sector; and ensuring the rational utilization of technology and medicines. Particular attention was also paid to results-based management, gender issues in relation to school and university health services, strict electronic management of the health information system, institutional governance and intersectoral studies and research.

Mr MAGNÚSSON (Iceland), speaking also on behalf of Denmark, Norway, Finland and Sweden, and referring to progress report K on social determinants of health, requested more information on implementation of policies and strategies to advance the social determinants of health and health equity agenda within health systems and society at large.

Regarding progress report M on the strategy for integrating gender analysis and actions into the work of WHO, he emphasized the importance of the strategy for further strengthening WHO's gender responsiveness. He commended the mainstreaming of gender issues across the Programme budget 2016–2017 and the focus on gender, equity and human rights in the second edition of the *WHO handbook for guideline development*. Further steps were needed to close the gender gap in staffing and meet the requirements of the United Nations system-wide action plan on gender equality and women's empowerment. The Secretariat should report back to the governing bodies on progress made.

Ms HELSY PAHLEMY (Indonesia), referring to progress report N on progress in the rational use of medicines, said that Indonesia had made efforts to improve the rational use of medicines through regulatory, managerial and educational strategies. Regulations and guidelines had been developed on the basis of Indonesia's national list of essential medicines and the 2006 national medicines policy took account of accessibility, equitability and rational use of medicines. An ongoing advocacy and socialization strategy was designed to ensure that the regulations were implemented. The promotion of the rational use of medicines had been carried out through continuing education and training programmes. She requested the Secretariat to provide technical support for full implementation of resolution WHA60.16.

Mr BROWN (United States of America) said that the Secretariat played an important role in helping identify best practices for countries and setting standards for collection and analysis of data on health disparities. He was encouraged by the large number of Member States that had taken advantage of the Organization's expertise to incorporate social determinants of health into their national policies. He commended WHO and the World Bank for the development of the May 2014 framework for monitoring progress towards universal health coverage at country and global levels and encouraged the Secretariat to support countries in implementing it. In the light of the lessons learnt from the Ebola virus disease epidemic in West Africa, WHO should make adequate financing for essential public health services an integral component of the financing of universal health care.

Dr THONGTANA PERMBOTASI (Thailand), referring to the progress report on social determinants of health, recognized progress in the implementation of the Rio Political Declaration on Social Determinants of Health, in particular through the health in all policies approach. Despite efforts to share experience, a WHO mechanism was needed to support intersectoral policy development.

Regarding the progress report on sustainable health financing structures and universal coverage, he said that the target of allocating 0.7% of gross domestic product to official development assistance was crucial but no clear information had been presented on how those funds were used to achieve development goals and targets. Although progress was being made in all regions in the direction of health financing reform and universal health coverage, many low-income countries continued to face challenges related to political commitment and adequate domestic resources.

On the strategy for integrating gender analysis and actions into the work of WHO (progress report M), he appreciated the Secretariat's sustained efforts at gender mainstreaming but emphasized the need for full implementation of the strategy. Gender inequality was an unacceptable obstacle to health care services.

In relation to progress report N, he called for stronger legislative enforcement of the rational use of medicines, in particular through a ban on the unethical promotion of medicine. Strategies to ensure rational use at the local level were crucial to implementing resolution WHA60.16.

Mr DE ANDRADE FILHO (Brazil), referring to progress report L on sustainable health financing structures and universal coverage, considered that the challenges to achieving universal health coverage were inseparably linked with broader issues related to the right of all to access high-quality health services. An emphasis on public spending was the key to ensuring that citizens were not unduly burdened with direct payments for services. Brazil had consistently taken the position that health care was a fundamental right of the citizen, not subordinate to the logic of the market place. Health system strengthening and proper governance of the health sector should be informed by an holistic, equity-based approach.

The rational use of medicines (progress report N) was an important tool to prevent the "commoditization" of medicines, which led to their excessive use and high levels of self-medication. He welcomed the inclusion of the issue of rational use in the global action plan on antimicrobial resistance. More emphasis should be placed on antimicrobial resistance by the Secretariat, including in the work of the regional offices.

Ms CAO Bin (China) recommended that, with regard to the social determinants of health, scientific assessments should be carried out on health and inequality. Health education should emphasize individual responsibility and community involvement. Multisectoral cooperation on health promotion was required and a cross-sectoral cooperation mechanism should be established for legislation, policies and planning.

With regard to progress report N, the Organization should play a greater role in developing standards on the rational use of medicines and training for pharmacists and health workers.

In the area of sustainable health financing (progress report L), the operability of universal health coverage should be improved by establishing a basic framework to solve common problems encountered by Member States, consolidate best practices and help countries to adopt cost-effective interventions. Objective and scientific monitoring and evaluation should be developed. The meaning of universal health coverage should be clarified and the Secretariat should develop a measurable assessment framework and a complete set of indicators to guide Member States.

With regard to the strategy for integrating gender analysis and actions into the work of WHO (progress report M), gender mainstreaming should be implemented in WHO's policies and programmes. More support should be provided to Member States to increase their capacity for gender analysis and relevant indicators, and a health information system should be developed. Progress made by Member States on gender equality and sexual and reproductive health should be monitored and reported regularly to the Health Assembly.

Miss SANTIAGO (Philippines) said that measures taken by her country to implement the rational use of medicines included continuously updating the national essential medicines list, developing a national action plan to combat antimicrobial resistance and providing guidance on clinical practice and medicine donations. Her country would continue to implement evidence-based strategies to encourage the rational use of medicines and achieve better health outcomes.

Dr USHIO (Japan) noted the importance of dealing with the social determinants of health in the context of universal health coverage and discussion on the post-2015 development agenda, where correcting health inequalities was a key issue. Member States should integrate social determinants of health into their policies.

Mr ALAOUI (Morocco), referring to the social determinants of health (progress report K), said that Morocco had not yet achieved the goal of "health in all policies", but was making progress towards universal health coverage by strengthening the health system and improving health programme governance. Legislation had been adopted on the provision of care and on health cards.

Ms GYANSA-LUTTERODT (Ghana), referring to the rational use of medicines, noted the additions made in 2015 to the WHO Model List of Essential Medicines. She urged the Secretariat to work with Member States to tackle affordability issues in relation to essential medicines. The adopted resolution on antimicrobial resistance would provide impetus to strengthen strategies that promoted the rational use of antimicrobials.

On the subject of health financing (progress report L), which was crucial to universal health coverage, she said that priority-setting mechanisms should be adopted, and she urged the Organization to act as a knowledge broker by selecting best practices to share with Member States.

Dr ASMA GALI (Niger), speaking on behalf of the Member States of the African Region and referring to the social determinants of health, said that steps had been taken to integrate health in all policies through a regional declaration drafted by the Regional Office for Africa. She welcomed the drafting of a regional strategy that would support Member States in that work. An evaluation of the measures taken by Member States and their outcome would provide useful information for future decision-making and target setting. Social determinants of health should be taken into account in the WHO reform process and the future activities of WHO. The Secretariat should support Member States in integrating health-in-all policies

with direct reference to the proposed sustainable development goals. The African Region remained committed to implementing the health-in-all-policies approach to ensure equity in health.

Dr BHARDWAJ (United Kingdom of Great Britain and Northern Ireland) welcomed the prioritization of social determinants of health in the strategic plans of WHO regional offices. Her Government had introduced the first-ever health inequalities duties in order to improve access to services for all, including the most disadvantaged groups, and advocated building a "health-equity-in-all-policies" approach at all levels.

With regard to sustainable health financing structures and universal coverage, she welcomed the focus on systems that avoided significant payments at the point of use and had strong prepayment and risk pooling mechanisms, as did the system in place in her country, which ensured that the poor and vulnerable faced no out-of-pocket expenses.

Problems relating to the rational use of medicines included non-adherence, medication errors and suboptimal generic use. She recognized the magnitude of the problems and said that her country was committed to doing more to combat them domestically and internationally. She endorsed the work of WHO in that field and noted the importance of better measurement of the scale and nature of the challenge. Promoting the rational use of medicines was a central pillar of efforts to combat antimicrobial resistance.

Ms FIERRO SEDAS (Mexico), noting the report, said that her country was committed to moving forward on the various topics that it covered.

Mr Chin-Shui SHIH (Chinese Taipei), referring to sustainable health financing structures and universal coverage, expressed his willingness to share the experience of Chinese Taipei in implementing its universal health insurance scheme, which provided free choice of health care providers to users and had low administrative costs.

Dr ELIASZ (The World Medical Association, Inc.), speaking at the invitation of the CHAIRMAN, urged further action by WHO on health equity and social determinants, in particular by: developing robust metrics and a detailed evaluation and surveillance strategy; making progress towards the allocation of 0.7% of gross domestic product to official development assistance; further collaboration within the United Nations system and with other organizations to deal with all social determinants of health; further investment in data collection and research to support evidence-based policies; and targeted action on potential global threats to health equity, including austerity policies and trade agreement negotiations. His organization called for the establishment of an international network and knowledge exchange platform on social determinants of health and health equity. He urged WHO to ensure that adequate resources were made available for implementation of the Rio Political Declaration on Social Determinants of Health and resolution WHA65.8.

Dr KIENY (Assistant Director-General) thanked speakers for their comments. As many delegates had stated, the inappropriate use of medicines remained a problem in all countries, which led to funds being wasted and patients missing out on the benefits of medicines and potentially suffering side effects. The misuse of antibiotics had led to antimicrobial resistance, which was growing everywhere. Countries should develop comprehensive national strategies to improve the prescription and use of medicines; in that connection, national essential medicines lists and the WHO Model List of Essential Medicines constituted a key policy tool for achieving universal health coverage. The Secretariat and the World Bank would continue jointly to refine the universal health coverage monitoring framework produced in 2014. As requested, the Secretariat would continue to work with Member States and their health ministers to implement sustainable health financing strategies in support of universal health coverage and to improve medicine use.

Dr BUSTREO (Assistant Director-General) thanked delegates for their contributions, underlining that the social determinants of health relied on the dedication and expertise of a large network of collaborating partners, stakeholders and health workers. She noted that, although the Rio Political Declaration on Social Determinants of Health was being implemented by Member States, more action was needed on the ground. The monitoring and measuring of social determinants needed to be improved. The Secretariat intended to work with Member States over the coming year to develop policy indicators and measurements, and to draft a report on the stage of advancement of measurements and policy action in each country. She appreciated the support of Member States that had, from the outset, supported work on integrating gender analysis and actions into the work of WHO. Some progress had been made; the Programme budget 2016–2017 showed that gender, equity and human rights mainstreaming was taking shape, as had been noted by the delegate of Iceland. Delegates had also highlighted the importance of continuing to promote gender analysis as a key component of equity and the development of public health programmes. Although more work was needed in that area, tools had been developed and Member States had been supported to develop their analysis, with the Region of the Americas playing a leading role. The Organization had met about half the 15 performance indicators for the United Nations system-wide action plan on gender equality and women's empowerment. She looked forward to reporting further progress towards meeting all the performance indicators.

Noncommunicable diseases

A. Comprehensive mental health action plan 2013–2020 (resolution WHA66.8)
B. Comprehensive and coordinated efforts for the management of autism spectrum disorders (resolution WHA67.8)
C. Disabling hearing loss (resolution WHA48.9)

Dr AMBOURHOUET-BIGMANN (Gabon), speaking on behalf of the Member States of the African Region, and referring to progress report B on comprehensive and coordinated efforts for the management of autism spectrum disorders, said that real engagement and commitment by Member States and civil society were crucial to the effective implementation of policies and plans for the management of autism spectrum disorders. Strategies should take into account inequalities in health care, and include awareness-raising, psychosocial support for families, and access to education and social integration for children with autism spectrum disorders. Resources should furthermore be mobilized to ensure the sustainability of such efforts. Challenges in the region included slow progress due to competing public health priorities, and the lack of funding and trained personnel. Accordingly, there was a need for multisectoral measures and public–private partnerships.

Turning to progress report C on disabling hearing loss, she said that disabling hearing loss was a major cause for concern in the Region. The prevalence of hearing disorders called for efforts to raise awareness in the interests of prevention and treatment. Much had changed since the adoption of resolution WHA48.9 and she requested the Director-General to submit a new draft resolution to the Sixty-ninth World Health Assembly, based on up-to-date evidence, which should cover matters related to prevention, screening, equipment, raising awareness of sign language, and research. The countries of the Region also needed skilled human resources and capacity building. Disabling hearing loss should be included in WHO's global disability action plan 2014–2021.

Dr USHIO (Japan), referring to progress report B, supported the efforts made to manage autism spectrum disorders, but considered that they should be looked at not only as a medical issue but also on the basis of a more comprehensive approach, taking account of educational, vocational and community factors.

Dr MONYAMANE (Lesotho), speaking on behalf of the Member States of the African Region and referring to progress report A on the comprehensive mental health action plan 2013–2020, said that since 2013, when the plan had been launched, numerous actions had been undertaken in the Region, including the development of a regional mental health plan and actions to update and develop mental health policies and laws. Progress had been achieved in the reorganization of services and the expansion of coverage, establishing interdisciplinary links, reducing the number of inpatient hospital beds, and procuring medicines for mental health at all levels. However, the implementation of health policies was hampered by the lack of adequate funding and skilled human resources. The Member States therefore called for adequate budgetary allocations to mental health in line with the burden of disease, an increase in human resource capacity for mental health programmes, and the inclusion of mental health in the action plan for universal health coverage.

Mr MAGNÚSSON (Iceland), speaking also on behalf of the Nordic countries Denmark, Finland, Norway and Sweden, said that the progress reports were an important part of oversight and evaluation, and should be linked to the results chain of the programme budget; their contribution to WHO deliverables should be made explicit.

Regarding progress report A, he welcomed the progress made in implementing the comprehensive mental health action plan 2013–2020. Action on promotion and prevention should be prioritized in the context of multisectoral planning and collaboration, and greater emphasis should be placed on the cost-effectiveness of population-oriented primary prevention measures. Furthermore, stakeholder collaboration and the empowerment of persons with mental health disorders and psychological disabilities were essential to further progress. The Nordic countries strongly supported the collection and dissemination of evidence and best practices to reduce mental ill-health and minimize social service gaps; they urged the Secretariat to take action to address disparities.

Dr ABDELGELIL (Egypt), referring to progress report B, said that autism spectrum disorders were beginning to emerge as an important health topic in her country. A national initiative for the support of persons with disabilities and persons with special needs had raised awareness of such disorders. Furthermore, Egypt's new constitution granted the right to social protection, education and health care to all persons with disabilities, and that had led to the adoption of relevant national regulations. Particular attention was given to work on advocacy and early detection; training centres had been established for caregivers and health care professionals, as had rehabilitation centres and speech, occupational, behavioural and other services to provide support for persons with special needs and their families.

Dr AL-TAAE (Iraq) said that the comprehensive mental health action plan 2013–2020 had been implemented in his country through changes to the structure of the health system and improvements in communication strategies. Further progress should centre on providing psychosocial support, especially for internally displaced persons, developing intersectoral and community collaboration, and capacity building for teachers and community leaders.

To meet the challenge of integrating the management of autism spectrum disorders into public health care, the private and public health sectors should work together for the prevention, early detection and management of cases. A multisectoral approach was needed, with the participation of the Ministry of Labour and Social Affairs and civil society institutions. Research should be carried out on primary health care approaches in general, and on neurosis and psychosis in particular, taking into account all epidemiological and demographic variables. Links should also be established with occupational health, integrating early detection of autism and other disabilities in both school and occupational health services.

Importance was attached in his country to incorporating early detection and treatment of disabling hearing loss in school health services and in the area of occupational health in general.

Ms MONIKA SARASWATI SITEPU (Indonesia), referring to progress report A, said that her country had pursued its commitment to implement the comprehensive mental health action plan 2013–2020 through policies and regulations to promote mental health and ensure its integration in the health care system, in particular in primary health care. It was also developing a monitoring and evaluation system, to be implemented through data collection and a core set of mental health indicators, as part of the national health information system. Developing countries required technical support to establish robust clinical and epidemiological data surveillance systems that could be used to strengthen mental health programmes at every level.

Autism spectrum disorders were given priority under Indonesian legislation and measures were being taken for the implementation of resolution WHA67.8. However, more time was needed to share experience with other countries and develop a sustainable implementation programme.

Turning to progress report C on disabling hearing loss, she said that her country had established a programme for the elimination of avoidable deafness and hearing impairment, but faced some challenges in relation to data collection and the lack of health workers. Its efforts would be strengthened by WHO's supervision and collaboration with other Member States and agencies.

Mr BROWN (United States of America) said that future reports on the comprehensive mental health action plan 2013–2020 should highlight the issue of mental health promotion and disease prevention, and WHO should publicize successful country strategies on suicide prevention.

With respect to progress report C, there was a need for increased action at country level to address the problem of disabling hearing loss and he encouraged the Secretariat to provide technical assistance to Member States wishing to increase their surveillance capacity. His Government supported global advocacy campaigns to increase awareness of the importance of hearing health.

Mrs VALLINI (Brazil) said that the comprehensive mental health action plan 2013–2020 strengthened regional initiatives and provided support for the development of national policies. Her country had changed its approach to mental health by replacing psychiatric hospitals with community-based services and applying a holistic and integrated health care approach. In view of the high prevalence of mental health disorders, she stressed the need to ensure access to health services, medicines and multidisciplinary treatment for all those affected.

Mr BEDFORD (Australia) said that his Government continued to endorse the vision, goals and objectives of the comprehensive mental health action plan 2013–2020, and had recently completed a national review of mental health programmes and services that would provide a framework for the development of national mental health strategies.

With regard to progress report B, he welcomed the progress made in implementing resolution WHA67.8, and said that Australia continued to implement its national disability insurance scheme, which provided additional care and support for persons with disabilities.

In relation to the work conducted to reduce the prevalence of preventable disabling hearing loss (progress report C), he highlighted the importance of continuing WHO's awareness-raising activities.

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

The meeting rose at 17:25.

FOURTEENTH MEETING

Tuesday, 26 May 2015, at 09:10

Chairman: Dr E. JARAMILLO NAVARRETE (Mexico)

1. WHO REFORM: Item 11 of the Agenda (continued)

Framework of engagement with non-State actors: Item 11.2 of the Agenda (Documents A68/5, A68/53 and EB136/2015/REC/1, decision EB136(3) (continued from the first meeting, section 2)

Dr MERCADO (Argentina), speaking in his capacity as chairman of the drafting group, said that the group would continue to deliberate on a draft resolution; he hoped to report to the Committee on an agreed text later that day.

(For continuation of the discussion and approval of the draft resolution, see the summary record of the fifteenth meeting, section 2.)

2. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 14 of the Agenda (continued)

Health and the environment: addressing the health impact of air pollution: Item 14.6 of the Agenda (Documents A68/18 and EB136/2015/REC/1, decision EB135(14)) (continued from the sixth meeting, section 2)

Mr AASLAND (Norway), speaking in his capacity as the chairman of the drafting group, said that the drafting group had agreed on the text of a revised draft resolution, which would be presented to the Committee later that morning.

(For resumption of the discussion, see section 5 below.)

3. FIFTH REPORT OF COMMITTEE A (Document A67/64)

Dr ROOVÄLI (Estonia), Rapporteur, read out the draft fifth report of Committee A.

The report was adopted.[1]

[1] See page 366.

4. PROGRESS REPORTS: Item 18 of the Agenda (Document A68/36) (continued)

Noncommunicable diseases (continued from the thirteenth meeting, section 2)

A. Comprehensive mental health action plan 2013–2020 (resolution WHA66.8)
B. Comprehensive and coordinated efforts for the management of autism spectrum disorders (resolution WHA67.8)
C. Disabling hearing loss (resolution WHA48.9)

Dr ROA RODRIGUEZ (Panama) said that 80% of people affected by hearing loss lived in low- and middle-income countries such as Panama, which lacked the resources and infrastructure to meet their needs. However, since the adoption of resolution WHA48.9, only 32 Member States had implemented policies and plans concerning hearing impairment. Despite the fact that newborns had been screened for hearing loss in her country since 1988, efforts in support of hearing care had not been integrated throughout the public sector and civil society. A workshop had been organized by PAHO and WHO in 2014 to draw up a strategic regional framework for primary ear and hearing care. She proposed that a revised version of resolution WHA48.9 be prepared, in order to draw attention to the need to provide access to ear and hearing care as a fundamental right.

Dr KONG Insik (Republic of Korea) welcomed the progress report on implementation of the comprehensive mental health action plan 2013–2020. In order to combat the suicide rate in the Republic of Korea, which was the highest among OECD countries, the Government had introduced a law and objectives to protect people from harmful information, restrict access to means of suicide, support community networks, and improve research and development. He sought WHO's support in confronting the challenges of post-traumatic stress following disease outbreaks and humanitarian disasters, as well as of behavioural addictions. He paid tribute to the leadership of Bangladesh in organizing a side event on autism spectrum disorder during the Health Assembly.

Dr BENJAMAS PRUKKANONE (Thailand) said that Thailand had boosted access to mental health care through its universal health coverage scheme. Advocacy against prejudice, empowering people with mental disorders (including autism spectrum disorders) and collaboration across sectors had increased awareness of mental health problems. A mental health action plan and an updated mental health act protected the rights of vulnerable people with mental illness and those of society as a whole. However, challenges remained in strengthening information systems, evidence and research, as well as in monitoring and evaluation of programme implementation. Continuity of support required political commitment and regional leadership.

Ms GURBANOVA (Azerbaijan) said that Azerbaijan had reformed mental health care in line with the comprehensive action plan, through the adoption of a national strategy and plan of action and the creation of a new network of mental health care centres and care in the community. The quality of care had been improved and the level of stigmatization reduced. Staff members had been retrained and new treatment protocols had been adopted. The parliament was currently reviewing measures to increase the number of qualified health care professionals in the field, and an electronic database of cases had been set up. Azerbaijan had adopted a multisectoral approach to mental health. She thanked WHO for the technical support it had provided.

Dr ESIN (Russian Federation) said that his country was carrying out screening tests for hearing in newborns and provided State-funded cochlear implants as needed. He urged the Secretariat to step up work on the provision of diagnostic tests and hearing devices in low-income countries, and to submit proposals to that end at future sessions of the Executive Board and World Health Assemblies.

Dr ASUNCION (Philippines) said that the comprehensive mental health action plan 2013–2020 had become the basis for three bills that were currently under review by the Congress of the Philippines. Mental health services would be further strengthened through revision of regulations. The Philippines had adopted WHO's Mental Health Gap Action Programme Intervention Guide for use in primary health care facilities, provided appropriate medicines, and established an information system on mental health conditions.

The Philippines had expanded action for the management of autistic spectrum disorder, designating the National Children's Hospital as a collaborating centre for the study and treatment of the disorder. It promoted public awareness of autism and included it in services for mental health and disability.

Action on disabling hearing loss included the operationalization of a newborn hearing screening programme and the future introduction of reimbursement of hearing aids through the health insurance system.

Ms FIERRO SEDAS (Mexico) noted that the comprehensive mental health action plan 2013–2020 took into account the requirements of the United Nations Convention on the Rights of Persons with Disabilities and said that her country was taking steps to achieve the objectives set out in that action plan, including the training of specialized staff in order to improve the quality of care. A national programme of action on mental health was being drawn up, which set out strategies and provided indicators for planning the resources required in mental health interventions.

Dr HU Xiang (China) recommended that the Secretariat support countries in developing mental health action plans that took into account epidemiological differences and, in line with paragraph 2 of resolution WHA66.8, were adapted to national priorities and circumstances. Training of existing mental health professionals should be enhanced in the areas of prevention, detection and treatment.

China had implemented five national programmes on prevention of hearing loss, trained personnel and introduced the provision of cochlear implants for children. Despite a successful annual national prevention campaign, China remained the country with the highest number of people suffering from hearing loss, a situation that was compounded by an ageing population and unevenly distributed medical resources. She looked forward to WHO's continued technical support in raising awareness and building comprehensive hearing loss services.

Dr JENYFA (Maldives) said that her country's national mental health policy was aligned with global targets; it recognized that, as mental health evolved throughout the life cycle, there was a need to protect both people with defined mental disorders and the health and mental well-being of all citizens. As up to 50% of mental disorders began before the age of 14 years, early intervention was important for children and adolescents. Maldives was developing a mental health strategic plan with a focus on improving access to care for autism spectrum disorders. Member States should work towards a comprehensive approach to address the needs of individuals and families living with autism spectrum disorders and other developmental disorders.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) welcomed WHO's planned development of tools and provision of technical support for capacity building, raising awareness and developing comprehensive hearing care services. The national Action Plan on Hearing Loss chimed with the Organization's work on the issue and aimed to tackle the rising prevalence of untreated hearing loss, as well as the related personal and socioeconomic costs and the variation in access to, and quality of, services. She encouraged Member States to take further action along similar lines at the global level.

Mr SPRINGER (Barbados) reaffirmed his country's commitment to WHO's approach to tackling mental health issues. The National Mental Health Commission aimed to provide policy advice and sharpen community focus on prevention, treatment and rehabilitation of mental disorders.

Development of core community services had reduced dependence on hospitalization and promoted early diagnosis, prompt treatment and follow-up care. The national strategic plan for mental health sought to provide a framework to protect the rights of persons with mental health disorders and facilitate their timely access to health care. National legislation was also being updated to ensure that the necessary framework was in place to support mental health policies. However, the lack of resources remained a challenge. He requested additional technical support, including in the areas of strengthening research capacity and development of a national suicide prevention strategy.

Dr DAKULALA (Papua New Guinea) said that his Government, with support from its partners, was working to improve mental health services. The goal of the National Mental Health Policy was to minimize the number of people affected by and dying from mental illness and to ensure access to good-quality care services and effective rehabilitation with the limited resources available. He welcomed the clear guidance and support provided by WHO in relation to the six global targets to measure progress made in implementing the comprehensive mental health action plan 2013–2020 and requested continued technical support to enable their integration into national policies.

Professor AYOUB MAGIMBA (United Republic of Tanzania) said that illicit drug use was a growing problem in his country. As part of national efforts to implement the comprehensive mental health action plan 2013–2020, his Government had developed substance use prevention programmes targeted at the most vulnerable populations, established treatment and rehabilitation centres within hospitals and scaled up programmes to treat drug users with methadone. Despite the progress achieved, challenges remained. Future strategies to deal with the problem of illicit drug use included development of regulatory mechanisms for treatment with controlled drugs and establishment of guidelines for facilities providing methadone.

Ms LEBESE (South Africa) said that the comprehensive mental health action plan 2013–2020 and its related objectives guided national efforts to improve mental health. The WHO Mental Health Atlas and MiNDbank were useful tools to measure progress, learn from best practices and boost motivation. South Africa was on track to meet the six global targets of the action plan and she thanked WHO for its support in that regard. Mental health actions were part of an integrated package of chronic care services. Her Government was working closely with nongovernmental organizations to further develop prevention and promotion programmes. The national mental health policy framework also provided for the development of suicide intervention programmes. The results of national research undertaken with partners on innovative approaches to improving mental health care could assist other low- and middle-income countries.

Ms Miao-Ching CHEN (Chinese Taipei) said that Chinese Taipei had implemented a wide range of measures aimed at improving screening, diagnosis and treatment of newborn hearing. In order to reduce hearing loss from congenital rubella syndrome, all infants and children aged between 12 months and five years received the combined live vaccine for measles, mumps and rubella. Legislation had also been passed to safeguard against noise-induced hearing loss, including at the workplace. Chinese Taipei endorsed WHO's actions and principles to prevent hearing loss and would work closely with nongovernmental organizations and medical institutions to further promote hearing health and exchange best practices.

Professor TAVARTKILADZE (International Society of Audiology), speaking at the invitation of the CHAIRMAN, welcomed WHO's efforts to prevent hearing loss. There had been a considerable increase in the prevalence of hearing loss since adoption of resolution WHA48.9 in 1995. However, great technological advances had been made since adoption of the resolution, resulting in more effective tools for diagnosis and treatment of hearing loss. Several causes of hearing loss, such as meningitis, rubella and chronic ear infections, were preventable. Many individuals surviving diseases such as drug-resistant tuberculosis and Ebola virus disease were faced with hearing loss and tinnitus.

Untreated hearing loss, especially in low-resource settings, impacted on an individual's ability to communicate, as well as on their education and employment opportunities. He therefore urged WHO to accord the item its due attention and to develop a new resolution to address hearing loss.

Dr SAXENA (Mental Health and Substance Abuse) was pleased to note the high level of interest among Member States regarding implementation of the comprehensive mental health action plan 2013–2020. Although the initial progress made in relation to its implementation was promising, mobilization of additional human and financial resources was required. Replying to points raised by delegates, he confirmed that the Secretariat would continue to provide technical support to countries in developing mental health policies and legislation. A revised version of the Mental Health Gap Action Programme Intervention Guide would soon be made available, in electronic as well as printed form. He had noted countries' suggestions regarding access to essential medicines for mental health disorders and the need for increased emphasis on mental health care for children. He had also taken note of Member States' comments with respect to providing mental health and psychosocial support to populations affected by emergencies, including disasters and conflicts; in that connection, the Secretariat was currently providing support in Nepal and conflict-affected countries in the Eastern Mediterranean Region. With regard to prevention, WHO's recently published global report on suicide[1] provided evidence-based strategies for suicide prevention. He thanked the Member States that had submitted data for use in the WHO Mental Health Atlas and requested full collaboration from all countries in relation to data collection.

He noted with satisfaction the level of support among Member States for implementation of resolution WHA67.8 on autism spectrum disorders and thanked Member States, including the Government of Bangladesh, for leading advocacy and awareness-raising activities. In the context of capacity building at national level, a parent-skills training programme would soon be launched with the aim of enabling parents to systematically assist in the development of children affected by autism spectrum disorders, especially in settings with weak health system capacity. The excellent network of civil society organizations also helped to raise awareness of autism.

Dr KRUG (Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention) thanked delegates for their comments on disabling hearing loss and WHO's related work. Member States' feedback was encouraging and would help the Secretariat to strengthen and fast-track programmes in areas such as policy development, data collection, prevention, and access to services. The Secretariat had noted and was responding to the increased number of requests for technical support. WHO's work in relation to advocacy, particularly the International Ear Care Day, which in 2015 had focused on the important and growing problem of noise-induced hearing loss, had received considerable support and several follow-up activities were planned. Member States' requests for follow-up discussions on disabling hearing loss at the forthcoming meetings of the governing bodies had also been noted.

Preparedness, surveillance and response

O. Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits (resolution WHA64.5)

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

Dr MOHAMED (United Republic of Tanzania) reaffirmed his country's strong commitment to implementation of the Pandemic Influenza Preparedness (PIP) Framework. Significant progress had been made in his country to improve influenza surveillance capacity. In 2011, his Government had adapted the Technical Guidelines for Integrated Disease Surveillance and Response in the African

[1] Preventing suicide: a global imperative. Geneva: World Health Organization; 2014.

Region, incorporating influenza-like illness and severe acute respiratory infections. Five sentinel sites had been established to monitor such illnesses. He thanked WHO and the United States Centers for Diseases Control and Prevention for their support in helping the national influenza laboratory to attain the status of a National Influenza Centre. However, challenges remained in terms of building capacity for detecting emerging non-influenza respiratory viruses, as well as other emerging and re-emerging diseases, testing for antiviral susceptibility, transporting laboratory samples, and combining epidemiological and laboratory data. He urged WHO and its partners to support efforts to expedite the review and registration of vaccines for use in both routine and pandemic situations.

Ms RAMIRO (Philippines) said that her country's active participation in the Global Influenza Surveillance and Response System had helped to build national capacity to detect influenza and establish a network with reference laboratories to confirm novel viruses with pandemic potential. The PIP Framework was also being used by the National Influenza Centre to improve and strengthen influenza surveillance and laboratory capacity, regulatory capacity, risk communication and deployment planning.

Dr USHIO (Japan) thanked WHO and the PIP Advisory Board for their cooperation in facilitating the sharing of influenza virus samples and expressed appreciation for the efforts of pharmaceutical companies. He welcomed the allocation of funds from the Partnership Contribution. The PIP Framework must be continuously updated to respond to new technologies. Noting the importance of incorporating issues related to the handling of genetic sequence data from influenza viruses with human pandemic potential in the PIP Framework, he requested the Technical Expert Working Group to publish its draft report as soon as possible. He urged Member States to strengthen implementation of international pandemic preparedness measures at the country level.

Dr AL-TAAE (Iraq) highlighted the need for an action plan to address pandemic influenza at regional and country levels. WHO had a key role to play by providing technical support to ensure regular and sustained influenza virus sharing and access to vaccines, and to strengthen the capacity of national laboratories to identify mutations in influenza virus strains. Any mutations identified should be communicated at interregional level and be the subject of further research. He called for the development of guidelines on how to improve laboratory quality assurance and accreditation and noted the need to scale up sentinel surveillance systems. Since 2014, there were 23 cases of pandemic influenza A(H1N1) that had been identified in Iraq through examination of more than 1000 samples of severe acute respiratory infections, thereby underscoring the urgent need for technical support to enhance the capacity of the national laboratory. A technical group should examine influenza vaccine use at country and regional levels. Further research was needed on smallpox eradication to prevent re-emergence of the disease.

Mr ZHANG Guoxin (China) said that China would continue to participate in global efforts to monitor influenza and would share influenza viruses in a timely manner. Where possible, China would donate to global vaccine stockpiles. WHO should continue to cooperate with vaccine manufacturers to improve implementation of the PIP Framework.

With regard to smallpox, the Secretariat should report in a timely manner to Member States on research regarding variola virus in order to enable Member States to share information on vaccine development and smallpox diagnostics.

Dr PONGTORN CHARTPITUCK (Thailand) noted with satisfaction that significant progress had been made on smallpox research and that all the requisite knowledge and tools were in place to deal with an intentional or accidental outbreak. Nonetheless, the threats posed by stocks of live variola virus outweighed the benefits and continued to put the world at risk. Thailand therefore supported the earliest possible destruction of variola virus stocks.

Ms ELVIEDA SARIWATI (Indonesia) said that efforts must be made to strengthen pandemic preparedness, including the development of early warning systems and measures to boost vaccination coverage. It was particularly important that Member States shared influenza viruses that had pandemic potential with WHO reference libraries. The Secretariat should strive to accelerate the process of negotiating Standard Material Transfer Agreements 2 with industry partners and ensure the appropriate distribution of Partnership Contribution resources. Member States should be involved in the review of the PIP Framework, and efforts should be made to ensure that plans to strengthen capacity for influenza pandemic preparedness were harmonized with plans to implement core capacities under the International Health Regulations (2005).

Mr KOLKER (United States of America) welcomed progress in implementing the PIP Framework and encouraged the Secretariat to convene a consultation with Member States to prepare for the PIP Framework review in 2016. Efforts should be made to continue to coordinate Partnership Contribution-funded preparedness activities with those of the Global Action Plan for Influenza Vaccines. He welcomed the completion of Category C Standard Material Transfer Agreements 2 and encouraged the conclusion of more Category A and B agreements to ensure real-time supply of vaccines, antiviral agents and diagnostic supplies during a pandemic. He commended the work being done by the PIP Advisory Group and Technical Expert Working Group on Genetic Sequence Data.

The United States of America appreciated the update on activities with regard to smallpox, in particular the progress made in establishing a group of experts to examine the implications of advances in synthetic biology for the existing research agenda on smallpox countermeasures.

Dr KARGBO (Sierra Leone), speaking on behalf of the Member States of the African Region, said that, given the decreased immunity among the population owing to reduced smallpox immunization coverage, it was important that health workers should be familiar with the clinical and epidemiological features of smallpox, and in particular how it differed from chickenpox and monkeypox. Noting a dramatic rise in monkeypox incidence in central Africa, he underscored the need to enhance surveillance and laboratory diagnosis. He called for greater balance in the composition of the WHO Advisory Committee on Variola Virus Research and drew attention to the African Region's need for technology transfer, capacity-building and laboratory networking.

Ms MORÓN DE PORRAS (Bolivarian Republic of Venezuela) said that her country had maintained a high capacity for influenza surveillance and research. Efforts were being made to participate in influenza virus exchanges, and 13 samples had been sent to the Regional Influenza Reference Centre in 2014. Prevention measures were under way, with vaccination campaigns among health workers, people aged over 59 years, and other groups at particular risk.

Ms FIERRO SEDAS (Mexico) said that Mexico relied on two types of influenza surveillance: a conventional system based on numerical data, and a sentinel system. A wide range of epidemiological data was provided with regard to influenza outbreaks in all areas, through collaboration with other sectors. With regard to smallpox, Mexico maintained its position that it was unnecessary to retain samples of live variola virus for the development of antiviral agents. Live virus would, however, be useful for researching new technologies for diagnosis and antiviral components. Steps must be taken to ensure that any stocks of live variola virus were only used for ethical purposes, and were kept in sites that had specific security and protection measures in place.

Ms Szu-Pei WU (Chinese Taipei) expressed support for implementation of the PIP Framework and said that when the first human case of avian influenza had been identified in Chinese Taipei, the virus had been shared with the WHO Collaborating Centre for Surveillance, Epidemiology and Control of Influenza at the Centers for Disease Control and Prevention in the United States. Chinese Taipei had completed development of two prototypes of an H7N9 vaccine, one of which was egg-based and the other cell-based, in 2014. As vaccine stockpiling and production were crucial to

influenza pandemic preparedness, she urged all Member States to continue to support the PIP Framework.

Dr FUKUDA (Assistant Director-General) said that the PIP Framework was a unique global framework that reflected enduring concern with regard to pandemic influenza. He was pleased to hear that the benefits and outcomes were being felt at country level. Efforts were being made to accelerate negotiations on Standard Material Transfer Agreements 2; thus far, negotiations on 11 agreements had been completed, three of which were with vaccine manufacturers, and 350 million doses of vaccine had been secured for use in the event of a pandemic.

Regarding genetic sequence data, the world was moving from an era in which vaccines were made from pathogens to one in which information on genetic sequences alone was sufficient to manufacture a vaccine. Such work to better understand the implications, in particular on the optimum use of information rather than viruses, must continue. Member States' input in the work of the Advisory Group would be encouraged. Discussions on the nature of the PIP Framework review process were under way, and consideration would be given to how best to engage Member States in that process.

With regard to smallpox, he had noted Member States' positions on the destruction of variola virus stocks. It was important to understand fully the implications of biosynthetic technology related to variola virus. The Secretariat had collected the scientific information necessary to understand those implications. An Advisory Group would assess that information and advise the Director-General accordingly.

The Committee noted the reports.

5. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 14 of the Agenda (resumed)

Health and the environment: addressing the health impact of air pollution: Item 14.6 of the Agenda (Documents A68/18 and EB136/2015/REC/1, decision EB136(14)) (resumed from section 2)

The CHAIRMAN drew attention to a revised version of the draft resolution on health and the environment: addressing the health impact of air pollution, proposed by the delegations of Albania, Chile, Colombia, France, Germany, Monaco, Norway, Panama, Sweden, Switzerland, Ukraine, United States of America, Uruguay and Zambia, which read:

> The Sixty-eighth World Health Assembly,
>
> Having considered the report on Health and the environment: addressing the health impact of air pollution;
>
> (PP0) Reaffirming our commitment to the outcome document of the Rio+20 Conference "The future we want", in which all States Members of the United Nations committed to promoting sustainable development policies that support healthy air quality in the context of sustainable cities and human settlements, and recognized that reducing air pollution leads to positive effects on health;[1]
>
> (PP1) Noting with deep concern that indoor and outdoor air pollution are both among the leading avoidable causes of disease and death globally, and the world's largest single environmental health risk;[2]

[1] United Nations Environment Assembly resolution 1/7, PP6.

[2] Global Health Observatory http://www.who.int/gho/phe/en/ (accessed 18 March 2015).

(PP2) Acknowledging that 4.3 million deaths occur each year from exposure to household (indoor) air pollution and that 3.7 million deaths each year are attributable to ambient (outdoor) air pollution, at a high cost to societies;[1]

(PP3) Aware that exposure to air pollutants, including fine particulate matter, is a leading risk factor for noncommunicable diseases in adults, including ischemic heart disease, stroke, chronic obstructive pulmonary disease, asthma and cancer, and poses a considerable health threat to current and future generations;

(PP4) Concerned that half of the deaths due to acute lower respiratory infections, including pneumonia in children aged less than five years, may be attributed to household air pollution, making it a leading risk factor for childhood mortality;

(PP5) Further concerned that air pollution, including fine particulate matter, is classified as a cause of lung cancer by WHO's International Agency on Research for Cancer;[2]

(PP6) Aware that both short- and long-term exposure to air pollution has a negative impact on public health, with a much greater impact resulting from long-term exposure and exposure at high levels, causing chronic diseases such as cardiovascular diseases and respiratory diseases, including chronic obstructive pulmonary disease (COPD), and also that for many pollutants, such as particles, long-term exposure even at low levels (below WHO air quality guidelines proposed levels) could result in some adverse health effects;

(PP7) Noting the strong significance of air pollution and its health effects for the objectives and targets contained in the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020, as well as the significance of the WHO Framework Convention on Tobacco Control, in particular Article 8 and Guidelines related to the protection from exposure to tobacco smoke, as applicable to the parties of the Convention;

(PP8) Noting that air pollution is a cause of global health inequities, affecting in particular women, children and old persons, as well as low-income populations who are often exposed to high levels of ambient air pollution, or in homes that have no other choice than to be exposed to air pollution from cooking, heating and, and that improving air quality is among the measures with the greatest potential impact on health equity;[3]

(PP9) Cognizant that most air pollutants are emitted as a result of the human activities identified as sources of air pollution[4] in the WHO guidelines on ambient and indoor air pollution, and that there are also naturally occurring phenomena that negatively affect air quality[5] and noting that there is a significant interrelation between outdoor and indoor air quality;

(PP9 bis) Aware that promoting energy efficiency and expanding the use of clean and renewable energy can have co-benefits for health and sustainable development and stressing that the affordability of this energy will help maximize these opportunities;

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[1] WHO. Burden of disease from ambient air pollution for 2012. http://www.who.int/phe/health_topics/outdoorair/databases/AAP_BoD_results_March2014.pdf?ua=1 (accessed 1 December 2014).

[2] IARC Monographs Working Group on the Evaluation of Carcinogenic Risks to Humans on the following issues:

- Outdoor Air Pollution (2013, Volume 109);
- Diesel and gasoline exhausts and some nitroarenes (2012, Volume 105);
- Household use of solid fuels and high-temperature frying (2010, Volume 95);
- Indoor emissions from household combustion of coal (2012, Volume 100E);
- Tobacco smoke and involuntary smoking (2004, Volume 83).

[3] WHO Burden of Disease, Indoor and Outdoor Air Pollution, 2014.

[4] WHO Guidelines for Air Quality: Global Update 2005; WHO guidelines for indoor air quality: household fuel combustion; WHO Guidelines for indoor air quality: select pollutants; WHO guidelines for indoor air quality: Dampness and Mould.

[5] These include, inter alia, Radon, [a carcinogenic], dust- and sandstorms, volcanic eruptions and forest fires.

(PP9 ter) Underscoring that the root causes of air pollution and its adverse impacts are predominantly socioeconomic in nature and cognizant of the need to address the social determinants of health related to development in urban and rural settings, including poverty eradication, as an indispensable element for sustainable development and for the reduction of the health impact of air pollution;

(PP9 cinc) Emphasizing the importance of promotion, transfer and diffusion of environmentally sound technologies, particularly to developing countries, to address the health impact of air pollution;

(PP10) Acknowledging recent global efforts to promote air quality, in particular the 2014 United Nations Environment Assembly resolution on air quality, as well as the many national and regional initiatives to mitigate the health impacts of indoor and outdoor air pollution, and noting that regional and subregional cooperation frameworks provide good opportunities to address air quality issues according to the specific circumstances of each region;

(PP11) Recognizing that in order to contribute to national policy choices that protect health and reduce health inequities, the health sector will need to engage in cross-sectoral approaches to health, including adopting a health-in-all policies approach;[1]

(PP12) Noting that WHO's air quality guidelines for both ambient air quality[2] (2005) and indoor air quality[3] (2014) provide guidance and recommendations for clean air that protect human health and recognizing that these need to be supported by activities, such as the promotion and facilitation of implementation;

(PP13) Acknowledging that while many of the most important and cost-effective actions against outdoor and indoor air pollution require the involvement and leadership of national governments as well as regional and local authorities, cities are both particularly affected by the consequences of air pollution and well-placed to promote healthy city activities to reduce air pollution and its associated health impacts, and can develop good practices, complement and implement national measures;

(PP14 bis) Acknowledging that mobilizing national and, as appropriate, international resources is important for re-tooling relevant infrastructure which contributes to air pollution reduction is an integral element of global sustainable development, and that air pollution-related health impacts can be a health-relevant indicator for sustainable development policies;

(PP15) Aware that promoting air quality is a priority to protect health and provide co-benefits for the climate, ecosystem services, biodiversity, and food security;[4]

(PP15 bis) Acknowledging also the complexity between improving air quality and reducing emissions of warming climate-altering pollutants, and that there can be meaningful opportunities to achieve co-benefits resulting from these actions;

(PP15 bis bis) Underlining that higher temperatures, heatwaves, dust- and sandstorms, volcanic eruptions and forest fires can also exacerbate the impact of anthropogenic air pollution on health,

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[1] Taking into account the context of federated states.

[2] WHO air quality guidelines for particulate matter, ozone, nitrogen dioxide and sulfur dioxide – WHO Air Quality Guidelines – Global Update 2005: summary of risk assessment. Geneva: World Health Organization; 2006 (document WHO/SDE/PHE/OEH/06.02).

[3] WHO indoor air quality guidelines: household fuel combustion; 2014; (http://www.who.int/indoorair/guidelines/hhfc/en/).

[4] United Nations Environment Assembly Resolution 1/7 (http://www.unep.org/unea/download.asp?ID=5171 accessed 20 March 2015). Smith, K.R., A. Woodward, et al, 2014: Human health: impacts, adaptation, and co-benefits. In: Climate Change 2014: Impacts, Adaptation, and Vulnerability. Part A: Global and Sectoral Aspects. Contribution of Working Group II to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change. Cambridge University Press, Cambridge, United Kingdom and New York, NY, USA, pp. 709–754.

(OP1) URGES Member States[1] to:

(OP1.1) Redouble their efforts to identify, address and prevent the health impacts of air pollution, by developing and strengthening, as appropriate, multisectoral cooperation on the international, regional and national levels, and through targeted, multisectoral measures in accordance with national priorities;

(OP1.2) Enable health systems, including health protection authorities, to take a leading role in raising awareness in the public and among all stakeholders of the impacts of air pollution on health and opportunities to reduce or avoid exposure, including by guiding preventive measures to help reduce these health effects, to interact effectively with the relevant sectors and other relevant public and private stakeholders to inform about sustainable solutions, and to ensure that health concerns are integrated into relevant national, regional and local policy, decision-making and evaluation processes, including public health prevention, preparedness and response measures, as well as health system strengthening;

(OP1.3) Facilitate relevant research, including developing and utilizing databases on morbidity and mortality; health impact assessment; the use and costs of health care services and the societal costs associated with ill health; supporting identification of research priorities and strategies; engaging with academia to address knowledge gaps; and supporting the strengthening of national research institutions and international cooperation in research to identify and implement sustainable solutions;

(OP1.4) Contribute to an enhanced global response to the adverse health effects of air pollution in accordance with the national context including by collecting, and utilizing data relevant to the health outcomes of air quality, contributing to the development of normative standards, dissemination of good practices and lessons from implementation and working towards harmonization of health-related indicators which could be used by decision makers;

(OP1.6) Improve the morbidity and mortality surveillance for all illnesses related to air pollution, and optimize the linkage with monitoring systems of air pollutants;

(OP1.7) Take into account the WHO Air Quality Guidelines and WHO Indoor Air Quality Guidelines and other relevant information in the development of a multisectoral national response to air pollution and carry out measures supporting the aims of those guidelines;

(OP1.8) Encourage and promote measures that will lead to meaningful progress in reducing levels of indoor air pollution such as clean cooking, heating and lighting practices and efficient energy use;

(OP1.9) Take effective steps, to address and to minimize as far as possible air pollution specifically associated with health care activities, including by implementing, as appropriate, relevant WHO guidelines;

(OP1.10) Develop policy dialogue, collaboration and information sharing between different sectors to facilitate a coordinated, multisectoral basis for future participation in regional and global processes to address the impact of air pollution on health;

(OP1.10 bis) Strengthen international cooperation to address health impacts of air pollution, including through facilitating transfer of expertise, technologies and scientific data in the field of air pollution, as well as exchanging good practices;

(OP 1.10 ter) Identify, at the national level, actions by the health sector that reduce health inequities related to air pollution and work closely with the communities at risk who can gain the most from effective equitable and sustained actions, so as to facilitate the full realization of the right to the enjoyment of the highest attainable standard of physical and mental health;

[1] And, where applicable, regional economic integration organizations.

(OP1.11) Meet the commitments made at the 2011 UN High level meeting on non-communicable diseases and to use, as appropriate, the road map and policy options contained in the WHO global action plan for noncommunicable diseases;
(OP1.11 bis) Meet the obligations of the WHO FCTC, if the Member State is a Party to this treaty;
(OP1.13) Collaborate with regional and international organizations in developing partnerships to promote access to adequate technical and financial resources to improve air quality;

2. REQUESTS the Director-General:
(OP2.1) To significantly strengthen WHO's capacities in the field of air pollution and health in order to provide:
(a) Support and guidance for Member States in implementing the WHO Air Quality Guidelines and WHO Indoor Air Quality Guidelines;
(a bis) Support and provide guidance for Parties of the WHO FCTC in implementing the obligations under article 8 of the treaty and its guidelines, in coordination with the Convention Secretariat;
(b) Enhanced technical support and guidance to Member States, including through appropriate capacities in regional and country offices to support country activities;
(c) Further identification, development and regular updating of WHO air quality guidelines and cost-benefit tools, including monitoring systems, to support effective and efficient decision making;
(d) Enhanced technical capacity of WHO to collaborate, as appropriate, with relevant international, regional and national stakeholders, to compile and analyse data on air quality, with particular emphasis on health-related aspects of air quality;
(e) Assistance to Member States to increase awareness and communicate to the general public and stakeholders, in particular communities at risk, about the effects of air pollution and actions to reduce it;
(f) Dissemination of evidence-based best practices on effective indoor and ambient air quality interventions and policies related to health;
(g) Enhanced ability of WHO to convene, guide and influence research strategies in the field of air pollution and health, in conjunction with the *WHO Global Health Observatory*;
(h) Appropriate advisory capacity and support tools to assist the health and other sectors at all levels of government, especially the local level and in urban areas, taking into account different sources of pollution in tackling air pollution and their health effects;
(i) Appropriate advisory capacity and support tools at regional and subregional level to help Member States address the health effects of air pollution and other challenges to air quality with a cross-border impact, and to facilitate coordination among Member States in this respect;
(j) To create, enhance and update, in cooperation with relevant UN agencies and programmes a public information tool of WHO analysis, including policy and cost-efficiency aspects, of specific and available clean air technologies to address the prevention and control of air pollution, and its impacts on health;
(OP2.2) To exercise global health leadership and maximize synergies, while avoiding duplication with relevant global efforts that promote health improvements related to air quality, and air pollution reduction while continuing to work on other environmental challenges to health through, among others, the implementation of the resolution WHA61.19 *Climate Change and Health*;

(OP2.2 bis) To work with other United Nations partners, programmes and agencies, in particular with reference to the UN Environment Assembly resolution on Air Quality;
(OP2.2 ter) To raise awareness of the public health risks of air pollution and the multiple benefits of improved air quality, in particular in the context of the discussions on the post-2015 development agenda;
(OP2.2 quart) To continue to exercise and enhance the leading role of WHO in the Strategic Approach to International Chemicals Management to foster the sound management of chemicals and waste with the objective of minimizing and, where possible, preventing significant adverse effects on health, including from air pollution;
(OP2.3) To strengthen, and where applicable, forge links with existing global health initiatives that can benefit from air pollution reduction, including global efforts to reduce noncommunicable diseases and improve children's health;[1]
(OP2.3 bis) To set aside adequate resources for the work in the Secretariat, in line with the Programme budget 2014–2015 and Proposed programme budget 2016–2017 and the Twelfth General Programme of Work 2014–2019;
(OP2.4) To report to the Sixty-ninth World Health Assembly on the implementation of this resolution and its progress in mitigating the health effects of air pollution; and other challenges to air quality;
(OP2.5) To propose to the Sixty-ninth World Health Assembly a road map for an enhanced global response to the adverse health effects of air pollution.

The financial and administrative implications for the Secretariat of adoption of the resolution remained unchanged.

Dr ASUNCION (Philippines) welcomed the revised text. Information gained through implementation of the recommendations would guide public health policy-making in the Philippines. International cooperation should be strengthened to address the health impact of air pollution, particularly through the transfer of expertise, technologies and scientific data. The Secretariat should provide Member States with enhanced technical support and guidance in developing, updating and implementing air quality guidelines, monitoring systems, and chemical and waste management.

Mr SCIAMA (France) said that the international community had to be made more aware of the urgency and seriousness of the situation. Given the complex relationship between air pollution and climate change, taking action on one meant also taking action on the other. Every measure adopted to raise awareness of the multiple health benefits resulting from the mitigation of climate change and air pollution would be advantageous in anticipation of the 21st session of the Conference of the Parties to the United Nations Framework Convention on Climate Change, to be held in Paris in late 2015. The Conference of the Parties would mobilize all global stakeholders to identify challenges and solutions, particularly at city level, to improve health and living conditions, especially among the most vulnerable populations.

Mr MLADENOVIĆ (Serbia), speaking also on behalf of Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Israel, Montenegro, the Republic of Moldova, Romania and the former Yugoslav Republic of Macedonia, and in his capacity as President of the South-eastern Europe Health Network, strongly supported the revised draft resolution. Outdoor air pollution had a major impact on public health in south-eastern Europe, and 90% of the urban population there was exposed to outdoor air pollution exceeding WHO-recommended levels. Air quality and health had been discussed at a

[1] Examples of such efforts are the WHO global action plan for noncommunicable diseases, Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD), The Global Strategy for Women's, Children's and Adolescents' Health and the Every Woman Every Child Movement.

subregional meeting in April 2015, when those Member States that had not yet done so had been urged to ratify and implement the 1979 Convention on Long-range Transboundary Air Pollution and its Protocols. He appreciated WHO's leadership on the health impact of air pollution and looked forward to updates of the air quality guidelines as a tool to guide future policy actions.

Ms DUSSEY-CAVASSINI (Switzerland) welcomed WHO's efforts regarding air pollution. Air pollution was a much more serious threat to health than originally thought. Stricter regulations on emissions would significantly reduce the high cost of mortality caused by air pollution in the European Region, and action taken through initiatives such as the Climate and Clean Air Coalition was urgently needed. Relatively simple yet effective measures to improve air quality and tackle climate change could make a significant difference to human health, and policies on those two issues would also contribute to the attainment of other goals, particularly those related to communicable and noncommunicable diseases and the post-2015 development agenda. It was to be hoped that a new agreement would be adopted at the 21st session of the Conference of the Parties to the United Nations Framework Convention on Climate Change with references to health included. Switzerland was sponsoring the draft resolution despite the removal of the mention of sectors responsible for the damaging health impact of air pollution and the lack of stronger wording on collaboration between the health sector and other relevant sectors. She noted with satisfaction that the evident health benefits resulting from simultaneous action against air pollution and climate change had been acknowledged.

Ms PETTERSEN (Norway) strongly supported the draft resolution. Its adoption would show that Member States had agreed to redouble their efforts to prevent the health impact of air pollution through a multisectoral, national response and regional and international cooperation. She appreciated WHO's work on the issue, which had been done with minimal resources. The Director-General should significantly strengthen the Secretariat's capacities on air pollution and health.

Ms LANTERI (Monaco) noted that a large number of avoidable deaths resulted from human activities that triggered air pollution and climate change. Given the critical importance of environmental issues, she expressed continued support for WHO's work on the health impacts of air pollution and climate change. Her country had therefore sponsored the draft resolution despite the fact that it was not as ambitious as she had hoped.

Dr AL-TAAE (Iraq) underscored the importance of multisectoral collaboration. Environmental health should be considered in conjunction with primary health care, and occupational health should be integrated into environmental health and safety. As environmental health was crucial to global health, industrialized countries should collaborate with other Member States at regional level to formulate plans to reduce air pollution and improve air quality, with financial and technical support from the Secretariat.

Ms HARMSTON (Canada) strongly supported the draft resolution. The capacities of the Secretariat should be strengthened to ensure that it was a focal point for technical and policy expertise on air pollution and health. As Member States had different air quality concerns, capacities and resources, WHO's guidance might be required to help prioritize actions and allocate resources to benefit the most vulnerable populations.

Mr BLACK (United Kingdom of Great Britain and Northern Ireland) noted that air pollution was a cause of global health inequality. Efforts to develop clean and renewable energy would benefit both health and sustainable development. The references to the WHO Framework Convention on Tobacco Control in the draft resolution would protect people from exposure to second-hand smoke. His Government fully supported the United Nations Environment Assembly resolution 1/7 on air pollution adopted at its first session in June 2014. His country wished to sponsor the draft resolution.

Mr SASTRE (Bolivarian Republic of Venezuela) said that his country had eliminated the use of chlorofluorocarbons and was supporting industry to develop more environmentally friendly products. Strategies to combat air pollution should set clearly defined objectives for air quality, taking into account health parameters and emission standards, and surveillance mechanisms should assess the effectiveness of measures adopted. Multisectoral collaboration based on the principle of sustainability was vital to achieve those objectives. A key element would be the integration of health in all public policy. Access to clean air was a human right.

Mr SAMAR (Algeria), speaking on behalf of the Member States of the African Region, said that, because most outdoor and indoor air pollution was related to the choice of fuels used, Member States should do more to mitigate the impact of those choices. Air pollution was also a cause of global health inequality. One prerequisite for finding sustainable solutions to the problem of air pollution was to eradicate poverty. Considerable technological and financial investments would be needed to tackle air pollution. International solidarity was required to mobilize appropriate technical and financial resources and to make alternative and environmentally friendly technologies available to developing countries. WHO should establish a programme to provide guidance on implementation of the air quality guidelines; to strengthen technical support at country level; and to raise awareness among stakeholders and the general public of the effects of air pollution and the measures to be taken, primarily by the health sector in collaboration with other sectors, to reduce it.

Ms ELVIEDA SARIWATI (Indonesia) said that her country had taken steps to address the health impacts of air pollution, including conducting research, regulating tobacco use and implementing programmes to reduce the use of traditional cooking stoves in homes. Key factors for successful air pollution control were strong policies and effective business and implementation models that could be replicated nationwide. She supported the draft resolution, stressing the need for multisectoral efforts in its implementation, involving the private sector and communities and the strong commitment of key national, regional and international stakeholders.

Dr BENJAWAN TAWATSUPA (Thailand) said that her country was affected by the health impact of outdoor air pollution, notably transboundary haze caused by agricultural practices and forest fires. Multisectoral collaboration was needed to study the causes of and provide solutions to air pollution. At-risk communities should collaborate with relevant stakeholders, including the health sector, to raise awareness of and take action to prevent the health impact of air pollution at all levels. The Secretariat should actively support countries by sharing evidence, building capacity and developing guidelines to increase awareness and multisectoral collaboration. Lessons learnt should be shared.

Mr MATUTE HERNÁNDEZ (Colombia) said that the prevention of diseases linked to air pollution required comprehensive multisectoral policies to reduce contaminants at their source. To that end, it was necessary to strengthen the capacities of the Secretariat to gather scientific evidence and provide technical support to Member States, which should share their experience in surveillance and the design of epidemiological and methodological studies. The adoption of low-cost technologies and reductions in the use of solid fuels and of exposure to indoor pollutants should be promoted. His country wished to sponsor the draft resolution.

Ms WANG Rongrong (China) endorsed the draft resolution. In recent years, her Government had attached great importance to the health impact of air pollution and had taken steps to combat the issue in the country. A national environment and health action plan had been drawn up, measures had been taken to improve air quality, surveillance measures had been scaled up, and research was being carried out in order to protect public health in the long term. WHO should collaborate with stakeholders to raise awareness of the issue among the international community, increase exchanges of

knowledge among the health, environment and energy sectors, and strengthen support for developing countries.

Mr CORRALES HIDALGO (Panama) noted that, although air pollution caused several noncommunicable diseases, it had not been specifically considered in the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. Air pollution was one of the most preventable causes of disease and deserved a strong and rapid response from the Secretariat and Member States. As air pollution could cross borders, concerted action between countries, economic sectors and other stakeholders was needed to tackle it. Air pollution was a concern for developed and developing countries and was a key issue in discussions on the post-2015 development agenda. He was confident that the Secretariat could support prevention activities against diseases caused by air pollution at national, regional and global levels through multisectoral efforts involving all relevant actors.

Ms JARASCH (Germany) said that her country was proud to be the host of and major financial contributor to the WHO European Centre for Environment and Health, thereby supporting WHO's mandate in air pollution. More attention needed to be paid to the connections between air pollution and health, and between reducing air pollution and mitigating climate change. At the Sixth Petersberg Dialogue held in Germany the previous week, the message had been repeated: climate change mitigation was not a luxury but an investment in health and prosperity. Her country had therefore sponsored the draft resolution.

Ms GONZÁLEZ (Uruguay) encouraged the Health Assembly to adopt the draft resolution. Her country had made several concessions to allow agreement to be reached, in particular the removal of allusions to sources of pollution. However, the health dimension had to prevail in all government policies. She said that her country expected leadership from a strengthened WHO to achieve the goals outlined in the draft resolution.

Ms LEBESE (South Africa) underscored the importance of an intersectoral approach. She supported the draft resolution.

Ms JORDAN-SULLIVAN (United States of America) said that her country was pleased to sponsor the resolution and urged its adoption, which would send a clear message that the health sector was committed to the global fight for clean air.

Dr PANDA (India) said that tackling air pollution was distinct from addressing climate change. Climate change mitigation should continue to be pursued through the United Nations Framework Convention on Climate Change and its accompanying institutional arrangements. The draft resolution, as amended, reaffirmed a commitment to developing and facilitating access to environmentally sound technologies and the corresponding know-how. It also recognized the need for partnerships to mobilize technical and financial resources in order to support the wide-scale and sustainable adoption of clean air technologies, particularly in low- and middle-income countries. He therefore supported the draft resolution.

Ms MUKUNDJI EKAKA-EALE (Democratic Republic of the Congo) said that control of air pollution must be based on genuine concerted action, especially with regard to the various sources of emissions. That would entail both mitigation and adaptation, with sustainable development promoted by capacity building and the transfer of technologies.

Dr OGAJA (Kenya) said that, as the country hosting the United Nations Environment Programme, Kenya undertook to implement the operative paragraphs in the draft resolution that were applicable to Member States.

Ms MIAO-CHING (Chinese Taipei) emphasized the environmental co-benefits of public health initiatives, for instance the reduction in transport-related air pollution resulting from the promotion of physical activities such as cycling. Health care professionals and institutions should set an example through initiatives such as "green hospitals". She welcomed the draft resolution.

Mrs PUNZO (Medicus Mundi International), speaking at the invitation of the CHAIRMAN, said that no robust analysis had been made of the underlying social determinants of health and no strategies had been put forward to tackle public health concerns. As poorer people were disproportionately affected by air pollution, such strategies must address the causes of inequality. The report also lacked a description of measures for ensuring access to medical treatment for air pollution-related conditions. Countries' right to set their own air quality standards must be protected; their regulatory capacity should not be restricted by corporate threats to have recourse to investor-state dispute settlement clauses. Open channels were needed to disseminate technology rapidly to low- and middle-income countries. Attention should be paid to the geographical distribution of air pollution within global production chains.

Ms MATZKE (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN and also on behalf of the International Union against Tuberculosis and Lung Disease, cited evidence linking health not just to air pollution but to climate change, and called on Member States and the Secretariat to broaden their focus and action. Intersectoral collaboration should be strengthened. Indicators and monitoring frameworks should be developed that incentivized multisectoral action and held individual sectors to account.

Ms HERRGARD (The World Medical Association, Inc.), speaking at the invitation of the CHAIRMAN and also on behalf of FDI World Dental Federation, the International Council of Nurses, the International Pharmaceutical Federation and the World Confederation for Physical Therapy, called for the adoption of a strong resolution that explicitly recognized the link between air pollution and climate change. The Secretariat and Member States should continue to pursue a health-in-all-policies approach to reducing air pollution, including through the dissemination of clean energy technologies. She encouraged Member States to phase out subsidies to resources such as coal, whose true cost should be recognized. Member States should also commit to adopting a comprehensive monitoring framework with clear health benchmarks and reporting mechanisms, as outlined in the report. The health sector must continue to be engaged in negotiations leading up to the 21st session of the Conference of the Parties to the United Nations Framework Convention on Climate Change.

Mr MELLO (International Federation of Medical Students Associations), speaking at the invitation of the CHAIRMAN, welcomed the draft resolution and in particular its allusions to climate change. It would focus attention on health during the forthcoming negotiations on the United Nations Framework Convention on Climate Change. The links between air pollution and noncommunicable diseases must be emphasized. The health sector should lead by example and increase divestment from fossil fuels.

Dr BUSTREO (Assistant Director-General) said that, as it had been the first time that the Health Assembly had discussed the health impact of air pollution, ideas and opinions were bound to differ. As delegates had noted, air pollution was the leading risk factor for health, no matter where people lived, and a strong and clear response was required from the public health sector, which should also assume a leadership and stewardship role in intersectoral action.

She thanked delegates for supporting a strengthening of the Secretariat's capacity to consolidate and share lessons learnt about the effectiveness of various policy measures, to monitor and report national, regional and global trends, and to provide technical support at country level. The Secretariat remained committed to working with Member States and other organizations in the United Nations system in order to ensure that the discussion at the Health Assembly would have an impact on the health of future generations.

The meeting rose at 12:00.

FIFTEENTH MEETING

Tuesday, 26 May 2015, at 14:40

Chairman: Dr E. JARAMILLO NAVARRETE (Mexico)

1. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 14 of the Agenda (continued)

Health and the environment: addressing the health impact of air pollution: Item 14.6 of the Agenda (Documents A68/18 and EB136.2015/REC/1, decision EB136(14)) (continued)

Mr AASLAND (Norway), speaking in his capacity as chairman of the drafting group, welcomed the commitment and spirit of compromise demonstrated by Member States during its deliberations. The agreed text of the draft resolution was strong and gave the Director-General a clear mandate. It established the evidence base, reiterated Member States' commitment to the different WHO guidelines on air quality and called for measures that would expand WHO's response. He paid tribute to the work of the technical unit in the Secretariat, which would serve as an excellent foundation for ongoing efforts to develop a road map for consideration by the Sixty-ninth World Health Assembly in 2016. Member States should maintain their commitment to tackling the issue and make use of the opportunity for an enhanced global response.

Professor ELIRA DOKEKIAS (Congo), expressing support for the draft resolution, said that the text was an important first step as it recognized the environmental impact of climate change and air pollution, issues that were inextricably linked. It would be irresponsible to ignore the matter any longer. Highlighting his country's commitment to tackling air pollution, he requested that Congo be added to the list of sponsors of the draft resolution and encouraged translation of the provisions of the draft resolution into tangible initiatives in the field.

Ms HARMSTON (Canada), Mrs NDLEDLA-SIMELANE (Swaziland) and Dr M.K.N. NDIAYE (Senegal) asked for their countries to be added to the list of sponsors of the draft resolution.

The draft resolution, as amended, was approved.[1]

2. WHO REFORM: Item 11 of the Agenda (continued)

Framework of engagement with non-State actors: Item 11.2 of the Agenda (Documents A68/5, A68/53 and EB136/2015/REC/1, decision EB136(3)) (continued from the fourteenth meeting, section 1)

The CHAIRMAN drew attention to the revised draft resolution on the framework of engagement with non-State actors which incorporated amendments by the drafting group and which read:

[1] Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA68.8.

The Sixty-eighth World Health Assembly,

Having considered the reports on the draft framework of engagement with non-State actors and the revised draft framework of engagement with non-State actors;[1]

Acknowledging the importance to WHO of engagement with non-State actors that benefits from a robust management of the risks of such engagement for all three levels of the Organization,

1. WELCOMES the consensus reflected in many parts of the draft framework of engagement with non-State actors, including in its introduction, rationale, principles, benefits of engagement, risks of engagement, non-State actors, types of interaction as contained in the Annex;

2. REQUESTS the Director General:

(1) to convene as soon as possible, and no later than October 2015, an open-ended intergovernmental meeting to finalize the draft framework of engagement with non-State actors on the basis of progress made during the Sixty-eighth World Health Assembly, as reflected in the Annex;

(2) to submit the finalized draft framework of engagement with non-State actors for adoption to the Sixty-ninth World Health Assembly, through the Executive Board at its 138th session;

(3) to develop the register of non-State actors in time for the Sixty-ninth World Health Assembly, taking into account progress made on the draft framework of engagement with non-State actors.

ANNEX

Framework of engagement with non-State actors

Draft resolution [submitted by Argentina as Chair of the Open-Ended Intergovernmental Meeting and the informal consultations on the draft Framework of engagement with non-State actors]

[The Sixty-Eighth World Health Assembly,

PP1 Having considered the report on the framework of engagement with non-State actors and the revised draft framework of engagement with non-State actors;[2]

PP2 Recalling resolution WHA64.2 and decision WHA65(9) on WHO reform, and decisions WHA67(14) and EB136(3) on a framework of engagement with non-State actors;

PP3 Acknowledging the importance to WHO of engagement with non-State actors that benefits from a robust management of the risks of such engagement for all three levels of the Organization,

[1] Documents A68/5, Annex and A68/53.

[2] Document A68/5 and Annex.

(OP1) 1. APPROVES the Framework of Engagement with non-State actors, as set out in the Annex to this resolution;[1]

(OP2) 2. DECIDES that the Framework of Engagement with non-State actors shall replace the Principles governing relations between the World Health Organization and nongovernmental organizations[2] and Guidelines on interaction with commercial enterprises to achieve health outcomes;[3]

(OP3) 3. REQUESTS the Director General:

(1) to implement the Framework of Engagement with non-State actors;

(2) to establish the register of non-State actors in time for the Sixty-ninth World Health Assembly;

(3) to report on the implementation of the Framework of Engagement with non-State actors to the Executive Board at each of its January sessions under a standing agenda item, through the Programme Budget and Administration Committee;

(4) to conduct in 2018 an evaluation of the implementation of the Framework of Engagement with non-State actors and its impact on the work of WHO with a view to submitting the results, together with any proposals for revisions of the Framework, to the Executive Board in January 2019, through the Programme Budget and Administration Committee.]

OR

[The Sixty-Eighth World Health Assembly,

Having considered the report on the framework of engagement with non-State actors and the revised draft framework of engagement with non-State actors;[4]

Acknowledging the importance to WHO of engagement with non-State actors that benefits from a robust management of the risks of such engagement for all three levels of the Organization,

1. WELCOMES the important progress made towards consensus on the framework of engagement with non-State actors, particularly on its introduction, rationale, principles, benefits of engagement, risks of engagement, non-State actors, types of engagement and types of interactions;

2. DECIDES to establish an Intergovernmental Working Group to finalize the Framework of engagement with non-State actors;[5] on the basis of the progress made during this Health Assembly as reflected in the paper A68/A/CONF./3 Rev.1;

3. REQUESTS the Director General:

(1) to convene the Intergovernmental Working Group on the Framework of engagement with non-State actors 2015;

(2) to establish the register of non-State actors in time for the Sixty-ninth World Health Assembly;

(3) to submit the finalized Framework of engagement with non-State actors for adoption to the Sixty-ninth World Health Assembly through the Executive Board]

[1] Consisting of an overarching framework and four specific policies on engagement with nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

[2] Adopted in resolution WHA40.25. See Basic documents, 48th ed. Geneva: World Health Organization; 2014.

[3] Document EB107/20, Annex.

[4] Document A68/5 and Annex.

[5] Consisting of an overarching framework and four specific policies on engagement with nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

APPENDIX

FRAMEWORK OF ENGAGEMENT WITH NON-STATE ACTORS

DRAFT OVERARCHING FRAMEWORK OF ENGAGEMENT WITH NON-STATE ACTORS

*DOCUMENT AS OF MONDAY 25TH MAY 2015 AT 17:20[1]

REFLECTING THE WORK OF THE DRAFTING GROUP OF COMMITTEE A

EXPLANATION OF COLOR CODE:
TEXT HIGHLIGHTED IN GREEN HAS BEEN AGREED BY THE OPEN-ENDED INTERGOVERNMENTAL MEETING OR THE INFORMAL CONSULTATIONS. TEXT HIGHLIGHTED IN YELLOW WAS CONSIDERED DURING THE MEETING BUT NO CONSENSUS WAS REACHED. TEXT HIGHLIGHTED IN GREY IS THE CHAIRPERSON'S PROPOSAL FOR A COMPROMISE CONCERNING THE PRECEEDING YELLOW HIGHLIGHTED PARAGRAPH. TEXT NOT HIGHLIGHTED HAS NOT BEEN CONSIDERED YET.

INTRODUCTION

1alt The overarching framework for engagement with non-State actors and the WHO policy and operational procedures on management of engagement with non-State actors apply to all engagements with non-State actors at all levels of the Organization,[2] whereas the four specific policies and operational procedures on engagement are limited in application to, respectively, nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

ENGAGEMENT: RATIONALE, PRINCIPLES, BENEFITS AND RISKS

Rationale

1. WHO is the directing and coordinating authority in global health in line with its constitutional mandate. The global health landscape has become more complex in many respects; among other things, there has been an increase in the number of players including non-State actors. WHO engages with non-State actors in view of their significant role in global health for the advancement and promotion of public health and to encourage non-State actors to use their own activities to protect and promote public health.

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[1] EDITOR'S NOTE: For the colour-coded version, see the Draft framework of engagement with non-State actors website, under the entry referring to "Documentation of the process leading to the 68th World Health Assembly (16-26 May 2015)", the draft resolution (referred to as A68/A/CONF./3 Rev.1), at http://www.who.int/about/collaborations/non-state-actors/nsa2/en/ (accessed 19 February 2016).

[2] Headquarters, regional offices and country offices, [entities set up under WHO] as well as [secretariats of] hosted partnerships. [While the framework applies to secretariats of hosted partnerships as well as the activities that hosted partnerships carry out through their secretariats, it is acknowledged that boards of hosted partnerships are responsible for their composition which includes all kind of non-state actors] **OR** [For the case of hosted partnerships, WHO's policy on engagement with global health partnerships and hosting arrangements (WHA63.10) will apply. In order to evaluate the risk associated with these partnerships as requested by paragraph 8 (g) of the resolution WHA63.10, WHO will apply the risk assessment provisions of the current framework.]

NEW CHAIRS PROPOSAL: Headquarters, regional offices and country offices.

2. The functions of WHO, as set out in Article 2 of its Constitution, include: to act as the directing and coordinating authority on international health work; to establish and maintain effective collaboration with diverse organizations; and to promote cooperation among scientific and professional groups which contribute to the advancement of health. The Constitution further mandates the Health Assembly or the Executive Board, and the Director-General, to enter into specific engagements with other organizations.[1] WHO shall, in relation to non-State actors, act in conformity with its Constitution and resolutions and decisions of the Health Assembly, and bearing in mind those of the United Nations General Assembly or the Economic and Social Council of the United Nations, if applicable.

3. (**DELETED**)

4. WHO's engagement with non-State actors supports implementation of the Organization's policies and recommendations as decided by the governing bodies, as well as the application of WHO's technical norms and standards. Such an effective engagement with non-State actors at global, regional and country levels, [in mutual respect,] also calls for due diligence and transparency measures applicable to non-State actors under this framework [, while exercising [particular] / [appropriate] caution when engaging with particular [industries] [and] / [entities].](**DEL**) In order to be able to strengthen its engagement with non-State actors for the benefit and interest of global public health, WHO needs simultaneously to strengthen its management of the associated potential risks. This requires a robust framework that enables engagement and serves also as an instrument to identify the risks, balancing them against the expected benefits, while protecting and preserving WHO's integrity, reputation and public health mandate.

Principles

5. WHO's engagement with non-State actors is guided by the following overarching principles.

Any engagement must:

(a) demonstrate a clear benefit to public health;
(abisnew) conform with WHO's Constitution, mandate and general programme of work
(b) respect the intergovernmental nature of WHO and the decision-making authority of Member States as set out in the WHO's Constitution
(c) support and enhance, without compromising, the scientific and evidence-based approach that underpins WHO's work;
(d) Protect WHO from any undue influence, in particular on the processes in setting and applying policies, norms and standards. (**ADD FOOTNOTE**: Policies, norms and standard setting includes information gathering, preparation for, elaboration of and the decision on the normative text.)
(e) not compromise WHO's integrity, independence, credibility and reputation;
(f) be effectively managed, including by, where possible avoiding conflict of interest (ADD FOOTNOTE: as set out in paragraphs 23 to 26) and other forms of risks to WHO
(g) be conducted on the basis of transparency, openness, inclusiveness, accountability, integrity and mutual respect;

[1] WHO Constitution, Articles 18, 33, 41 and 71.

Benefits of engagement

7. WHO's engagement with non-State actors can bring important benefits to global public health and to the Organization itself in fulfilment of its constitutional principles and objectives, including its directing and coordinating role in global health. Engagements range from major, longer-term collaborations to smaller, briefer interactions. Benefits arising from such engagement can also include:

(a) (DELETED)

(b) the contribution of non-State actors to the work of WHO

(c) the influence that WHO can have on non-State actors to enhance their impact on global public health or to influence the social, economic and environmental determinants of health

(d) the influence that WHO can have on non-State actors' compliance with WHO's policies, norms and standards

(e) the additional resources non-State actors can contribute to WHO's work

(f) the wider dissemination of and adherence by non-State actors to WHO's policies, norms and standards

[g) non-State actors engaging with WHO [fully implement]/[more readily conform with] WHO public health policies [, norms and standards], including in their own activities in the areas of food safety, chemical safety, ethical promotion of medicinal drug products, tobacco control and others.]

OR

(g) alt [Improved understanding of and conformity with WHO's policies, norms and standards.] [by non-State actors]

Risks of engagement

8 alt WHO's engagement with non-State actors can involve risks which need to be effectively managed, and where appropriate avoided. Risks relate inter alia to the occurrence in particular of the following:

(a) conflicts of interest;
(b) undue or improper influence exercised by a non-State actor on WHO's work, especially in, but not limited to, policies, norms and standard setting (ADD FOOTNOTE: Policies, norms and standard setting includes information gathering, preparation for, elaboration of and the decision on the normative text)
(c) a negative impact on WHO's integrity, independence, reputation and credibility; and public health mandate;
(d) the engagement being primarily used to serve the interests of the non-State actor concerned with limited or no benefits for WHO and public health;
(e) the engagement conferring an endorsement of the non-State actor's name, brand, product, views or activity; (ADD FOOTNOTE: endorsement does not include established processes such as prequalifications or WHO PES)
(f) the whitewashing of a non-State actor's image through an engagement with WHO;

(g) a competitive advantage for a non-State actor.

NON-STATE ACTORS

9. For the purpose of this framework, [a non-State actor is an entity that [operates independently from the government]/[is not part of any State or public institution. N] (DEL) non-State actors include nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions. [other international organizations]

CHAIR'S PROPOSAL

9. alt For the purpose of this framework, a non-State actor is an entity that operates independently from the government is not part of any State or public institution. Non-State actors include nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

10. **Nongovernmental organizations** are non-profit entities that operate independently of governments. They are usually membership-based, with non-profit entities or individuals as members exercising voting rights in relation to the policies of the nongovernmental organization, or are otherwise constituted with non-profit, public-interest goals. They shall be free from concerns which are primarily of a private, commercial or profit-making nature and are not [unduly] dependant on [a single industry sector]/[private sector entities] for their financial resources. [They shall have the authority to speak for their members through their authorized representatives.] (**DEL**) They [could] include [for example] grassroots community organizations, civil society groups and networks, faith-based organizations, professional groups, disease-specific groups, and patient groups [non-financed by the private sector]

10alt Nongovernmental organizations are non-profit entities that operate independently of governments. They are usually membership-based, with non-profit entities or individuals as members exercising voting rights in relation to the policies of the nongovernmental organization, or are otherwise constituted with non-profit, public-interest goals. They are free from concerns which are primarily of a private, commercial or profit-making nature and are not unduly dependant on private sector entities for their financial resources. They could include, for example, grassroots community organizations, civil society groups and networks, faith-based organizations, professional groups, disease-specific groups, and patient groups.

11. **Private sector** entities are commercial enterprises, that is to say businesses that are intended to make a profit for their owners. The term also refers to entities that represent, or are governed or controlled by, private sector entities. This group includes (but is not limited to) business associations representing commercial enterprises, entities not "at arm's length"[1] from their commercial sponsors, and partially or fully State-owned commercial enterprises acting like private sector entities.

International business associations are private sector entities that do not intend to make a profit for themselves but represent the interests of their members, which are commercial enterprises and/or national or other business associations. For the purposes of this framework, they shall have the

[1] An entity is "at arm's length" from another entity if it is independent from the other entity, does not take instructions and is clearly not influenced or clearly not reasonably perceived to be influenced in its decisions and work by the other entity.

authority to speak for their members through their authorized representatives. Their members shall exercise voting rights in relation to the policies of the international business association.

12. **Philanthropic foundations** are non-profit entities whose assets are provided by donors and whose income is spent on socially useful purposes. They shall be clearly independent from any private sector entity in their governance and decision-making.

13 alt: Academic institutions are entities engaged in the pursuit and dissemination of knowledge through research, education and training .(ADD FOOTNOTE : This can include think tanks which are policy-oriented institutions, as long as they primarily perform research; while international associations of academic institutions are considered as non-governmental organizations, subject to paragraph 14.

14alt For each of the four groups of entities above, the overarching framework and the respective specific policy on engagement apply. WHO will determine through its due diligence if a non-State actor is subject to the influence of private sector entities to the extent that the non-State actor has to be considered itself a private sector entity. Such influence can be exerted through financing, participation in decision making or otherwise. Provided that the decision-making processes and bodies of a non-State actor remain independent of undue influence from the private sector, WHO can decide to consider the entity as a nongovernmental organization, a philanthropic foundation or an academic institution, but may apply relevant provisions of the [WHO's policy and operational procedures on engagement with private sector entities, [STOP HERE] [such as not accepting financial and in-kind contributions for use in the normative work.]

14bis. [Public–private partnerships between NGOs, academia, philanthropic foundations and private sector entities can be important business models resulting in affordable and accessible innovations with significant positive impact on global public health, particularly for developing countries. WHO's engagement with public–private partnerships should not be prohibited or restricted solely on the basis of a business model which includes multiple types of non-State actors.]

OLD CHAIR'S PROPOSAL

14bis alt. [Partnerships including NGOs, academia, philanthropic foundations and private sector entities can be important organizational models promoting public health. WHO engages with partnerships in accordance to its partnership policy (footnote: as described in paragraph 48) and this framework. Depending on the nature and composition of a partnership, WHO will apply one of the four specific policies to its engagement with this partnership.] OR (**DEL**)

OR

[14alt bis. WHO engages with partnerships that promote public health, including NGOs, academia, philanthropic foundations and private sector entities. In those situations in which the secretariat identifies the need for, or is asked to participate in, a partnership without hosting it, both the current framework and the framework on partnerships (WHA63.10) will apply,[1] as set out in paragraph 48 [of the current framework]. Depending on the nature of composition of the partnership, WHO will apply one of the four specific policies to its engagement with this partnership.]

[1] [WHO's engagement with formal partnerships that do not fall within the scope of article 7 of WHO's policy on engagement with global health partnerships and hosting arrangements (WHA63.10), will still be subject to the principles and provisions of the current framework. Depending on the nature and composition of such partnerships, WHO will apply one of the four specific policies to its engagement with these partnerships.]

NEW CHAIR'S PROPOSAL

13. bis alt alt WHO engages with different actors falling in the above mentioned categories, in the context of partnerships and collaborative arrangements that promote public health. WHO engages with such partnerships in accordance with its policy on engagement with global health partnerships and hosting arrangements* (WHA63.10), and subject to the provisions of this framework. Furthermore the framework also applies to WHO's engagement with collaborative arrangements in which WHO does not participate.

* ADD FOOTNOTE: Hosted partnerships derive their legal personality from WHO and are subject to the organizations rules and regulations. Therefore the Framework applies to their engagement with non-State actors. They have a formal governance structure, separate from that of the WHO governing bodies, in which decisions are taken on direction, work plans and budgets; and their programmatic accountability frameworks are also independent from those of the Organization. In the same way the Framework applies to other hosted entities which are subject to the Organizations Rules and Regulations.

TYPES OF INTERACTION

15. The following are categories of interaction in which WHO engages with non-State actors. Each type of interaction can take different forms, be subject to different levels of risk and can involve different levels and types of engagement by the Organization.

Participation

16. Non-State actors may attend various types of meetings organized by WHO. The nature of their participation depends on the type of meeting concerned. The format, modalities, and the participation of non-State actors in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat.

(a) **Meetings of the governing bodies**. This type involves sessions of the World Health Assembly, the Executive Board and the six regional committees. Non-State actors' participation is determined by the governing bodies' respective rules of procedure, policies and practices as well as the section of this framework that deals with official relations.
(b) **Consultations**. This type includes any physical or virtual meeting, other than governing body sessions, organized for the purpose of exchanging information and views. Inputs received from non-State actors shall be made publicly available, wherever possible.
(c) **Hearings**. These are meetings in which the participants can present their evidence, views and positions and be questioned about them but do not enter into a debate. Hearings can be electronic or in person. All interested entities should be invited on the same basis. The participants and positions presented during hearings shall be documented and shall be made publicly available, wherever possible.
(d) **Other meetings**. These are meetings that are not part of the process of setting policies or norms; examples include information meetings, briefings, scientific conferences, and platforms for coordination of actors.

17. WHO's involvement in meetings organized wholly or partly by a non-State actor can – subject to the provisions of this framework, its four specific policies and operational procedures, and other applicable WHO rules, policies and procedures – consist of any one of the following possibilities:

- WHO jointly organizes the meeting with the non-State actor

- WHO cosponsors a meeting (INSERT FOOTNOTE) organized by the non-State actor
- WHO staff make a presentation or act as panellists at a meeting organized by the non-State actor
- WHO staff attend a meeting organized by a non-State actor.

FOOTNOTE: "cosponsorship of a meeting means: 1) another entity has the primary responsibility for organizing the meeting; and 2) WHO supports and contributes to the meeting and its proceedings; and 3) WHO reserves the right to clear the agenda of the meeting, the list of participants and the outcome documents of the meeting".

Resources

18. Resources [can be]/[include] funds, [personnel] OR [personnel for technical work or implementation of WHO's programmes and policies and emergency response,] or in-kind contributions. In-kind contributions include donations of medicines and other goods and free provision of services.

OR

New text to be proposed

AND/OR

18bis [SPECIFY TYPE OF PERSONNEL]

AND/OR

[ADD FOOTNOTE SPECIFYING PERSONNEL]

[ADD 18ter. The WHO could establish ceiling in the voluntary contribution from non-state actors. Any contribution beyond that amount should go to the core voluntary fund which gives enough freedom to the Secretariat to allocate resources to underfunded programmes. The Member States assessed contributions should be allocated to the programmes that are underfunded under voluntary contribution]/DELETE

CHAIR's PROPOSAL

18alt: Resources include funds [ADD FOOTNOTE: [Non-State actors are urged to provide their contribution, as flexible as possible, in line with the General Programme of Work and the Programme Budget] personnel, [ADD FOOTNOTE: Personnel does not comprise WHO staff members, or secondments to WHO. Personnel may be accepted for emergency work. Personnel must never be used for activities related to policies, norms and standard setting.] or in-kind contribution. In-kind contribution include donations of medicines and other goods and free provision of services (ADD FOOTNOTE TO PERSONNEL: short-term contribution by persons employed by non-State actors other than staff secondments [This personnel do not represent the WHO, do not have badge..]) (TO BE READ IN CONJUNCTION WHITH PARAGRAPH 7 OF THE NGO POLICY, PARAGRAPH 15 OF THE PRIVATE SECTOR POLICY, PARAGRAPH 7 OF THE PHILANTHROPIC FOUNDATION POLICY AND PARAGRAPH 8 OF THE ACADEMIC INSTITUTION POLICY)

ADD FOOTNOTE: [Non-State actors [are urged to]/[should] provide their [contribution]/[resources], as flexible [and non-earmarked] as possible. As any contribution, it has to be fully in line with the Programme Budget]
OR
[ADD FOOTNOTE: [Resources may only be provided in line with the General Programme of Work and Programme Budget and should be as flexible as possible]
OR
[WHO shall make available a detailed information with regard to the financial or in-kind resources received from non-State actors, including the name of donor, amount, the purpose and allocation.] (TO MOVE AFTER PARA 38)
[ADD FOOTNOTE: Personnel does not comprise WHO staff members, or secondments to WHO. Personnel may be accepted for emergency work. Personnel must never be used for activities related to policies, norms and standard setting.] or in-kind contribution.

Evidence

19. For the purposes of this framework, evidence refers to inputs based on up-to-date information, knowledge on technical issues, and consideration of scientific facts, independently analysed by WHO. Evidence generation by WHO includes information gathering, analysis, generation of information and the management of knowledge and research. Non-State actors may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of this framework, its four specific policies and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

Advocacy

20. Advocacy is action to increase awareness of health issues, including issues that receive insufficient attention; to change behaviours in the interest of public health; and to foster collaboration and greater coherence between non-State actors where joint action is required.

Technical collaboration

21. For the purpose of this framework, technical collaboration refers to other collaboration with non-State actors, as appropriate, in activities that fall within the General Programme of Work, including:

- product development
- capacity-building
- operational collaboration in emergencies
- contributing to the implementation of WHO’s policies.

MANAGEMENT OF CONFLICT OF INTEREST AND OTHER RISKS OF ENGAGEMENT

22. Managing, including by, where appropriate, avoiding, conflict of interest and other risks of engagement requires a series of steps, as set out below:[1]

- WHO needs to know the non-State actors that it engages with. Therefore each non-State actor is required to provide all relevant (ADD FOOTNOTE TO PARAGRAPH 38) information about itself and its activities, following which WHO conducts the necessary due diligence.

- WHO conducts a risk assessment in order to identify the specific risks of engagement associated with each engagement with a non-State actor.

- Risks of engagement need to be managed and communicated coherently in each of the three levels of the Organization and throughout the Organization. To that end, WHO manages engagement through a single, Organization-wide electronic tool.[2] (ADD REFERENCE TO PARAGRAPH 38 IN FOOTNOTE).

- [Member States [need to] exercise oversight over WHO's engagement with non-State actors. With this in mind, the Director-General reports [annually] on engagement involving non-State actors] [[focusing in particular] / [including] on [policy-related] (**DEL**) challenges arising from the [proposals of engagement referred to the] Engagement Coordination Group] [and to the Director-General] / [and the decision by the DG not to enter into engagement] [and makes it a standing agenda item for the PBAC] [to the [regular meetings of the] Executive Board] through the Programme, Budget and Administration Committee [to the [regular meetings of the] Executive Board] [and makes all engagements publicly known through the register of non-State actors.] (**DEL**) (ADD FOOTNOTE: See paragraph 38ter)

- OR SPLIT PARA INTO TWO:

- PROCESS

- CONTENT OF THE REPORT OF THE DG

- **NEW CHAIRs PROPOSAL**: Member States exercise oversight over WHO's engagement with non-State actors in accordance with the provisions in paragraphs 64 and 65

- [Request the Independent Expert Oversight Advisory Committee to report annually on WHO's engagement with non-state actors, focusing particularly on cases handled by the Engagement Coordination Group, and to provide Member States with the opportunity to discuss the report with the Chairperson of the Independent Expert Oversight Advisory Committee prior to its adoption by the Programme, Budget and Administration Committee] (**DEL**)

[1] The framework is designed to regulate institutional engagements; its implementation is closely coordinated with the implementation of other organizational policies regulating conflict of interest in respect of individuals (see paragraph 48).

[2] WHO uses an electronic tool for managing engagement. The publicly visible part of the tool is the register of non-State actors; the tool also provides an electronic workflow for the internal management of engagement. A similar electronic tool is used for the management of individual conflicts of interest, in order to harmonize the implementation of the framework with the implementation of the policy on management of individual conflicts of interest for experts.

- 38ter. [In addition to the publicly available information, Member States have electronic access to a summary report on due diligence of non-State actor, and risk assessments and risk management on engagement. Further details of the information used by the Secretariat to manage such engagement, can be made available for Member States to consult, upon request and as far as legally feasible.] [In addition, Member States have access to proposals of engagement referred to the Engagement Coordination Group and the Director-General.] (**DEL**)

[Conflict of interest] (NOTE: ENTIRE SECTION IN BRACKETS)

23. A conflict of interest arises in circumstances where there is potential for a secondary interest (a vested interest in the outcome of WHO's work in a given area) to unduly influence, or where it may be reasonably perceived to unduly influence, either the independence or objectivity of professional judgement or actions regarding a primary interest (WHO's work) The existence of conflict of interest in all its forms does not as such mean that improper action has occurred, but rather the risk of such improper action occurring. Conflicts of interest are not only financial, but can take other forms as well.

23bis. Individual conflicts of interests within WHO are those involving experts, regardless of their status, and staff members; these are addressed in accordance with the policies listed under paragraph 48 of the present framework.

24. All institutions have multiple interests, which means that in engaging with non-State actors WHO is often faced with a combination of converging and conflicting interests. An **institutional conflict of interest** is a situation where WHO's primary interest as reflected in its Constitution may be unduly influenced by the conflicting interest of a non-State actor in a way that affects, or may reasonably be perceived to affect, the independence and objectivity of WHO's work.

25. In actively managing institutional conflict of interest and the other risks of engagement mentioned in paragraph 8 above, WHO aims to avoid allowing the conflicting interests of a non-State actor to exert, or be reasonably perceived to exert, undue influence over the Organization's decision-making process or to prevail over its interests;

26. For WHO, the potential risk of institutional conflicts of interest could be the highest in situations where the interest of non-State actors, in particular economic, commercial or financial, are in conflict with WHO's public health policies, constitutional mandate and interests, in particular the Organization's independence and impartiality in setting policies, norms and standards.

Due diligence and risk assessment

27. When the possibility of entering into an engagement is being considered, the relevant technical unit in the Secretariat conducts an initial examination in order to establish whether such an engagement would be in the interest of the Organization and in line with the principles of WHO's engagement with non-State actors in paragraph 6 and the priorities defined in the General Programme of Work and Programme budget. If this seems to be the case, the technical unit asks the non-State actor to provide its basic information. Using the Organization-wide electronic tool, the unit then complements this information with a description of the proposed engagement and its own assessment of the benefits and risks involved. This information is then transmitted to a specialized central unit which is responsible for analysing the information provided.

28. Before engaging with any non-State actor, WHO, in order to preserve its integrity, conducts due diligence and risk assessment. **Due diligence** refers to the steps taken by WHO to find and verify

relevant information on a non-State actor and to reach a clear understanding of its profile. While due diligence refers to the nature of the non-State actor concerned, **risk assessment** refers to the assessment of a specific proposed engagement with that non-State actor.

29. **Due diligence** combines a review of the information provided by the non-State actor, a search for information about the entity concerned from other sources, and an analysis of all the information obtained. This includes a screening of different public, legal and commercial sources of information, including: media; the entity's website companies' analyst reports, directories and profiles; and public, legal and governmental sources.

30. The core functions of due diligence are to:

- clarify the nature and purpose of the entity proposed to engage with WHO;
- clarify the interest and objectives of the entity in engaging with WHO and what it expects in return;
- determine the entity's legal status, area of activities, membership, governance, sources of funding, constitution, statutes, and by-laws and affiliation;
- define the main elements of the history and activities of the entity in terms of the following: health, human and labour issues; environmental, ethical and business issues; reputation and image; and financial stability;
- ORIGINAL CHAIR/S PROPOSAL Identify if the nature or activities of a NSA are incompatible with WHO/s work and mandate (e.g. links to be tobacco and arms industries) or if they require the Organization to exercise particular caution when engaging with the entity (e.g. links to other industries affecting human health or affected by WHO/s norms and standards (FOOTNOTE As described in paragraph 44)

  OR

  [Identify if the nature or activities of a non-State actor and the type of relationship foreseen with WHO are incompatible with WHO's work and mandate or if they require the Organization to exercise particular caution when engaging with the entity after applying the provisions of paragraphs 44 and 44bis]

  OR

  [Identify if the nature or activities of a non-State actor are incompatible with WHO/s work and mandate or if they require the Organization to exercise particular caution when engaging …]

31. Due diligence also allows the Secretariat for the purpose of its engagement to categorize each non-State actor in relation to one of the four groups of non-State actors on the basis of its nature, objectives, governance, funding, independence and membership. This categorization is indicated in the register of non-State actors.

32. Risks are the expression of the likelihood and potential impact of an event that would affect the Organization's ability to achieve its objectives. A **risk assessment** on a proposed engagement is conducted in addition to due diligence. This involves the assessment of risks associated with an engagement with a non-State actor, in particular the risks described in paragraph 8

Risk management

33. **Risk management** concerns the process leading to a management decision whereby the Secretariat decides explicitly and justifiably on entry into engagement (FOOTNOTE: Other than decisions related to official relations as set out in paragraphs 49 to 55), continuation of engagement, engagement with measures to mitigate risks, non-engagement or disengagement from an existing or planned engagement with non-State actors. It is a management decision usually taken by the unit engaging with the non-State actor.

34. The specialized unit responsible for performing due diligence and risk assessment, as described in paragraph 27, formulates recommendations on the engagement-related options listed in paragraph 33 above, along with reasons for such recommendations. If the proposing unit agrees with the recommendations, it implements them. If there are disagreements, they can be referred to the Engagement Coordination Group. (FOOTNOTE: The **Engagement Coordination Group** is a Secretariat group appointed by the Director-General that includes representation from regional offices.)

35. The Engagement Coordination Group reviews referred proposals of engagement and recommends engagement, continuation of engagement, engagement with measures to mitigate risks, non-engagement or disengagement from an existing or planned engagement with non-State actors. In cases where the unit responsible for the engagement disagrees with this recommendation, the final decision rests with the Director-General.

36. In line with WHO's risk management framework (FOOTNOTE See EB133/10), WHO takes a risk-management approach to engagement, only entering into an engagement with a non-State actor when the benefits in terms of direct or indirect contributions to public health and the fulfilment of the Organization's mandate as mentioned in paragraph 7 outweigh any residual risks of engagement as mentioned in paragraph 8, as well as the time and expense involved in establishing and maintaining the engagement.

Transparency

37. WHO's interaction with non-State actors [is]/[should be] managed transparently. WHO provides the governing bodies with annual reports on its engagement with non-State actors [, including the work of the Engagement Coordination Group] and makes publicly available basic information on the non-State actors it engages with and the individual engagements concerned.

OR

[WHO's interaction with non-State actors is managed transparently. WHO provides the governing bodies with annual reports on its engagement with non-State actors,

[, including a summary information of the due diligence, risk assessment and risk management undertaken by the Secretariat.]

including the work of the Engagement Coordination Group, and makes publicly available appropriate information on the non-State actors it engages with and the individual engagements concerned.]

[, including a summary report of the due diligence, risk assessment and risk management undertaken by the Secretariat.]

(**CHAIR'S PROPOSAL** TO KEEP THE CHAIRS TEXT ONLY)

38. The **WHO register of non-State actors** is an Internet-based, publicly available electronic tool used by the Secretariat[1] to document and coordinate engagement with non-State actors. It contains the main standard information provided by non-State actors and high-level descriptions of the engagement that WHO has with these actors.[2] [The register will be finished in March 2016 and can be consulted [and updated] in an ongoing fashion, including its preliminary versions]/[MOVE this text to the resolution] [Non-State actors engaging with WHO are required to provide information on their organization. This information includes: name, legal status, objective, governance structure, composition of main decision-making bodies, assets, annual income and funding sources, main relevant affiliations, webpage and one or more focal points for WHO contacts.] (DELETE, put in paragraph 38bis) [ADD FOOTNOTE on the three levels of access]

38bis. Non-State actors engaging with WHO are required to provide information on their organization. This information includes: name, legal status, objective, governance structure, composition of main decision-making bodies, assets, annual income and funding sources, main relevant affiliations, webpage and one or more focal points for WHO contacts.

38ter [The due diligence reports, [including] (DELETE) the decisions related to risk assessment and risk management [, including decisions to refuse to engage] / (DELETE) will be made available to Member States] [and relevant information shall be made publicly available] / (DELETE) OR [The due diligence and risk assessment reports, as well as decisions on engagement-related options listed in paragraph 33, will be made available to Member States.]

OR REPLACE 38, 38bis and 38ter WITH:

38. The **WHO register of non-State actors** is an Internet-based, publicly available electronic tool used by the Secretariat (FOOTNOTE 1) to document and coordinate engagement with non-State actors. It contains the main standard information provided by non-State actors (FOOTNOTE 2) and high-level descriptions of the engagement that WHO has with these actors (FOOTNOTE 3);

(FOOTNOTE 1: The register of non-State actors is the first level of a tool used by the Secretariat containing four levels of information: a publicly available level, a level made available to Member States, a working level for the Secretariat, and a level of confidential and sensitive information accessible to a limited number of individuals within the Secretariat).

(FOOTNOTE 2: Information on financial contributions received from non-State actors is documented in this register and in the Programme Budget web portal)

[FOOTNOTE 3: The register covers all three levels of the Organization – global, regional and country – and includes hosted partnerships and joint programmes]

AND

38bis. [Non-State actors engaging with WHO are required to provide information on their organization. This information includes: name, membership, legal status, objective, governance

[1] The register covers all three levels of the Organization – global, regional and country – and includes hosted partnerships and joint programmes.

[2] Information on financial contributions received from non-State actors is documented in this register and in the Programme budget web portal.

structure, composition of main decision-making bodies, assets, annual income and funding sources, main relevant affiliations, webpage and one or more focal points for WHO contacts.]

AND

38ter. [In addition to the publicly available information, Member States have electronic access to a summary report on due diligence of non-State actor, and risk assessments and risk management on engagement. Further details of the information used by the Secretariat to manage such engagement, can be made available for Member States to consult, upon request and as far as legally feasible.]

NEW CHAIR's TEXT: 38ter. In addition to the publicly available information, Member States have electronic access to a summary report on due diligence of non-State actor, and risk assessments and risk management on engagement. [Further details of the information used by the Secretariat to manage such engagement, can be made available for Member States to consult, upon request and as far as legally feasible.] Furthermore Member States can search for such information concerning cases considered by the engagement coordination group.
AND

[Add to resolution text a timeline for establishing and rolling out the register.]

(**CHAIR'S PROPOSAL** TO KEEP THE CHAIRS TEXT FOR 38, 38BIS AND 38TER. A REFERENCE TO THE ROLLING OUT OF THE REGISTER HAS BEEN ADDED TO THE RESOLUTION)

39. When the Secretariat decides on an engagement with a non-State actor, a summary of the information submitted by that entity and held in the WHO register of non-State actors is made public. The accuracy of the information provided by the non-State actor and published in the register is the responsibility of the non-State actor concerned and does not constitute any form of endorsement by WHO.

40. Non-State actors described in the register must update the information provided on themselves annually or upon the request of WHO. Information in the WHO register of non-State actors will be dated. Information on entities that are no longer engaged with WHO or that have not updated their information will be marked as "archived". Archived information from the WHO register of non-State actors can be considered in relation to future applications for engagement, where relevant.

41. WHO maintains a handbook to guide non-State actors in their interaction with WHO in line with this framework. A guide for staff is also maintained on the implementation of the framework for engagement with non-State actors.

NOTE: The following text from paragraph 41 has been "parked" to serve as input for discussions on paragraph 48

[this shall be applied in conjunction with the framework] (DELETE:)

OR

[All the relevant WHO guidelines will be [aligned] / [coordinated] with this framework (FOOTNOTE: LIST ALL RELEVANT DOCUMENTS)]

OR

MOVE (AS FOOTNOTE) TO PARAGRAPH 48

(**CHAIR'S PROPOSAL** DELETE ALL YELLOW AS IT WILL BE DISCUSSED IN PARAGRAPH 48)

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42. (DELETED)

43. (DELETED)

SPECIFIC PROVISIONS

44. WHO does not engage with the tobacco or arms industries [and its affiliates]

(**CHAIR'S PROPOSAL** TO ACCEPT "AND ITS AFFILIATES")

[Engagement with particular industries]/[non-state actors]

44bis. [WHO will exercise [particular]/[appropriate]/(**DEL**) caution [consistent with and subject to the rules of this framework] especially while conducting due diligence and risk assessment analyses when engaging with [non-state actors]/[other industries]/[private sector and some industries] [negatively] affecting human health, or affected by the WHO's norms and standards.][STOP HERE] [[such as]/[for example][, but not limited to,] alcohol and food and beverage industries]

CHAIRS PROPOSAL: 44 bis WHO will exercise particular caution especially while conducting due diligence and risk assessment when engaging with private sector entities or other non-State actors affected by WHO's policies, norms and standards.

Association with WHO's name and emblem

45. WHO's **name and emblem** are recognized by the public as symbols of integrity and quality assurance. WHO's name, acronym and emblem shall not, therefore, be used for, or in conjunction with, commercial, promotional marketing and advertisement purposes. Any use of the name or emblem needs an explicit written authorization by the Director-General of WHO.[1]

Secondments

46. [WHO does not accept secondments from non-State actors.]/(DELETE:)

OR

[WHO does not accept secondments from private sector entities. Secondments from other types of non-State actors shall be accepted, in accordance with WHA67/7.]

[1] See http://www.who.int/about/licensing/emblem/en/.

OR

[WHO can accept secondments from non-State actors for technical work or implementation of WHO's programmes and policies and emergency response.]

CHAIRS PROPOSAL: 46. WHO does not accept secondments from non-State actors

RELATION OF THE FRAMEWORK TO WHO'S OTHER POLICIES

47. This framework replaces the Principles Governing Relations between the World Health Organization and Nongovernmental Organizations[1] and the Guidelines on interaction with commercial enterprises to achieve health outcomes (noted by the Executive Board).[2]

48. The implementation of the framework for engagement with non-State actors is coordinated with the following related policies, which remain valid. [In the case of conflict this framework shall prevail over the policies listed below] [PENDING RESPONSE FROM LEGAL COUNSEL]:

(a) WHO's involvement in external partnerships is regulated by the policy on WHO's engagement with global health partnerships and hosting arrangements.[3] For the management of risks of WHO's engagement in these partnerships the present framework for engagement with non-State actors applies.

(b) The management of WHO's relations with individual experts is regulated by the Regulations for Expert Advisory Panels and Committees[4] and the Guidelines for Declaration of Interests (WHO Experts).

(c) The Organization's Staff Regulations and Staff Rules and in particular the provisions of declaration of interest therein: according to Article 1.1 of the Staff Regulations of the World Health Organization, all staff members "pledge themselves to discharge their functions and to regulate their conduct with the interests of the World Health Organization only in view."

(d) Scientific collaborations are regulated by the Regulations for Study and Scientific Groups, Collaborating Institutions and other Mechanisms of Collaboration.[5]

(e) The procurement of goods and services is regulated by the Financial Rules and Financial Regulations;[6] it not covered by the framework for engagement with non-State actors, although pro-bono contributions from non-State actors are covered.

(f) Like any other financing of WHO, financing from non-State actors should be considered as part of the financing dialogue and is regulated by the Financial Rules and Financial Regulations; the decision on accepting such a financial contribution is regulated by this framework.

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[1] Basic documents, 47th ed. Geneva: World Health Organization; 2009: 81–86.

[2] See document EB107/2001/REC/2, summary record of the twelfth meeting.

[3] Endorsed by the Health Assembly in resolution WHA63.10 on partnerships.

[4] See Basic documents, 47th ed. Geneva: World Health Organization; 2009, pp 104–112 (http://apps.who.int/gb/bd/PDF/bd47/EN/basic-documents-47-en.pdf, accessed 1 December 2014).

[5] Basic documents, 47th ed. Geneva: World Health Organization; 2009, pp.113–120.

[6] Basic documents, 47th ed. Geneva: World Health Organization; 2009, pp.87–97.

CHAIRS PROPOSAL: ACCEPT TEXT, DELETE TEXT IN SQUARE BRACKETS TO BE ADDRESSED IN THE RESOLUTION:

OR

[48a) alt. WHO's involvement in external partnerships is regulated by the policy on WHO's engagement with global health partnerships and hosting arrangements and the current framework, in a complementary way. In particular, for the purposes of due diligence, risk assessment and risk management of WHO's involvement in formal partnerships, the current Framework will apply.]

OFFICIAL RELATIONS

49. **"Official relations"** is a privilege that the Executive Board may grant to nongovernmental organizations, international business associations and philanthropic foundations that have had and continue to have a sustained and systematic engagement[1] in the interest of the Organization. The aims and activities of all these entities shall be in conformity with the spirit, purposes and principles of WHO's Constitution, and they shall contribute significantly to the advancement of public health. Organizations in official relations can attend governing body meetings of WHO but are otherwise subject to the same rules as other non-State actors when engaging with WHO.

50. [All entities in official relations shall have a constitution or similar basic document, an established headquarters, a directing or governing body, an administrative structure, and a regularly updated entry in the WHO register of non-State actors.]

OR

50alt. [Entities in official relations (INSERT FOOTNOTE) are international in membership and/or scope. All entities in official relations shall have a constitution or similar basic document, an established headquarters, a directing or governing body, an administrative structure, and a regularly updated entry in the WHO register of non-State actors.]

[FOOTNOTE: Before working relations are established between WHO and a national NGO, and before a programme of collaboration with such an organization is agreed, appropriate measures will be taken to consult with the government concerned in accordance with article 71 of the WHO Constitution).]

OR

50alt(Chair). Entities in official relations are international in membership and [/or] scope. All entities in official relations shall have a constitution or similar basic document, an established headquarters, a [directing]/[steering] or governing body, an administrative structure, and a regularly updated entry in the WHO register of non-State actors. (+ DELETION OF PARAGRAPH 55)

CHAIRS PROPOSAL NEW: Entities in official relations are international in membership and/or scope. All entities in official relations shall have a constitution or similar basic document, an established headquarters, a governing body, an administrative structure, and a regularly updated entry in the WHO register of non-State actors. (+ DELETION OF PARAGRAPH 55)

51. A plan for collaboration [with agreed objectives/results/targets and]

[1] At least two years of systematic engagement as documented in the WHO register of non-State actors, assessed by both parties to be mutually beneficial. Participation in each other's meetings alone is not considered to be a systematic engagement.

[based on mutually agreed objectives and] (DELETE)

outlining activities for the coming three-year period structured in accordance with the General Programme of Work and Programme budget shall form the basis of official relations between WHO and organizations in official relations. This plan shall also be published in the WHO register of non-State actors. These organizations shall provide annually a short report on the progress made in implementing the plan of collaboration and other related activities which will also be published in the WHO register.

CHAIRS PROPOSAL: Art. 51. Official relations shall be based on a plan for collaboration between WHO and the entity with agreed objectives and outlining activities for the coming three-year period structured in accordance with the General Programme of Work and Programme budget This plan shall also be published in the WHO register of non-State actors. These organizations shall provide annually a short report on the progress made in implementing the plan of collaboration and other related activities which will also be published in the WHO register.

52. The Executive Board shall be responsible for deciding on the admission of organizations into official relations with WHO and shall review this status every three years. The Director-General may propose international nongovernmental organizations, philanthropic foundations and international business associations for admission. The Director-General can also propose an earlier review based on the experience in the collaboration with the organization concerned.

53. Entities in official relations are invited to participate in sessions of WHO's governing bodies. This privilege shall include:

(a) the possibility to appoint a representative to participate, without right of vote, in meetings of WHO's governing bodies or in meetings of the committees and conferences convened under its authority;
(b) the possibility to make a statement if the Chairman of the meeting (i) invites them to do so or (ii) accedes to their request when an item in which the related entity is particularly interested is being discussed;
(c) the possibility to submit the statement referred to in subparagraph (b) above in advance of the debate for the Secretariat to post on a dedicated website.

54. Non-State actors participating in WHO governing bodies' meetings shall designate a head of their delegation and declare the affiliations of their delegates. This declaration shall include the function of each delegate within the non-State actor itself and, where applicable, the function of that delegate within any affiliated organization.

55. [Entities in official relations are international in membership and/or scope. The organization or its affiliates can also attend meetings of the regional committees. Regional committees may decide on a procedure granting accreditation to their meetings to other non-State actors not in official relations as long as the procedure is managed in accordance with this framework.] (DISCUSS WITH P51)

(CHAIR PROPOSAL TO DELETE PARAGRAPH 55 SINCE IT IS MERGED WITH PARAGRAPH 50)

Procedure for admitting and reviewing organizations in official relations

56. The application for admission into official relations shall be based on the up-to-date entries in the WHO register of non-State actors, providing all the necessary information as requested on the non-State actor's nature and activities. The application shall include a summary of past engagement as

documented in the register of non-State actors and a three-year plan for collaboration with WHO that has been developed and agreed on jointly by the non-State actor and WHO.

57. A signed letter certifying the accuracy of the application for official relations submitted online shall reach WHO headquarters no later than the end of the month of July for submission to the Executive Board at its session the following January. Applications for official relations shall be reviewed to ensure that the established criteria and other requirements are fulfilled as set out in this framework. Applications should be transmitted to the Executive Board members by the Secretariat six weeks before the opening of the January session of the Executive Board at which they will be considered.

58. The entities in official relations and the Secretariat should name focal points for collaboration who are responsible for informing each other and their organizations of any developments in the implementation of the plan for collaboration and who are the first points of contact for any changes or problems. [MOVE PARA TO AFTER P61]

59. During the Board's January session, the Programme, Budget and Administration Committee shall consider applications submitted and shall make recommendations to the Board. A representative of an applicant organization may be invited by the Committee to speak before it in connection with that organization's application. Should the applicant organization be considered not to meet the established criteria, and bearing in mind the desirability of ensuring a valuable continuing partnership based on defined objectives and evidenced by a record of successful past engagement and a framework for future collaborative activities, the Committee may recommend postponement of consideration or rejection of an application.

60. The Board, after considering the recommendations of the Committee, shall decide whether an organization is to be admitted into official relations with WHO. A reapplication from a non-State actor shall not normally be considered until two years have elapsed since the Board's decision on the previous application.

61. The Director-General shall inform each organization of the Board's decision on its application. The Director-General shall document decisions taken within the Secretariat and by the Executive Board on applications from non-State actors, reflect this status in the WHO register of non-State actors, and maintain a list of the organizations admitted into official relations.

62. The Board, through its Programme, Budget and Administration Committee, shall review collaboration with each non-State actor in official relations every three years and shall decide on the desirability of maintaining official relations or defer the decision on the review to the following year. The Board's review shall be spread over a three-year period, one third of the entities in official relations being reviewed each year.

63. The Director-General can propose earlier reviews of a non-State actor's official relations with WHO by the EB through the Programme, Budget and Administration Committee in case of issues such as non-fulfilment of the entity's part in the plan of collaboration, lack of contact, failure by the non-State actor to fulfil its reporting requirements or changes in the nature or activities of the organization concerned, the non-State actor ceasing to fulfil the criteria for admission, or any potential new risks for the collaboration.

64. The Board may discontinue official relations if it considers that such relations are no longer appropriate or necessary in the light of changing programmes or other circumstances. Similarly, the Board may suspend or discontinue official relations if an organization no longer meets the criteria that applied at the time of the establishment of such relations, fails to update its information and report on

the collaboration in the WHO register on non-State actors or fails to fulfil its part in the agreed programme of collaboration.

[ACCREDITATION OF NGOS

64 bis To be eligible for accreditation to the Health Assembly, Executive Board and committees and conferences convened under their authority, a nongovernmental organization shall:

(a) have aims and purposes consistent with WHO's Constitution and in conformity with the policies of the Organization as well as resolutions and decisions adopted by the Executive Board and the World Health Assembly;
(b) demonstrate competence in a field of activity related to the work of WHO;
(c) have membership and/or activities that are international in scope;
(d) be non-profit and public interest in nature, and in its activities and advocacy;
(e) have an established structure, a constitutive act, and accountability mechanisms;
(f) for a membership organization, have the authority to speak for its members and have a representative structure; The Membership should not contain private sector entities, individuals associated with private sector entities or philanthropic foundations and academic institutions not at arm's length with private sector;
(g) have existed formally for at least three years as of date of receipt of the application by WHO;
(h) disclose information on its objectives, structure, membership of executive body, field of activities and source of financing, and, where applicable, its status with other entities of the United Nations system;
(i) agree to provide WHO regularly with updated information as well as to inform WHO of any changes with respect to its status as « non-governmental organization » as soon such changes take place.

Completed applications should reach WHO headquarters by the beginning of June in order to be considered by the Executive Board in January of the following year. Applications should be transmitted to Member States by the Secretariat two months in advance of the session at which they will be considered. A re-application from a "nongovernmental organization" shall not be considered until two years have elapsed since the Board's decision on the original application. Once a nongovernmental organization is accredited, information gathered on its objectives, structure, membership of executive body, field of activities and source of funding, including updated information, shall be made publicly available. A report on accredited nongovernmental organizations shall be submitted every two years to the Executive Board.]

(CHAIRS PROPOSAL: DELETE**)**

OVERSIGHT OF ENGAGEMENT

65. The Executive Board, through its Programme, Budget and Administration Committee, oversees the implementation of WHO's ~~policy~~ Framework of engagement with non-State actors, proposes revisions to the Framework and can grant the privileges of official relations to international nongovernmental organizations, philanthropic foundations and international business associations.

66. The Programme Budget and Administration Committee shall review, provide guidance and, as appropriate, make recommendations to the Executive Board on:

(a) oversight of WHO's implementation of the framework for engagement with non-State actors including:

(i) consideration of the annual report on engagement with non-State actors submitted by the Director-General which provides a summary of engagements and highlights challenges arising from such engagement.

AND

(i bis) [consideration of the annual report of the Independent Expert Oversight Advisory Committee on WHO's engagement with non-State actors]

(ii) any other matter on engagement referred to the Committee by the Board

(b) entities in official relations with WHO, including:

(i) proposals for admitting non-State actors into official relations

(ii) review of renewals of entities in official relations

(c) any proposal, when needed, for revision of the framework of engagement with non-State actors.

CHAIRS PROPOSAL: KEEP TEXT INCLUDING ibis

NON-COMPLIANCE WITH THIS FRAMEWORK

67. Non-compliance can include *inter alia* the following: significant delays in the provision of information to the WHO register of non-State actors; the provision of wrong information; the use of the engagement with WHO for commercial, promotional, marketing and advertisement purposes; [engagement in [political activities]/[partisan politics];] misuse of WHO's name and emblem; and abuse of the privileges conferred by official relations.

CHAIRS PROPOSAL 67 alt: Non-compliance can include *inter alia* the following: significant delays in the provision of information to the WHO register of non-State actors; the provision of wrong information; the use of the engagement with WHO for commercial, promotional, marketing and advertisement purposes; misuse of WHO's name and emblem; misuse of the fact of engaging with WHO for other than public health purposes, and abuse of the privileges conferred by official relations.

68. Non-compliance by a non-State actor with the provisions of this framework can have consequences for the entity concerned after due process including a reminder, a warning, a cease-and-desist letter, a rejection of renewal of engagement and termination of engagement. The review of the status of official relations by the Executive Board can be anticipated and non-compliance can be the reason for non-renewal of official relations. Except in the case of important and intentional cases of non-compliance the non-State actor concerned should not be automatically excluded from other engagements with WHO.

69. Any financial contribution received by WHO that is subsequently discovered to be non-compliant with the terms of this framework shall be returned to the contributor.

MONITORING AND EVALUATION OF THE FRAMEWORK

70. The implementation of the framework will be constantly monitored internally through the engagement coordination group and by the Executive Board through the Programme, Budget and Administration Committee in the annual report on engagement with non-State actors and the assessment of information available in the register of non-State actors.

71. Furthermore, the implementation of the framework should be periodically evaluated. The results of such evaluation, together with any proposals for revisions of the framework, shall also be submitted to the Executive Board through the Programme, Budget and Administration Committee.[PERIODICITY TO BE DECIDED BY THE RESOLUTION]

[New72. The following steps shall be taken for the effective implementation of the framework:

(a) Review existing list of non-State actors in official relation and to apply the categorization of non-State actors as set out in this Framework.
(b) Review of WHO's existing external and hosted partnerships, collaborations in the light of this Framework and to take appropriate measures to avoid and manage risk. Towards this purpose the Secretariat should invite comments from the public.
(c) Review and amend all the policies listed in Paragraph 48 of EB136/5 to fully align those policies with the existing framework. Towards this end, the Secretariat will hold web consultations open for Member States and public to pinpoint the areas of the existing policies which need to be reviewed and amended in the light of framework;
(d) The non-State actors registry shall be made operational within six months of the adoption of the Framework of Engagement with Non-State actors.] [MAKE REFERENCE TO THE RESOLUTION]
(CHAIRS PROPOSAL: DELETE 72 AS ISSUES ARE ADDRESSED IN THE RESOLUTION)

DRAFT WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH NONGOVERNMENTAL ORGANIZATIONS

1. Nongovernmental organizations make important contributions to global health because they often have deep roots in local communities, have special flexibilities to respond to health needs, represent affected populations and other key groups, and promote innovative solutions. Therefore WHO engages with this group of key actors in global health in order to leverage their support in the fulfilment of WHO's mandate.

(**CHAIR'S PROPOSAL** TO KEEP THE PARAGRAPH)

2. This policy regulates specifically WHO's engagement with nongovernmental organizations by type of interaction.[1] The generic provisions of the framework also apply to all engagements with nongovernmental organizations.

[1] See paragraphs 15–21 of the overarching framework for the five types of interaction.

PARTICIPATION

Participation by nongovernmental organizations in WHO meetings[1]

3. WHO can invite NGOs to participate in consultations, hearings or other meetings in accordance with paragraph 16 of the Overarching Framework. Consultations and hearings can be electronic or in person.

4. Participation in other meetings is on the basis of discussion of an item in which the nongovernmental organization has a particular interest and where its participation adds value to the deliberations of the meeting. Such participation is for the exchange of information and views, but never for the formulation of advice.

4bis. The nature of participation of nongovernmental organizations depends on the type of meeting concerned. The format, modalities, and the participation of nongovernmental organizations in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat. Participation and inputs received from nongovernmental organizations shall be made publicly available, wherever possible. Nongovernmental organizations do not take part in any decision making process of the Organization.

Involvement of the Secretariat in meetings organized by nongovernmental organizations

5. WHO can organize joint meetings, or cosponsor meetings organized by nongovernmental organizations, as long as the integrity and independence of the Organization are preserved, and as long as this participation furthers WHO's objectives as expressed in the General Programme of Work. WHO staff members may participate in meetings organized by nongovernmental organizations in accordance with the internal rules of the Organization. The nongovernmental organization shall not misrepresent WHO's participation as official WHO support for, or endorsement of, the meeting, and shall agree not to use WHO's participation for promotional purposes.

Operational procedures

6. The participation of WHO in meetings organized by nongovernmental organizations as co-organizers, cosponsors, panellists or speakers shall be managed according to the provisions of the framework for engagement with non-State actors.

RESOURCES

7. WHO can accept funds, personnel and in-kind contributions from nongovernmental organizations as long as such contributions fall within WHO's General Programme of Work, do not create conflicts of interest, are managed in accordance with the framework, and comply with other relevant regulations, rules and policies of WHO.

KEEP TEXT; ADD FOOTNOTE TO PERSONNEL: Contribution of personnel are only acceptable for short term assignments that do not involve normative work and if potential risks are managed in accordance with this framework.

[1] Other than sessions of the governing bodies, which are regulated by the policy on management of engagement.

8. WHO can provide resources to a nongovernmental organization for implementation of particular work in accordance with the Programme budget, the Financial Regulations and Financial Rules and other applicable rules and policies. The resources concerned can be either for a project of the institution which WHO considers merits support and is consistent with WHO's programme of work, or for a project organized or coordinated by WHO. The former constitutes a grant, the latter a service.

Specific policies and operational procedures

9. Any acceptance of resources from a nongovernmental organization is handled in accordance with the provisions of this framework and relevant other rules such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and WHO's policies governing procurement.

10. For reasons of transparency, contributions and donations from nongovernmental organizations must be publicly acknowledged by WHO in accordance with its policies and practices.

11. Acknowledgements shall usually be worded along the following lines: "The World Health Organization gratefully acknowledges the financial contribution of [NGO] towards [description of the outcome or activity]".

12. Contributions received from nongovernmental organizations are listed in the financial report and audited financial statements of WHO as well as the Programme budget web portal and the WHO register of non-State actors.

13. Nongovernmental organizations may not use the fact that they have made a contribution in their materials used for commercial, promotional, marketing and advertisement purposes. However, they may make reference to the contribution in their annual reports or similar documents. In addition, they may mention the contribution on their websites, and in special non-promotional publications, provided that the content and context have been agreed with WHO.

EVIDENCE

14. Non-governmental organizations may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of the overarching framework, and this specific policy and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

ADVOCACY

15. WHO collaborates with nongovernmental organizations on advocacy for health and increasing awareness of health issues; for changing behaviours in the interest of public health; and for fostering collaboration and greater coherence between non-State actors where joint action is required.

16. WHO favours independent monitoring functions and therefore engages with nongovernmental organizations working in this field. Nongovernmental organizations are encouraged to disseminate WHO's policies, guidelines, norms and standards and other tools through their networks so as to extend WHO's own reach.

TECHNICAL COLLABORATION

17. The Secretariat is encouraged to undertake technical collaboration with nongovernmental organizations, provided that it is in the interests of the Organization and managed in accordance with the framework for engagement with non-State actors.

DRAFT WHO POLICY AND OPERATIONAL PROCEDURE ON ENGAGEMENT WITH PRIVATE SECTOR ENTITIES

1. Private sector entities are key players in global health as providers, both within and beyond the health sector, of goods and services that can have important effects on health. Therefore WHO engages with this group of key actors in global health to improve their positive contribution, limit their negative effects on health and leverage their support in the fulfilment of WHO's mandate.

AND

[This policy is applicable to private sector firms, international business associations, academic institutions and philanthropic foundations not at arm's length with the private sector and other not-for-profit organizations, which are not qualified as NGOs under the overarching framework on the engagement of non-State actors.]

CHAIR PROPOSAL: KEEP FIRST VERSION ALTERNATIVE

2. This policy regulates specifically WHO's engagement with private sector entities by type of interaction.[1] The general provisions of the framework also apply to all engagements with private sector entities.

CHAIR PROPOSAL: KEEP TEXT

3. [In engaging with private sector entities, WHO will aim to operate on a competitively neutral basis.] OR DELETE

CHAIR PROPOSAL: KEEP TEXT

PARTICIPATION

Participation by private sector entities in WHO meetings[2]

4. WHO can invite private sector entities to participate in consultations, hearings or other meetings in accordance with paragraph 16 of the Overarching Framework. Consultations and hearings can be electronic or in person.

5. Participation in other meetings is on the basis of discussion of an item in which the private sector entity has a particular interest and where its participation adds value to the deliberations of the

[1] See paragraphs 15–21 of the overarching framework for the five types of interaction.

[2] Other than sessions of the governing bodies, which are regulated by the policy on management of engagement.

meeting. Such participation is for the exchange of information and views, but never for the formulation of advice.

5bis The nature of participation of private sector entities depends on the type of meeting concerned. The format, modalities, and the participation of private sector entities in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat. Participation and inputs received from private sector entities shall be made publicly available, wherever possible. Private sector entities do not take part in any decision making process of the Organization.

Involvement of the Secretariat in meetings organized by private sector entities

6. WHO staff members may participate in meetings organized by a private sector entity as long as the integrity, independence and reputation of the Organization are preserved and as long as this participation furthers WHO's objectives as expressed in the General Programme of Work. The private sector entity shall not misrepresent WHO's participation as official WHO support for, or endorsement of, the meeting, and shall agree not to use WHO's participation for commercial and/or promotional purposes.

Specific policies and operational procedures

7. The participation of WHO staff members in meetings of private sector entities as panellists, speakers or in any other capacity shall be managed according to the provisions of the overarching framework and this specific policy.

8. WHO does not cosponsor meetings organized wholly or partly by private sector entities. It may, however, cosponsor a meeting for which the scientific initiators have hired a commercial conference organizer to deal with the logistical aspects, provided that the commercial organizer makes no contribution to the scientific content of the meeting.

9. WHO does not cosponsor meetings organized by other actors where one or more health-related private sector entities are also cosponsors. Other instances of cosponsorship of meetings organized by other actors where non health-related private sector entities are also cosponsors should be reviewed on a case-by-case basis and are subject to the provisions of this framework.

10. There shall be no commercial exhibitions on WHO premises and at WHO's meetings.

11. WHO does not cosponsor commercial exhibitions, whether as part of meetings organized by private sector entities or as part of meetings organized by other actors.

RESOURCES

12. The level of risk associated with the acceptance of resources from private sector entities depends on the field of activity of the private sector entity, the WHO activity for which the resources are used and the modalities of the contributions.

(a) Funds may be accepted from private sector entities whose business is unrelated to that of WHO, provided they are not engaged in any activity [or affiliated with any entity] that is incompatible with WHO's mandate and work.

(b) Funds may not be sought or accepted from private sector entities that have, themselves or through their affiliated companies, a direct commercial interest in the outcome of the project

toward which they would be contributing, unless approved in conformity with the provisions for clinical trials or product development (see paragraph 38 below).

(c) Caution should be exercised in accepting financing from private sector entities that have even an indirect interest in the outcome of the project (i.e. the activity is related to the entities' field of interest, without there being a conflict as referred to above). In such an event, other commercial enterprises having a similar indirect interest should be invited to contribute, and the reason clearly described if this does not prove possible. The larger the proportion of the contribution from any one source, the greater the care that should be taken to avoid the possibility of a conflict of interest or appearance of an inappropriate association with one contributor.

[(d) WHO shall not receive financial resources from private sector entities as well as non-state actors with links to private sector entities whose activities [or advocacy] are undermining the mandate of WHO as stated in its Constitution]/DISCUSS WITH PARA 44

[(e) The WHO should establish ceiling in the voluntary contribution from non-state actors. Any contribution beyond that amount should go to the core voluntary fund which gives enough freedom to the Secretariat to allocate resources to underfunded programmes. The Member States assessed contributions should be allocated to the programmes that are underfunded under voluntary contribution]/OR MOVE TO 18ter in the overarching framework/DELETE

CHAIRS PROPOSAL a) Funds may be accepted from private sector entities whose business is unrelated to that of WHO, provided they are not engaged in any activity or have close ties with any entity that is incompatible with WHO's mandate and work.

DELETE d) AND e)

13. Financial and in-kind contributions from private sector entities to WHO's programmes are only acceptable in the following conditions:

(a) the contribution is not used for normative work;

(b) if a contribution is used for activities other than normative work in which the private sector entity could have a commercial interest, the public health benefit of the engagement needs clearly to outweigh its potential risks;

(c) the proportion of funding of any activity coming from the private sector cannot be such that the programme's continuation would become dependent on this support;

(d) the acceptance of the contribution does not constitute an endorsement by WHO of the private sector entity, or its activities, products or services;

(e) the contributor may not use the results of WHO's work for commercial purposes or use the fact of its contribution in its promotional material;

(f) the acceptance of the contribution does not afford the contributor any privilege or advantage;

(g) the acceptance of the contribution does not offer the contributor any possibility for advising, influencing, participating in, or being in command of the management or implementation of operational activities;

(h) WHO keeps its discretionary right to decline a contribution, without any further explanation.

14. [The Director-General can set up mechanisms for pooling contributions from multiple sources, if the mechanisms are designed in such a manner as to avoid any perceived influence from the contributors on WHO's work; if the mechanism is open to all interested contributors; and if the mechanism is subject to the conditions in paragraph 12 above and transparency is achieved through the WHO register of non-State actors and the Programme budget web portal].

CHAIRS PROPOSAL KEEP TEXT

Specific policies and operational procedures

14. Any acceptance of financial, personnel or in-kind contribution from private sector entities shall be managed in accordance with this framework and based on a signed agreement.

KEEP TEXT; ADD FOOTNOTE TO PERSONNEL: Contribution of personnel are only acceptable for short term assignments that do not involve normative work and if potential risks are managed in accordance with this framework.

16 For reasons of transparency, contributions from private sector entities must be publicly acknowledged by WHO in accordance with its policies and practices.

17. Acknowledgements shall usually be worded along the following lines: "The World Health Organization gratefully acknowledges the financial contribution of [private sector entity] towards [description of the outcome or activity]".

18. Contributions received from private sector entities, are listed in the financial report and audited financial statements of WHO as well as the Programme budget web portal and the register of non-State actors.

[18bis. Any donation received by WHO which is subsequently discovered to be noncompliant with this Framework shall be returned to the donor.]

CHAIR PROPOSAL: DELETE AS IT IS COVERED BY OVERARCHING FRAMEWORK PARAGRAPH 69

19. Private sector entities may not use [WHO's logo]/[[such]/[the] results of WHO's work for commercial purposes] and may not use the fact that they have made a contribution in their promotional materials. However, they may make reference to their contribution in their corporate annual reports or similar documents. In addition they may mention the contribution in a transparency listing on their websites, in special non-promotional or product-related corporate responsibility pages on their website and in similar publications provided that the content and context have been agreed with WHO.

CHAIRS PROPOSAL Art. 19 alt: Private sector entities may not use the results of WHO's work to which they have contributed for commercial purposes and may not use the fact that they have made a contribution in their promotional materials. However, they may make reference to their contribution in their corporate annual reports or similar documents. In addition they may mention the contribution in a transparency listing on their websites, in special non-promotional or product-related corporate responsibility pages on their website and in similar publications provided that the content and context have been agreed with WHO.

(COMMENT: USE OF NAME AND EMBLEM IS REGULATED BY REGULATED BY PARAGRAPH 45 OF THE OVERARCHING FRAMEWORK

Donations of medicines and other health technologies[1]

20. In determining the acceptability of large-scale donations of medicines and other health-related products, the following criteria should be met.

(a) Sound evidence exists of the safety and efficacy of the product in the indication for which it is being donated. The product is approved or otherwise authorized by the recipient country for use in that indication; it should also preferably appear in the WHO Model List of Essential Medicines for that indication.
(b) Objective and justifiable criteria for the selection of recipient countries, communities or patients have been determined. In emergency situations, flexibilities may be required.
(c) A supply system is in place and consideration is given to means of preventing waste, theft and misuse (including leakage back into the market).
(d) A training and supervision programme is in place for all personnel involved in the efficient administration of supply, storage and distribution at every point from the donor to the end-user.
(e) A donation of medicines and other health-related products is not of a promotional nature, either with regard to the company itself or insofar as it creates a demand for the products that is not sustainable once the donation has ended.
(f) WHO does not accept products at the end of their shelf life.
(g) A phase-out plan for the donation has been agreed upon with recipient countries.
(h) A system for monitoring adverse reactions to the product has been set up with the participation of the donating company.

21. In consultation with the department responsible for financial matters in WHO, the value of donations of medicines and other health-related products is determined and is formally recorded in the audited statements and the WHO register of non-State actors.

Financial contributions for clinical trials

22. Except as provided in paragraph 38 below on product development, financial contributions from a commercial enterprise for a clinical trial arranged by WHO on that company's proprietary product are considered on a case-by-case basis and always decided by the Engagement coordination group. In this connection, it should be ensured that:

(a) the research or development activity is of public health importance;
(b) the research is conducted at WHO's request and potential conflicts of interest are managed;
(c) WHO only accepts such financial contributions, if the research would not take place without WHO's involvement or if WHO's involvement is necessary in order to ensure that the research is undertaken in conformity with internationally accepted technical and ethical standards and guidelines.

23 If the above-mentioned requirements are met, a financial contribution may be accepted from a company having a direct commercial interest in the trial in question, provided that appropriate mechanisms are put in place to ensure that WHO controls the conduct and the dissemination of the

[1] Such donations shall be in line with interagency guidelines: World Health Organization, Ecumenical Pharmaceutical Network, International Pharmaceutical Federation, International Federation of Red Cross and Red Crescent Societies, International Health Partners, The Partnership for Quality Medical Donations, et al. Guidelines for medicine donations – revised 2010. Geneva: World Health Organization; 2011.

outcomes of the trials, including the content of any resulting publication, and that the trial results are free from any inappropriate influence or perceived influence from the company concerned.

Contributions for WHO meetings

24. For meetings convened by WHO, a contribution from a private sector entity may not be accepted if it is designated to support the participation of specific invitees (including such invitees' travel and accommodation), regardless of whether such contribution would be provided directly to the participants or channelled through WHO.

25. Contributions may be accepted to support the overall costs of a meeting.

26. WHO receptions and similar functions shall not be paid for by private sector entities.

Contributions for WHO staff participating in external meetings

27. An external meeting is one convened by a party other than WHO. Support from private sector entities for travel of WHO staff members to attend external meetings or conferences may fall into two categories:

(a) meetings held by the private sector entity paying for travel: financing for travel may be accepted in accordance with WHO's rules if the private sector entity is also supporting the travel and ancillary expenses of other participants in the meeting, and the risk of a conflict of interest has been assessed and managed;
(b) meetings held by a third party (i.e. a party other than the private sector entity proposing to pay for the travel): financing for travel may not be accepted from a private sector entity.

Contributions for publications

28. Funds may be accepted from private sector entities for meeting the printing costs of WHO publications, as long as no conflict of interest arises. In no event may commercial advertisements be placed in WHO publications.

Contributions for financing staff salaries

29. [Funds designated to support the salary of specific staff members or posts (including short-term consultants) may not be accepted from private sector entities] [STOP HERE]

[if they could give rise to a real or perceived conflict of interest in relation to WHO's work.]

(DELETE)

OR

(DELETE PARAGRAPH)

CHAIR PROPOSAL: DELETE PARAGRAPH

Cost recovery

30. In cases where a WHO evaluation scheme is in place (i.e. to evaluate certain products, processes or services against official WHO guidelines), the Organization may charge private sector entities for such services on the basis of cost recovery. The purpose of WHO's evaluation schemes is always to provide advice to governments and/or international organizations for procurement. Evaluation does not constitute endorsement by WHO of the product(s), process or service in question.

EVIDENCE

31. Private sector entities may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of the overarching framework, and this specific policy and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

[31bis. If information gathering is done in the preparation of the development of norms and standards, private sector entities can only be involved in the form of hearings]/(**DEL**)

32. Individuals working for interested private sector entities are excluded from participating in expert groups; however, expert groups need to be able, where appropriate, to conduct hearings with such individuals in order to access their knowledge.

CHAIRS PROPOSAL KEEP TEXT

ADVOCACY

33. WHO encourages private sector entities to implement and advocate for the implementation of WHO's norms and standards. WHO engages in dialogue with private sector entities in order to promote the implementation of WHO's policies, norms and standards.

34. Private sector entities can only collaborate with WHO in advocacy for the implementation of a WHO norm or standard if they commit themselves to implement these norms and standards in their entirety. No partial or selective implementation is acceptable. [SUBJECT TO AGREEMENT ON SPECIFIC PARAGRAPHS IN THE FOUR SPECIFIC POLICIES]

CHAIRS PROPOSAL KEEP TEXT IN THIS POLICY ONLY

35. International business associations are encouraged to work with their members in order to improve their public health impact and the implementation of WHO policies, norms and standards.

TECHNICAL COLLABORATION

36. Technical collaboration with the private sector is welcomed if potential risks of engagement are managed or mitigated and provided that the normative work of WHO is protected from any undue influence and there is no interference with WHO's advisory function to Member States.

OR

[Technical collaboration with the private sector is welcomed provided that it is in the interests of the Organization and managed in accordance with the framework for engagement with non-State actors.]

[and [in particular] provided that the normative work of WHO is protected from any undue influence and there is no interference with WHO's advisory function to Member States.]

CHAIR PROPOSAL 36 alt: Technical collaboration with the private sector is welcomed provided that it is in the interests of the Organization and managed in accordance with this framework and in particular provided that the normative work of WHO is protected from any undue influence and there is no interference with WHO's advisory function to Member States.]

Specific policies and operational procedures

37. If WHO has drawn up official specifications for a product, it may provide technical advice to manufacturers for development of their product in accordance with these specifications, provided that all private sector entities known to have an interest in such a product are given the opportunity to collaborate with WHO in the same way.

Product development

38. WHO collaborates with private sector entities in the development of health-related technology, either by conducting research and development on their products and supporting transfers and licensing of technology or by licensing its intellectual property to such enterprises. Collaborative research and development, technology transfer and licensing should, as a general rule, be undertaken only if WHO and the entity concerned have concluded an agreement cleared by the Office of the Legal Counsel that ensures that the final product will ultimately be made widely available [and] [,] accessible, [and affordable,] (DELETE) including to [~~the public sector~~] (DELETE) of low- and middle-income countries [~~at a preferential price~~] (DELETE). If such an agreement is concluded, financing may be accepted from the private sector entity for a clinical trial arranged by WHO on the product in question, as contractual commitments obtained from the entity in the public interest outweigh any potential conflict of interest in accepting the financial contribution. These contributions should be distinguished from the acceptance of contributions for a clinical trial arranged by WHO on a proprietary product as described in paragraph 23.

OR

[ALTERNATIVE LANGUAGE AT HIGHER LEVEL]

OR

[CHAIR'S PROPOSAL]

38alt. WHO collaborates with private sector entities in the development of health-related technology, either by conducting research and development on their products and supporting transfers and licensing of technology or by licensing its intellectual property to such enterprises based on an agreement cleared by the Office of the Legal Counsel. Such collaboration must contribute to increasing access to quality, safe, efficacious and affordable medical products. If such an agreement is concluded, financing may be accepted from the private sector entity for a clinical trial arranged by WHO on the product in question, as contractual commitments obtained from the entity in the public interest outweigh any potential conflict of interest in accepting the financial contribution. These contributions should be distinguished from the acceptance of contributions for a clinical trial arranged by WHO on a proprietary product as described in paragraph 23.

(COMMENT TO CHAIR'S PROPOSAL ON PARAGRAPH: THE TEXT "increasing access to quality, safe, efficacious and affordable medical products" COMES FROM THE AGREED LEADERSHIP PRIORITIES OF THE 12TH GENERAL PROGRAMME OF WORK)

DRAFT WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH PHILANTHROPIC FOUNDATIONS

1. Philanthropic foundations are making significant contributions to global health in general, and to WHO's work in particular, in many areas ranging from innovation to capacity-building and to service delivery. Therefore WHO engages with this group of key actors in global health to leverage their support in the fulfilment of WHO's mandate.

(**CHAIR'S PROPOSAL** TO KEEP THE PARAGRAPH)

2. This policy regulates specifically WHO's engagement with philanthropic foundations by type of interaction.[1] The generic provisions of the framework also apply to all engagements with philanthropic foundations.

PARTICIPATION

Participation by philanthropic foundations in WHO meetings[2]

3. WHO can invite philanthropic foundations to participate in consultations, hearings or other meetings in accordance with paragraph 16 of the Overarching Framework. Consultations and hearings can be electronic or in person.

4. Participation in other meetings is on the basis of discussion of an item in which the philanthropic foundation has a particular interest and where its participation adds value to the deliberations of the meeting. Such participation is for the exchange of information and views, but never for the formulation of advice.

4bis. The nature of participation of philanthropic foundations depends on the type of meeting concerned. The format, modalities, and the participation of philanthropic foundations in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat. Participation and inputs received from philanthropic foundations shall be made publicly available, wherever possible. Philanthropic foundations do not take part in any decision making process of the Organization.

Involvement of the Secretariat in meetings organized by philanthropic foundations

5. WHO can organize joint meetings, or cosponsor meetings organized by philanthropic foundations, as long as the integrity, independence and reputation of the Organization are preserved, and as long as this participation furthers WHO's objectives as expressed in the General Programme of Work. WHO staff members may participate in meetings organized by philanthropic foundations in

[1] See paragraphs 15–21 of the overarching framework for the five types of interaction.

[2] Other than sessions of the governing bodies, which are regulated by the policy on management of engagement.

accordance with the Organization's internal rules. The philanthropic foundations shall not misrepresent WHO's participation as official WHO support for, or endorsement of, the meeting, and shall agree not to use WHO's participation for promotional purposes.

Operational procedures

6. The participation of WHO in meetings organized by philanthropic foundations as co-organizers, cosponsors, panellists or speakers shall be managed according to the provisions of the framework for engagement with non-State actors.

RESOURCES

7. WHO can accept funds, personnel and in-kind contributions from philanthropic foundations as long as such contributions fall within WHO's General Programme of Work, do not create conflicts of interest, are managed in accordance with the framework, and comply with other relevant regulations, rules and policies of WHO.

KEEP TEXT; ADD FOOTNOTE TO PERSONNEL: Contribution of personnel are only acceptable for short term assignments that do not involve normative work and if potential risks are managed in accordance with this framework.

8. As for all contributors, philanthropic foundations shall align their contributions to the priorities set by the Health Assembly in the approved Programme budget.

9. Philanthropic foundations are invited to participate in the financing dialogue, which is designed to improve the alignment, predictability, flexibility and transparency of WHO's funding and to reduce budgetary vulnerability.

10. WHO's programmes and offices should strive to ensure that they do not depend on one single source of funding.

11. The acceptance of contributions (whether in cash or in kind) should be made subject to the following conditions:

(a) the acceptance of a contribution does not constitute an endorsement by WHO of the philanthropic foundation;
(b) the acceptance of a contribution does not confer on the contributor any privilege or advantage;
(c) the acceptance of a contribution as such does not offer the contributor any possibility for advising, influencing, participating in, or being in command of the management or implementation of operational activities;
(d) WHO keeps its discretionary right to decline a contribution, without any further explanation.

Specific policies and operational procedures

12. Any acceptance of resources from a philanthropic foundation is handled in accordance with the provisions of this framework and relevant other rules such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and WHO's policies governing procurement.

13. For reasons of transparency, contributions from philanthropic foundations must be publicly acknowledged by WHO in accordance with its policies and practices.

14. Acknowledgements shall usually be worded along the following lines: "The World Health Organization gratefully acknowledges the financial contribution of [philanthropic foundation] towards [description of the outcome or activity]".

15. Contributions received from philanthropic foundations are listed in the financial report and audited financial statements of WHO as well as the Programme budget web portal and the WHO register of non-State actors.

16. Philanthropic foundations may not use the fact that they have made a contribution in their promotional materials. However, they may make reference to the contribution in their annual reports or similar documents. In addition, they may mention the contribution in a transparency listing on their websites, in special non-promotional pages of their website and similar publications, provided that the content and context have been agreed with WHO.

EVIDENCE

17. Philanthropic foundations may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of the overarching framework, and this specific policy and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

ADVOCACY

18. WHO collaborates with philanthropic foundations on advocacy for health and increasing awareness of health issues; for changing behaviours in the interest of public health; and for fostering collaboration and greater coherence between non-State actors where joint action is required. Philanthropic foundations are encouraged to disseminate WHO's policies, guidelines, norms and standards and other tools through their networks so as to extend WHO's own reach.

TECHNICAL COLLABORATION

19. The Secretariat is encouraged to undertake technical collaboration with philanthropic foundations provided that it is in the interests of the Organization and managed in accordance with the framework for engagement with non-State actors.

DRAFT WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH ACADEMIC INSTITUTIONS

1. Academic institutions contribute to global health through education, research, clinical care and the generation, synthesis and analysis of evidence. Therefore, WHO engages with this group of key actors in global health to leverage their support in the fulfilment of WHO's mandate.

(**CHAIR'S PROPOSAL** TO KEEP THE PARAGRAPH)

2. This policy regulates specifically WHO's engagement with academic institutions by type of interaction.[1] The generic provisions of the framework also apply to all engagements with academic institutions.

3. The engagement with academic institutions at the institutional level has to be distinguished from the collaboration with individual experts working for academic institutions.

PARTICIPATION

Participation by academic institutions in WHO meetings

4. WHO can invite academic institutions to participate in consultations, hearings or other meetings in accordance with paragraph 16 of the Overarching Framework. Consultations and hearings can be electronic or in person.

5. Participation in other meetings is on the basis of discussion of an item in which the academic institution has a particular interest and where its participation adds value to the deliberations of the meeting. Such participation is for the exchange of information and views, but never for the formulation of advice.

5bis. The nature of participation of academic institution depends on the type of meeting concerned. The format, modalities, and the participation of academic institution in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat. Participation and inputs received from academic institutions shall be made publicly available, wherever possible. Academic institutions do not take part in any decision making process of the Organization.

Involvement of the Secretariat in meetings organized by academic institutions

6. WHO can organize joint meetings, or cosponsor meetings organized by academic institutions, as long as the integrity, independence and reputation of the Organization are preserved, and as long as this participation furthers WHO's objectives as expressed in the General Programme of Work. WHO staff members may participate in meetings organized by academic institutions in accordance with the Organization's internal rules. The academic institution shall not misrepresent WHO's participation as official WHO support for, or endorsement of, the meeting, and shall agree not to use WHO's participation for promotional purposes.

Operational procedures

7. The participation of WHO in meetings organized by academic institutions as co-organizers, cosponsors, panellists or speakers shall be managed according to the provisions of the framework for engagement with non-State actors.

RESOURCES

8. WHO can accept funds, personnel and in-kind contributions from academic institutions as long as such contributions fall within WHO's General Programme of Work, do not create conflicts of

[1] See paragraphs 15–21 of the overarching framework for the five types of interaction.

interest, are managed in accordance with the framework, and comply with other relevant regulations, rules and policies of WHO.

KEEP TEXT; ADD FOOTNOTE TO PERSONNEL: Contribution of personnel are only acceptable for short term assignments that do not involve normative work and if potential risks are managed in accordance with this framework.

9. WHO can provide resources to an academic institution for implementation of particular work (such as research, a clinical trial, laboratory work and preparation of a document). This can be either for a project of the institution which WHO considers merits support and is consistent with WHO's programme of work, or for a project organized or coordinated by WHO. The former constitutes a grant, the latter a service.

Specific policies and operational procedures

10. Any acceptance of resources from an academic institution is handled in accordance with this framework and relevant other rules such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and WHO's policies governing procurement.

11. For reasons of transparency, contributions from academic institutions must be publicly acknowledged by WHO in accordance with its policies and practices.

12. Acknowledgements shall usually be worded along the following lines: "The World Health Organization gratefully acknowledges the financial contribution of [academic institution] towards [description of the outcome or activity]".

13. Contributions received from academic institutions are listed in the financial report and audited financial statements of WHO as well as the Programme budget web portal and the WHO register of non-State actors.

14. Academic institutions may not use the results of WHO's work for commercial purposes and may not use the fact that they have made a contribution in their promotional materials. However, they may make reference to the contribution in their annual reports or similar documents. In addition they may mention the contribution in a transparency listing on their websites, in special non-promotional pages of their website and similar publications, provided that the content and context have been agreed with WHO.

EVIDENCE

15. Academic institutions may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of the overarching framework, and this specific policy and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

16. Intellectual property arising from collaborations with academic institutions is regulated by the agreement with the academic institution. This should be addressed in consultation with the Office of the Legal Counsel.

ADVOCACY

17. WHO collaborates with academic institutions on advocacy for health and increasing awareness of health issues; for changing behaviours in the interest of public health; and for fostering collaboration and greater coherence between non-State actors where joint action is required. WHO favours independent monitoring functions and therefore engages with academic institutions working in this field. Academic institutions are encouraged to disseminate WHO's policies, guidelines, norms and standards and other tools through their networks so as to extend WHO's own reach.

TECHNICAL COLLABORATION

18. The Secretariat is encouraged to undertake technical collaboration with academic institutions, provided that it is in the interests of the Organization and managed in accordance with the framework for engagement with non-State actors.

19. Scientific collaborations are regulated by the Regulations for Study and Scientific Groups, Collaborating Institutions and other Mechanisms of Collaboration.[1]

20. Academic institutions or parts thereof can be designated as WHO collaborating centres in accordance with the Regulations mentioned above. In this context, before granting the status of WHO collaborating centre a due diligence and risk assessment in accordance with this framework is conducted. The collaboration with these collaborating centres is regulated by the aforementioned regulations and reflected in the register of non-State actors.

Mr MERCADO (Argentina), speaking in his capacity as chairman of the drafting group, welcomed the commitment shown by Member States and the culture of respect that had prevailed during its deliberations. During discussions the previous evening and that morning, the drafting group had agreed on proposed amendments to the Annex to the draft resolution. On the first page, the text "submitted by Argentina as Chair of the Open-Ended Intergovernmental Meeting and the informal consultation on the draft Framework of engagement with non-State actors" in the subtitle should be deleted. The phrase "The Sixty-eighth World Health Assembly" at the start of the draft resolution should be replaced with "The Sixty-ninth World Health Assembly" and the word "OR" and the alternate draft resolution text in square brackets should be deleted.

On the third page of the Annex, the word "draft" should be inserted before "Framework of engagement with non-State actors" in the title. In the third line of the title, the date and time should be replaced with "the conclusion of the Sixty-eighth World Health Assembly". The first part of the paragraph explaining the colour code had been amended to read:

> "Text highlighted in green has been agreed ad referendum. Text highlighted in yellow was considered but no consensus was reached."

The footnote at the bottom of the third page should be replaced by the following text:

> "Headquarters, regional offices and country offices, entities established under WHO, as well as hosted partnerships. For hosted partnerships the framework of engagement with non-State actors will apply, subject to WHO's policy on engagement with global health partnerships and hosting arrangements (WHA63.10). Hosted as well as external partnerships are explained in paragraph 48."

[1] Basic documents, 47th ed. Geneva: World Health Organization; 2009, pp 113–120.

On the sixth page of the Annex, paragraph 10 on nongovernmental organizations, which was highlighted in yellow, should be deleted. The phrase "and are not unduly dependent on private sector entities for their financial resources" should be deleted from the grey paragraph 10alt, and the entire paragraph should be highlighted in green.

On the seventh page, the phrase "[STOP HERE]" in paragraph 14alt should be deleted, and the yellow text following that phrase should be highlighted in green. That paragraph should be renumbered as paragraph 14, and the subsequent paragraphs 14bis, 14bis alt, 14alt bis, 13bis alt alt and the one starting "*ADD FOOTNOTE:" should be deleted.

On the fifteenth page, paragraph 38, highlighted in yellow, should be deleted, as there was agreed text replacing it on the following page.

On the nineteenth page, the introductory section of paragraph 48 should read:

> "The implementation of the framework for engagement with non-State actors is coordinated [and aligned] with the [related policies listed below. In the case of conflict, this framework will prevail] [following related policies], ~~which remain valid. [In the case of conflict, this framework shall prevail over the policies listed below]~~:

Immediately following the introductory section to paragraph 48, the following text should be inserted:

> "OR
>
> [The implementation of the policies listed below will be coordinated and aligned with the framework of engagement with non-State actors]"

A new paragraph 48(a) should be added in square brackets to read: "[(a) WHO's engagement with global health partnerships and hosting arrangements]". Additionally, a new paragraph 48(a)(i) should be added, which should read:

> "Hosted partnerships derive their legal personality from WHO and are subject to the Organization's rules and regulations. Therefore the Framework applies to their engagement with non-State actors. They have a formal governance structure, separate from that of the WHO governing bodies, in which decisions are taken on direction, work plans and budgets; and their programmatic accountability frameworks are also independent from those of the Organization. In the same way the Framework applies to other hosted entities which are subject to the Organization's Rules and Regulations."

Paragraph 48(a) would become paragraph 48(a)(ii) and would be followed by the following additional text:

> "[(a) Partnerships and entities hosted by WHO will be subject to this framework as applicable for WHO.]
>
> [For hosted partnerships the framework of engagement with non-State actors will apply, subject to WHO's policy on engagement with global health partnerships and hosting arrangements (WHA63.10).]"

The entirety of the introductory section of paragraph 48 remained in yellow and in brackets.

He expressed appreciation to Member States and the Secretariat for their work and expressed the hope that future discussions on the issue would continue to be productive.

Ms LANTERI (Monaco) supported the draft resolution and the adoption of the draft framework of engagement with non-State actors at the Sixty-ninth World Health Assembly. She looked forward to taking part in future negotiations.

Mr KOLKER (United States of America) said the document was needed because neither the benefits nor the risks of engaging with non-State actors had been fully articulated within WHO or to the partners, including Member States. Through the process, the safeguards necessary for reinforcing WHO's core mandate and protecting the integrity of its norm-setting function had been reaffirmed. The document already had numerous agreed paragraphs in that regard. The registry that was called for would reinforce the existing mechanisms, make the benefits of engagement more transparent and help to manage the risks. He expressed disappointment that the drafting group had not been able to provide a full framework to the Secretariat and potential partners, and urged WHO and non-State actors to continue their engagement for the benefit of public health.

Ms COLE (United Kingdom of Great Britain and Northern Ireland) aligned herself with the statement made by the delegate of the United States of America regarding the importance of the work that had been undertaken. Her country was committed to ensuring that the framework was finalized and presented for approval.

Dr GWINJI (Zimbabwe), speaking on behalf of the Member States of the African Region, said that the Region was committed to the process of reaching consensus among Member States. He underlined the importance of WHO having a sound framework for engagement with non-State actors, which promoted public health and respected the intergovernmental nature of decision-making by the Member States. He welcomed the commendable progress made in reaching a common understanding of important elements of the framework and recommended that a meeting should be held to finalize it as soon as possible. He supported the draft resolution.

Ms MATSOSO (South Africa) supported the draft resolution and urged Member States to conclude the matter as soon as possible. She drew attention to a minor error in the paragraph numbering of the Annex.

Mr REMON MIRANZO (Spain) said that credibility was one of WHO's core assets, and preserving it was a priority. He welcomed the great progress that had been made and looked forward to being able to approve the framework in the near future and thereby resolve one of the most complicated aspects of the WHO reform process.

Mr ROLLIANSYAH SOEMIRAT (Indonesia) said that the framework would provide clear guidelines for stakeholders in addressing global public health challenges while respecting, preserving and protecting the integrity and credibility of the Organization. The draft resolution set out a feasible way forward, but considerable efforts would be required to finalize the framework for submission to the Sixty-ninth World Health Assembly. His country would continue to work closely with other Member States to that end.

Dr BUSUTTIL (Malta) supported the proposal that the draft framework should be presented to the Sixty-ninth World Health Assembly for approval. However, he proposed two further amendments to the draft resolution. In paragraph 1, the phrase "reached in the drafting group" should be added after the word "consensus". A new subparagraph should be added in paragraph 2, requesting the Director-General "to submit, to the Sixty-ninth World Health Assembly through the Executive Board at its 138th session, a report on the practical and resource implications of implementation of the proposed

framework". He also requested clarification as to why subparagraph 2(3) called for the onset of implementation of one particular paragraph of the framework (development of the register of non-State actors) while the framework was still in a draft form.

Mr BOISNEL (France) said that the framework was of the utmost importance for WHO reform and for its capacity for action. Although its adoption had not been possible at the Sixty-eighth World Health Assembly, great progress had been made in terms of the content and the procedure that would enable the framework to be finalized in 2016. The challenge was not only to reach a political agreement but also to clearly understand the many legal and organizational implications of the framework. He strongly supported the draft resolution.

Mr SEGARD (Canada) supported continued efforts to complete work on the draft framework of engagement with non-State actors. The draft framework should enable WHO to execute its broad mandate in a cost-effective and innovative manner. Non-State actors could play an important role in collaborating with WHO to advance public health, and the draft framework would foster inclusive and transparent engagement and provide WHO with the tools it needed to continue to lead in the field of global health. He looked forward to submission of the draft framework to the Executive Board at its 138th session.

Mrs PENEVEYRE (Switzerland) welcomed the progress made and expressed the hope that discussions would maintain their momentum. The Organization must adapt to the changing landscape of actors in global health and continue to play its unique normative role. She therefore supported the draft resolution and hoped that the Sixty-ninth World Health Assembly would adopt a framework for active and transparent engagement with non-State actors.

Ms PADILLA RODRIGUEZ (Mexico) reiterated her commitment to adopting the framework at the Sixty-ninth World Health Assembly and strongly supported the draft resolution.

Ms HEYWARD (Australia) fully supported the draft resolution and remained committed to finalizing the framework as a key part of WHO reform. The draft framework should be submitted to the Executive Board in January 2016.

Dr USHIO (Japan) expressed support for the direction of work on the draft framework. Although he recognized the need for a rigorous approach to conflict of interest, the appropriate operation of engagement with non-State actors should be based on trust in the Secretariat and avoidance of micro-management by Member States. The framework was intended to enable collaborative relationships with non-State actors for the sake of public health and avoid violations of WHO policy. Further discussion should reflect those points.

Mr DALCERO (Brazil) observed that remarkable work had been done. Momentum should not be lost; the months ahead should be used in a pragmatic manner to discuss and agree on the few outstanding issues. The international health landscape was changing fast, and one of the lessons learnt from the outbreak of Ebola virus disease was the growing role of non-State actors. In order to be prepared for the future, WHO should be strengthened as the leading operational, normative and scientific body in the field of global health, which required a robust framework of engagement with non-State actors. He supported the adoption of the draft resolution.

Mr EMANUELE (Ecuador) reiterated his commitment to WHO reform and emphasized the importance of strengthening transparency and reformulating its framework for engagement with non-State actors in order to achieve the goals of WHO. The reform process should not compromise the authority of Member States in the decision-making process. He reiterated the request to make available to Member States information on current relationships with non-State actors, in order to

inform work on the draft framework. He supported the adoption of the draft resolution and looked to approval of the framework by the World Health Assembly in 2016.

Dr PHUSIT PRAKONGSAI (Thailand) looked forward to the convening of an open-ended intergovernmental meeting and supported the draft resolution.

Ms BOTERO HERNÁNDEZ (Colombia) supported the draft resolution. With regard to the amendments proposed by the delegate of Malta, she said that in paragraph 1 it was not necessary to add the phrase "reached in the drafting group", since the drafting group had been established by Committee A as a formal part of the work of the Health Assembly. With regard to the proposed addition to paragraph 2, she asked the Secretariat whether it was necessary to state explicitly in the draft resolution that a report should be submitted on the practical and resource implications of implementation of the proposed framework. The framework would have permanent application as part of the Organization's legal structure, unlike resolutions on time-limited action plans, and she was therefore uncertain whether that specific concern should be mentioned in the draft resolution.

Mr ALI ABADI (Islamic Republic of Iran) noted that further deliberation on the issue was needed but said that his country was committed to finalizing the draft framework, which was a vital part of WHO reform. He supported the draft resolution, which described the progress made and the way forward.

Ms KUIVASNIEMI (Finland) said that the continued role of WHO as the directing and coordinating authority on international health work required it to have the capacity to interact with the multitude of actors in global health. The draft framework would facilitate such interaction and protect the Organization's integrity. Her Government remained committed to the continued negotiation process and hoped to see the draft framework approved at the Sixty-ninth World Health Assembly.

Dr PANDA (India) said that his Government remained strongly committed to the negotiation process and supported the draft resolution as proposed by the drafting group.

Mr SASTRE (Bolivarian Republic of Venezuela) said that, although the Committee had not managed to finalize the draft framework, he remained convinced of the value of the reform and was in favour of a framework that provided for collaboration based on transparency and clearly defined criteria.

Ms ZHANG Yang (China) supported the continuation of the reform process and was fully committed to participating actively in the negotiations alongside other Member States.

Dr AL-TAAE (Iraq) highlighted the importance of the role of non-State actors in crisis management. Investments should be made in the private sector so that it had the capacity to work in coordination with the public sector. Roles should be distributed on the basis of results-based management, and gap analysis should be used to improve performance. While avoiding any conflict of interest, WHO should accept more sponsorship for building its capacity to provide regular and sustainable technical support. He accordingly supported the submission of a draft resolution to the Executive Board for subsequent consideration by the Sixty-ninth World Health Assembly.

Dr REYNDERS (Belgium) said that the complexity of the draft framework, and the scope of the impact it would have on the Organization, had prevented the negotiations from being finalized, but they were close to reaching that objective. He supported the proposal made by the delegate of Malta to use the following weeks to examine the practical and administrative implications of implementing the framework for each level and department of WHO, while ensuring that the Organization remained dynamic and fit for purpose, especially after the Ebola crisis.

Mr MERCADO (Argentina) said that, in chairing the many sessions of the drafting group, his delegation had sought to reflect the participants' constructive spirit of mutual respect throughout the negotiation process, and he encouraged delegates to approve the draft resolution in its current version. Paragraph 1 had been the subject of lengthy discussion, and the consensus to which it referred had indeed been reached not only in the drafting group but also, he believed, within the Committee and the Health Assembly as a whole. Regarding the amendment on the economic consequences of the resolution, he explained that all WHO resolutions were accompanied by a document on their financial implications, making any further provisions in that regard redundant. Regarding the establishment of a register of non-State actors, the drafting group had recognized that the Director-General had already made a commitment to develop such a register before the draft resolution had been drawn up, and believed that its inclusion in the draft resolution would have a positive effect on the continued work of the drafting group.

Dr BUSUTTIL (Malta) said that he had no wish to stall progress towards approval of the draft resolution. He expressed satisfaction with the explanation regarding paragraphs 1 and 2(3) of the draft resolution and was prepared to withdraw his proposed amendments to them. However, he continued to have reservations regarding the reasons for not introducing a new paragraph requesting a report setting out the practical and resource implications of the resolution. As stated by other delegates, the draft resolution did not apply to a time-limited strategy or action plan; the framework would govern the operation of one of the major lifelines of the Organization, and a more detailed and extensive explanation was therefore needed of its implications for the three levels of the Organization.

Ms BOTERO HERNÁNDEZ (Colombia) said that the Health Assembly was not being asked to adopt the draft framework of engagement at the current time. The draft resolution under consideration reflected an ongoing process. She asked the Secretariat to clarify whether reference to a more extensive document on the practical and resource implications of implementing the framework could be included in the draft resolution.

Mr BURCI (Legal Counsel) said that, in accordance with the Rules of Procedure of the World Health Assembly and the Financial Regulations of the World Health Organization, the Secretariat would prepare a document on the budgetary and financial implications of the draft resolution adopting the framework. A document on the practical implications of a resolution would be something new, for which the Secretariat would require a specific mandate.

Mr SIMPSON (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN and also on behalf of the International Council of Nurses, the International Pharmaceutical Federation and the World Confederation for Physical Therapy, supported a unified approach applicable to all non-State actors and questioned the relevance of setting categories. It was important to consider not only the potential conflicts of interest of non-State actors but also the conflicts of interest of each individual member of a delegation of experts appointed by them. Non-State actors should be informed of the process and timetable for implementation of the framework, to enable them to prepare for the new requirements. Implementation had already begun on some of the processes described in the framework. For instance, non-State actors in official relations with WHO had been invited to disclose information on governance, financing, membership, and activities related to WHO's programme of work. A report on the analysis of that data would help increase transparency and strengthen confidence in the process.

Ms KOLAPPA (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, praised the Member States' initiative in drafting the framework but drew attention to three areas of concern. First, WHO should exercise particular caution when dealing with industries directly affected by WHO's norms and standards, and it should consider listing in the framework those industries that had previously sought to exert an influence in the field of public health. Secondly,

evidence gathered by non-State actors should be made available for independent verification. Thirdly, a ceiling should be set for financial contributions from non-State actors, with any money beyond that limit going to the core voluntary fund. She urged Member States to create a strong enough framework to safeguard public health from commercial interests.

Dr LHOTSKA (International Baby Food Action Network), speaking at the invitation of the CHAIRMAN, expressed concern that the draft framework did not adequately safeguard WHO from undue influence. Instead of re-examining the constitutionality of accrediting business-interest associations as nongovernmental organizations, the new policy on official relations proposed their wholesale admission. New channels of undue industry influence could be opened up by practices such as "generation of evidence" and "advocacy". Furthermore, the framework distorted the concept of "conflict of interest" and gave a false impression that the risks of interactions with transnational corporations and philanthropic foundations had been adequately addressed. She accordingly called for a re-evaluation of the framework.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the purpose of the framework should be to afford global actors better protection and more interaction, thereby facilitating health outcomes. He called for transparent engagement with all non-State actors and accountability by all. When conflicts of interest arose, they must be managed in a robust, clear, transparent and equitable manner. He called for the equitable application of the provisions of the framework across the different categories of non-State actors.

Ms BURDET (Medicus Mundi International), speaking at the invitation of the CHAIRMAN, said that corporate interests, which ran counter to public health interests, were the main risk arising from WHO's engagement with non-State actors. The proposed protocols did not address the issue of Member States' responsibility to protect WHO's integrity, despite the fact that there had been examples of Member States engaging in initiatives that compromised the Organization's decision-making process. WHO was under continuing pressure to treat corporations as equal and legitimate "partners" and "stakeholders" in public affairs. Therefore, it was essential that delegates defended the integrity and independence of WHO and took such time as was necessary to achieve a robust framework.

Dr ASAMOA-BAAH (Deputy Director-General) said that the only outstanding issue was the delegate of Malta's request that the framework be accompanied by an analysis of its practical and resource implications. The Secretariat was prepared to present such an analysis at the time of the framework's submission to the Executive Board and the Health Assembly. If that proposal was acceptable to the Maltese delegation, it seemed that Member States were ready to approve the resolution.

Dr BUSUTTIL (Malta) confirmed that he sought clarity on the exact implications of the framework so as to allow Member States to make an informed decision at the time of its approval. As the Secretariat had guaranteed that a comprehensive analysis would be provided, he had no objection to withdrawing his proposed amendment.

The CHAIRMAN took it that the Committee wished to approve the draft resolution.

The draft resolution, as amended, was approved.[1]

3. SIXTH REPORT OF COMMITTEE A (Document A68/75)

Dr ROOVÄLI (Estonia), Rapporteur, read out the draft sixth report of Committee A.

The report was adopted.[2]

4. CLOSURE OF THE MEETING

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

The meeting rose at 16:30.

[1] Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA68.9.

[2] See page 366.

COMMITTEE B

FIRST MEETING

Wednesday, 20 May 2015, at 15:00

Chairman: Mr M. MALABAG (Papua New Guinea)

1. OPENING OF THE COMMITTEE: Item 19 of the Agenda

The CHAIRMAN, welcoming participants, extended a special welcome to Dr Cuypers (Belgium), Dr Ammar (Lebanon) and Dr Matchock-Mahouri (Chad), representatives of the Executive Board at the Sixty-eighth World Health Assembly and to Mrs Tyson (United Kingdom of Great Britain and Northern Ireland), Chairman of the Programme, Budget and Administration Committee of the Executive Board, who would report on several agenda items dealt with on behalf of the Board by that Committee at its twenty-second meeting (Geneva, 14–15 May 2015).

Election of Vice-Chairmen and Rapporteur

The CHAIRMAN informed the Committee that Dr Raymond Busuttil (Malta) and Mr Khaga Raj Adhikari (Nepal) had been nominated as Vice-Chairmen and Dr Guy Fones (Chile) as Rapporteur.

Decision: Committee B elected Dr Raymond Busuttil (Malta) and Mr Khaga Raj Adhikari (Nepal) as Vice-Chairmen, and Dr Guy Fones (Chile) as Rapporteur.[1]

2. ORGANIZATION OF WORK

The CHAIRMAN said that the agenda items allocated to the Committee (contained in document A68/1 Rev.1) would be dealt with in the order in which they appeared in the programme of work published daily in the *Journal* of the Health Assembly.

It was so agreed.

3. HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN: Item 20 of the Agenda (Documents A68/37, A68/INF./2, A68/INF./3, A68/INF./4 and A68/INF./5)

The CHAIRMAN drew attention to a draft decision proposed by the delegations of Cuba, Nicaragua, Pakistan, Tunisia (on behalf of the Arab Group) and Venezuela (Bolivarian Republic of), which read:

[1] Decision WHA68(3).

The Sixty-eighth World Health Assembly,

PP1 Mindful of the basic principle established in the Constitution of the World Health Organization, which affirms that the health of all peoples is fundamental to the attainment of peace and security, and stressing that unimpeded access to health care is a crucial component of the right to health;

PP2 Taking note of the report of the Director-General on Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, and noting also the Report of a field assessment of health conditions in the occupied Palestinian territory,

Requests the Director-General:

(OP.1) to report on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, to the Sixty-ninth World Health Assembly, through a field assessment conducted by the World Health Organization, with special focus on:

(a) barriers to health access in the occupied Palestinian territory, including as a result of movement restrictions and territorial fragmentation, as well as progress made in the implementation of the recommendations contained in the World Health Organization 2014 report Right to health: Crossing barriers to access health in the occupied Palestinian territory, 2013;

(b) physical injuries and disabilities, and damage to and destruction of medical infrastructure and facilities as well as impediments to the safety of health care workers;

(c) access to adequate health services on the part of Palestinian prisoners;

(d) the effect of prolonged occupation and human rights violations on mental and physical health, particularly the health consequences of the Israeli military detention system on Palestinian prisoners and detainees especially child detainees, and of insecure living conditions in the occupied Palestinian territory, including east Jerusalem;

(e) the effect of impeded access to water and sanitation, as well as food insecurity, on health conditions in the occupied Palestinian territory, particularly in the Gaza Strip;

(f) the provision of financial and technical assistance and support by the international donor community, and its contribution to improving health conditions in the occupied Palestinian territory;

(OP.2) to provide support to the Palestinian health services, including capacity-building programmes;

(OP.3) to provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;

(OP.4) to continue providing necessary technical assistance in order to meet the health needs of the Palestinian people, including prisoners and detainees, in cooperation with the efforts of the International Committee of the Red Cross, as well as the health needs of handicapped and injured people;

(OP.5) to provide support to the Palestinian health sector in preparing for emergency situations and scaling up emergency preparedness and response capacities and in reducing shortages in life-saving drugs and medical disposables;

(OP.6) to support the development of the health system in the occupied Palestinian territory, including development of human resources.

The administrative and financial implications for the Secretariat of adopting the draft decision were:

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

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: All

Programme areas: The decision links to programme areas in all categories

Outcome: All
Output: All

How would this decision contribute to the achievement of the outcomes of the above programme areas?

The actions requested in the decision would contribute to all the programmatic outcomes.

Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the decision during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US$ 10 000).

(i) 1 year (covering the period May 2015 to May 2016)

(ii) Total: US$ 11 110 000 (staff: US$ 3 860 000; activities: US$ 7 250 000)

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US$ 10 000).

Total: US$ 6 480 000 (staff: US$ 2 250 000; activities: US$ 4 230 000)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

The activities will be implemented through the WHO Office in Jerusalem responsible for WHO's cooperation programme with the Palestinian Authority. WHO's work at country-level will be supported by the Regional Office for the Eastern Mediterranean and by headquarters.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If "no", indicate how much is not included.

Not applicable.

(c) Staffing implications

Could the decision be implemented by existing staff? (Yes/no)

Yes.

If "no", indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

Not applicable.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US$ 1 390 000; source(s) of funds: funding will continue to be sought through voluntary contributions, including against the Strategic Response Plan.

Mr DOUDECH (Tunisia), introducing the draft decision on behalf of the Arab Group, said that the cooperation of individuals and States was essential in order to remove obstacles to the exercise of the fundamental right to health enshrined in the WHO Constitution and guaranteed by international law. The content of the report by the Secretariat on health conditions in the occupied Arab territories reaffirmed the need for a report on the subject in 2016. The report should include greater detail and focus in particular on the matters highlighted in paragraph 1 of the draft decision, which he urged Member States to support.

Dr AWAD (Palestine) said that, major challenges notwithstanding, the Palestinian Ministry of Health had been remarkably successful in controlling and eliminating communicable diseases through epidemiological surveillance activities and immunization. However, prevention and control of noncommunicable diseases remained problematic, owing not only to the usual risk factors but also to the mental and physical health consequences ensuing from the decades-long Israeli occupation. The sustained Israeli attacks on Gaza were indiscriminate and killed and injured women and children and health workers, damaged medical facilities and disabled hundreds of citizens, including children, thereby exacerbating existing health and socioeconomic burdens. The impact on access to fuel, water, electricity, food and shelter was no less onerous. The repercussions for children's mental health of living in constant fear and insecurity were being documented. The delivery of and access to health services was impeded by the Israeli-built apartheid wall. Those held captive in Israeli prisons were commonly refused treatment for chronic medical conditions and mental illnesses unless they shouldered the cost. He, too, urged support for the draft decision.

Mr YAZJI (Syrian Arab Republic) said that Israel, the occupying Power, was responsible for the deteriorating health conditions in the occupied Syrian Golan, where its practices impeded access to health services for citizens, in breach of the principle that the highest attainable standard of health was a fundamental right of every human being. Syrian citizens were denied adequate access to health care, and their environment and health were gravely damaged by such practices as the burial of nuclear waste and the storage of toxic and radioactive materials in secret landfill sites. Syrian detainees in Israeli prisons were vulnerable to life-threatening diseases and to permanent disabilities, as a result of the inhumane conditions in which they were kept. The Israeli authorities persistently ignored repeated requests for the delivery of medical services to the occupied Golan and were cynically attempting to hide their support for terrorist organizations in the buffer zone behind a humanitarian facade, which included medical treatment for injured members of groups named on international terrorist watch lists, thus enabling them to return to attacking, inter alia, health facilities and workers on Syrian soil.

He supported the draft decision and called on the Secretariat to continue monitoring health conditions in the occupied Arab territories, providing support to Syrian citizens in the occupied Golan and striving to remove obstacles to the conduct of a field mission to the area.

Mr ÇARIKÇI (Turkey) noted with regret that people in the occupied territories continued to endure very poor living conditions. Israeli attacks had caused immense human suffering and loss of life. Children had been particularly affected. Universal values and human conscience required every member of the international community to reject the illegal practices and restrictions on the Palestinian people that undermined their fundamental rights and freedoms, including the right to health. The main

health concerns continued to stem from avoidable and preventable causes associated with the occupation, particularly the restrictions imposed on people's movements and the lack of access to health services. The health conditions of Palestinian prisoners held in Israeli jails were a further cause for concern. The efforts of WHO and other United Nations organizations to alleviate the sufferings of the Palestinian people were to be commended, but the results achieved were unsatisfactory because of the extraordinary conditions prevailing in the occupied territories. Turkey had delivered humanitarian aid, including fuel, food and medicine, and had pledged additional financial support during the Cairo International Conference on Palestine in 2014. However, long-term solutions were urgently needed in order to avoid greater humanitarian risks. As a sponsor of the draft resolution, Turkey invited all Member States to support it.

Professor L'HADJ (Algeria), speaking on behalf of the Member States of the African Region, said that the ongoing situation in the occupied Palestinian territory was a serious obstacle to the enjoyment of the right to health. The restrictions on people's movements should be lifted. The occupation made it extremely difficult for the Palestinian Ministry of Health to ensure the proper functioning of health services. The living and health conditions of Palestinian prisoners constituted a breach of international human rights law. Resolution of the health crisis, through support for health services and provision of humanitarian aid, was urgently needed. Algeria supported the draft decision.

Mr AHMAD (Pakistan) said that his Government was deeply concerned at the deteriorating health situation in the occupied Palestinian territories. Prolonged occupation and brutal use of force by the occupying Power – of which the wave of terror unleashed in the summer of 2014 was only one example – had wreaked devastation on the Palestinian people. Restrictions on the movement of patients, health personnel and goods had resulted in the denial of access to health care and inhibited the development of an adequate health system. The international community must not shy away from its responsibility to ensure that the basic human right to health was respected. While WHO's work was valuable, more needed to be done to stem a rapidly developing health crisis. WHO should increase its support to UNRWA and the Health Assembly should call for an end to the economic and political repression that continued to jeopardize Palestinians' access to health services. Pakistan fully supported the draft decision.

Mr HAMEDANI (Islamic Republic of Iran) said that the people in the occupied Palestinian territory, especially in the Gaza Strip, had for years been prevented from enjoying the highest attainable standard of health, which was their fundamental right. The world should not stand idly by as a whole population was deprived of its most basic needs. Collective action was needed to force Israel to lift the restrictions on Palestinians, including restrictions on access to medical services. WHO should systematically monitor the situation of Palestinian prisoners in Israeli jails and regularly report thereon to the Health Assembly. It was of serious concern that WHO still did not have access to the occupied Syrian Golan and thus could not report on the health situation there. As in previous years, his delegation had reservations about parts of the draft decision that might be construed as recognition of the Israeli regime.

Mr ROUSHDY (Egypt) said that the Secretariat's report had fallen short of its objective and failed to portray sufficiently the harsh reality of the deteriorating health conditions in Palestine. Moreover, the Secretariat should stop using outdated terminology that did not take account of recent developments concerning the status of Palestine in the United Nations, as reflected in United Nations General Assembly resolution 67/19. The Israeli occupation authorities must respect international human rights law and international humanitarian law, including the Geneva Convention relative to the Protection of Civilian Persons in Time of War, and ensure that people in urgent need of medical care, particularly pregnant women, were given prompt and unhindered access to the appropriate facilities. Egypt welcomed international efforts, including those of WHO, in support of better health conditions

in Palestine. Nevertheless, an immediate end to the Israeli occupation and the full materialization of Palestinian statehood were the only means by which a sustainable health system could be established.

Mr SASTRE (Bolivarian Republic of Venezuela), expressing support for the draft decision, said that WHO's Member States, under the Director-General's leadership, should do their utmost to ensure access to health care and respect for human rights in the occupied Palestinian territory and the occupied Syrian Golan. Israel must withdraw from the occupied territory; the apartheid to which the Palestinian people were subjected could no longer be ignored. The denial of the basic and universal right to health was unacceptable. His Government would firmly support any measures to end the occupation and resolve the grave problems resulting from the deterioration of health services.

Ms WANG Ying (China) said that the health conditions described in the Secretariat's report were worrying. China appreciated WHO's support for the establishment of a health system in the occupied Palestinian territory; it should pursue those efforts. Her Government had worked to improve health conditions in the region and encouraged all parties to take effective steps to that end. China emphasized the need for WHO to have access to the occupied Syrian Golan to enable it to evaluate health conditions.

Ms PÉREZ ÁLVAREZ (Cuba) said that the health situation in the occupied territories had worsened as a result of the aggressions of the occupying Power in 2014, which had further limited access to health services. Although, regrettably, WHO had not been able to gain access to the occupied Syrian Golan and thus had not been able to report on health conditions there, the Syrian authorities had submitted a report (document A68/INF./2) which revealed the gravity of the situation and underlined the need for urgent action by WHO. Cuba reaffirmed its strong support for the inalienable right of the Palestinian people to establish an independent State and demanded that Israel return all occupied territories. It supported the draft decision and called on other Member States to do the same.

Mr MULREAN (United States of America) said that, although the draft decision represented a changed approach from the draft resolutions proposed in previous years, it was not consistent with the shared objective of a Health Assembly focused purely on public health that refrained from singling out countries on a political basis. By requesting the Director-General to prepare a report for the Sixty-ninth World Health Assembly, the proposed decision perpetuated a politicized agenda. Moreover, it would not lead to improved health among Palestinians or help to make peace between Israelis and Palestinians. His Government remained concerned about conditions in the area, particularly in the Gaza Strip, and would continue to work with Israel, the Palestinians and others to advance the needs of the Palestinian people; it would also continue to support UNRWA. His delegation called for a vote on the draft decision, to which it was opposed.

Dr HAUFIKU (Namibia) said that the fact that the current item had become a standing item on the agenda of the Health Assembly underlined the ongoing nature of the violations of fundamental freedoms and human rights of the Palestinian people. Namibia appreciated the work of the Palestinian Ministry of Health, UNRWA and the International Red Cross and Red Crescent Movement to develop health care services and appealed to the international community to continue providing assistance. All parties concerned should implement the recommendations contained in the field assessment of health conditions in the occupied Palestinian territory mentioned in paragraph 15 of the Secretariat's report. The right to health was an inalienable human right, and the Palestinian people must not be denied it. Namibia supported the draft decision.

Mr EL SHEHABI (Bahrain), expressing deep concern at the deterioration in the health conditions in the occupied Palestinian territory, called on the Director-General to report further on the situation at the next Health Assembly. Her report should be based on a technical field assessment, which should focus, inter alia, on obstacles to the delivery of humanitarian aid, damage to medical

infrastructure, effects of prolonged occupation on mental health and progress achieved in implementing the recommendations contained in the WHO report *Right to health: crossing barriers to access health in the occupied Palestinian territory, 2013*.[1] WHO and other organizations should continue their efforts to meet the health needs of the Palestinian people, including prisoners and detainees. Bahrain supported the draft decision.

Ms PRETORIUS (South Africa) said that her Government remained concerned about the deteriorating health conditions in the occupied Palestinian territories. It was incomprehensible that basic principles of human rights and international humanitarian law were being ignored. South Africa called on WHO and the international community to continue to support the Palestinian people and on Israel to end all restrictions impeding the free movement of people and preventing them from accessing health services. The Health Assembly's resolution WHA65.9 must be implemented. Her Government supported the establishment of medical facilities and the provision of health-related technical assistance to the Syrian population in the occupied Syrian Golan. South Africa supported the draft decision.

Mr MANOR (Israel) said that the yearly ritual of singling out and shaming Israel diverted attention away from serious discussion of the health challenges facing the world. The Health Assembly should not be a forum for biased and discriminatory political discussions. It was a fact that 130 000 sick and wounded people from Gaza, the West Bank and east Jerusalem had received treatment in Israeli medical facilities in 2014, and an Israeli field hospital had provided medical assistance to 51 wounded civilians. More people could have been treated had Hamas and other terrorist organizations not bombed the area around the hospital. The Druze community in the Golan enjoyed a state-of-the-art medical system, unlike people on the other side of the border, where attacks on hospitals had killed more than 600 health professionals. He wondered why the Health Assembly engaged in a detailed discussion of the situation in the West Bank, the Gaza Strip and the Golan Heights but remained silent with regard to health conditions in Yemen, for example, which the International Committee of the Red Cross had characterized as a humanitarian catastrophe, or those in Libya. The present discussion was absurd and should not be repeated. He called for a vote on the decision and urged Member States to vote against it.

Ms MORENO (Ecuador) said that her delegation could not remain silent in the face of the flagrant violation of the right of the Palestinian people to enjoy the highest attainable standard of health. The restrictions on access to health services, especially as a result of the blockade on the Gaza Strip and the separation wall, were unacceptable. Ecuador strongly supported the draft decision and called on the Director-General to continue reporting on the critical health situation in the Palestinian territory. The Organization should continue to provide technical and financial support with a view to enhancing the response capacity of the Palestinian health sector and meeting the health needs of the Palestinian people, including political prisoners in Israeli prisons. The specific needs of the disabled deserved particular attention.

Mr LEWIS (Canada) said that his delegation remained concerned at the discussion of a political matter within the Health Assembly, a specialized body where there should be no room for politicization. As in previous years, the draft decision singled out only one side for criticism and called for a one-sided approach, which was inappropriate. Canada was therefore unable to support the draft decision.

Dr SAGUNI (Indonesia) expressed grave concern about the deteriorating health situation in the occupied Palestinian territories. He called upon all parties to tackle the issue as a matter of urgency

[1] See http://www.emro.who.int/images/stories/palestine/documents/who_-_rth_crossing_barriers_to_access_health.pdf?ua=1&ua=1.

and provide the necessary support, and urged WHO to expand the scope of its work in the occupied Palestinian territories. He fully supported the draft decision.

Dr ABDALLRAHIM ELFADUL (Sudan) said that unimpeded access to health services was a crucial component of the right to health. That right could not be ensured in the circumstances prevailing in the occupied territories. All members of the United Nations should be committed to helping people deprived of their rights to regain them. He called upon all Member States to support the draft decision.

Mr ARAFA (Lebanon) expressed deep concern at the actions of the occupying forces in the occupied territories, which had caused the suffering described in the field assessment mentioned in the Secretariat's report. He called upon the Director-General to present a report to the Sixty-ninth World Health Assembly and urged all countries to support the draft decision.

Ms ALI (Maldives) said that her Government remained concerned about the restrictions imposed on the movement of patients and health staff and the impediments to the development of the health system in the occupied Palestinian territories. It also noted with deep concern that restrictions on WHO's access to the occupied Syrian Golan prevented the Organization from providing a proper report on health conditions there. All such restrictions should be lifted. She commended the work of WHO to improve the health status of Palestinians and supported the draft decision.

Ms EL BERRAK (Morocco) also called for an end to all restrictions hindering the enjoyment of the fundamental right to health in the occupied Palestinian territories and the occupied Syrian Golan and urged WHO to take all necessary measures to guarantee that right. Morocco supported the draft decision.

Mr ALAKHDER (Libya) said that his Government shared the concerns of others regarding the deteriorating health conditions in the occupied Palestinian territories, particularly east Jerusalem, and the occupied Syrian Golan. At the least, the occupying forces should, as a matter of moral duty, treat the wounded. Acknowledging that Libya, too, had problems and required assistance, he urged Israel to put a stop to the further deterioration of conditions in the occupied territories. Libya supported the draft decision.

Ms KOCHLEF (Tunisia) deplored the restrictions on movement imposed by the occupying Power, the blockade on the Gaza Strip, the separation wall and the permit system impeding not only trade but also access to medical facilities in east Jerusalem, thereby denying the Palestinian people their right to adequate health care, in violation of international human rights instruments and international humanitarian law. She commended the support provided by WHO and other agencies to help to build the capacity of the Palestinian Ministry of Health and bolster its endeavours in such areas as noncommunicable diseases, poliomyelitis, rights of persons with disabilities, and nutrition. She called on WHO to pursue and intensify its efforts and endorsed the draft decision.

Dr GONZÁLEZ GONZÁLEZ (Nicaragua) said that the situation in the Palestinian territories was an emergency that had gone on for far too long. It was morally unacceptable that action had not been taken to remedy it. He urged all Member States to support the draft decision and called upon the Director-General to do everything possible to alleviate the suffering of the Palestinian people.

Mr TRAD (Saudi Arabia), expressing strong support for the draft decision, affirmed that health was a fundamental human right and that WHO had an essential responsibility to guarantee equal access for all to that right. The Secretariat's successive reports on health conditions in the occupied Arab territories attested to the persistent Israeli intransigence in response to all earlier resolutions and decisions. The regrettable outcome was that the inhabitants of those territories continued to be denied

their fundamental right of access to health care, which was unacceptable. He called on all Member States to endorse the draft decision.

Dr ABDALHADI (Kuwait) said that the worsening health conditions in Palestine were all too well known. The consequences of the situation, among them epidemic disease, had an adverse impact on all States in the region. Inasmuch as the right to health was an integral part of human rights and universally enshrined, the draft decision should likewise be universally supported. A WHO fact-finding mission to investigate the health conditions in Palestine was also imperative.

Dr TARAWNEH (Jordan) said that, by virtue of its closeness to the land and people of Palestine, Jordan was keenly aware of the pain and suffering endured by the Palestinian people as a result of the ongoing repression and its humanitarian and health consequences. Israeli military checkpoint procedures impeded access to vital health care for Palestinian citizens, including children, pregnant women and older persons, and likewise prevented health workers from performing their noble humanitarian mission. He called on all Member States to shoulder their responsibilities by adopting the draft decision.

Dr SEITA (Director of Health, UNRWA) said that circumstances in Gaza had been very difficult in 2014, owing to the outbreak of the fourth war in 10 years. Out of 20 UNRWA health centres, seven had been permanently closed and access to health services at the remaining 13 had been seriously affected. The situation in the West Bank remained volatile. Access to health care continued to be affected by checkpoints and other factors outlined in the Secretariat's report. UNRWA would continue striving to improve health services in the occupied Palestinian territory, working closely with the Palestinian Ministry of Health, WHO and other partners towards the achievement of universal health coverage. He thanked Member States for their continued support of the Agency's efforts and urged them to recognize the importance of political determinants of health among Palestinian refugees.

The CHAIRMAN said that Palestine had inadvertently been excluded from the list of sponsors of the draft decision and that Afghanistan, Bahrain, Congo, Croatia, Ecuador, Saudi Arabia, Syrian Arab Republic and United Arab Emirates had also become sponsors. At the request of the delegation of Israel, the Committee would proceed to a recorded vote on the draft decision.

Ms KURAL (Turkey) and Ms ALAKHDER (Libya) said that their countries also wished to be added to the list of sponsors.

At the invitation of the CHAIRMAN, Mr BURCI (Legal Counsel) explained that the vote would be taken by roll-call, the names of the Member States being called in the English alphabetical order, starting with Fiji, the letter F having been determined by lot. The Member States whose right to vote had been suspended by virtue of Article 7 of the Constitution, or which were not represented at the Health Assembly, and would therefore not participate in the vote were: Belize, Central African Republic, Comoros, Dominica, Guinea-Bissau, Guyana, Kyrgyzstan, Marshall Islands, Micronesia (Federated States of), Niue, Palau, Saint Lucia, Saint Vincent and the Grenadines, Somalia, and Ukraine.

The result of the vote was:

In favour: Afghanistan, Albania, Algeria, Angola, Argentina, Austria, Azerbaijan, Bahrain, Bangladesh, Belarus, Belgium, Benin, Bhutan, Bolivia (Plurinational State of), Bosnia and Herzegovina, Brazil, Brunei Darussalam, Bulgaria, Chile, China, Congo, Costa Rica, Croatia, Cuba, Cyprus, Czech Republic, Denmark, Dominican Republic, Ecuador, El Salvador, Egypt, Estonia, Finland, France, Germany, Greece, Guatemala, Hungary, Iceland, India, Indonesia, Iran (Islamic Republic of), Iraq, Ireland, Italy, Japan, Jordan, Kazakhstan, Kuwait, Latvia, Lebanon,

Liberia, Libya, Lithuania, Luxembourg, Malaysia, Maldives, Malta, Mauritania, Mauritius, Mexico, Monaco, Mongolia, Montenegro, Morocco, Namibia, Netherlands, Nicaragua, Nigeria, Norway, Oman, Pakistan, Panama, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Saudi Arabia, Senegal, Serbia, Singapore, Slovakia, Slovenia, South Africa, Spain, Sri Lanka, Sudan, Sweden, Switzerland, Syrian Arab Republic, Thailand, The former Yugoslav Republic of Macedonia, Tunisia, Turkey, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Uruguay, Venezuela (Bolivarian Republic of), Yemen.

Against: Australia, Canada, Israel, United States of America.

Abstaining: Armenia, Colombia, Fiji, New Zealand, Papua New Guinea, Paraguay.

Absent: Andorra, Antigua and Barbuda, Bahamas, Barbados, Botswana, Burkina Faso, Burundi, Cabo Verde, Cambodia, Cameroon, Chad, Cook Islands, Côte d'Ivoire, Democratic People's Republic of Korea, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Georgia, Ghana, Grenada, Guinea, Haiti, Honduras, Jamaica, Kenya, Kiribati, Lao People's Democratic Republic, Lesotho, Madagascar, Malawi, Mali, Mozambique, Myanmar, Nauru, Nepal, Niger, Rwanda, Saint Kitts and Nevis, Samoa, San Marino, Sao Tome and Principe, Seychelles, Sierra Leone, Solomon Islands, South Sudan, Suriname, Swaziland, Tajikistan, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Turkmenistan, Tuvalu, Uganda, United Republic of Tanzania, Uzbekistan, Vanuatu, Viet Nam, Zambia, Zimbabwe.

The draft decision was therefore approved by 104 votes to 4, with 6 abstentions.[1]

Mr JANSONS (Latvia), speaking on behalf of the European Union and in explanation of vote, said that the European Union was of the view that the Health Assembly should remain a technical body and that any decisions on health conditions in the occupied Palestinian territory and in the occupied Syrian Golan should focus on technical considerations and on the requests made of the Director-General. Against that background, the European Union had supported the decision.

The meeting rose at 17:25.

[1] Transmitted to the Health Assembly in the Committee's first report and adopted as decision WHA68(8).

SECOND MEETING

Thursday, 21 May 2015, at 09:25

Chairman: Mr M. MALABAG (Papua New Guinea)

1. FINANCIAL MATTERS: Item 21 of the Agenda

Financial report and audited financial statements for the year ended 31 December 2014: Item 21.1 of the Agenda (Documents A68/38, A68/57 and A68/INF./1)

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, reported on the Committee's discussion of the Director-General's financial report and the audited financial statements for the year ended 31 December 2014, as reflected in document A68/57. The Committee recommended, on behalf of the Executive Board, that the Health Assembly should adopt the draft resolution contained in paragraph 6 of that document, accepting the report and financial statements for the year ended 31 December 2014.

Dr JIDDOU (Mauritania), speaking on behalf of the Member States of the African Region, commended the conformity of the Organization's financial statements with the International Public Sector Accounting Standards (IPSAS), and the soundness of its financial situation, showing a surplus of US$ 313 million. He urged WHO to allocate further resources to countries in order to enhance their capacities in accordance with the targets under the reform. However, the predominance of earmarked voluntary contributions posed a problem. WHO should diversify its pool of donors, since a significant proportion of contributions derived from only 10 Member States. He expressed the hope that the flow of revenue, which had been modest in the period under consideration, to the Ebola outbreak response would not be interrupted and the goal of zero cases would be achieved. The recommendations of the Programme, Budget and Administration Committee, such as those concerning the increase in contractual services and the staff health insurance liability, should be put into effect. He supported the draft resolution.

Ms GARCIA ARREOLA (Mexico) welcomed the report and the conformity of the Organization's financial statements with IPSAS, and supported the draft resolution. She expressed concern that, despite efforts made in the area, disparities remained regarding the financing of the programming categories, expense planning and the allocation of resources. She urged the Organization to take all possible measures to ensure that staff health insurance liabilities were mitigated through effective management and synergies with other international organization health insurance regimes. In addition, she urged WHO to ensure compliance with IPSAS transitional provision standard No. 17 by the end of 2016.

Ms MATSOSO (South Africa) welcomed the report and the Organization's fulfilment of international standards. She highlighted the importance of achieving objectives, such as the tracking of inventory, and giving effect to the recommendations to transform the Global Management System and develop knowledge transfer strategies.

Ms HAN Jianli (China) welcomed the report and the positive comments of the External Auditor which underlined the Organization's compliance with international standards. She noted with

satisfaction that staff expenses had reached a record low level. While acknowledging efforts to economize, lessons should be learnt from the Ebola virus disease outbreak and the Organization's core capacities should not be compromised particularly when responding to public health emergencies. In order to channel funds more effectively, earmarked voluntary contributions should be aligned with WHO's priorities, and information on that alignment should be given in future financial reports. China contributed to the work of WHO to an extent far higher than the relative size of its gross domestic product, and it was to be hoped that the Secretariat could continue to improve its financial management so that WHO's output did not fall short of expectations.

Mr JEFFREYS (Comptroller) said that speakers' comments had been duly taken into consideration. As reflected in the financial report, most of the US$ 2.4 billion fund balance consisted of voluntary contributions, and most of those were earmarked. It was true that by 31 December 2014, no more than US$ 220 million had been raised for the Ebola virus disease outbreak, but it was important to note that since that date substantial additional funds had been raised for that purpose. The Organization was making efforts to ensure close cooperation and identify opportunities for harmonization with other agencies of the United Nations system regarding the staff health insurance liability, which represented a long-term financial risk for all agencies. In terms of personnel costs, while the Geneva headquarters constituted one of the most expensive locations of the Organization, it was also in Geneva that the most significant savings had been made.

The draft resolution was approved.[1]

Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution: Item 21.2 of the Agenda (Documents A68/39 and A68/58)

The CHAIRMAN said that the draft resolution contained in document A68/58 had been amended following payments made by South Sudan and Saint Lucia before the meeting of the Programme, Budget and Administration Committee concerning the status of collection of assessed contributions. South Sudan and Saint Lucia had therefore been removed from the list of Member States in arrears to an extent that would justify invoking Article 7 of the Constitution.

Ms MORENO (Ecuador) said that the budget was a complex matter for all concerned with strengthening the governance of the Organization. She was pleased to inform the Committee that Ecuador had paid its contributions. However, that payment had not been reflected in the latest report owing to a technical error and she requested that it be included in the revised version of the report.

The CHAIRMAN said that the Secretariat had noted the comments of the delegate of Ecuador.

The draft resolution, as amended, was approved.[2]

Scale of assessments for 2016–2017: Item 21.4 of the Agenda (Documents A68/40 and EB136/2015/REC/1, resolution EB136.R9)

Ms GARCIA ARREOLA (Mexico) supported the draft resolution contained in resolution EB136.R9, welcomed the fact that assessed contributions would be the same in the biennium 2016–2017 as in 2014–2015, and emphasized her country's commitment to working with the Organization towards the achievement of the targets set in the Programme budget 2016–2017. She recognized the

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA68.10.

[2] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA68.11.

need to ensure that sufficient resources were available for WHO to carry out its activities, but nevertheless reiterated the importance of savings and austerity measures, which would allow the resources from assessed contributions to be maintained at their current levels, and to be used strategically to fund programme areas, particularly those areas that tended to be underfinanced.

Ms MATSOSO (South Africa) expressed support for the draft resolution. She urged Member States to consider increasing assessed contributions, as even a marginal increase could have a significant impact and it was essential to ensure that programmes were fully funded. Her country would be donating US$ 1 million to demonstration projects, a sum that exceeded its increase in assessed contributions. In addition, it would contribute US$ 50 000 to the Alliance for Health Policy and Systems Research.

The CHAIRMAN expressed appreciation for South Africa's generosity.

The draft resolution was approved.[1]

2. FIRST REPORT OF COMMITTEE B (Document A68/66)

Dr FONES (Chile), Rapporteur, read out the draft first report of Committee B.

The report was adopted.[2]

3. AUDIT AND OVERSIGHT MATTERS: Item 22 of the Agenda

Report of the External Auditor: Item 22.1 of the Agenda (Documents A68/41, A68/59 and EBPBAC22/4)

The CHAIRMAN drew attention to the fact that the report by the Secretariat to the Programme, Budget and Administration Committee on external and internal audit recommendations: progress on implementation (document EBPBAC22/4), had been made available to the Health Assembly.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee had considered the report of the External Auditor and welcomed the recommendations on, inter alia, human resource management and the planned programme monitoring framework. The Committee recommended that the Health Assembly should adopt the draft resolution contained in paragraph 7 of document A68/59, accepting the report of the External Auditor.

Ms MENDOZA (External Auditor) introduced the report of the External Auditor (document A68/41). The audit of the Organization's financial statements and operations for 2014 had been carried out with a specific focus on programme, human resource and risk management, at headquarters, the Global Service Centre, two regional and two country offices and six non-consolidated entities, and it had resulted in the issuance of an unqualified audit opinion, and a

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA68.12.

[2] See page 367.

finding that accounting policies were applied on a basis consistent with that of the previous year. The report provided WHO's management with a set of 10 recommendations aimed at improving efficiency, transparency and accountability through the implementation of a centralized tracking tool for donor agreements; the introduction of global standard operating procedures to enhance inventory management and enforce compliance with direct financial cooperation requirements; the formalization of terms of reference for communication, facilitation, monitoring and evaluation mechanisms; and the development of a workforce planning model, to name but a few.

Dr McPHERSON (Lesotho), speaking on behalf of the Member States of the African Region, expressed appreciation for the report of the External Auditor and called for the effective implementation of the recommendations.

Ms HERNANDEZ NARVAEZ (Mexico) noted with satisfaction the unqualified audit opinion once again issued by the External Auditor. Also noting the recommendations aimed at improving the recording, processing and reporting of financial transactions and ensuring the fair presentation of the statements in the next reporting period, she urged the Secretariat to implement in particular those pertaining to, inter alia, the timely recording of cash and in-kind contributions, procedures for letters of agreement and direct financial cooperation, as well as the planned programme monitoring framework and performance assessment, which would support the adoption of appropriate decisions and enable lessons to be drawn from programme results.

The draft resolution was approved.[1]

Report of the Internal Auditor: Item 22.2 of the Agenda (Documents A68/42 and A68/60)

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, introduced the Committee's report on the item (document A68/60) and drew attention to its recommendation, on behalf of the Executive Board, that the Health Assembly should note the report of the Internal Auditor (document A68/42).

Mr DIKMEN (Turkey) noted some of the signs of positive change in the Internal Auditor's report in regard to, inter alia, strengthening of the internal control framework, operational effectiveness and the implementation of recommendations. Significant steps should be taken to improve organizational coherence, transparency, accountability and the control of direct financial cooperation.

Dr BRYANT (Australia), expressing concern about the number of audit findings deemed unsatisfactory or partially satisfactory, welcomed the commitment shown recently by the Director-General and regional directors to improving compliance with financial controls and the implementation of audit recommendations at every level. Australia looked forward to a culture of routine compliance within the Organization.

Dr DIARRA (Mali), speaking on behalf of the Member States of the African Region, endorsed the report of the Internal Auditor. In view of the significant deficiencies identified in major process areas such as direct financial cooperation, services procurement and fixed assets, he called on the Secretariat and Member States to strive to improve support to countries by strengthening the capacity and internal controls of country offices.

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA68.13.

Dr HOLM (Sweden), speaking on behalf of the Nordic countries Denmark, Iceland, Norway and Sweden, expressed serious concerns about the findings in the report of the Internal Auditor regarding, among other things, the continuing weaknesses in the internal control environment, the unacceptably risky incidences of financial and other misconduct, especially at the country offices, and unsatisfactory control processes for direct financial cooperation that were therefore incapable of mitigating the risks. Requesting more information on WHO's actions to improve the situation at the country level, he called for the strengthening and effective implementation of preventive controls; for compliance with the WHO internal control framework to be incorporated, with associated sanctions, into the performance management system; and for the lessons learnt from individual audits to be handled from an Organization-wide rather than a case-by-case perspective. A systemic response was needed to match with action the Director-General's strong words on zero tolerance for non-compliance.

Mr KUEMMEL (Germany), aligning himself with the statement made by the delegate of Sweden, expressed concern regarding unsatisfactory internal controls resulting from a lack of knowledge and implementation and the culture of non-compliance. Noting that such issues had arisen in several audits, he welcomed WHO's new policy on direct financial cooperation, and said that the Secretariat and Member States had a shared responsibility to act to improve the situation. He said that there could be merit in using external partners for post-implementation assurance activities. He asked the Secretariat to provide more information on potential trends in individual wrongdoings, and expressed concern regarding the perceived culture of tolerance for non-compliance. Welcome progress had been made in the quality of oversight executed by the governing bodies and the Secretariat's transparency regarding internal control deficits, and he noted the recognition by senior management that further improvements to internal controls were required. Establishing the necessary culture of compliance would require time and sustainable political pressure.

Dr HINOSHITA (Japan), welcoming the report of the Internal Auditor, noted that the Secretariat had been reporting conscientiously on the progress of its governance process. Japan considered that an independent evaluation of that reform process was necessary to maximize the effectiveness of audits being carried out with limited financial and human resources.

Ms BLACKWOOD (United States of America) noted the Internal Auditor's disturbing findings on audits and investigations, but welcomed WHO's commitment to addressing those issues systematically and building a culture of no tolerance for non-compliance at all levels. She acknowledged progress towards improved internal accountability, the revised accountability framework, risk management framework, and a procurement strategy. As Member States had decided to increase the resources they provided to WHO, real progress had to be made in the control environment.

Ms HERNANDEZ NARVAEZ (Mexico) said that the results contained in the report supported Member States in their oversight responsibilities, which were shared with the Secretariat. Expressing concern regarding direct financial cooperation, she suggested that the shortcomings arose from a lack of understanding of roles and responsibilities and inadequate monitoring and evaluation mechanisms. She supported steps to clarify the conditions governing the use of direct financial cooperation, harmonize implementation processes, and enforce sanctions for non-compliance. She also expressed concern regarding weak or non-existent mechanisms to identify conflicts of interest, and urged the establishment of transparent processes for selecting service providers. The 100% increase in the number of cases of fraud, irregularities, corruption or harassment could be a result of a growing culture of no tolerance for wrongdoing, and a greater readiness to report it. She encouraged further measures to speed up the implementation of recommendations, and asked for additional information regarding outstanding audit recommendations, and whether they related to the Roll Back Malaria Partnership. She supported the draft decision.

Mrs SHIPTON-YATES (United Kingdom of Great Britain and Northern Ireland) emphasized the importance of a culture of control and oversight, and welcomed the plan to strengthen the human resources capacity of the Office of Internal Oversight Services, which would facilitate accountability, financial management and efficiency, and creation of a culture of compliance, all of which became more important in the light of the budget increase agreed on the previous day. WHO's initiative to implement a secure web-based platform for Member States' remote access to internal audit reports would further increase transparency. Considering the persistent systematic weaknesses identified in the report, such as fraud, she asked what steps the Secretariat was taking to learn lessons and develop a strategic response. She agreed with the recommendation to link compliance with individual performance evaluation, which would ensure accountability for delegated authority. Noting with concern that 73% of country office audits had found unsatisfactory issues relating to direct financial cooperation, she asked how the Secretariat was planning to address that problem, given the potential usefulness of the mechanism.

Ms HAN Jianli (China) noted that audits had been carried out at the Global Service Centre and regional and country offices, and welcomed the suggestions and recommendations. She drew attention to those audit recommendations that remained outstanding, and encouraged their implementation. Due attention should be given to fraud and other similar issues, and ethics should be included in staff development plans and training in order to enhance staff awareness of compliance.

Ms JAKAB (Regional Director for Europe) assured the Committee that accountability was a serious issue within good governance, and that the Regional Committee for Europe would consider the implementation of audit recommendations at the Regional Office for Europe and country offices. The Regional Office had created a compliance unit with responsibility for reviewing financial compliance, assisting in staff training, and providing advice on financial and administrative matters. Monthly management reports containing information on finance, human resources, programme implementation and procurement were produced, and discussed by the newly formed management group of directors and senior staff members. Extensive oversight reports were submitted to the Regional Committee's Standing Committee five times per year, and key issues were discussed with Member States to strengthen national oversight functions. The use of compliance checks had been expanded to non-staff contracts, which were a source of potential reputational risks. Audit recommendations were strictly monitored, and as a result, the Region had no audit observations outstanding. A responsibility matrix had been developed, clarifying roles and responsibilities of the Regional Office and the country offices. That would be introduced in the Regional Office, and would include a new template for the delegation of authority. Other future steps would include linking compliance with audit recommendations and financial rules, working to implement the risk register, and strengthening administrative capacity in country offices by recruiting administrative officers. She would work with other regional directors and colleagues to increase standardization of compliance across the Organization.

Dr ALWAN (Regional Director for the Eastern Mediterranean) reiterated his commitment to improving compliance and, while recognizing the need to address ongoing gaps, noted that progress made over the previous three years had been documented in the report of the Internal Auditor. Good practice in the Region had been recognized and could be shared with other parts of WHO. The Region's compliance and risk management mechanism had been presented to the Programme, Budget and Administration Committee in 2014, and had since been complemented with a training and capacity-building programme for Member States.

Direct financial cooperation was an area of concern, and had been an area of priority. A compliance dashboard, which was monitored monthly, had been developed; and compliance in direct financial cooperation was included in performance appraisals of WHO Representatives and some managers. The Regional Office had achieved direct implementation of control activities in a number of countries without direct financial cooperation. There was also a new policy that no new direct

financial cooperation activities would be approved in countries with outstanding reports. Moreover, as responsibility for direct financial cooperation was shared between Member States and the Secretariat, the Regional Office was working with health ministers and other partners to improve compliance. The number of direct financial cooperation agreements had decreased from 500 to 100 in 2014. Steps had been taken to strengthen country offices, including the appointment of WHO Representatives in some countries, provision of training for WHO Representatives, directors and budget-centre managers, and the introduction of the aforementioned compliance dashboard.

Dr MOETI (Regional Director for Africa), taking note of concerns expressed by Member States, assured the Committee that steps were being taken in the African Region to address systemic weaknesses in internal controls through building staff awareness and capacity, and providing tools to monitor and track targeted interventions. In collaboration with the Office of Compliance, Risk Management and Ethics, the Regional Office for Africa had reviewed its compliance and quality control functions, and was the first regional office to establish a compliance unit. However, the optimum performance of those functions had to be ensured, and a balance found between prevention and detection, as well as considering the use of sanctions in cases of non-compliance.

Recognizing concerns over direct financial cooperation, the Regional Office had increased dialogue with Member States on outstanding reports in order to continue the current positive trend, and no new agreements were being approved in countries with outstanding reports, except in emergency situations. A website had been developed to raise staff awareness and provide access to reports and business intelligence, and key performance indicators for budget centres were being finalized and linked to staff and manager performance. Nine international operations officers had been recruited for country offices in order to improve compliance capacity, and mandatory training had been introduced for staff in procurement units. The Regional Office had issued a Request for Proposals for an independent review of its business processes and functional structures.

Dr KHETRAPAL SINGH (Regional Director for South-East Asia) reiterated the high priority accorded to compliance, consideration of audit reports and implementation of audit recommendations. Half the country offices in the South-East Asia Region had been audited, and the rest of the audits were planned for 2015; and visits had been carried out to two countries in collaboration with the Office of Compliance, Risk Management and Ethics. Dashboards implemented in 2014 provided country and regional managers with information relating to implementation, compliance and follow-up, but those dashboards would be further developed to include elements on leave, absence, travel and procurement. Risk registers, created in 2014 and introduced in country offices and the Regional Office, provided a baseline for regional risks and the approaches used to mitigate those risks. The internal control framework had been examined carefully, and the managers' guide and self-assessment checklist had been distributed.

In addition, compliance in direct financial cooperation had been closely monitored to ensure timely submission of reports, and partners with overdue reports were suspended. Agreements for Performance of Work were being monitored, with specific focus on compliance with applicable rules, procedures, and value-for-money mechanisms. Managerial reform, including accountability of senior management in compliance and internal control, remained a regional priority.

Dr SHIN Young-soo (Regional Director for the Western Pacific) echoed the comments made by other regional directors regarding WHO's commitment to improving compliance. The Global Policy Group met regularly to discuss the Organization and how it could perform better in the WHO reform context, discussing internal compliance activities and planned improvements. As one result of those deliberations, each Region had created a focal point to manage direct financial cooperation and appointed a compliance officer. In the Western Pacific Region, the management of direct financial cooperation was strict; overdue reports had been reduced by 50%, and the aim was to eliminate them within two years. Closer relationships between the Regional Office and country offices were being

developed through face-to-face meetings and video conferences, used as opportunities to discuss how to improve management and programme implementation.

Dr ETIENNE (Regional Director for the Americas) explained that the Region of the Americas had an independent audit mechanism, consisting of an internal audit, an external audit and an audit committee. The internal audit involved some 12 audits every year, conducted on site at country offices, covering an average of six countries each year. No country waited longer than five years to be audited. Depending on the resources available, audits were sometimes conducted three times a year, for example, in Brazil, or annually in the case of Columbia. The executive management, the internal auditor and regional managers met every six months to review the audit recommendations and explore ways of institutionalizing mechanisms to improve the Region's compliance record, which was already quite satisfactory. During the past biennium, progress had been made in closing direct financial cooperation agreements. The Regional Office pursued a policy of zero tolerance for fraud; and compliance and accountability were discussed at annual subregional and global meetings. The agenda of the forthcoming Executive Committee meeting included the reports of the external and internal auditors and the audit committee, which were available for inspection by Member States.

Mr WEBB (Office of Internal Oversight Services), responding to points raised, concurred with the suggestion that the increase in the number of reports of suspected wrongdoing was in part the result of a more encouraging attitude towards whistleblowing within the Organization, and the referral of more cases by management for independent investigation. Most of the outstanding matters from previous audits were in the process of being resolved, through implementation of recommendations, and in the specific case of the Roll Back Malaria Partnership information from the Secretariat indicated that the matter should soon be closed. The question of direct financial cooperation was a shared responsibility; he reminded Member States of their role in providing feedback on how funds had been implemented. Various new initiatives had been mentioned that should play a critical role in improving the internal control environment and the Secretariat would continue to monitor and report on the progress made in implementing them.

Dr TROEDSSON (Assistant Director-General) said the Secretariat shared the concerns that had been raised and was committed to pursuing a policy of no tolerance for non-compliance. However, the detection of irregularities should be seen as a sign that control mechanisms, such as the internal and external audits and the Independent Expert Oversight Advisory Committee, were working. He recognized the need to increase transparency and was confident that, in future, cases of fraud would be more effectively dealt with through the new policy on whistleblowing and the external hotline. A Department of Compliance, Risk Management and Ethics had been established in headquarters and all new WHO Representatives and headquarters staff members received training in ethics as part of the induction process. A new ethics code was being drawn up. At regional level, there were compliance units in all the regional offices.

The upgrading of the Global Management System and a new procurement strategy should help to strengthen controls and accountability throughout the Organization. The information provided to the Committee on direct financial cooperation was no longer up to date: the number of overdue reports had been reduced by 60%. A more systematic approach was being pursued to address recurring issues, such as direct financial cooperation, which had been mentioned in almost every audit report. The numerous initiatives being undertaken in the context of WHO reform needed to be analysed in order to gauge their effectiveness and compatibility, as well as their impact on the workload of staff members. The Director-General had made it clear that sanctions would be imposed for repeated wrongdoing, with dismissal the ultimate option.

Improvement would take time, but senior management was committed to achieving it.

The Committee noted the report.

4. HEALTH SYSTEMS: Item 17 of the Agenda [Transferred from Committee A][1]

Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage: Item 17.1 of the Agenda (Documents A68/31 and EB136/2015/REC/1, resolution EB136.R7)

Dr KASONDE (Zambia), speaking on behalf of the Member States of the African Region, drew attention to the lack of life-saving surgical and anaesthesia services, as well as institutional capacity, in many parts of the world, at a time when noncommunicable diseases, frequently needing such services, were becoming more prevalent. He urged WHO and the global community to recognize surgery and anaesthesia as key components of primary health care and part of the essential health package under universal health coverage; to recognize the potential positive impact of improved provision of safe essential and emergency surgical and anaesthesia services at district hospital level on poverty reduction, economic development and job creation; and to adopt the draft resolution contained in resolution EB136.R7. He urged those countries that were attracting away medical staff trained at developing countries' expense to consider supporting training institutions in the Region. He called on the Director-General to strengthen the existing essential and emergency surgery and anaesthesia programme and to take advantage of existing innovative training mechanisms in the African Region.

Dr LUONG NGOC KHUE (Viet Nam) said that 20% to 25% of all inpatient visits in Viet Nam required emergency surgical care and anaesthesia. Recently, the focus had been on transferring medical technologies from higher to lower hospital levels in order to broaden access to medical services. However, capacity, in terms of human resources, consultants and medical equipment, varied among hospitals. He supported the draft resolution, but requested more guidance on minimum quality standards and the accreditation of operating theatres in district and provincial hospitals.

Dr FORSTER (Namibia) observed that conditions requiring surgery often went untreated or received inadequate treatment, resulting in unnecessary complications, greater morbidity and higher mortality. Hence, the strengthening of emergency and essential surgical care needed to be placed higher on the agenda. Further, capacity-building of human resources in that area was pivotal. Ready availability of anaesthetic agents facilitated the timely provision of surgical care, especially in remote and rural settings. The logistical resources of emergency and essential surgical care services needed to be enhanced in order to reach communities in a timely manner. In strengthening such services certain fundamental principles needed to be upheld, such as the provision of emergency care within the "golden hour", and reliable referral of patients as soon as indicated. At the same time, it was important to remember that primary prevention of many conditions requiring surgery was possible, and that aspect should be pursued also. It was unacceptable that 2000 million people in the world should lack access to basic essential surgical care and safe anaesthesia, and he therefore called for the adoption of the draft resolution.

Dr HINOSHITA (Japan) said that, in order to ensure universal access to essential surgical care and anaesthesia, it would first be necessary to establish referral systems and strengthen health systems, including through human resources development, in accordance with countries' particular priorities. As mentioned in the draft resolution, Member States and the Secretariat should collaborate with the United Nations Office on Drugs and Crime and the International Narcotics Control Board to ensure that essential surgical care and anaesthesia were available to all. He supported the draft resolution.

[1] See the summary record of the General Committee, first meeting, section 2.

Professor OGENDO (Kenya) said that the greatest need for surgical care and anaesthesia was currently in low- and middle-income countries, and particularly in most parts of Africa. Investing in surgical services in low- and middle-income countries was affordable and would create jobs, alleviate poverty and improve the economy. Shortcomings in the delivery of surgical care and anaesthesia in such regions included limited access to anaesthetic equipment and medicines, and lack of skilled personnel. He called on Member States to pursue the recommended actions contained in the report.

Dr GNASSINGBE (Togo), noting the strategies put forward by the Secretariat to strengthen surgical care, particularly at the level of district hospitals, said that the availability of affordable medicines for surgical procedures remained a challenge to be overcome in order to meet the objective of universal health coverage. He expressed support for the draft resolution.

Dr JON Sang Chol (Democratic People's Republic of Korea), speaking on behalf of the Member States of the South-East Asia Region, said that the Region endorsed the draft resolution. However, while the proposed action of improving workforce distribution with a focus on rural areas was welcome, human resource distribution varied from country to country and any action would need to be country-specific. As there were shortages of health workers in rural and remote areas, one of the policy choices could be for patients to undergo elective surgery performed by visiting surgeons and anaesthetists at community hospitals, rather than be referred to regional or general hospitals. Member States, the Secretariat and partners should support local surgical training. Pre-hospital care, first aid management by primary health care centres and effective ambulance services were essential for patients requiring emergency surgery. The use of telemedicine should be encouraged, as it linked primary health care with secondary and tertiary hospitals, and could be cost-effective in low- and middle-income countries. Some surgical and anaesthetic skills should also be shared with other health workers.

Mr CONSTANT (Trinidad and Tobago) commended the Director-General and participants in the WHO Programme for Emergency and Essential Surgical Care on their continued advocacy and work, and underlined the commitment of his country to improving such surgical services. Trinidad and Tobago had hosted two global conferences on the issue, was part of the WHO High 5s Project and had implemented the related operating protocol. WHO should demonstrate strong leadership in addressing the barriers to the delivery of essential surgical services, such as the perception of surgery as resource-intensive and costly, and infrastructure and human resource capacity deficiencies. Strengthening the delivery of essential surgical services at primary care level should be prioritized to reduce death and disability, and as an integral part of achieving universal health coverage. He supported the draft resolution.

Ms UNTERNAEHRER (Switzerland) said that the concept of access to care should serve as a guiding principle when making future decisions on the international control of medicines, in accordance with the Convention on Psychotropic Substances, 1971. Placing ketamine under international control would equate to disregarding the use of the substance for medical purposes and the consequent need for it to be available, including in humanitarian situations. Her country was a cosponsor of the draft resolution.

Mr LEWIS (Canada), expressing support for the expansion of access to emergency and essential surgical services where needed, noted that some level of balance was needed, as such action in certain areas could be cost-prohibitive. For example, in Canada, transportation to and from urban health care centres was usually more cost-effective than providing continuous service in remote regions. It was paramount that programmes to improve access to surgical care be adapted to the specific needs and contexts of each country. The need for task shifting to primary care should only be underscored for countries with a very limited surgical health workforce. As some conditions requiring surgery were

completely avoidable through the management of risk factors, emphasis should be placed on prevention. He supported the draft resolution.

Dr ISMAIL (Malaysia) commended the Secretariat on completing the WHO Integrated Management for Emergency and Essential Surgical Care e-learning toolkit and the 23 country assessments. He acknowledged the gaps identified and actions needed by Member States and said that his Government would strive to improve the standard of care at all levels, particularly in district hospitals through, inter alia, the networking of surgical, emergency and anaesthesia services, creation of mobile surgical teams and strengthening of delivery through regular training and improved equipment availability. It had been implementing indicators and targets on the issue since 2009 to monitor progress. He supported the draft resolution.

Dr AL THANI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, encouraged the Secretariat and Member States to work together to address the inadequate level of surgical and anaesthesia care in secondary care hospitals in many countries. Member States should demonstrate greater commitment and allocate more resources to strengthen those services in district and secondary care hospitals, for example, deploying qualified staff to perform surgical and anaesthesia-related procedures, and ensuring the availability of well-functioning equipment. WHO should further intensify its technical support by promoting low-cost yet reliable medical devices, developing training programmes particularly for anaesthetists and anaesthetic technicians, and building local capacity in health technology management.

Professor BAGGOLEY (Australia) stressed that access to essential surgical care and anaesthesia should be supported by a strong health workforce with appropriate training, including in rural and remote areas. That issue was particularly relevant in Australia where the provision of health services in such locations was an ongoing challenge. Collection and sharing of basic surgical procedure data was vital to improving patient care. Australia wished to cosponsor the draft resolution.

Mr CRUZ (Philippines), expressing support for the draft resolution, said that providing access to essential surgical and anaesthesia services was crucial to ensure the delivery of appropriate and timely care to those who needed it. That would entail providing skilled and sufficient medical human resources; drugs and other supplies; appropriate equipment, infrastructure, transportation and communication, and health care financing through improved insurance benefits, particularly for disadvantaged and poor families.

Ms MARTONE (United States of America), announcing that her country was pleased to cosponsor the draft resolution, said that access to essential and emergency surgery and anaesthesia was a critical component of comprehensive health care. She drew attention to the importance of preventing surgical site infections, particularly given the spread of antimicrobial resistance. The draft resolution highlighted the urgent need to strengthen infection control, disinfection and sterilization of medical devices, and the judicious use of antimicrobial prophylaxis.

Dr LIMPANYALERS (Thailand) endorsed the proposals regarding the performance of elective surgery at community hospitals rather than referring patients to tertiary care hospitals, and the use of telemedicine to reduce costs. Both approaches had already been successfully applied in Thailand and his country was willing to share its experience. The proposal to share some surgical and anaesthetic skills with other health workers was welcome. In Thailand, resources were shared between tertiary-care hospitals and community hospitals. He supported the draft resolution.

Mrs VALLINI (Brazil) welcomed the work by PAHO and WHO to support the countries of Latin America and the Caribbean in implementing evidence-based practices aimed at guaranteeing safety and quality services for patients. Reduction of maternal and infant mortality and morbidity was

particularly important and promoting access and improving surgical services helped prevent obstetric and perinatal complications. Regarding caesarean sections, Brazil was working hard to ensure that such deliveries were carried out only on women who were fully informed and only where there was a finding of public health necessity. Inadvisable surgical interventions and unnecessary risks could be avoided if combined efforts were made to guarantee maternal and infant health. She supported the draft resolution.

Ms MORENO (Ecuador) said that the right to health, health care access and universal health coverage were priorities in Ecuador's national health care reform. Ensuring the right to health should take into account principles such as equality, solidarity and universality. Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage was a complex issue and Ecuador was taking measures to ensure provision of such services, including investment in infrastructure, medicines and medical supplies, and especially in human resources. Her country was committed to working with the Secretariat and other Member States to ensure universal health coverage, and supported the draft resolution.

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

The meeting rose at 12:10.

THIRD MEETING

Thursday, 21 May 2015, at 14:40

Chairman: Dr R. BUSUTTIL (Malta)

AUDIT AND OVERSIGHT MATTERS: Item 22 of the Agenda (continued)

Appointment of the External Auditor: Item 22.3 of the Agenda (Document A68/43)

The CHAIRMAN said that the four countries that had nominated candidates to be considered for the position of External Auditor were, in alphabetical order, Canada, Pakistan, the Philippines and Sierra Leone. He invited the candidates to make their personal presentations to the Committee, which should be limited to a maximum of 15 minutes, following which a vote would be taken by secret ballot.

Ms McMAHON (Canada), on behalf of the Office of the Auditor General of Canada, said that the Office had close to 140 years' experience as the legislative auditor of Canada, promoting effective governance in the federal public sector, as well as more than 60 years' experience of working with international organizations, including ILO, UNESCO, ICAO and IAEA. It had chaired the United Nations Panel of External Auditors since January 2014 and had also been an active member of the United Nations Board of Auditors, the International Organization of Supreme Audit Institutions and the International Public Sector Accounting Standards Board. The Office was therefore fully qualified to provide the senior management of WHO with independent, objective and reliable financial and auditing information.

If appointed as External Auditor, the Office would put together an audit team comprising highly qualified auditors who were fluent in English and French and proficient in Chinese, Italian and Spanish, and would work closely with the current External Auditor, the Internal Auditor, WHO's senior management, the Independent Expert Oversight Advisory Committee and the World Health Assembly to ensure a seamless transition. In addition, it would identify the main issues and challenges facing the Organization and would carry out a thorough risk assessment of the Organization's diverse activities and operations, which would form the basis for its audit work.

The proposal represented good value for money; the Office was sensitive to the cost management pressures faced by WHO and its fees for the first year would not include the cost of documenting financial systems and tailoring audit software to the Organization's needs. In consultation with management, the Office would travel to WHO regional and subregional offices to carry out work as needed. The Office's auditors were adept at working in multicultural settings and understood the control procedures necessary for the effective management of large organizations with decentralized operations.

Mr JEHANGIR (Pakistan), on behalf of the Auditor General of Pakistan, said that the latter was appointed under Article 168 of the Constitution to head the supreme audit institution of the country, an institution with more than 4000 employees. The independence of the Auditor General was guaranteed by the Constitution and he enjoyed security of tenure. The Auditor General's Department had proved to be an effective tool for promoting transparency, accountability and good governance in the public sector. In recent years, a project to improve financial reporting standards funded by the World Bank had enabled the Department to align its functions and procedures with the most up-to-date international practices. As a knowledge-based institution, the Department's most valuable asset was its

pool of more than 800 officers whose competencies were regularly updated through continuous training programmes. The Department's comprehensive auditing skills included competence to operate state-of-the-art Enterprise Resource Planning systems.

The Auditor General had a wealth of international experience: he sat on the Governing Board of the International Organization of Supreme Audit Institutions and served as Secretary General of the Economic Co-operation Organization Supreme Audit Institutions. His Department had also been represented on the United Nations Board of Auditors from 1961 to 1974 and had many years' experience of auditing bodies both within and outside the United Nations system, such as UNIDO, the South-Asian Association for Regional Cooperation and the Organisation for the Prohibition of Chemical Weapons. It had thus acquired a working knowledge of the financial environment of the United Nations system. Moreover, it delivered a range of financial management courses to improve auditing skills in many developing countries.

If appointed to act as External Auditor, the Department's first task would be to identify high-risk areas and assess WHO's compliance and control mechanisms. A total of more than 50 staff members, divided into 19 teams, would be deployed to carry out WHO audits and would be subject to quality assurance supervision. They would use a toolkit developed for use at UNIDO in order to standardize procedures throughout all WHO bodies.

Ms MENDOZA (Philippines), on behalf of the Philippines Commission on Audit, said that the Commission had served as External Auditor of WHO since July 2012 with integrity, technical competence and professionalism. The request for renewal of its term of office for a further four years was in line with WHO's Financial Regulations as well as with past practice, since the terms of office of previous External Auditors had been renewed in the interests of international courtesy. The Commission had delivered value for money, and its proposed audit fees for the period 2016–2019 were the lowest of the four candidates. It had conducted audits not only at WHO headquarters but in the country and regional offices, and the commitment, professionalism and work ethic of its auditors had been reflected in the three long-form reports it had delivered thus far, which had met the Organization's expectations.

The Commission's audit milestones included assistance to WHO in the successful implementation of the International Public Sector Accounting Standards (IPSAS), resulting in enhanced financial stewardship and certification of the first IPSAS-compliant financial statements, and the recommendation of measures to strengthen accountability and transparency and to improve systems and processes for efficient and effective operations. Apart from having performed an operations review and value-for-money audit in critical areas of WHO, such as programme/project management, results-based management and governance, the Commission would be remembered for the development of the global management inventory system, enhancement of the emergency response framework, enhancement of programme management reporting under the results-based management system, and implementation and maintenance of the global tracking system. It had provided independent assurance to Member States on governance as well as financial aspects of the Organization. Its cross-cutting mandate had also covered asset, inventory, procurement and human resource management, and regional and country operations.

Renewing the Commission's term of office would mean leveraging its extensive knowledge and understanding of WHO business. A flat learning curve meant that resources would be focused on what mattered most, and more efficient and effective audits, while continuity in approach and consistency in delivery meant value for money for the Organization.

The Commission was governed by a code of professional and ethical standards and had extensive experience, summarized in Annex 4 to document A68/43, of auditing United Nations bodies and other international organizations.

Mr MOMOH (Sierra Leone), on behalf of Ms L. Taylor-Pearce, Auditor General of Sierra Leone, said that, uniquely, Sierra Leone's Audit Service had conducted a real-time audit of the funds donated by citizens to support the Government in its recent efforts to combat the Ebola virus disease. The report resulting from that exercise had received both national and international recognition.

The Audit Service, Sierra Leone's supreme audit institution, was financially independent of central government, in line with the Lima Declaration of Guidelines on Auditing Precepts. It was expanding its work in various sectors of auditing, as well as looking to the future. Ms Pearce had joined the Audit Service as a Deputy Auditor General and had 20 years' professional experience in various institutions, including the Ministry of Finance and Economic Development of Sierra Leone. She had trained with accountancy firm KPMG and was a Fellow of the Association of Chartered Certified Accountants. She was currently the chairperson of the African Organization of Supreme Audit Institutions and had been involved in many development initiatives of the International Organization of Supreme Audit Institutions, as a facilitator and in other capacities. Her audit plan was simple: a team of auditors with a range of skills and backgrounds had been assembled, and would work to add value to WHO. The team's members had been involved in audits of various donor-funded agencies and projects, and some of them had also been involved in complex domestic and international audits. The team's approach would be risk-based and would comply with international auditing standards. The team would work within the agreed budget and time frame, without obstructing WHO's operations. It would make judicious recommendations and would contribute to improving WHO's efficiency.

The CHAIRMAN, in accordance with Rule 78 of the Rules of Procedure of the World Health Assembly, invited the Committee to proceed to a secret ballot to appoint the External Auditor. He proposed that, in order to save time, the Secretariat should pass around the room with ballot boxes to collect the ballot papers, rather than delegations being called to the front of the room to cast their ballots.

It was so agreed.

Ms Stiegler (Austria) and Dr Warisa Panichkriangkrai (Thailand) were appointed as tellers.

Mr BURCI (Legal Counsel) said that ballot papers would be distributed only to delegations represented at the Health Assembly and entitled to vote. Those Member States not represented at the current Health Assembly were Belize, Dominica, Guyana, Marshall Islands, Micronesia (Federated States of), Niue, Palau, Saint Lucia, and Saint Vincent and the Grenadines. Those whose voting rights had been suspended under Article 7 of the WHO Constitution were Central African Republic, Comoros, Guinea-Bissau, Kyrgyzstan, Somalia and Ukraine.

A vote was taken by secret ballot.

The result of the secret ballot was as follows:

Members entitled to vote	179
Members absent	61
Abstentions	0
Papers null and void	0
Members present and voting	118
Canada	42
Pakistan	29
Philippines	35
Sierra Leone	12
Number required for a simple majority	60

The CHAIRMAN said that, as no candidate had obtained the required majority, a second ballot would be held. It would be restricted to the three candidates who had obtained the largest number of votes in the first ballot: those nominated by Canada, Pakistan and the Philippines.

Mr BURCI (Legal Counsel) repeated the names of those Member States whose voting rights had been suspended or that were not represented at the current Health Assembly.

A second vote was taken by secret ballot.

The result of the secret ballot was as follows:

Members entitled to vote	179
Members absent	63
Abstentions	2
Papers null and void	0
Members present and voting	114
Canada	46
Pakistan	30
Philippines	38
Number required for a simple majority	58

The CHAIRMAN said that, as no candidate had obtained the required majority, a third ballot would be held. It would be restricted to the two candidates who had obtained the largest number of votes in the second ballot: those nominated by Canada and the Philippines.

Mr BURCI (Legal Counsel) repeated the names of those Member States whose voting rights had been suspended or that were not represented at the current Health Assembly.

A third vote was taken by secret ballot.

The result of the secret ballot was as follows:

Members entitled to vote	179
Members absent	64
Abstentions	2
Papers null and void	1
Members present and voting	112
Canada	50
Philippines	62
Number required for a simple majority	57

Having obtained the required majority, the Philippines' candidate for the position of External Auditor was elected.

The draft resolution contained in paragraph 6 of document A68/43, completed in accordance with the result of the secret ballot, was approved.[1]

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA68.14.

Mr TALISAYON (Philippines) thanked Member States for their support and continued trust in the Philippine Commission on Audit. The Commission would continue its work to promote transparency, good governance and accountability in financial reporting at all levels of WHO. Member States could be assured of the commitment and dedication of the Philippines and the professional and prompt delivery of audit services to the highest international standards.

The meeting rose at 17:15.

FOURTH MEETING

Friday, 22 May 2015, at 09:45

Chairman: Dr R. BUSUTTIL (Malta)

1. SECOND REPORT OF COMMITTEE B (Document A68/68)

Dr FONES (Chile), Rapporteur, read out the draft second report of Committee B.

The CHAIRMAN informed the Committee that a payment had been received from Haiti in respect of its assessed contribution; however, no change would be made to the resolution on the status of collection of assessed contributions as it had already been adopted.

The report was adopted.[1]

2. HEALTH SYSTEMS: Item 17 of the Agenda (continued) [Transferred from Committee A][2]

Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage: Item 17.1 of the Agenda (Documents A68/31 and EB136/2015/REC/1, resolution EB136.R7) (continued from the second meeting, section 4)

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) welcomed the report and the wide-ranging actions proposed in the draft resolution, which the United Kingdom wished to cosponsor. Welcoming the emphasis placed on prevention, urgent action to combat antimicrobial resistance and access to essential medicines, including controlled medicines, she said that ketamine, in particular, must remain available to doctors, especially in low- and middle-income countries and in emergency and military situations. A greater focus might be needed on post-surgical care to minimize the risk of mortality. It was vital to tackle the health workforce crisis in order to ensure adequate availability of motivated service providers with the proper training and equipment.

Dr PIUKALA (Tonga) highlighted the financial and technical difficulties faced by small island States in the Pacific region in ensuring the delivery of core surgical and anaesthetic services. The ability to provide such services was critical to those countries' ability to respond to natural disasters, to which they were particularly vulnerable. Improved access to those services was also crucial to achieving universal health coverage and reducing mortality, morbidity and disability. He urged fellow Member States and donor partners to prioritize support to Pacific countries in order to enable them to enhance their capacity and build on progress in developing standards, guidelines and training support for surgeons and anaesthetists.

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[1] See page 367.

[2] See the summary record of the General Committee, first meeting, section 2.

Dr DUSHIME (Rwanda) affirmed that sustainable provision of emergency and essential surgical care and anaesthesia was a critical part of integrated primary health care and of countries' ability to achieve the Millennium Development Goals and universal health coverage. As a sponsor of the draft resolution, Rwanda encouraged the Health Assembly to adopt it.

Dr RUSTANDI (Indonesia) said that Indonesia had taken various steps to strengthen emergency and essential surgical and anaesthesia services, including the development of an integrated emergency response system, training for health care workers and the introduction of regulations for the proper use of safe and affordable essential medicines and equipment. Access to care and the provision of quality services, however, continued to be hindered by infrastructure and human resources limitations. Indonesia therefore appreciated the emphasis in the draft resolution on actions to promote training, task-sharing and intersectoral coordination, and looked to the Secretariat for the timely provision of technical support for capacity-building and the monitoring and evaluation of services.

Ms HAN Jianli (China) said that coordination between district hospitals and health care centres was an important means of ensuring adequate access to surgical care. It was important to envisage a transitional period for developing countries during which they would require support in ensuring adequate infrastructure and training for health workers, with a particular emphasis on the monitoring of infections in hospitals. China supported the draft resolution.

Dr CHASOKELA (Zimbabwe) said that the sustainable delivery of surgical care and anaesthesia services, especially to mothers and children in rural areas, called for infrastructure development and training for service providers, together with appropriate protocols and guidelines and reliable data collection. Advanced training for nurses in emergency and surgical care and anaesthesia would help to ensure the availability and affordability of surgical services in rural areas. Emphasis must be placed on patient safety, with a robust prevention and control programme to avoid post-surgery infection. Zimbabwe, which was an active participant in a South–South cooperation initiative to support other countries with limited capacity, encouraged the Health Assembly to adopt the draft resolution.

Mrs IRO (Cook Islands), highlighting the importance of networks and global partnerships in surgical capacity-building, said that it was important to ensure that surgical services at district and sub-district level were assessed and monitored by means of standardized tools such as the WHO Integrated Management for Emergency and Essential Surgical Care toolkit. The Cook Islands supported the draft resolution.

Dr ALFRED (Haiti) said that, in addition to the elements mentioned in the report, a system of emergency ambulance transport was an important component of universal health coverage. Haiti was finalizing a package of core services aimed at, inter alia, reducing maternal mortality and accident-related deaths. Haiti supported the draft resolution and would welcome information on best practices.

Mr KASEM (Jordan) commented that focused training for improving the skills of general practitioners, surgeons and anaesthesiologists in the area of emergency and essential surgical services would do much to address the lack of those services in rural and remote areas and alleviate the suffering it caused. Jordan supported the draft resolution.

Mr TEGENE (Ethiopia) stressed the importance of integrating safe basic and essential surgical care into primary health care as a critical means of tackling maternal and neonatal mortality. Progress had been made in Ethiopia in improving access to quality care, but more needed to be done to overcome the challenges posed by inadequate infrastructure, human resources, equipment and training facilities. Developed countries that had benefited from the brain drain experienced by low- and middle-income countries had a moral obligation to provide support for medical schools in countries

such as his in order to assist them in remedying the resulting shortages of skilled health workers. The Secretariat, too, should prioritize capacity-building at the global and regional levels. Ethiopia supported the draft resolution.

Dr ZEIDAN (Egypt) said that, although her Government had taken steps to ensure rapid access to emergency and essential surgical services for all citizens, the country faced challenges, particularly at district level, where there was a serious shortage of emergency physicians. Its efforts were also hindered by infrastructure problems and the lack of a referral system. Egypt supported the draft resolution.

Dr Tsung-Hsi WANG (Chinese Taipei) said that Chinese Taipei had taken steps to ensure safe, effective, patient-centred emergency and essential care services as a key part of its efforts to achieve universal health coverage. Its emergency medical care system comprised 14 referral networks, with an advanced-level hospital in each network and at least one intermediate-level hospital in every city and county except for one, on an outlying island.

Professor ABENSTEIN (World Federation of Societies of Anaesthesiologists), speaking at the invitation of the CHAIRMAN, expressed unequivocal support for the draft resolution and urged all Member States to endorse its adoption. It was crucial to expand efforts to enable low- and middle-income countries to improve access to safe, affordable and high-quality surgical and anaesthesia care, starting immediately with the current earthquake relief efforts in Nepal. The World Federation stood ready to work with WHO, health ministries and other organizations in strengthening capacity in relation to the health workforce, essential medicines, equipment and infrastructure.

Professor GUNN (International Federation of Surgical Colleges), speaking at the invitation of the CHAIRMAN, noted with satisfaction the support for the Secretariat's proposal to strengthen emergency and essential surgical care. His organization had long advocated such action and affirmed its commitment to work with WHO in order to ensure that the draft resolution led to positive action.

Ms MORTON DOHERTY (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN, said that improving surgical capacity would reduce cancer deaths and alleviate suffering. She welcomed the draft resolution and Member States' commitment to improving access to safe, affordable and equitable cancer surgery. Regular monitoring and evaluation of surgical care capacity would be important, as would development of benchmarks and reporting on surgical safety and adequate resourcing of the Secretariat to enable it to support Member States. The Lancet Oncology Commission on Global Cancer Surgery, to be launched later in 2015, would help to identify needs and opportunities for improvement in surgical care systems.

Dr KIENY (Assistant Director-General) welcomed the commitment of Member States and civil society organizations to strengthening emergency and essential surgical care and anaesthesia. The Secretariat had taken note of the various requests for technical support. Observing that many delegates had emphasized the importance of the availability of ketamine, she encouraged them also to raise the issue with the United Nations' Commission on Narcotic Drugs. She had also noted the comments on health workforce challenges, including with regard to numbers, distribution, training and working conditions. The Secretariat would continue to work with Member States to improve human resources for health, and would coordinate the implementation of the draft resolution.

Commenting on the CHAIRMAN's invitation to the Committee to consider the draft resolution contained in resolution EB136.R7, Dr MAKASA (Zambia), speaking as chairman of the intergovernmental drafting group that had prepared the draft resolution and on behalf of its sponsors, said that the draft resolution had global consensus and urged the Committee to approve it.

The draft resolution was approved.[1]

WHO Global Code of Practice on the International Recruitment of Health Personnel: Item 17.2 of the Agenda (Documents A68/32 and A68/32 Add.1)

The CHAIRMAN drew attention to a draft decision proposed by the delegations of Bangladesh, Brazil, Estonia, Germany, Italy, Iran (Islamic Republic of), Ireland, Japan, Maldives, Romania, Slovakia, South Africa, Spain, Thailand and Zimbabwe, which read:

> The Sixty-eighth World Health Assembly, having reviewed the report of the Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010),[2]
>
> (1) recognized the relevance of the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010) in the context of growing regional and interregional labour mobility, and demographic and epidemiological transition that increases demand for health workforce;
>
> (2) urged Member States and other stakeholders to expand awareness and implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010), in particular by strengthening of institutional capacity and resources to complete the second round of national reporting by 31 July 2015;
>
> (3) requested the Secretariat at the global, regional and country levels to expand its capacity to raise awareness, provide technical support and promote effective implementation and reporting of the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010);
>
> (4) decided that the further assessment of the relevance and effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010) should be considered in line with the third round of national reporting in 2018 and the scheduled progress report to the Seventy-second World Health Assembly in 2019.

The financial and administrative implications for the Secretariat of adoption of the draft decision were:

1. Decision: WHO Global Code of Practice on the International Recruitment of Health Personnel	
2. Linkage to the Programme budget 2016–2017 (see document http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_7-en.pdf)	
Category: 4. Health systems	
Programme area: Integrated people-centred health services	Outcome: 4.2 Output: 4.2.2
How would this decision contribute to the achievement of the outcomes of the above programme area?	
It would contribute to supporting countries to a full implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel.	

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA68.15.

[2] Document A68/32 Add.1.

Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the decision during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US$ 10 000).

(i) Four years (covering the period 2016–2019)

(ii) Total: US$ 6.25 million (staff: US$ 1.75 million; activities: US$ 4.5 million)

(b) Cost for the biennium 2016–2017

Indicate how much of the cost indicated in 3(a) is for the biennium 2016–2017 (estimated to the nearest US$ 10 000).

Total: US$ 3.125 million (staff: US$ 0.875 million; activities: US$ 2.25million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Regional and subregional offices, 80%; and headquarters, 20%.

Is the estimated cost fully included within the approved Programme budget 2016–2017? (Yes/no)

Yes.

If "no", indicate how much is not included.

(c) Staffing implications

Could the decision be implemented by existing staff? (Yes/no)

Yes, provided that current vacancies at headquarters and the regional offices are filled.

If "no", indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2016–2017 indicated in 3(b) fully funded? (Yes/no)

No.

If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

In the biennium 2016–2017, the gap is estimated at US$ 1.25 million (US$ 2.5 million for the four-year period 2016–2019). This funding gap will be tackled as part of the Organization-wide coordinated resource mobilization plan to deal with funding shortfalls in the Programme budget 2016–2017.

Ms JACOB (Ireland) said that her country, which had co-chaired the Expert Advisory Group on the Relevance and Effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel, was committed to implementing the Global Code of Practice, which was a key framework for addressing health workforce challenges. Although steps had been taken at the national level to build a sustainable and resilient health workforce, the human resources for health agenda had to be addressed also regionally and globally.

Having analysed available evidence, workforce trends and global drivers, the Advisory Group had concluded that the Code remained not only relevant, but essential to health systems strengthening. Recognizing the context of increasing regional and interregional labour mobility, the Group called for the Code's periodic review to ensure its continued relevance in response to emerging trends and drivers. Although gaps in implementation had limited the Group's ability to conduct a full assessment,

some evidence of the Code's effectiveness had been noted. It was important to raise awareness of the Code and ensure its dissemination and implementation in all Member States. She drew attention to the recommendations contained in the report of the Expert Advisory Group (document A68/32 Add.1) and called for support for the draft decision. She asked the Secretariat to confirm that its activities set out therein were included within the Programme budget 2016–2017.

Ms SAMIYA (Maldives) said that her country remained committed to implementing the Code and was preparing for the second round of national reporting. She expressed concern that limited reporting by Member States during the first round had hindered the Expert Advisory Group's assessment. Having no national medical training institution, Maldives was reliant on other Member States to meet training requirements. Initiatives were in place to move from receiving health care workers under bilateral and collaborative agreements to developing proficient local human resources. International migration could negatively affect the performance and quality of health services not only in source countries, but also in destination countries, owing to language and cultural barriers and the need for retraining on local standards and guidelines. As a sponsor of the draft decision, Maldives urged Member States to support it.

Dr HINOSHITA (Japan) said that networks and policy dialogues between source and destination countries could promote not brain drain, but brain circulation. Such mechanisms would be particularly important in Asian countries that would require more foreign health workers in coming years to care for their ageing populations. At the same time, the entry of profit-driven medical institutions from developed countries into the health care market in developing countries could affect their health systems detrimentally. Developing countries needed to establish legal frameworks for international recruitment of health workers.

Ms UNTERNAEHRER (Switzerland), expressing support for the draft decision, welcomed collaboration with OECD during the second round of national reporting, which would provide better information on statistical trends. She commended the increased involvement of civil society organizations in the consultation process. Relevant nongovernmental organizations in her country would be approached for information on activities related to implementation of the Global Code of Practice. She encouraged the Secretariat to seek to improve the response rate among Member States, especially source countries. All Member States should be supported in establishing a monitoring and reporting system that reflected various migration patterns, and the exchange of best practice and information should be facilitated.

Professor OKONG (Uganda), speaking on behalf of the Member States of the African Region, said that they were implementing the Code with varying degrees of success. Accurate data on workforce production, deployment and mobility were essential, but many African Member States lacked adequate information systems to enable them to gather such information and design measures to mitigate the negative effects of human resources migration. The number of countries that had designated national authorities remained unacceptably low, especially in source countries. The African countries were committed to implementing the Code, including by increasing the production and compensation of health care workers; they called on destination countries also to implement the Code in order to strengthen health systems worldwide. The Member States of the Region supported the draft decision.

Dr BRYANT (Australia), noting that the Advisory Group's report rightly recognized that changes to health system capacity took time to effect, said that Australia was continuing to invest in building health workforce capacity and was expanding training opportunities for health care personnel, leading to an increase in medical graduates. It was also implementing policies aimed at attracting, training and retaining increased numbers of health care professionals with the goal of achieving self-

sufficiency. She supported the draft decision but proposed the addition of "within the approved Programme budget" at the end of paragraph (3).

Ms USIKU (Namibia) said that many Member States, including her own, would continue to rely on foreign health care professionals while they were in the process of increasing the number, quality and competencies of local personnel. The implementation of the Code in Namibia had led to bilateral agreements on international recruitment, accelerated training of local health personnel, improved community access to health services and policies that favoured the attraction and retention of health personnel. She urged the Secretariat to continue providing technical support for the implementation of the Code.

Dr AHMED ELBASHIR (Sudan) said that her Government had submitted a report during the first round of reporting and was preparing its report for the second round. Concerning the relevance and effectiveness of the Code, progress achieved through its application in Sudan had included the training of numerous new health workers. The retention of health personnel was a problem, however. As a source country profoundly affected by the migration of its health personnel, Sudan advocated continuing application of the Code. In order to enhance the Code's effectiveness and positive impact, the Secretariat should promote it more widely, gather more information on migration and develop a methodology for monitoring and evaluation, while working to build institutional capacities.

Dr NAREERUT PUDPONG (Thailand) affirmed the relevance of the Code as a key instrument in health systems strengthening in the context of increasing health workforce demand in middle- and high-income countries undergoing demographic and epidemiological transitions. International migration of health care workers was inevitable, owing to recognized pull and push factors; however, such migration adversely affected the health system of source countries and would hamper the attainment of sustainable development goals. In the South-East Asia Region, five Member States had been identified as having a critical health workforce shortage, exacerbated by unequal workforce distribution between urban and rural areas. Member States in the Region were preparing for the second round of national reporting, and a workshop would be organized for that purpose. Thailand supported the draft decision.

Ms HARMSTON (Canada), noting the importance of monitoring the migration of health personnel, encouraged Member States to respond to reporting requests in order to better support global efforts to address health workforce mobility. Her Government was continuing to work towards a sustainable health workforce, and the country's designated national authority would continue to ensure that Canada met its national reporting requirements.

Mr MAGNÚSSON (Iceland), speaking also on behalf of Estonia, Latvia, Lithuania and Norway, said that, along with Iceland, those countries wished to be added to the list of sponsors of the draft decision. Outbreaks of diseases such as Ebola virus disease, the rise in noncommunicable diseases and other trends underscored the need for qualified health workers. The Code was as relevant as it had been in 2010, and he fully supported the recommendations of the Expert Advisory Group. Every effort should be made to increase the number of countries reporting in the second round.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that he had not examined the report in detail owing to its late arrival. He would welcome more evidence on the relevance and effectiveness of the Code, including how many agreements existed between source and destination countries and whether the former were contributing to the training of health personnel in the latter. He also wondered when the results of the second round of national reporting would be available.

Mrs VALLINI (Brazil), joining the delegate of Cuba in calling for timely provision of documents, said that, in Brazil, the Code had provided guidelines for the temporary recruitment of

foreign doctors under a trilateral cooperation arrangement supported by PAHO and WHO. The programme had increased access to primary health care, including for those living in remote areas, and had also increased recruitment of Brazilian doctors, ensuring the programme's sustainability. The programme provided for enhancement of infrastructure and training in order to strengthen the national health system, thereby demonstrating Brazil's commitment not to rely on personnel from countries experiencing similar difficulties. She supported the draft decision.

Dr SHOHANI (Iraq) said that appropriate mechanisms for international recruitment of health personnel should also be established in the context of the Code of Practice and that health ministries should play a leading role in such recruitment. Interregional and intraregional cooperation was needed in order to regulate the movement and recruitment of health personnel in line with the Code, as was training and capacity-building, for which support from the Secretariat was needed.

Dr SAGUNI (Indonesia) said that his country was committed to implementing the Code, which was particularly relevant at a time when the migration of health personnel continued to increase as a result of globalization and other factors. The Code was effective in giving direction to and underpinning policies on human resources strengthening, both in terms of international recruitment and improvement of planning and utilization of domestic health personnel. Adoption of the Code by all Member States and its translation into domestic regulations would contribute to health systems strengthening.

Dr ELSOBKY (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the findings of the Expert Advisory Group and looked forward to receiving the results of the second round of national reporting. The forced migration of populations, including health personnel, in strife- and conflict-ridden countries was placing a huge burden on national health systems in the Region. Several countries had already lost some of their most qualified health personnel. The question of health workforce migration needed to be discussed in a transparent and fair manner. He called on the Secretariat to support the development, implementation and monitoring of national health workforce strategic plans and urged Member States to accelerate their implementation of the Code, including through further multilateral negotiations aimed at scaling up assistance to source countries in the Region in order to increase the training of health professionals.

Dr GWINJI (Zimbabwe) said that the Code remained relevant, but could be implemented to greater effect. The recommendations of the Expert Advisory Group would contribute to better implementation and monitoring. Zimbabwe supported the draft decision.

Mr PABLOS-MÉNDEZ (United States of America) expressed support for the Code and commended the work carried out in 2014 towards the development of a global human resources strategy. Noting that few countries had provided data for the first reporting period, he asked the Secretariat to identify barriers to reporting and to the designation of a national authority. The national reporting instrument was unduly broad, and he encouraged the Secretariat to develop a more focused instrument linked to national health workforce accounts for better national planning and international reporting, drawing on the expertise of the Expert Advisory Group and other experts and in coordination with ILO, the World Bank and other relevant bodies.

Dr RONQUILLO (Philippines) said that discussion of ethical recruitment practices was of great importance to the Philippines as a major source country with 10.5 million professionals working overseas in 2011. He welcomed ongoing dialogue among national and international stakeholders in order to encourage active participation in assessing recruitment practices and bring about changes in their perspectives. He endorsed the draft decision.

Mr EMANUELE (Ecuador), affirming his Government's commitment to implementation of the Code, said that international recruitment processes should be quantifiable and transparent. Technical support from the Secretariat was needed for the formulation of public policies on human resources for health. With the aim of implementing a common strategy and mechanisms at regional level for the recruitment of health professionals, working groups responsible for monitoring and evaluating human resources policies under the Code should be strengthened. Dialogue on training of health personnel should be encouraged, with a focus on Member States' respective strengths and needs. He endorsed the comments made by the delegate of Cuba and expressed support for the draft decision.

Mr ALAOUI (Morocco) said that many countries were experiencing difficulties in providing health care to their populations owing to shortages of qualified health personnel, particularly in rural areas. The situation posed a threat to the achievement of universal health coverage. Measures for the training, motivation and retention of health personnel should be envisaged under the Code with a view to ensuring a stable supply of health professionals in source countries. His Government was considering the introduction of a period of compulsory national service for health professionals as a means of ensuring health services for the entire population.

Ms GONZÁLEZ (Uruguay) drew attention to the recent creation of an Ibero-American network on migration of health professionals, aimed at strengthening the capacity of health ministries for health workforce regulation. The health ministries of the Ibero-American countries had also agreed to integrate and strengthen information systems in order to enhance the availability of information on health worker migration. The Code was an incentive for the region to develop synergies with other organizations that had similar objectives. The Secretariat should encourage such regional arrangements with a view to promoting responsible migration agreements.

Dr Tsung-Hsi WANG (Chinese Taipei) said that Chinese Taipei was taking steps to strengthen its health system and ensure that it could maintain its 99% coverage rate in the face of demographic changes, for instance by enhancing the skills of its health workers and striving to improve their working conditions. Chinese Taipei also provided training for numerous international health professionals. Chinese Taipei aimed to establish a mechanism for long-term cooperation and sharing of experiences.

Ms WISKOW (International Labour Organization) said that the Code took a holistic approach, emphasizing the need not only for ethical international recruitment of health workers but also for health systems strengthening and health workforce development, which was particularly relevant for achieving universal health coverage. Decent work, including appropriate education, fair wages and safe working conditions, was critical for the sustainable development of countries' health workforces. The effectiveness of the Code would depend on its being implemented in an inclusive manner that included multi-stakeholder participation. Such an approach had been adopted in several countries, such as the Philippines, which provided an example of good practice. ILO would continue collaborating with WHO and other partners to raise awareness and promote implementation of the Code.

Dr HORNUNG (The World Medical Association, Inc.), speaking at the invitation of the CHAIRMAN, said that lack of adequate training and poor workforce planning led to shortages of health professionals, which were often exacerbated by maldistribution of workers, a phenomenon that encouraged unethical international recruitment practices. He encouraged the Secretariat and Member States to include information on internal distribution of the health workforce in periodic reports, address economic and regulatory factors resulting in attrition of health professionals and work to improve workforce planning in order to counter worrying recruitment practices and developments, such as bilateral agreements that might result in denial of basic labour protections and benefits for health professionals and the introduction of special laws limiting their mobility.

Mrs MANS (Medicus Mundi International), speaking at the invitation of the CHAIRMAN, welcomed the recommendation of the Expert Advisory Group for a review of the Code in 2018 and 2019. The Code should be viewed as a dynamic instrument and updated as needed, particularly in order to remedy shortfalls such as the lack of provisions on compensation. Gaps in implementation meant that the Code was not yet an effective tool for achieving urgently needed changes such as protection of labour rights for migrating health workers. She endorsed the recommendations of the Expert Advisory Group and urged Member States to implement the Code, report on its implementation before 31 July 2015 and strengthen the Secretariat's capacity to manage implementation.

Ms DIJK (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, expressed concern that the current Code focused primarily on regulating the migration of health personnel. It was essential also to tackle the causes of migration, such as poor or unsafe work environments and excessive workloads. Health professionals and students must be guaranteed protection from violence, discrimination and exploitation in the workplace. Evidence-based data on core factors leading to migration were urgently needed. She urged Member States to increase the engagement of health workers, educators and students in data collection and in the development of national implementation strategies and called on the Secretariat to acknowledge the value of input from stakeholders in enhancing accountability.

Dr KIENY (Assistant Director-General) thanked the Expert Advisory Group for its inputs and report and expressed gratitude to the Member States sponsoring the draft decision for their commitment to improving the second round of national reporting, the future work of the Secretariat and the next review in 2018 and 2019. The Code was an integral part of the Programme budget 2016–2017; support for its implementation was included in output 4.2.2, which dealt with health workforce strategies oriented towards universal health coverage. For the biennium 2016–2017, the estimated cost for the Secretariat of implementing the draft decision was fully included in the approved Programme budget. Mindful of the Expert Advisory Group's recommendation on the need for concerted efforts to support institutional capacities, the Secretariat would organize a series of country-level consultations to encourage policy dialogue among sectors and stakeholders. At the regional level, it would oversee several intra- and inter-regional action plans on human resources for health that had used the Code as a foundation. The Secretariat would respond directly to the delegate of Cuba on the questions he had raised. It would also consider the suggestion by the delegate of the United States of America on developing a more focused national reporting instrument. The Secretariat had noted and acknowledged the contributions by non-State actors and would continue collaborating with relevant stakeholders.

The CHAIRMAN invited the Committee to consider the draft decision, recalling that the delegation of Australia had proposed an amendment to paragraph (3).

The draft decision, as amended, was approved.[1]

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: Item 17.3 of the Agenda (Documents A68/33 and EB136/2015/REC/1, decision EB136(1))

Mr CIMA (Argentina), recalling that Argentina had chaired the Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products in 2014–2015, said that the recommendations emanating from the third meeting of the Member State mechanism (document A68/33, Annex 1) would help to strengthen the capacities of Member States and he appealed to the Secretariat to ensure that they were effectively disseminated. The mechanism had also identified six prioritized activities for 2014–2015 (document A68/33, Annex 3). An expert working

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as decision WHA68(11).

group was being established to conduct a study on the public health and socioeconomic impact of SSFFC medical products. The results to date demonstrated the capacity of the mechanism to establish technical guidance for preventing the introduction of and controlling SSFFC medical products. The final versions of the five documents produced to date by the mechanism had been posted for comment by Member States on the web portal set up by the Secretariat and were expected to be approved at the mechanism's next plenary meeting in late 2015. At its third meeting, the mechanism had decided to request the Health Assembly to postpone the scheduled review of the mechanism by one year, to 2017, as reflected in decision EB136(1).

Dr AL MOSAWI (Bahrain) said that Bahrain complied with WHO's surveillance and monitoring system and had taken significant steps to reduce the flow of SSFFC medical products into the country, including through the establishment of strict quality monitoring and control systems, import conditions and a post-marketing tracking system. Laboratory testing also played a key role in the detection of such products. The health authorities systematically reported any side effects or other issues associated with medicines, worked closely with the customs authorities, and exchanged information with Gulf States and the Regional Office for the Eastern Mediterranean. She called on headquarters and the Regional Office to provide support for an assessment to identify gaps in national legislation and in local monitoring and control procedures with a view to strengthening the capacities of national regulatory systems.

Ms GARCÍA ARREOLA (Mexico), suggesting that an update should be presented on the prioritized activities carried out in 2014–2015, said that Mexico looked forward to the results of the study on the links between accessibility and affordability and their impact on the emergence of SSFFC medical products. It was important to consider applying an austerity policy in respect of the activities planned for the coming biennium, including adequate costing and scheduling, in order to align the activities with the availability of resources under the Programme budget 2016–2017. Mexico would continue collaborating with the mechanism, strengthening national and regional quality-control laboratories and facilitating transparent consultations and cooperation with concerned stakeholders.

Dr HINOSHITA (Japan) expressed support for the proposal to postpone the review of the mechanism by one year. Member States should maximize their efforts and cooperation to combat SSFFC medical products. It was important to strengthen health systems and regulatory authorities, identify the public health risks and socioeconomic impact of such products and encourage information-sharing between countries. Member States should accelerate discussions on strengthening international cooperation through the mechanism and increase capacity-building, with the Secretariat's technical support.

Mrs OGBECHIE (Nigeria), speaking on behalf of the Member States of the African Region, said that SSFFC medical products were a serious threat in the Region, and that it was a major governance responsibility to ensure quality, safe and efficacious medical products through measures such as implementing strong regulatory mechanisms and pharmaceutical reforms. The Member States had taken significant steps to combat the marketing of such products, including the deployment and use of cutting-edge technology and the boosting of local pharmaceutical production. Those measures had had positive impacts; however, continuous and effective collaboration between policy-makers and regulatory authorities in Member States was necessary. She urged governments to demonstrate strong political will and requested technical and financial support from the Secretariat and other partners to tackle the issue. She supported the draft decision.

Mrs VALLINI (Brazil) noted the need to deepen the debate on the actions, activities and behaviours that fell within the scope of the mechanism, with particular reference to medical products in transit. The use of public health and quality-related arguments when seizing such products could create barriers to legitimate trade and was inappropriate. Her Government affirmed its interest in

coordinating the working group that would draft recommendations and develop training materials on prevention, detection and response to SSFFC medical products and its commitment to contribute financially to the Member State mechanism. The WHO Project for the Surveillance and Monitoring of SSFFC Medical Products was welcome, but should be linked to the mechanism. The use of concepts such as "suspicion" and "theft" was not in line with the spirit of the mechanism, as such language might favour a criminalization and enforcement approach. The debate should focus on the health aspects of SSFFC medical products and not on intellectual property and criminalization.

Mr SILLO (United Republic of Tanzania), welcoming the recommendations contained in the report of the third meeting of the mechanism, said that his Government had taken steps to reinforce national regulatory systems, such as the posting of medicines inspectors at major ports of entry, and was working with other governments in the East African Community to implement harmonized guidelines for regulation of medical products. However, SSFFC medical products remained a major public health concern requiring national, regional and global cooperation and continued technical and financial support from WHO, particularly in the African Region. He supported the draft decision.

Ms YOU Yousoon (Republic of Korea) also supported the draft decision. In order to prevent the distribution of SSFFC medical products, the Secretariat and Member States needed to cooperate closely and reach consensus on the definition and regulation of such products. It was essential that guidelines were in place, including track and trace systems, to prevent the distribution of SSFFC medical products at national and regional levels. To that end, her country had established a serial number system for medicines.

Ms GONZÁLEZ (Uruguay), speaking on behalf of the Member States of the Union of South American Nations, expressed support for the postponement of the review of the Member State mechanism. The mechanism had formulated sound technical recommendations for national health authorities and set out prioritized activities, but funding for those activities remained insufficient. She requested that the Director-General take steps to fill that gap, preferably from assessed contributions, in order to ensure the sustainability of the mechanism. Measures to prevent the marketing of SSFFC medical products should not become barriers to access to safe and efficacious generic medicines. The legitimacy of medical products in transit which complied with the standards of the export and destination countries should not be questioned by the regulatory authorities of transit countries, since such products posed no risk to public health. Ensuring the quality and efficacy of medicines was the sovereign responsibility of national health authorities.

The progress made with regard to the WHO Project for the Surveillance and Monitoring of SSFFC Medical Products was welcome, but closer linkage between that project and the Member State mechanism was needed. She expressed concern at the emergence of numerous international initiatives to combat SSFFC medical products that failed to take account of the agreements reached on the issue within WHO and called on the Secretariat not to take part in the related initiative of the Global Fund to Fight AIDS, Tuberculosis and Malaria until the Member State mechanism had had the opportunity to consider whether such participation was appropriate.

Dr PANDA (India), expressing support for the draft decision, said that the formulation, by consensus, of practical recommendations for regulatory authorities demonstrated the effectiveness of the mechanism, to which his country was pleased to contribute US$ 100 000. Although trademark and intellectual property considerations clearly fell outside the mandate of the mechanism, the absence of a common understanding of the term "substandard/spurious/falsely-labelled/falsified/counterfeit" meant that alleged intellectual property infringements might be equated with substandard or spurious products, which would jeopardize a basic objective of the mechanism: to ensure access to safe and affordable medicines. It was cause for concern that some countries appeared determined to justify their assumed rights to intercept genuine affordable medicines under the pretext that they were SSFFC

products, and that they were promoting their agendas within other United Nations forums, thus undermining the progress of the Member State mechanism.

Unfortunately, his country's proposal to delineate the scope of the mechanism's work by establishing a list of actions, activities and behaviours that did not result in SSFFC medical products had not been finalized at the third meeting, although good progress had been made. Priority in future work should be given to early completion of definitions of SSFFC medical products, with a focus on strengthening regulation while ensuring access to affordable medicines. Emphasis on regulation alone could not solve the problem of spurious medicines.

Dr FONES (Chile) said that sufficient funding was essential in order to strengthen the work of the mechanism. Monitoring activities needed to be conducted at all stages of the supply chain in order to combat the distribution of SSFFC medical products. His Government affirmed its interest in participating in the working groups proposed for activities A, C and D of the list of prioritized activities and requested that particular priority be given to activity B. Measures to prevent the falsification of medical products should not become barriers to access to safe generic medicines, and the legitimacy of medical products in transit that met standards in the export and destination countries should not be questioned. International debate on that matter should be in line with discussions held in the context of the mechanism with a view to developing coherent guidelines with a focus on public health. In that connection, the initiative of the Global Fund to Fight AIDS, Tuberculosis and Malaria should be examined in greater depth. He supported the draft decision.

Mr ARUSTIYONO (Indonesia) said that his country's regulatory authority monitored medical products and had launched awareness-raising campaigns with respect to SSFFC medical products, but still faced challenges in regulatory system strengthening. Indonesia therefore strongly supported WHO's efforts in that regard. In order to effectively combat the distribution of substandard medical products, enhanced cooperation and exchange of best practices among countries was pivotal.

Miss SANTIAGO (Philippines), endorsing the recommendations and work plan of the Member State mechanism, said that she had no objection to postponing the review of the mechanism by one year. Her country was establishing a single inter-agency body to ensure a coordinated approach to combating SSFFC medical products. She proposed that official definitions should be formulated for the terms "substandard", "spurious", "falsely labelled", "falsified" and "counterfeit" in order to ensure a uniform understanding on the part of all Member States.

Mrs SITANUN POONPOLSUB (Thailand) said that regulatory authorities should establish strategies that gave priority to public health rather than to intellectual property in order to combat SSFFC medical products. The WHO Project for the Surveillance and Monitoring of SSFFC Medical Products would provide reliable evidence for policy decisions and should be allocated resources and implemented by all Member States. Thailand looked forward to the study on the links between accessibility and affordability and their impact on the emergence of SSFFC medical products. She underlined the importance of ensuring that activities pursuant to resolution WHA67.20 with a view to strengthening regulatory systems for medical products did not duplicate the work plan and mandate of the Member State mechanism. She asked for information regarding the funds allocated under the Programme budget 2016–2017 for activities related to SSFFC medical products. Thailand supported the draft decision.

Dr GWINJI (Zimbabwe) said that close cooperation within and among regions and the strengthening of regulatory authorities was needed in order to deal with the complex issue of SSFFC medical products. It was also essential to leverage current information technologies in order to track the manufacture and distribution of such products and reduce their harmful effects. Noting that his country's regulatory activities had been recognized as best practice by other countries in Africa, he expressed support for the proposal to postpone the review of the Member State mechanism.

Dr TAKIAN (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that insufficient funding impeded implementation of the work plan of the Member State mechanism. Member States should report to the WHO Project for the Surveillance and Monitoring of SSFFC Products with a view to safeguarding public health. Data showed that all countries were affected by the issue, including transit countries and countries with significant free-trade zones. He called on the Secretariat to provide guidance to such countries in reporting to the Project and technical support to all Member States, on request, for the investigation of suspected SSFFC medical products.

Dr GACHOKI (Kenya) supported the postponement of the review of the Member State mechanism. His country had taken measures with a view to preventing the distribution of SSFFC medical products and ensuring the safety and efficacy of medicines in the Kenyan market, including a review of its legislation and the introduction of a surveillance programme and online information-sharing systems and procedures. It also collaborated with national, regional and international bodies.

Dr GARCÍA TUÑÓN (Spain) said that the falsification of medical products had become a lucrative business owing to the constant demand for low-cost medicines and the fact that the sanctions imposed for falsification were often not proportional to the threat posed to public health. Spain had amended its criminal code so as to prosecute more effectively offences relating to such medical products and was finalizing a new strategy to combat falsified medicines which built on its 2008 strategy and was in line with the European Union directive on the subject. It was also participating in a rapid alert and information-sharing system with other Ibero-American countries. In order to ensure the success of the Member State mechanism, sufficient funding must be provided to enable it to carry out its prioritized activities and countries must try harder to find common ground in their national positions.

Mr ALEMNEH (Ethiopia) said that Ethiopia remained committed to the work of the Member State mechanism, which was moving in the right direction. It supported the mechanism's work plan and the list of prioritized activities and requested that, at its fourth meeting, the mechanism consider recommendations for minimizing the impact of SSFFC medical products. He expected that costing of mechanism activities had been taken into account in the Programme budget 2016–2017. The Secretariat should provide an update on the implementation of resolution WHA67.20, particularly the request to the Director-General to ensure that activities carried out to strengthen regulatory systems for medical products did not duplicate or circumvent the work of the Member State mechanism. He called for increased participation of regulatory authorities from developing countries in the activities of the mechanism.

The meeting rose at 12:50.

FIFTH MEETING

Friday, 22 May 2015, at 14:40

Chairman: Dr R. BUSUTTIL (Malta)

1. HEALTH SYSTEMS: Item 17 of the Agenda (continued) [Transferred from Committee A][1]

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: Item 17.3 of the Agenda (Documents A68/33 and EB136/2015/REC/1, decision EB136(1)) (continued)

Mr WANG Songlin (China) said that his country's national regulatory authority stood ready to work with the Organization to tackle the problem in a more active and comprehensive manner. China had taken administrative, regulatory and judicial measures in order to combat such products and ensure the safety of medicines, including specialized operations against SSFFC medical products and intellectual property infringement and regular testing of medicines. The complex fight against SSFFC medical products required detailed consultation and further studies among Member States. China therefore supported the proposal contained in decision EB136(1) to postpone review of the Member State mechanism until 2017.

Dr ABDGABBAR ABDULLAH (Sudan) accepted a one-year postponement of the review of the Member State mechanism. SSFFC medical products constituted a grave public health risk worldwide and were circulating in such disproportionately large numbers as to undermine national efforts to improve health status, especially in developing countries. The multitude of cross-cutting legal, economic and other issues involved exacerbated the challenge. Bold action was therefore urgently required to provide the support needed to enable the mechanism to discharge its functions speedily and efficiently and produce recommendations for the preparation of regional and national action plans.

Ms CEYHAN (Turkey) said that her Government was convinced of the importance of joint action and sharing of best practices in the fight against SSFFC medical products. Its own actions included developing a pharmaceutical track-and-trace system and cooperating with law enforcement agencies and telecommunications companies to prevent online sales of unlicensed, illegal and counterfeit drugs. Turkey welcomed the list of prioritized activities proposed by the Member State mechanism (document A68/33, Annex 3) and wished to participate in the working group that would assess track-and-trace systems under activity C. She supported the draft decision.

Ms ANDIA (Colombia), stressing that measures taken to combat SSFFC medical products should not limit access to safe and efficacious generic products, observed that the achievements of the Member State mechanism had demonstrated its ability to meet the objective for which it had been created. The study on the links between accessibility and affordability and their impact on the emergence of SSFFC medical products would be particularly useful to Member States. The mechanism had proved an effective means of conveying technical information in a democratic and transparent manner and had provided a model for future expert groups and informal consultations on technical topics. In addition, it had yielded important lessons, with implications for WHO's

[1] See the summary record of the General Committee, first meeting, section 2.

governance, about Member States' capacity to participate and take decisions in global forums such as WHO that were considered purely technical. She supported the draft decision.

Ms LEBESE (South Africa) applauded the Member State mechanism for asking the Secretariat to ensure that Member States were provided with a schedule of future workshops and further information on the working definitions used by the Secretariat to identify SSFFC medical products under the WHO Project for the Surveillance and Monitoring of SSFFC Medical Products. She fully supported the recommendations on actions, activities and behaviours that resulted in SSFFC medical products, which represented a milestone in strengthening national and regional regulatory authority capacities. South Africa supported the draft decision.

Mr BROWN (United States of America) said that the Member State mechanism required ongoing support, engagement and resources from the Secretariat and Member States. He was encouraged by the progress made in developing the WHO Project for the Surveillance and Monitoring of SSFFC Medical Products, but was concerned that so far his country had been the only donor to the system. He welcomed the commitment by India to contribute and urged other Member States also to contribute in order to ensure sustainability. It was also cause for concern that, although Member States had identified work on SSFFC medical products as a priority, it was not prioritized in WHO's Programme budget. The United States looked forward to continued collaboration on all technical papers currently open for discussion, including reaching consensus on activities and behaviours falling outside the mechanism's mandate.

Dr HAFED (Algeria) said that his country's strategy to combat SSFFC medical products included technical inspection of every lot of medicines entering the market, whether locally produced or imported, which had enabled the country to reduce the problem. Effective action against SSFFC medical products required coordination among the health authorities of Member States: isolated actions by individual countries were inadequate. He emphasized that, alongside its activities to combat SSFFC products, WHO needed to work to ensure access to affordable medicines. His country supported the draft decision.

Ms Wen-Huey KAO (Chinese Taipei) said that Chinese Taipei had instituted both pre- and post-marketing measures to tackle SSFFC medical products and had developed monitoring and surveillance to track global and regional alerts issues by regulatory authorities. It had significantly restricted access to counterfeit drugs, but globalization and developments in new technology meant that a realistic action plan was needed to deal with online marketing and sale of such products. Cooperation among partners was also vital.

Ms GENOLET (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that more than half the fake medicines reaching the legitimate supply chain were falsified versions of life-saving medicines. Such products undermined patient trust in health systems and providers, governments and manufacturers of genuine medicines. WHO had a leading role in combating them. Her organization welcomed the focus of the Member State mechanism on strengthening regulatory capacity, risk communication and analysis of the impact of SSFFC products and stood ready to play its part in combating such products.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that consistency and coordination were needed in tackling SSFFC products, especially given the emergence of numerous different public and private initiatives on the issue. It was important to regulate those who dealt with raw materials as well as manufacturers of pharmaceutical ingredients, as globalization had led to a fragmented supply chain and made it difficult to trace raw materials. A simple reporting process would encourage reporting of suspected cases. Reporting would

also be facilitated by proper training for health care professionals on SSFFC medical products. Awareness-raising should target the public as well as health professionals and associations.

Mrs BURDET (Medicus Mundi International), speaking at the invitation of the CHAIRMAN, said that lack of precision in the terminology used in respect of SSFFC medical products had led to confusion about the issues to be addressed. In particular, the term "counterfeit" referred to two distinct problems: poor-quality medicines, which, unquestionably, was a public health problem, and trademark protection, a commercial issue. She called on Member States to set aside commercial considerations and focus on the public health aspects of the problem. The practice of seizing generic medicines in transit, although they complied with the standards of both exporting and importing countries, impeded access to medicines; such practices fell outside the mandate of the Member State mechanism. WHO's budget crisis had severely undermined its capacity to support national and regional regulatory agencies, and she expressed the hope that the freeze on assessed contributions would soon be lifted.

Dr KIENY (Assistant Director-General) said that it was clear that the globalization of production and distribution of SSFFC medical products had made it increasingly difficult for countries to combat the threat individually. It was essential for them to work together to develop tools for better protection of the supply chain and sharing of information and best practices. It was also clear that the work of the mechanism was gaining momentum, thanks to the active role of various Member States in leading work in areas such as track-and-trace methods, strengthening of national and regional regulatory agencies and establishment of a focal point network. A body of evidence was being compiled about the nature and magnitude of SSFFC issues that would help everyone to combat the problem effectively. Almost 700 notifications had been received in the previous two years. Each had immediately been followed up with countries in order to minimize any negative health effects. Welcoming the Indian delegation's announcement of a financial contribution to the Member State mechanism, she acknowledged that, although the work on SSFFC medical products was included in the Programme budget 2016–2017, funding for the mechanism's work plan remained a problem. The Secretariat looked forward to expanded support for work on the issue, which was critical for safeguarding the health of patients worldwide.

The CHAIRMAN invited the Committee to consider the draft decision contained in decision EB136(1).

The draft decision was approved.[1]

Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination: Item 17.4 of the Agenda (Documents A68/34 and A68/34 Add.1)

Mr NETO (Angola), speaking on behalf of the Member States of the African Region, endorsed the proposed mechanism for the management of the pooled fund for global health research and development by a new scientific working group under the technical oversight of the Special Programme for Research and Training in Tropical Diseases. He welcomed the five demonstration projects already selected, two of which involved institutions from the Region, and expressed the hope that the project on malaria proposed by the Council of Scientific and Industrial Research of South Africa would receive the technical assistance needed to enable it to qualify as a demonstration project. The countries of the Region noted with appreciation the funding pledged by some developed countries and encouraged developing countries also to make financial contributions to support implementation of the demonstration projects.

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as decision WHA68(12).

Dr YILMAZ (Turkey) said that the Global Health Research and Development Observatory would help to foster a health research culture, especially in developing countries. It would be important to review existing health research mechanisms, try to reduce operational costs and ensure that funds were carefully spent. Financial contributions for health research and development should be voluntary. Turkey could offer support in areas such as sharing of knowledge and experience and identification of common research and development needs.

Dr WARISA PANICHKRIANGKRAI (Thailand) said that an effective fund-raising mechanism would be vital to the long-term sustainability of the pooled fund. She favoured a replenishment model similar to that of The GAVI Alliance or UNITAID. Accountable and efficient programme management as well as credible and well-functioning governance structures would be required to attract donations to the fund. Management of the fund by a third-party trustee, rather than directly by the Special Programme for Research and Training in Tropical Diseases, would create an additional layer of administrative complexity and might reduce the operating budget for research and development activities. Selection of projects on the basis of evidence generated by the Global Observatory would guard against a donor-driven research agenda.

Mr SILLO (United Republic of Tanzania) said that the Special Programme for Research and Training in Tropical Diseases, with its 40 years of experience in overseeing research, was well suited to manage the pooled fund. He urged high- and middle-income countries to contribute funding. Swifter progress in establishing the coordination mechanism was needed, as was more detailed information on the Global Observatory. He urged the Secretariat to intensify its efforts to put an observatory in place in order to ensure that the pooled funds would indeed address priority issues. He welcomed the demonstration projects but expressed concern that they perpetuated a North-South dichotomy in research, lacked country ownership and would not help to build research capacity in developing countries.

Mr JAISINGH (Trinidad and Tobago) supported the establishment of a pooled fund for voluntary contributions to be hosted by the Special Programme for Research and Training in Tropical Diseases. The fund would help to build research capacity, increase the availability of credible and relevant research to inform policy- and decision-making, foster innovation, promote the development of affordable methods of tackling type II and type III diseases and, ultimately, contribute to better population health.

Ms SCHMITT (France), speaking on behalf of the Member States of the European Region, said that the recent Ebola virus disease epidemic had revealed the unmet medical needs of developing countries and underscored the importance of global-level funding for research and development related to diseases that disproportionately affected low- and middle-income countries. She welcomed the progress made towards a pooled fund for voluntary contributions; acknowledged the proposed governance structure, emphasizing that it should be as lean and efficient as possible; and supported the proposed role of Member States in approving fund allocation for research and development projects. A functional observatory and coordination group were needed in order to allocate funding on the basis of evidence. As continuous analysis of health research needs was a core function of WHO, the operating costs of the Global Observatory should be met through the WHO Programme budget.

Ms DUSSEY-CAVASSINI (Switzerland), noting that Switzerland had pledged more than US$ 6.2 million in funding for demonstration projects, the pooled fund and the start-up of the Global Health Research and Development Observatory, emphasized that the success of efforts to tackle diseases that disproportionately affected low- and middle-income countries would depend on the political and financial support of Member States. If the ambitious proposed post-2015 sustainable development goals were to be met, countries would have to assume their shared responsibility. She therefore urged other Member States to make contributions.

Dr SAGUNI (Indonesia) said that, although numerous national institutions were conducting medical research in his country, there was a lack of funding and difficulties in translating research findings into practical applications. Indonesia supported management of the pooled fund by the Special Programme for Research and Training in Tropical Diseases, but requested assurance that there would be no conflict of interest in decision-making and fund allocation. The Joint Coordinating Board of the Special Programme had a key role to play in facilitating international collaboration and networking, which were crucial to improve research capacity.

Ms GONZÁLEZ (Uruguay), speaking on behalf of the Members of the Union of South American Nations, welcomed the progress made with regard to demonstration projects and called for additional contributions from Member States to those initiatives. Regarding the pooled fund, she asked for further details about possible adjustments in the governance structure of the Special Programme to ensure Member State oversight and recalled that, in line with decision WHA67(15), the current discussion was without prejudice to future consideration of other sustainable research and development mechanisms.

Health research and development systems should be based on dissemination of knowledge for the benefit of all of humanity and on de-linkage of the cost of research and development from the price of health care technologies. The discussions suspended in 2013 should be resumed and, in line with resolution WHA66.22, the Director-General should convene an open-ended Member State working group on the recommendations of the Consultative Expert Working Group prior to the 138th session of the Executive Board. The Secretariat should prepare a document setting out some basic criteria that should be met by a global fund in order to be considered sustainable, including the possibility of both voluntary and mandatory contributions, and proposing practices to improve global coordination within current research and development systems.

Dr REYES (Plurinational State of Bolivia) said that the Special Programme for Research and Training in Tropical Diseases seemed the most appropriate body to manage the pooled fund. However, as noted by the delegate of Uruguay, Member State oversight must be assured. Additional innovative and sustainable means of funding research on diseases that disproportionately affected developing countries should be explored, and an open-ended working group of Member States should be convened to assess progress and discuss pending issues relating to financing and coordination of research and development.

Dr PANDA (India), noting that India had provided support for the demonstration projects and favoured the inclusion of the project put forward by the Council of Scientific and Industrial Research of South Africa, said that the South-East Asia Member States had developed a grid that might be used by the Global Observatory for the classification of norms and standards concerning research and development relating to health products. Expressing support for a pooled fund for voluntary contributions with sustainable funding sources and a transparent governance structure, he called for the establishment of an open-ended meeting of Member States, in accordance with resolution WHA66.22, to continue discussions on issues relating to monitoring, coordination and financing for health research and development.

Professor AZAD (Bangladesh) said that progress had been made towards realizing the objectives of resolution WHA66.22, but much remained to be done. He called for subsequent reports by the Secretariat to provide more detailed information about activities carried out at country level and requested more detail about the Global Observatory.

Mr BROWN (United States of America), expressing satisfaction at the progress of the demonstration projects and affirming support for the work of the Consultative Expert Working Group, said that the successful establishment of a pooled fund would depend on adequate oversight of its

resource management, formulation of research and development proposals, and identification of new sources of funding.

Mrs VALLINI (Brazil) supported the establishment of a pooled fund, which could be managed by the Special Programme for Research and Training in Tropical Diseases, provided that there was a clear methodology for project selection and transparent mechanisms for Member States' participation, possibly modelled on those of UNITAID. She requested updated information on the current status of the Global Observatory, which would be important for identifying gaps and opportunities in health research and development, and called on the Secretariat to convene an open-ended working group before the 138th session of the Executive Board to discuss pending research and development issues.

Ms VILAS (Argentina) requested more detailed information on how the governance structure of the Special Programme might be adapted to strengthen Member States' governance of the pooled fund and noted that, in accordance with decision WHA67(15), the current discussions were taking place without prejudice to further discussion on other sustainable mechanisms for health research and development. She stressed the importance of convening an open-ended meeting of Member States before the 138th session of the Executive Board and called on the Secretariat to prepare a report detailing the basic criteria required to ensure the sustainability of the pooled fund.

Dr DOGBE (Togo) said that his country supported the establishment of a pooled fund for voluntary contributions and had launched a national strategy in 2014 which aimed to promote health research and development and improve the availability and use of up-to-date health information.

Dr SALLEH (Malaysia) welcomed the establishment of a pooled fund for voluntary contributions hosted by the Special Programme for Research and Training in Tropical Diseases and said that the fund should be governed in accordance with the principle of equal but differentiated responsibilities.

Mr ALAOUI (Morocco) said that WHO should ensure that the funding of health research and development remained a national, regional and international priority. His country recognized the important link between health status of the population and sustainable development and had prepared a financial strategy for its national health care system with a view to extending universal health coverage.

Ms XING Ruoqi (China), expressing support for the establishment of a pooled fund, said that the Secretariat should set out detailed criteria regarding the number and professional background of the members of the proposed scientific working group of the Special Programme for Research and Training in Tropical Diseases. It should be ensured that a certain percentage of members came from developing countries. China supported management of the pooled fund by the Special Programme for Research and Training in Tropical Diseases and a replenishment model for its financing.

Ms HARMSTON (Canada) said that Canada supported the establishment of a pooled fund as part of the Special Programme for Research and Training in Tropical Diseases, rather than as a new structure, provided that contributions remained voluntary and the fund continued to be managed by the Special Programme. She was pleased that policies on management of conflicts of interest had been envisaged. A business plan should be prepared that took account of existing priorities, such as Ebola response and preparedness, and clearly defined the roles, responsibilities and funding required by the Special Programme and the Global Observatory.

Ms MATSOSO (South Africa), expressing support for the establishment of a pooled fund, said that her country planned to contribute to the demonstration projects and to the Alliance for Health Policy and Systems Research. The demonstration project proposed by the Council of Scientific and

Industrial Research of South Africa would be resubmitted. Significant progress had been made towards element 7 of the global strategy and plan of action on public health, innovation and intellectual property to promote sustainable financing mechanisms, but she urged Member States to implement all eight elements and called for regular reviews of the outcomes of the Global Strategy and Plan of Action in accordance with resolution WHA62.16.

Dr AHMED BASHEIR ABUKARAIG (Sudan) welcomed the establishment of a pooled fund for voluntary contributions and said that the current demonstration project under the Visceral Leishmaniasis Global Research and Development Initiative managed by the Drugs for Neglected Diseases Initiative had greatly increased her country's research capacity and its ability to combat the disease.

Ms SAMIYA (Maldives) asked the Secretariat to provide updated information on its progress towards establishing the Global Observatory. She welcomed the proposed pooled fund and governance structure, but stressed the need to establish a more concrete and predictable funding mechanism to support the long-term health research and development needs of developing countries.

Ms Wen-Huey KAO (Chinese Taipei) said that Chinese Taipei supported the goals concerning financing and coordination set by the Consultative Expert Working Group on Research and Development and was prepared to promote technology transfer and invest in research and development capacity on tropical diseases in developing countries.

Ms CASSEDY (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, said that the proposed pooled funding mechanism should cover all type I, II and III diseases for which the market-driven research and development model had failed to provide sustainable funding and should be governed in accordance with norms and standards that promoted needs-based research and development and affordable access to medical products.

Mrs BARRIA (Medicus Mundi International), speaking at the invitation of the CHAIRMAN, noted that the voluntary nature of the pooled fund would make it unsustainable and vulnerable to undue influence by donor countries, private entities and philanthropic organizations. She therefore urged Member States to defer their decision on the proposed pooled fund until the Sixty-ninth World Health Assembly.

Ms SANJUAN (MSF International), speaking at the invitation of the CHAIRMAN, said that the response to the Ebola virus disease epidemic showed what could be accomplished by applying some of the recommendations of the Consultative Expert Working Group. Voluntary contributions to demonstration projects were welcome, but were just a first step. A global biomedical research and development fund was needed. A date in 2015 should be set for an open-ended meeting of Member States to prepare for discussions during the Sixty-ninth World Health Assembly on the full report of the Consultative Expert Working Group.

Mrs HEUMBER (Drugs for Neglected Diseases initiative), speaking at the invitation of the CHAIRMAN, welcomed the establishment of the Global Observatory and Member States' commitment to the development of a global pooled fund. She urged WHO to address the urgent need for new and affordable health technologies for all types of diseases.

Dr KIENY (Assistant Director-General) welcomed the recent financial contributions made by Brazil, Norway, South Africa and Switzerland to implement the Consultative Expert Working Group strategic work plan and said that the Secretariat was in discussions with the European Commission to secure additional funding. She also thanked India for its efforts to classify different types of research for use by the Global Observatory. Responding to points raised, she said that the Secretariat had

started to develop the coordination mechanism and would inform Member States of its progress in the next report to the governing bodies on the strategic work plan. It would also prepare a comprehensive report on the progress made towards implementing the strategic work plan before the open-ended meeting of Member States and would make every effort to find a suitable date for the meeting in 2015. The Secretariat was working with South Africa in order to refine its demonstration project proposal. Updated information on the status of the Global Observatory was available online, including details on its expected launch date in January 2016.

The Committee noted the report.

Global strategy and plan of action on public health, innovation and intellectual property: Item 17.5 of the Agenda (Documents A68/35 and EB136/2015/REC/1, decision EB136(17))

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Bolivia (Plurinational State of), Brazil, Ecuador, India and South Africa, which read:

The Sixty-eighth World Health Assembly,

PP1 Having considered the report by the Secretariat on the global strategy and plan of action on public health, innovation and intellectual property,[1]

PP2 Recalling resolutions WHA61.21 and WHA62.16 on the global strategy and plan of action on public health, innovation and intellectual property that aims to promote new thinking on innovation and access to medicines, as well as, based on the recommendation of the report of the Commission on Intellectual Property Rights, Innovation and Public Health, provide a medium-term framework to secure an enhanced and sustainable basis for needs-driven, essential health research and development relevant to diseases that disproportionately affect developing countries, proposing clear objectives and priorities for research and development, and estimating funding needs in this area;

PP3 Recognizing the central role the global strategy and plan of action on public health, innovation and intellectual property plays in directing and coordinating WHO's policies and programme of work on public health, innovation and intellectual property;

PP4 Welcoming resolution EBSS3.R1 entitled "Ebola: ending the current outbreak, strengthening global preparedness and ensuring WHO's capacity to prepare for and respond to future large-scale outbreaks and emergencies with health consequences" which reaffirms the global strategy and plan of action on public health, innovation and intellectual property;

PP5 Concerned that Governments, WHO, other international intergovernmental organizations and other relevant stakeholders have yet to fully implement the global strategy and plan of action on public health, innovation and intellectual property;

PP6 Having considered the recommendations of the Executive Board to the Sixty-eighth World Health Assembly contained in decision EB136(17),

(OP.1) DECIDES:

(OP1.1) to extend the time frames of the plan of action on public health, innovation and intellectual property from 2015 until 2022;

(OP1.2) to extend the deadline of the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property on its achievements, remaining challenges and recommendations on the way forward to 2018, recognizing that it was not presented in 2015, as requested by resolution WHA62.16;

[1] Document A68/35.

(OP1.3) to undertake the comprehensive evaluation and overall programme review of the global strategy and plan of action on public health, innovation and intellectual property separately in a staggered manner, in consultation with Member States, as set out in document A68/35 and its Annex;

(OP.2) REQUESTS the Director-General:

(OP2.1) to initiate the comprehensive evaluation of the global strategy and plan of action on public health, innovation and intellectual property in June 2015; to present the inception report and comments of the Evaluation Management Group for the consideration of the Executive Board at its 138th session in January 2016; and to submit the final comprehensive evaluation report for the consideration of the Seventieth World Health Assembly in 2017, through the Executive Board;

(OP2.2) to convene an ad hoc Evaluation Management Group to assist the comprehensive evaluation composed of 12 independent external experts (all subject matter experts, identified from a pool of experts proposed by Member States, and representing all six regions), and two evaluation experts from the United Nations Evaluation Group;

(OP2.3) to establish a panel of experts to conduct the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property with a broad mix of expertise, practical experience and backgrounds covering the eight elements of the global strategy and plan of action on public health, innovation and intellectual property, and including experts from developed and developing countries identified by the Director-General from a pool of experts proposed by Member States;

(OP2.4) to invite Member States to nominate experts to compose the panel of experts of the overall programme review whose details, following consultations with regional committees to achieve gender balance and diversity of technical competence and expertise, shall be submitted to the Director-General through the respective Regional Directors;

(OP2.5) to present the Terms of Reference and the composition of the overall programme review panel for the consideration of the Executive Board at its 140th session in January 2017;

(OP2.6) to present a progress report on the overall programme review to the Seventieth World Health Assembly in 2017 and to present the final report of the overall programme review of the global strategy and plan of action on public health, innovation and intellectual property to the Seventy-first World Health Assembly in 2018, through the Executive Board, giving details of its achievements, the remaining challenges faced and its recommendations on the way forward.

The financial and administrative implications for the Secretariat of adoption of the draft resolution were:

1. Resolution: Global strategy and plan of action on public health, innovation and intellectual property	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)	
Category: 4. Health systems	
Programme areas: Access to medicines and health technologies and strengthening regulatory capacity	Outcome: 4.3. Improved access to and rational use of safe, efficacious and quality medicines and health technologies Output: 4.3.2. Implementation of the global strategy and plan of action on public health, innovation and intellectual property

How would this resolution contribute to the achievement of the outcome of the above programme areas?

The global strategy and plan of action on public health, innovation and intellectual property aims to increase research and development needed for products for diseases that disproportionally affect developing countries, where access to needed medical technologies is hindered by market failures. By extending the time frame of the global strategy and plan of action, WHO will be able to keep its momentum and continue to advocate the implementation of policies and activities that increase the availability of the most needed products. The results of the evaluation exercise will help the Health Assembly to determine new policies to improve the current strategy and ensure the effectiveness of WHO's actions.

Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US$ 10 000).

(i) The global strategy and plan of action will be extended, covering the period 2015–2022; the evaluation of the global strategy and plan of action will be for the period from June 2015 to May 2017; overall programme review, covering the period 2017–2018.

(ii) Extension of the global strategy and plan of action: US$ 100 million (staff: US$ 60 million; activities: US$ 40 million).

Evaluation of the global strategy and plan of action: US$ 470 000 (staff: US$ 70 000; activities: US$ 400 000).

Overall programme review: US$ 1.6 million (staff: US$ 1.1 million; activities US$ 500 000)

Total: US$ 102.07 million.

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US$ 10 000).

Evaluation of the global strategy and plan of action: US$ 250 000 (staff: US$ 30 000; activities: US$ 220 000)

Total: US$ 250 000

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

The majority of the activities will take place at headquarters and in the regional offices.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If "no", indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If "no", indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

For the implementation of the strategy from 2015 to 2022, nine additional full-time equivalent staff members in the professional and higher categories and three full-time equivalent staff members in the general service category will be required at headquarters, and two full-time equivalent staff members in the professional and higher categories and one full-time equivalent staff member in the general service category will be required in each regional office. For the programme review, two full-time equivalent staff members in the professional and higher categories and one full-time equivalent staff member in the general service category will be required for 18 months at headquarters.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)

No.

If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The funding gap is US$ 250 000. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) expressed support for the proposal regarding the evaluation exercise. Accepting the plan put forward in the report (document A68/35) would enable the planned evaluation to go ahead and lend credibility to the work on the topic. The proposed timeline was challenging, however, and she cautioned that rushing the process risked compromising the quality of the output.

Ms GONZÁLEZ (Uruguay), speaking on behalf of the Members of the Union of South American Nations, said that the Ebola virus disease outbreak had reminded everybody of the importance of investing in research and development, particularly in relation to diseases for which there were not sufficient financial incentives for innovation. The proposal put forward in the report was a significant improvement with respect to that in the document submitted to the Executive Board at its 136th session. The evaluation should be conducted in stages and with the greater involvement of and consultation with Member States through the regional offices. She supported the extension of the time frame of the plan of action on public health, innovation and intellectual property and the deadline for the overall programme review, in line with decision EB136(17).

Dr SHOHANI (Iraq) underscored the importance of the topic, not only for innovation but also for reducing the price of medicines, vaccines and other essential requirements for public health. Appropriate regulation guaranteeing intellectual property rights would preserve the continuity of research, development and innovation for progress benefiting resource-poor and low-income communities, in addition to ensuring the delivery of improved services to vulnerable groups in all countries as part of an agreed strategy.

Ms VILAS (Argentina), underlining the importance of regional consultations coordinated by the regional offices, said that the proposed ad hoc evaluation management group and the panel of experts should be composed of 18 Member States each, three from each region. Argentina was willing to take part in those efforts. The evaluation should include the progress indicators proposed in document A62/16 Add.2 and accepted in resolution WHA62.16, together with a disaggregated analysis taking into account the specific characteristics of each element of the global strategy and plan of action.

Mrs UTEEM (Mauritius), speaking on behalf of the Member States of the African Region, said that high reliance on imported pharmaceutical and medical products remained a concern for African countries. The amendment to Article 31 of the Agreement on Trade-Related Intellectual Property Rights (TRIPS), allowing imports of pharmaceutical products manufactured under compulsory licensing, had not yet come into force. Research and development resources must be more focused on addressing the health needs of the developing world. The main challenges were tariff protection, limited financial resources and lack of capacity and skilled human resources in the area of intellectual property. Moreover, many African countries had yet to develop the essential manufacturing capacity for the efficient use of compulsory licensing. The Member States of the Region supported the proposed extensions of the deadline for the overall programme review and time frame of the global strategy and plan of action, the composition of an ad hoc evaluation management group and the proposed terms of reference for the overall programme review.

Dr MUSTAPHA (Malaysia) asked to what extent the global strategy and plan of action, five years after adoption, had achieved the aims of fostering innovation and improving access to health products for people in developing countries, especially in relation to overly broad intellectual property

protection and multilateral trade agreements. Noting that many stakeholders had yet to implement the global strategy and plan of action, he expressed support for the draft resolution.

Dr PANDA (India) said that the proposed extension of the global strategy and plan of action until 2022 would lead to investment with implications for innovation, research and development. Greater involvement of Member States and stakeholders was needed to ensure sustainable outcomes from research and development to generate health products and tackle diseases. India supported the draft resolution and strongly urged other Member States to do so. The evaluation mechanism should be Member State-driven, and account should be taken of their determination to de-link the cost of research and development from the price of medical products.

Ms XING Ruoqi (China), supporting the draft decision, said that China agreed that the comprehensive evaluation and overall programme review should be undertaken separately in a staggered manner and endorsed the convening of an ad hoc evaluation management group. She agreed that the panel of experts should include persons from developed and developing countries identified by the Director-General from a pool of experts proposed by Member States. The review should be policy-oriented in order to ensure a better understanding of policy environments and lead to forward-looking suggestions.

Dr PERERA DE SILVA (Sri Lanka) recalled that Sri Lanka had been the first country to carry out a country assessment and draw up recommended strategies for a plan of action. That document was available as a joint publication by the Sri Lankan Ministry of Health and Indigenous Medicine and WHO. Sri Lanka was willing to share the lessons it had learnt with Member States intending to undertake a country assessment.

Mr MOUNTAKA BOUARÉ (Mali) said that the global strategy on public health, innovation and intellectual property was an integral part of the national research framework of Mali.

Dr SAGUNI (Indonesia) said that, driven by public health needs, Indonesia had generated patents and copyright on products such as herbal medicines and invested in medical product research and development. However, research budget constraints posed a challenge. His Government strongly supported implementation of the TRIPS agreement, notably the provisions on compulsory licences and "Bolar exemptions", in order to increase access to affordable medicines. Indonesia supported the draft resolution.

Mr MAMACOS (United States of America) expressed surprise that the draft resolution differed from the apparent agreement reached during informal discussions in the context of the 136th session of the Executive Board, which had moved towards consensus on an evaluation looking at the implementation of the global strategy and plan of action and a more forward-looking programme review in terms of implementation. His country remained committed to that approach. The evaluation should adhere to the guidelines in WHO's *Evaluation Practice Handbook*. He expressed concern about the proposal for Member State selection of the evaluation management group, which was inappropriate and risked politicizing the process, and requested suspension of discussion on the item in order to carry out consultations on the draft resolution.

Mrs SITANUN POONPOLSUB (Thailand), supporting the draft resolution, said that Thailand agreed on the need to extend the deadline for the programme review to 2018 and the time frame for the plan of action to 2022 and to conduct the comprehensive evaluation and overall programme review in a staggered manner. It also agreed with the proposed appointment of a panel of experts for the overall programme review identified by the Director-General from a pool of experts proposed by Member States.

Ms PACHECO RODRÍGUEZ (Plurinational State of Bolivia) expressed support for the development of a global framework for the development of medicines based on public health criteria. She also supported the extension of the time frame of the plan of action and the extension of the deadline for the overall programme review. The review should be conducted by an ad hoc evaluation management group composed of 12 independent external experts proposed by Member States. The overall programme review should be carried out by a panel of 18–24 experts in order to have at least three or four regional representatives.

Mrs VALLINI (Brazil) said that the challenges to the global strategy on public health, innovation and intellectual property remained real, especially for developing countries. During the 136th session of the Executive Board, Brazil had highlighted the importance of greater involvement of and consultation with Member States in the comprehensive evaluation and the overall programme review, and she continued to emphasize the importance of Member State consultation, with ample involvement of regional offices. She supported the proposed extensions of the deadline for the programme review and the time frame of the plan of action.

Ms ANDIA (Colombia) welcomed the additional indicators proposed by the Secretariat to measure progress, which were in line with the criteria and recommendations of the Consultative Expert Working Group. A comprehensive and substantive evaluation would help Member States to make better-informed decisions, and she therefore supported the proposed extension of the deadline for the review. The global strategy and plan of action were fundamental to the promotion of new forms of innovation and development that would expand therapeutic alternatives and ensure better access to medicines. Colombia supported the draft resolution.

Dr FONES (Chile) said that the global strategy and plan of action had provided a clear mandate to address challenges relating to innovation and access to medical products, especially for developing countries, with a focus on public health and an emphasis on equitable, sustainable and affordable access. The global strategy's eight elements remained highly relevant. Although some progress had been made, much remained to be done. Chile supported the draft resolution.

Dr BRYANT (Australia) sought clarification from the Secretariat regarding an appropriate time frame for the evaluation, in the light of decision EB136(17). The evaluation should comply with WHO's evaluation policy and be impartial, independent, useful and transparent. Ad hoc evaluation processes should be rigorously avoided. Any agreed time frame should be closely followed to avoid further delays in completion of the evaluation. In line with the evaluation policy, the evaluation management group should be a technical, expert-led group with limited Member State involvement, in order to ensure that it provided comprehensive technical advice on the process.

Mr Lin-Huang HUANG (Chinese Taipei) emphasized the urgent need for improvements in international cooperation and priority-setting for research and innovation. Funding for research and development on public health in developing countries, while also promoting respect for intellectual property, would contribute to healthy societies. Chinese Taipei was working to build its capacity for innovation with regard to health care and medical treatments and was willing to share its experience with others.

Mr JENKINS (World Federation of Public Health Associations), speaking at the invitation of the CHAIRMAN, said that the global strategy focused overly on intellectual property. Member States might consider either revising the innovation and public health parts of the strategy or renaming it and then formulating a separate strategy that really focused on the public health action and innovation that were desperately needed in a rapidly changing globalized world. His organization was finalizing a comprehensive and flexible global framework for public health functions, which should be one of the information documents considered in future discussions of the global strategy and plan of action.

Dr ELIASZ (The World Medical Association, Inc.), speaking at the invitation of the CHAIRMAN, welcomed the proposal to extend the time frame of the global strategy and plan of action to 2022. As the goals of the plan had not been fully realized, it was vital that a robust and comprehensive evaluation be conducted and adequate support for work under the plan ensured. WHO's role in ensuring policy coherence between trade and health at regional and global levels was of paramount importance. In the context of current negotiations on a new generation of "mega" trade agreements, WHO should seek to protect and prioritize public health over commercial interests and ensure that trade agreements did not hinder access to health services or medicines or interfere with governments' ability to guarantee the right to health to all their citizens.

Ms GUPTA (MSF International), speaking at the invitation of the CHAIRMAN, expressed support for the extension of the time frame of the global strategy, which was far from being fully implemented. The failings of the current research and development system were increasingly apparent: new essential medicines were coming to the market at unaffordable prices and the price of the basic vaccine package was 68 times higher than in 2001. Some governments, pushed by multinational pharmaceutical companies, were seeking to increase intellectual property protection worldwide, which would further hinder access to treatments, diagnostics and vaccines. The Trans-Pacific Partnership agreement could be the most damaging trade agreement to date in terms of access to medicines. She called on WHO to take bold, decisive action to introduce policies that increased access to medicines and new models of innovation that de-linked research and development financing from the price of medicines.

Ms SINGHROY (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, said that a strong, effective global strategy and plan of action were urgently needed in order to address gaps in access to life-saving medicines. Broad multilateral trade agreements such as the Trans-Pacific Partnership could profoundly harm global health. She urged the Health Assembly to call on Member States not to adopt free trade agreement provisions that would undermine their public health needs and to implement the principle of de-linkage. She encouraged the Secretariat to support countries wishing to exercise their rights under the TRIPS agreement and to increase transparency in the extension process and new evaluation procedures.

Dr KIENY (Assistant Director-General) thanked speakers for their commitment to the implementation of the global strategy and for their willingness to extend the time frame for the plan of action.

The Committee noted the report.

The CHAIRMAN recalled a request to suspend deliberations in order to allow more time for consultations among Member States on the draft resolution and on the draft decision contained in decision EB136(17).

Mr BURCI (Legal Counsel) clarified that decision EB136(17) did not contain a draft decision for consideration by the Health Assembly; it made recommendations to the Health Assembly concerning the extension of the deadline for the review of the global strategy and plan of action and the time frame of the plan of action and made several requests of the Director-General. The draft resolution in essence proposed several actions in response to those elements of the decision. Accordingly, the only decision to be taken by the Committee concerned the draft resolution.

Following a discussion on the feasibility of establishing a formal drafting group, in which Mrs VALLINI and Mr DALCERO (Brazil), Mr MAMACOS (United States of America), Ms MATSOSO (South Africa), Ms LUNA (Ecuador), Ms PACHECO RODRÍGUEZ (Plurinational State of Bolivia) and Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) took part,

the CHAIRMAN suggested that the interested Member States should hold informal consultations with a view to reaching consensus on the draft resolution.

It was so agreed.

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

2. STAFFING MATTERS: Item 23 of the Agenda

Human resources: Item 23.1 of the Agenda (Documents A68/44 and A68/61)

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, reported on the Committee's consideration of the report by the Secretariat on human resources, as reflected in document A68/61. The Committee, on behalf of the Executive Board, had recommended that the Health Assembly take note of the report contained in document A68/44.

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

The meeting rose at 17:30.

SIXTH MEETING

Monday, 25 May 2015, at 09:15

Chairman: Mr M. MALABAG (Papua New Guinea)

1. STAFFING MATTERS: Item 23 of the Agenda (continued)

Human resources: Item 23.1 of the Agenda (Document A68/44) (continued from the fifth meeting, section 2)

Dr HINOSHITA (Japan) welcomed the work on staff mobility, but drew attention to the need to estimate adequately the funding required for implementing the scheme, and to take account of the particular expertise of staff when assigning them to a particular post. The geographical representation of Member States needed to reflect better the concerns of different regions, and the appropriate distribution of human resources should be taken into account in the recruitment process.

Mr KUEMMEL (Germany) said that the mobility policy represented a strategic step towards enhancing corporate alignment, although there was still a need to increase knowledge transfer across the three levels of the Organization. To be successful, rotation needed to be centrally administered; have the support of staff members, with the reasons and incentives for rotation being better communicated to them; and be implemented in a fair and transparent manner. In that connection, he sought clarification on the non-rotation of posts. He also requested information on the number of interns currently working in the Organization, and on the rules governing their presence, taking into account the high cost of living in many locations of WHO offices.

Ms ANDERSSON (Sweden), speaking on behalf of the Nordic and Baltic countries, Denmark, Finland, Norway, Sweden, Estonia, Latvia and Lithuania, highlighted the need for a skills inventory, adding that such an inventory would have made it easier to identify staff with the right skill set for immediate deployment during the Ebola virus disease outbreak. While supporting the introduction of the new global staff mobility scheme as a fundamental part of WHO reform that would help to make it a truly global rather than regionalized organization, and commending the progress made in implementing the human resources strategy and new performance management and development framework, she sought clarification regarding the measures being undertaken to accelerate the attainment of gender balance.

Mrs SHIPTON-YATES (United Kingdom of Great Britain and Northern Ireland) said that it had been difficult to review the report owing to its late arrival. The outbreak of Ebola virus disease had shown that WHO had not had the necessary processes in place to facilitate deployment of people with the right skills. It was reassuring to learn that a new recruitment system was being developed, and she would welcome an indication of the expected deadline for drawing up a skills inventory. Commending the changes to staff mobility and performance management, she asked for feedback on the recommendation of the Independent Expert Oversight Advisory Committee that compliance should be linked to individual performance evaluation. Welcoming the progress so far in human resources management, and the acceleration of the human resources strategy relative to the original time frame, she called on the Director-General and regional directors to support all efforts to take those processes further.

Ms WANG Qianyun (China) said that improvements being carried out within the Organization since the outbreak of Ebola virus disease would enhance its capabilities in future emergencies. In implementing the staff mobility scheme, the Secretariat should hold consultations with Member States to ensure that international and regional mobility schemes were in line with the needs of local situations and that cooperation between countries would be enhanced. Efforts being made to achieve geographical balance in recruitment were welcome, but the Organization needed to take further steps to increase the proportion of personnel recruited from certain underrepresented Member States.

Mr COTTERELL (Australia) commended WHO's efforts to strengthen its human resource capability, and hence urged the Secretariat to accelerate the process of human resource management reform in consultation with regional and country office staff members. The Ebola crisis had demonstrated the importance of a strong WHO with the capability to deploy people with the right skills to respond to health emergencies. Retaining talent and adapting to changing circumstances were crucial for WHO's ongoing effectiveness. While welcoming the progress made in developing the global mobility scheme, he drew attention to the need to improve gender balance and geographical representation across the three levels of the Organization.

Ms HERNANDEZ NARVAEZ (Mexico) requested that future reports on human resources include aggregated information on the geographical distribution of staff and gender balance, so that progress in those areas could be assessed. With regard to geographical representation, noting that numerous countries were either underrepresented or unrepresented, she suggested taking account of projected retirements over the next 10 years in order to achieve a better balance. Further efforts were required to reach gender parity, particularly in the professional and higher categories. In implementing the staff mobility scheme, a balance should be maintained between costs and benefits, and some basic criteria should be established to ensure a match between skills and assignment, as well as a transparent selection process.

Mr KOLKER (United States of America) placed emphasis on the importance of initiatives that kept human resources policies at the forefront of a dynamic, relevant and adaptable WHO. Human resources policies and practices were the key to creating a WHO with a more flexible and mobile workforce and a high-performance culture. With regard to the new performance management and development framework, he particularly welcomed the policy on rewarding excellence and dealing with underperformance, with its clear guidance to supervisors in those areas and its toolkit of practical steps to be taken, and urged the Secretariat to oversee the cultural change needed to implement the framework. In the administration of justice, he supported a system that included informal mechanisms for managing conflict, mediation and a well-functioning ombudsman. He echoed the positive comments of the Independent Expert Oversight Advisory Committee about the human resources strategy, but shared its concern over the level of buy-in by all stakeholders.

Dr DUSHIME (Rwanda), speaking on behalf of the Member States of the African Region, observed that one key lesson learnt from the outbreak of Ebola virus disease was that WHO urgently required an internal infrastructure, systems and tools, including adequate human resources equitably distributed throughout WHO, in order to ensure a rapid response and the deployment of a specialized workforce. It was therefore important to accelerate the process of reform, in particular managerial reform including human resources management, to enable WHO to attract and retain competent and skilled human resources.

Mr DIKMEN (Turkey) expressed disappointment over the slow rate of progress in implementing the human resources strategy and indicated that his Government attached great importance to a transparent and coherent process, and an approach which prioritized both gender and geographical balance in the selection and distribution of staff.

Ms MATSOSO (South Africa) welcomed the increase in the percentage of women in the professional and higher categories, which was now 41.7%. The strengthening of human resources through the appointment of high-calibre candidates would help to ensure continuity in the transition from Millennium Development Goals to sustainable development goals.

Ms NOCQUET (Human Resources Management) said that measures had been taken to raise managers' awareness of the need for improvement in both gender balance and geographical representation, as part of the accountability compact and of performance appraisals. Umbrella agreements had been concluded with search firms to help to identify qualified candidates from underrepresented countries for senior positions. Gender balance and geographical representation had been included among the performance indicators for the Programme budget 2016–2017, and managers would be asked to use staff retirements as an opportunity to achieve improvements in both areas. The response to the Ebola virus disease crisis had demonstrated the need for better systems and tools in order to attract candidates and map skills and competencies. A new computerized system was under development and she would report on the outcome to the Sixty-ninth World Health Assembly. Turning to mobility across the Organization and the importance of a transparent process, she stated that staff representatives would be included in future mobility exercises. Mobility would be operated on a voluntary basis for two or three years beginning in 2016, after which the outcome would be assessed.

The recent amendments to the Staff Rules would make it easier to deal more effectively with non-compliance with standards of conduct.

Mr DE ANDRADE FILHO (Brazil) expressed the view that the debate on WHO reform should go beyond issues of scarcity of financial resources or interaction with non-State actors to include the need for further changes in the role of WHO as the leader in global health. That would involve strengthening human resources through a transparent reform process and ensuring enough human resources with the right skills to carry out priority actions agreed by the Member States and the governing bodies. Such optimization was essential for retaining personnel centrally and at the regional level, with a view to greater productivity and dealing with the real problems at the local level.

In response, Dr TROEDSSON (Assistant Director-General) said that when discussing the resource situation, it should not be forgotten that staff were WHO's most important asset, and should be managed and utilized in an optimal way. The human resources reform was therefore a key priority for the Secretariat. Regarding the issues raised on the Ebola virus disease outbreak, work was in hand to develop a staff skills inventory for the whole Organization. With a view to rapid deployment, which had been observed to be the key response in any emergency, the inventory would be complemented by a roster of staff members, at all three levels of the Organization, who could be deployed rapidly as a team to a developing emergency situation. The proposed mobility scheme would be Organization-wide and would foster a corporate approach. In reply to the delegate of China, he said that the scheme could be used to provide more effective and flexible technical cooperation with Member States, based on their individual needs, and would allow for new positions to be created in countries when needs arose and old ones to be abolished when country offices no longer required them. He welcomed the proposal by the United Kingdom to link compliance with the performance assessment process, which the Secretariat would follow up.

Mr KASE (Papua New Guinea) said that human resources in all countries were vital for the delivery of health care to their populations. Strengthening of WHO systems, including development of a flexible human resources strategy, was important to a timely and appropriate global response to outbreaks. Referring to the failure to pay health workers in Sierra Leone despite the provision of billions of dollars for the response to Ebola in that country, and to the very low salaries of health workers in developing countries in general, he suggested that mechanisms be implemented to address salary disparities and ensure that local health workers remained committed during disease outbreaks,

rather than retreating as had been the case in Papua New Guinea, where health staff unions were very strong.

The Committee noted the report.

Report of the International Civil Service Commission: Item 23.2 of the Agenda (Document A68/45)

Ms HERNANDEZ NARVAEZ (Mexico) said that the work of the International Civil Service Commission, particularly the decisions adopted in 2015 by the United Nations General Assembly, would have a significant impact on human resources management in organizations and specialized agencies, including WHO. Regarding the review of the common system compensation package, Mexico had requested the Commission to present a new straightforward package that was easy to manage and would take into account the financial difficulties faced by United Nations agencies as a result of rising staff costs. With regard to the pending General Assembly decision on when to raise the age of retirement of current staff to 65 years, the Mexican delegation would be attentive to the repercussions that would have on human resources management in the Organization. In the light of the poor progress so far, WHO should apply the recommendations of the Commission to achieve gender parity, including the request for organizations to hold managers accountable for achieving established gender targets.

Ms EL-HALABI (Botswana), speaking on behalf of the Member States of the African Region, welcomed the Commission's work but said that the issues of poor geographical representation and gender parity in the United Nations system urgently needed to be addressed, to ensure wide ownership by all the peoples of the United Nations and to meet the challenges posed by the increasingly diverse assignments given by Member States. The organizations within the system, including WHO, should therefore fully implement the Commission's recommendations as well as the existing policies and measures on the issue. Continuous reviews to improve the conditions of service for United Nations staff, including WHO, were indispensable. It was imperative to keep searching for ways to recognize high performance and address underperformance, and to boost staff morale, particularly in difficult duty stations. She noted with appreciation the progress report on the compensation review and looked forward to the finalization of the package proposal. The Director-General should accelerate the implementation of decisions taken by the General Assembly on the Commission's recommendations that required a revision of WHO's Staff Rules.

Ms MNISI (South Africa) welcomed the report and commended the International Civil Service Commission for organizing the global staff survey. However, a solution needed to be found to the problems faced by senior management in ensuring that their organizations had the technical capacity to fulfil their mandates. It was concerning that the goal of gender parity in the United Nations common system had not been met, and that organizations had failed to implement all of the Commission's previous recommendations.

Ms NOCQUET (Human Resource Management) noted the relevant comments on the Commission's activities and reiterated that the General Assembly's decisions would need to be reflected in WHO's Staff Regulations and Staff Rules. She would respond to Member States when the Secretariat presented the amendments to the Staff Rules.

The Committee noted the report.

Amendments to the Staff Regulations and Staff Rules: Item 23.3 of the Agenda (Documents A68/46 and EB136/2015/REC/1, resolutions EB136.R12 and EB136.R15)

Dr COMBARY (Burkina Faso), speaking on behalf of the Member States of the African Region, said that the financial implications relating to the adoption of resolution EB136.R12 had been examined and validated. The adoption of resolution EB136.R15, which would require amendments to several Staff Regulations, would lead to more effective management of human resources. As the Staff Regulations and Staff Rules for the Region of the Americas were different, mobility to and from the Region would be limited.

The Committee noted the report and approved the draft resolutions contained in EB136.R12 and EB136.R15.[1]

Report of the United Nations Joint Staff Pension Board: Item 23.4 of the Agenda (Document A68/47)

The Committee noted the report.

Appointment of representatives to the WHO Staff Pension Committee: Item 23.5 of the Agenda (Document A68/48)

The CHAIRMAN proposed the nomination of Dr Michel Tailhades (Switzerland) as a member of the WHO Staff Pension Committee for a three-year term until May 2018.

It was so decided.[2]

2. THIRD REPORT OF COMMITTEE B (Document A68/70)

Dr FONES (Chile), Rapporteur, read out the draft third report of Committee B.

The report was adopted.[3]

3. HEALTH SYSTEMS: Item 17 of the Agenda (continued) [Transferred from Committee A][4]

Global strategy and plan of action on public health, innovation and intellectual property: Item 17.5 of the Agenda (Document A68/35) (continued from the fifth meeting, section 1)

Dr ONDARI (Secretary) said that he had been informed that the reference to the footnote to operative paragraph 2.5 would be deleted.

Mr VON KESSEL (Switzerland) underscored the importance of implementing the global strategy and plan of action on public health, innovation and intellectual property. As considerable challenges remained with respect to research, development and access to medicines against diseases

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolutions WHA68.16 and WHA68.17.

[2] Transmitted to the Health Assembly in the Committee's fourth report and adopted as decision WHA68(13).

[3] See page 368.

[4] See the summary record of the General Committee, first meeting, section 2.

that disproportionately affected low- and middle-income countries, he supported extension of the period covered by the action plan to 2022. Although his country would have opted for combining the comprehensive evaluation and the overall programme review, it accepted the compromise reached to undertake a separate review in a staggered manner. The evaluation should remain as technical and non-politicized as possible in order that it could serve as a basis for the drafting of recommendations.

Mr SVERSUT (Brazil) thanked the delegate of South Africa for leading the informal discussions and applauded the spirit of compromise shown by all Member States involved. The overall programme review would assist in identifying remaining challenges and driving the discussion forward, while the comprehensive evaluation would provide important input for the whole process.

Mr MAMACOS (United States of America) said that the issue of public health, innovation and intellectual property, which was important worldwide, was often contentious. He appreciated the spirit of compromise that had enabled agreement on the approach for the evaluation and review.

The draft resolution, as amended, was approved.[1]

4. MANAGEMENT MATTERS: Item 24 of the Agenda

Real estate: update on the Geneva buildings renovation strategy: Item 24.1 of the Agenda (Documents A68/49 and A68/62)

Mr MORIKO (Côte d'Ivoire), speaking on behalf of the Member States of the African Region, endorsed the selection of Option 1 as a strategy for the construction, demolition, refurbishment and sale of the buildings on WHO's headquarters site, which was in line with environmental protection standards, incorporated new information technologies and the use of renewable energy, and took into account access for persons with disabilities. He urged the project team to consider planning for additional work-spaces needed during the construction phase; undertaking a more thorough evaluation of the main benefits of the renovation and establishing measures to ensure their attainment; and conducting a risk assessment regarding security and environmental damage arising from the demolition of some of the buildings and establishing measures to minimize those risks. Given the fluctuation of the Swiss franc, he emphasized the need for detailed planning in order to manage the total cost of the project.

Ms HERNANDEZ NARVAEZ (Mexico) said that the final report should take into account the various financing mechanisms, a comprehensive risk assessment framework and cash flow forecasts. She noted the figure of 250 million Swiss francs as the estimated final cost, but urged WHO to make every effort to prevent a rise in that estimate and asked how the construction of the new buildings would be funded in the event of an increase. Noting that the Real Estate Fund would finance the total renovation cost of the main building, she urged WHO to ensure the viability of that financing mechanism to prevent any impact on the programme budget and thus on Member States' assessed contributions. As the new buildings would entail smaller-scale maintenance tasks in the future, further information would be appreciated on the financing of the Real Estate Fund post-2025. It was essential to establish a sound governance structure from the outset of the construction project in order to aim for its completion within the estimated time limits and costs.

Mrs SHIPTON-YATES (United Kingdom of Great Britain and Northern Ireland) welcomed the recent holding of a meeting to inform Member States of the status of the renovation strategy, which demonstrated increased transparency. She welcomed the proposed governance structure, urging that

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA68.18.

the briefings to Member States should continue. Encouraging the Secretariat to develop appropriate mechanisms to manage the timelines, costs and risks of the renovation project, she urged that future maintenance costs should be incorporated into project planning. Further information would be welcomed concerning the life-cycle management of the new buildings and on the financing of the project, including the discussions relating to innovative financing mechanisms.

Mr LEWIS (Canada) welcomed the commitment to provide regular briefings to Member States on the Geneva buildings renovation strategy and the addition of a Member State advisory group to the governance structure. The comprehensive technical and financial report, to be presented to the Executive Board in January 2016, should be released as early as possible to enable meaningful review by Member States, especially if the report was to be the basis for a decision to be taken at the Sixty-ninth World Health Assembly. The financing details should be fully spelt out in the report in order that Member States should not be faced with an increase in costs. He stressed the need for a detailed life-cycle management plan from the outset, which was essential to ensure that the buildings were fit for purpose and durable.

Mr PRESTON (Operational Support and Services) said that past failure to account for life-cycle maintenance had resulted in the present need to reconstruct and renovate the headquarters buildings. For the future, the building information modelling system would specify all items involved in the reconstruction and renovation, and would enable the project team to forecast costs, establish a comprehensive maintenance schedule for the life cycle of the building and estimate the requirements for the forthcoming 40 years. Acknowledging the concerns regarding the budgeting and timelines of the project, he recalled that the governance structure had been set up to manage those aspects and that regular briefings would be held to update Member States on the progress of the project. The Real Estate Fund would not be used to pay directly for the construction. Furthermore, a contingency amount was integrated into the renovation budget but would not be used without prior consultation with the Member States. He said that he firmly believed that the project could be carried out in accordance with the predicted budget.

The Committee noted the report.

5. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 25 of the Agenda (Document A68/50)

Mr KASEM (Jordan) asserted the importance of coordination and consultation among international organizations and in turn between them and government entities, in particular ministries of health, with regard to the alignment of agreed action plans with national health plans and strategies. Such coordination was particularly vital in times of crisis so as to bring together relief and response efforts and thus avoid their duplication and fragmentation. It must furthermore take place at the highest levels and primarily involve WHO representative offices or other international bodies.

Mr BROWN (United States of America) noted that the Ebola virus disease outbreak had created a particularly challenging year for WHO, requiring it to broaden its collaboration with other United Nations agencies. He noted the importance of the interplay between the Ebola Interim Assessment Panel and the United Nations Secretary-General's High-Level Panel on the Global Response to Health Crises. He appreciated the contribution of the Organization to the post-2015 development agenda, which was important in reaching a technically sound set of targets and indicators. He also applauded WHO's commitment to joint efforts, which promoted best practices and maximized resources.

The Committee noted the report.

6. NONCOMMUNICABLE DISEASES: Item 13 of the Agenda [Transferred from Committee A][1]

Outcome of the Second International Conference on Nutrition: Item 13.1 of the Agenda (Documents A68/8 and EB136/2015/REC/1, decision EB136(4))

Mr COTTERELL (Australia) congratulated all involved in the development and adoption of the Rome Declaration on Nutrition and the Framework for Action, which provided voluntary policy options for Governments to implement in accordance with their national situations. With a view to increased effectiveness, the follow-up to the Second International Conference on Nutrition should be consistent with the post-2015 development agenda. He supported the draft resolution endorsing the outcome documents of the Second International Conference on Nutrition.

Dr HINOSHITA (Japan) welcomed the Rome Declaration and Framework for Action and called for their prompt implementation. Nutrition-related frameworks should be developed for all life stages and a multisectoral approach should be adopted to address issues with respect to nutrition, such as food safety and education. Increased coordination would be required between agencies and authorities in the fields of health and agriculture.

Dr THITIKORN TOPOTHAI (Thailand) said that the report would assist his country in implementing its national strategy on maternal, infant and young child nutrition, which remained a challenging process. He requested the Secretariat to provide technical assistance to Member States in order to ensure effective implementation at national level of the outcome documents of the Second International Conference on Nutrition and to develop accountability frameworks with a view to attaining the six global nutrition targets for 2025 adopted by the Sixty-fifth World Health Assembly in May 2012. The success of those targets was dependent on the willingness of Member States to implement the Rome Declaration and the Framework for Action, with the support of WHO.

Mr FELKNER (Germany) reaffirmed Germany's commitment to the Rome Declaration on Nutrition and the Framework for Action and urged all countries and stakeholders to ensure their implementation. Germany also supported the proposal to declare a Decade of Action on Nutrition (2016–2025), within existing structures and available resources, which could help to raise awareness of the importance for sustainable development of enhancing nutritional status. The concept note on the subject prepared by WHO and FAO would provide a sound basis for further discussion on the follow-up to the Second International Conference on Nutrition. Germany looked forward to more fruitful discussions, and a more positive outcome at the seventieth session of the United Nations General Assembly than at the sixty-ninth session.

Dr ALI YAHIA ELABBASSI (Sudan), speaking on behalf of the Member States of the Eastern Mediterranean Region and expressing appreciation for the report by the Director-General, said that the Region stood ready to implement the Rome Declaration on Nutrition and the Framework for Action, through steps to identify the major causes of malnutrition and cost-effective interventions to tackle its multiple burdens. To that end, he requested the Directors-General of WHO and FAO to ensure accountability and monitoring for progress towards the 2025 global nutrition targets; to support governments in achieving the global targets and establishing national targets based on their respective contexts; and to use the existing monitoring and accountability mechanisms to monitor programme implementation, outcomes and impacts.

Ms GARCIA ARREOLA (Mexico) reaffirmed Mexico's commitment to the Rome Declaration on Nutrition and the Framework for Action and expressed support for the proposal to declare a Decade

[1] See the summary record of Committee A, thirteenth meeting, section 2.

of Action on Nutrition (2016–2025). She described her country's national strategy for prevention and control of overweight, obesity and diabetes, aligned with the relevant international recommendations, and the initiatives that followed from it.

Mr BROWN (United States of America) said that his country supported WHO's development of tools and the provision of technical assistance to Member States as they sought to incorporate the Framework for Action into national policies and programmes aimed at achieving the 2025 global nutrition targets, in coordination with FAO and other United Nations agencies. The United States was keen to work with other countries to identify harmonized approaches, where appropriate, including through the Codex Alimentarius Commission, and it welcomed the joint efforts of WHO and FAO to enhance the resources available for the Commission's critical standard-setting work.

Mrs VALLINI (Brazil) encouraged the Health Assembly to adopt the draft resolution endorsing the Rome Declaration on Nutrition, calling on Member States to implement the recommendations in the Framework for Action. With the support and guidance of WHO, FAO and other United Nations agencies, the alarming trends in overweight and obesity, especially among children, could be reversed. Access to adequate, healthy, food was without question a human right, and it called for an environmentally sustainable and social food system that also ensured the protection of biodiversity and traditional crops. Given the health aspects of nutrition, Brazil recommended that WHO participate in the Advisory Group of the Committee on World Food Security and requested the Secretariat to include a discussion on child obesity on the agenda of the Sixty-ninth World Health Assembly.

Ms WANG Rongrong (China) expressing appreciation for the report and the positive outcomes of the Second International Conference on Nutrition, described progress against malnutrition in China. Acknowledging the work done by WHO and other United Nations entities in response to the Framework for Action, she called on WHO to assist developing countries in their efforts to implement the commitments of the Rome Declaration on Nutrition.

Dr HIRMAN ISMAIL (Malaysia) took note of the report and expressed support for the draft resolution endorsing the Rome Declaration on Nutrition and the Framework for Action. Malaysia was taking those documents into consideration in preparing its ten-year plan of action on nutrition (2016–2025).

Ms BOTERO HERNÁNDEZ (Colombia), speaking on behalf of the Member States of the Region of the Americas, reiterated the Region's commitment to the six global targets for improving maternal, infant and young child nutrition by 2025; and outlined the concrete steps taken to meet the increasing challenges of chronic malnutrition and obesity, as reflected in the adoption of the Plan of Action for the Prevention of Obesity in Children and Adolescents at the fifty-third meeting of the PAHO Directing Council. WHO should incorporate the policy areas identified in the Rome Declaration on Nutrition and the Framework for Action, into the guidance provided to Member States seeking assistance to develop and implement national programmes and plans to meet the multiple challenges of malnutrition, and United Nations agencies and other international organizations could use them to develop an integrated approach to public health challenges. Meanwhile, WHO should participate in the Committee on World Food Security, which was a key forum for sharing knowledge on various aspects of nutrition, including food system sustainability, as the outcomes could provide Member States with the underpinnings for decisions that paved the way to a hunger-free world.

The Region of the Americas supported the draft resolution and endorsed the recommendation that the Secretariat include progress reports on the implementation of the Declaration and Framework on the agendas of regular governing bodies meetings, including those of the regional committees, and transmit those reports, when appropriate, to the United Nations General Assembly.

Dr JENYFA (Maldives) said that while Maldives had made significant progress in tackling undernourishment, intake of micronutrients remained inadequate, especially among mothers and

infants under the age of two years, which inhibited physical and intellectual development and diminished academic achievement throughout the life course. Commending WHO, FAO and other health partners on their endeavours to strengthen nutritional status at the country level, she called for national leadership and efforts to provide financial and technical support for the implementation of national plans and facilitate information-sharing on the Rome Declaration on Nutrition, also urging Member States to implement policies to improve their national nutritional status.

Mr EMANUELE (Ecuador), speaking on behalf of the Members of the Union of South American Nations, reiterated the Union's commitment to the Rome Declaration on Nutrition and the recommendations in the Framework for Action. Malnutrition required a multisectoral response, ensuring that agriculture was sustainable and the environment protected; reforming food systems, with a central position for the social determinants of health; formulating coherent policies that extended from production to consumption; and strengthening the role of the consumer and the food safety authorities. It was essential also, in developing national and regional strategies, to take into account the importance of regulatory and tax policies. The process of implementing the outcomes of the Second International Conference on Nutrition and seeking solutions to the public health challenges had fostered closer relations between WHO and FAO, and the Organization should now take part in the Committee on World Food Security, which was a forum for dialogue where further progress could be made on the subject. The Union's Members looked forward to contributing to the declaration of a Decade of Action on Nutrition (2016–2025) at the seventieth session of the United Nations General Assembly.

Dr AL MOSAWI (Bahrain) said that Bahrain had acted promptly to prepare a national strategy for implementation of the recommendations from the Conference and incorporate it into the country's plans for nutrition, health, agriculture, education, development and investment. It had achieved tremendous progress in the area of nutrition by conducting nation-wide studies and surveys, introducing measures to combat obesity and eliminate micronutrient deficiencies, implementing a national strategy for reducing mortality from chronic disease, and promoting food security through reliance on local resources. In order to facilitate implementation of the recommendations, healthy diet guidelines should be prepared as an aid for promoting the gradual reduction of saturated fats, sugars, salt/sodium and trans-fat from foods and beverages. The establishment of "Action networks" among Member States at the regional and global levels would also be vital for information exchange. Bahrain was fully committed to the implementation of the Rome Declaration on Nutrition and the Framework for Action.

Dr MWANSAMBO (Malawi) commended WHO's leadership in facilitating the preparation of a robust declaration and its companion framework for action on nutrition, in collaboration with FAO and other agencies. He also welcomed the emphasis in the finalized Rome Declaration on Nutrition on the need for policies and strategies entailing measures to deal with inequalities, especially gender inequalities, in the area of nutrition. Malawi fully supported endorsement of the Rome Declaration and the Framework for Action.

Dr BORE (Mali) expressed support for the Rome Declaration on Nutrition and the Framework for Action, which Mali was committed to implementing as part of its national nutrition policy, and stressed the importance of an intersectoral, multidisciplinary and participatory approach to identifying and resolving nutrition-related problems, especially at local community level. He also underscored the importance of strengthening the institutions in charge of combating malnutrition, as their effectiveness was often undermined by structural weaknesses.

Mr ALAOUI (Morocco) said that the promotion of health depended on healthy lifestyles, which were closely related to nutrition, in particular in the case of mothers and children. Ensuring adequate nutrition required intersectoral and inter-organizational collaboration led by WHO through its regional

and country offices. The Secretariat should also ensure better awareness of the ongoing need to finance nutrition programmes, which would reduce health-related expenditure and should be at the heart of interventions in vulnerable countries.

Dr ROY (Bangladesh), speaking on behalf of the Member States of the South-East Asia Region, noted the outcome documents from the Second International Conference on Nutrition, which addressed emerging challenges. It was important to eliminate all forms of malnutrition, and he acknowledged the inclusion of food security, equity, dietary guidelines, healthy lifestyle and infant and young child feeding in those documents; as well as the increased focus on vulnerable groups. He called for the creation of an effective monitoring and evaluation system; involvement of Member States in planning activities on nutrition; provision of international cooperation and official development assistance to support national efforts on nutrition and monitoring and evaluation; and promotion of multisectoral cooperation.

Mr BOYCE (Barbados), referring to the growing challenge of overnutrition in Barbados and the Caribbean, which had been linked to rises in several noncommunicable diseases, drew attention to the recognition in the Rome Declaration of the coexistence of different forms of malnutrition; challenges facing food systems; and the need to address food security in trade policies. He described his Government's initiatives to promote healthy nutrition, including promoting breastfeeding, baby-friendly hospital initiatives, school feeding programmes, surveillance of nutrition in children under 5 years old, and a food preparation plan.

Mr GWIAZDA (Poland) recognized the growing global threat of overweight and obesity, which was a particular problem in his country. Intersectoral actions were being implemented in Poland, as for the first time Polish children had a lower life expectancy than their parents. He called on the Committee to approve the draft resolution.

Dr RANAOU (Niger) drew attention to a national initiative to provide agricultural inputs and machinery to improve local production of foodstuffs, in order to protect the population from unpredictable weather conditions and resulting nutritional crises.

Dr SAGUNI (Indonesia), said that, although there had been some progress in his country, levels of underweight, stunting and wasting in children under 5 years of age were high and the problem of overweight in that age group was worsening. The Rome Declaration and Framework for Action on Nutrition should be used to develop national policies, strategies and indicators to combat malnutrition and eradicate hunger. Indonesia had developed a Food and Nutrition Action Plan 2015–2019, including an indicator on obesity, and had issued a government regulation on food security and nutrition, which would promote food diversification. He called on the Director-General to support Member States' efforts to combat malnutrition.

Ms Miao-Ching CHEN (Chinese Taipei) endorsed the Rome Declaration and its recommended actions, with particular regard to creating an enabling environment for effective action and promoting healthy diets through sustainable food systems. Chinese Taipei had developed legislation and public policies on nutrition and guidelines on recommended dietary allowances, and had implemented nutrition and health surveys. In response to the recommended action of providing nutrition education and information, Chinese Taipei had developed a healthy weight management programme, created websites and a hotline to raise awareness of nutrition, and encouraged physical fitness in schools. In consequence, rates of obesity had dropped considerably, and Chinese Taipei had thus achieved WHO's target to reduce prevalence of obesity by 2025.

Mr COLMENARES CORONA (Bolivarian Republic of Venezuela), noting that policies should be coherent and cover all elements of food and nutrition and education thereon, described various food

and nutrition actions being carried out in his country, in line with the Rome Declaration and the Framework for Action, including the drafting of legislation on healthy food which prioritized infant nutrition, encouraged breastfeeding, promoted healthy eating and physical exercise, and regulated food labelling and advertising, in particular of high-calorie foods of low nutritional value.

Mr BERTONI (Italy) supported the two outcome documents of the Second International Conference on Nutrition and looked forward to working with the WHO and FAO Secretariats on implementation of the follow-up work. He supported the draft resolution.

Ms MIKKONEN-JEANNERET (World Obesity Federation), speaking at the invitation of the CHAIRMAN, spoke on behalf of Consumers International, HelpAge International, and the International Diabetes Federation. Welcoming the focus on nutrition, she supported efforts to address malnutrition in all its forms, through strengthening healthy food systems. She called on Member States to consider an independent framework convention, similar to the WHO Framework Convention on Tobacco Control, which had proved successful in reducing tobacco use. She supported WHO's Guideline on sugars intake for adults and children, and regional plans including the European Food and Nutrition Action Plan 2015–2020, the WHO Regional Office for Europe nutrient profile model, and PAHO's Plan of Action for the Prevention of Obesity in Children and Adolescents.

Mrs PUNZO (Medicus Mundi International), speaking at the invitation of the CHAIRMAN, noted the increasing power of transnational corporations in trade and investment agreements which contained barriers to food security and food sovereignty. She urged Member States to oppose investor-State dispute settlement, which prevented effective regulation, and to return to agro-ecological principles, instead of promoting corporate agriculture. She called for a commission to investigate and report on food sovereignty in addressing the challenges of food security. As access to decent food was a basic human right, she urged WHO to work with the United Nations Human Rights Council to prepare information on the human rights dimension of food and nutrition policies.

Dr CHESTNOV (Assistant Director-General) commended the actions of Member States during the Second International Conference on Nutrition to further the nutrition agenda. Food security could not be achieved without steps to improve nutrition. Everyone had the right to sufficient information to make sound decisions about their intake of food. Obesity was emerging as a challenge alongside undernutrition. It was important that the Secretariat and the Member States determine the next steps following the International Conference. He acknowledged the Framework for Action and the many recommended actions that came under the remit of WHO, including those relating to healthy nutrition, nutrition education, breastfeeding, wasting and obesity. WHO and FAO had to work together to prioritize the nutrition agenda at the strategic level, and he drew attention to the six global targets on nutrition, and existing guidelines and tools. The United Nations Interagency Task Force on the Prevention and Control of Noncommunicable Diseases had addressed elements related to nutrition; and recommendations regarding tax and other incentives had been discussed. He hoped that the Decade of Action on Nutrition, with its targeted actions, would enable successful reporting to the next International Conference on Nutrition. Lastly, he thanked the Government of Italy for hosting the Conference.

The draft resolution contained in document A68/8 was approved.[1]

The meeting rose at 11:55.

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA68.19.

SEVENTH MEETING

Monday, 25 May 2015, at 14:35

Chairman: Mr M. MALABAG (Papua New Guinea)

NONCOMMUNICABLE DISEASES: Item 13 of the Agenda [transferred from Committee A] (continued)

Maternal, infant and young child nutrition: development of the core set of indicators: Item 13.2 of the Agenda (Document A68/9)

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) said that the Secretariat should make clear when, how and through what mechanism Member States would be required to report on the proposed indicators. It should increase the compatibility between international reporting requirements and national data collection mechanisms, using existing collection mechanisms where possible. Her Government could not make a commitment to generating new data sets that would only be used for work related to maternal and child nutrition. In order to increase the likelihood of meeting the targets set for 2025, WHO should provide clear definitions of all indicators and convene the proposed technical expert advisory group as soon as possible: any delay would affect her country's ability to submit the correct information. Final decisions on process indicators 2 and 3 (safe water and sanitation) should be delayed so that they could be aligned with the sustainable development goals when the latter were eventually adopted.

Dr FORSTER (Namibia), speaking on behalf of the Member States of the African Region, recalled that, in view of the high human and economic cost of malnutrition in Africa, the Heads of State and Government of the African Union had adopted the Malabo Declaration on Accelerated Agricultural Growth and Transformation for Shared Prosperity and Improved Livelihoods in 2014, setting targets aimed at reducing the incidence of underweight children and stunting. The adoption of the proposed indicators would help to reduce malnutrition further. In view of the cost implications of adding new indicators, phasing in their introduction would enable national measurement systems to adapt more effectively to new international requirements. He called on the Secretariat to facilitate greater harmonization among the measurement systems used by the many partners working with Member States in the Region on maternal and child nutrition.

Dr SHOHANI (Iraq) said that the contributory role of an unhealthy and unbalanced diet to noncommunicable diseases was emphasized in the strategies for nutrition and food safety and maternal, child and reproductive health. The promotion of breastfeeding and compliance with the International Code of Marketing of Breast-milk Substitutes were also central to the design of the country's nutritional policy.

Ms CORLUKA (Canada) said that the indicators for the three additional categories proposed, which required more technical work, were process indicators 1, 4 and 6 and the policy, environment and capacity indicator 1. She welcomed the opportunity to review those indicators when they had been prepared. She proposed that paragraph 2 of the draft decision contained in document A68/9 should be amended to read: "… indicator 1, that will be reviewed by the Executive Board once available, for approval, and which will be reported on starting from 2018". Member States should submit the required information every two years.

Ms HARB (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the indicators would contribute to national action plans and nutrition surveillance systems, while encouraging national decision-makers to establish or modify their policies to achieve the WHO nutrition targets. Member States should be given technical support to help them to build national capacity and strengthen their surveillance systems.

Ms SAMIYA (Maldives), speaking on behalf of the Member States of the South-East Asia Region, said that the factors impeding national action to reduce malnutrition in the Region included weaknesses and inadequacies in the areas of strategic planning, political commitment, multisectoral interventions, and monitoring and evaluation of nutrition targets. She supported the proposed draft decision, but urged that the proposed indicators be harmonized with the systems currently used by Member States. The Secretariat should support Member States in their efforts to report the status of the indicators or to suggest proxy indicators where appropriate.

Dr SAIPIN CHOTVICHIEN (Thailand) said that it would be important to establish common definitions of the indicators and ensure that they could be both applied locally and compared internationally. With regard to policy environment and capacity indicator 1, health-care professionals, who had a critical role to play in giving advice and encouraging good practice at a local level, were hindered, particularly in providing nutritional counselling, by lack of capacity, competing work burdens and poor human resource management. To improve matters, the training of health-care professionals on nutritional issues should be tailored to suit the different audiences they would be advising. She called for WHO's support in the establishment of standards for capacity-building tailored to different health-care settings, and in skills training and assessment and better human resources management. Any increase in the numbers of health-care professionals trained in nutrition could be of limited value if they were poorly distributed, poorly managed or underemployed.

Dr RONQUILLO (Philippines) said that the selection of indicators should take into account the availability of data and the ease with which they could be collected and verified. Regarding intermediate outcome indicator 2, it would be important to ensure that Member States had the capacity to conduct surveys to measure the body mass index of women aged 15–49 years. He suggested that process indicator 5 should be amended to read "percentage of births in *mother- and* baby-friendly facilities", as birth facilities in his country were assessed according to how mother-friendly they were. He requested further guidance on ways of determining core indicators that should apply to all countries and standardizing indicator definitions, collection, analysis and validation methods, and on the level of flexibility countries might have in defining secondary indicators.

Dr AL MOSAWI (Bahrain) said that Bahrain intended to focus efforts on integrating nutrition into maternal and child health programmes, promoting foods fortified with micronutrients, and reducing the consumption of salt, fats and the like; developing nutrition programmes for different age groups with the aim of changing dietary behaviours; formulating food and nutrition policies for pregnant women and infants; expanding the database and advice on health and nutrition interventions targeting women and infants; and providing the human and financial resources needed to implement programmes for infants, children and adolescents. She concurred with the suggestion of a five-year period for review of the monitoring framework.

Ms GARCIA ARREOLA (Mexico) said that the criteria for data collection and harmonization of reporting must be strengthened. Promotion of breastfeeding was a priority in her country as current breastfeeding rates were low. Ensuring the best nutrition for mothers and children helped to reduce the incidence of cancer, cardiovascular disease, diabetes and other noncommunicable diseases.

Mr GWIAZDA (Poland), speaking also on behalf of Austria, Estonia and Latvia, supported the draft decision, as amended by Canada.

Mr BROWN (United States of America) said that his country supported the targets and proposed indicators as an effective way to monitor progress and ensure the accountability of countries and donors.

Dr AL LAMKI (Oman) said that WHO should provide technical support to promote the application of the proposed indicators, which must be evidence-based, measurable and realistic. Both malnutrition and overnutrition, exacerbated by such factors as a lack of national policies on food consumption and poor public awareness of healthy food choices, placed a burden on health systems. The inclusion of healthy maternal, infant and young child nutrition among the new sustainable development goals was therefore vital.

Dr MUSTAPHA (Malaysia) supported the additional core indicators and the proposal to start reporting on the indicators in 2016 or 2018. He asked for operational and reporting guidance to help his country to generate the necessary data. He also supported the proposal to review the extended set of indicators and provide definitions of the indicators, the availability of data and their applicability in certain countries.

Mr KASEM (Jordan) said that the promotion of maternal and infant nutrition was a main focus of the national strategy for nutrition in his country, where a country-wide nutrition survey had shown a substantial reduction in anaemia and in deficiencies in iron and vitamins A and D, as well as improved indicators for stunting and wasting. Flour had long been enriched with various micronutrients and more recently with vitamin D, with all costs absorbed by the Government, and iron and folic acid supplements were provided for pregnant women. Breastfeeding was promoted and the International Code of Marketing of Breast-milk Substitutes was reflected in the country's laws and regulations. Certain foodstuffs were also banned from school and kindergarten canteens.

Dr MUKENGESHAYI KUPA (Democratic Republic of the Congo) said that, with chronic malnutrition rates of more than 30% in his country, the Government had developed a multisectoral strategic plan to tackle malnutrition and participated in the Scaling Up Nutrition initiative. He called on WHO to continue identifying essential process and outcome indicators.

Mr BORDVIK (Norway) appreciated the efforts made to reduce the data collection burden on Member States through alignment of the proposed indicators with the Global Reference List of 100 Core Health Indicators. He sought more information about how the two sets of indicators would be harmonized and how to deal with the nutrition indicators that were not part of the Global Reference List. Consideration should be given to indicators that could be reported through existing information systems as well as by surveys.

Dr ROY (Bangladesh) proposed that institutional capacity building should be provided for the use of the core indicators rather than age-for-height Z-scores to monitor under-5 mortality. He supported the draft decision and the proposed set of indicators. He called on WHO and development partners to provide support and mobilize resources and hoped that WHO would support a monitoring and evaluation system.

Ms CAO Bin (China) said that countries should establish national core indicators in line with the WHO core indicators, but adapted to their own domestic situation.

Dr KAITUU (Solomon Islands) supported the proposals to strengthen the core set of indicators and thanked donors, WHO and other United Nations agencies for their support of his country's work in maternal, infant and young child nutrition.

Dr BORE (Mali), welcoming the preparation of the core set of indicators, said that his country had introduced a variety of measures to tackle malnutrition and had established indicators for maternal, infant and young child nutrition. He supported the draft decision.

Mr COLMENARES CORONA (Bolivarian Republic of Venezuela) expressed support for the proposed additional core indicators, which would provide the data needed to inform policy. His country had amended its legislation to incorporate the provisions of the WHO International Code of Marketing of Breast-milk Substitutes.

Ms Miao-Ching CHEN (Chinese Taipei), welcoming the elaboration of process indicators 5 and 6 and policy environment and capacity indicators 2 and 3, said that Chinese Taipei would integrate the core set of indicators into its existing monitoring system. A new nutrition and health survey would be established to collect data on new indicators, such as process indicator 1, and the extended set of indicators. Chinese Taipei wished to share its surveillance knowledge in the new technical expert advisory group on nutrition monitoring.

Ms CHING (International Baby Food Action Network), speaking at the invitation of the CHAIRMAN, welcomed the new indicators, but said that process indicator 6 had been weakened by amending the text to refer to counselling, support "or messages for mothers", rather than "and messages for mothers": women should have access to all three forms of support. She also stressed that intermediate outcome indicator 5 should be amended so that countries were required to identify the causes of obesity in school-age children and adolescents and that national databases should interpret data on the prevalence of diarrhoea in children under 5 years of age in the light of data on exclusive breastfeeding. In the interests of transparency regarding the process of developing the indicators, she asked for the list of participants in the October 2013 consultations to be published.

Dr BRANCA (Nutrition for Health and Development) said that the core set of indicators would facilitate the establishment of national surveillance systems and better management of resources. WHO remained committed to filling the gaps in data collection and national nutrition policy and had established a technical expert advisory group on nutrition monitoring in partnership with UNICEF, whose first meeting would be held in July 2015. He recognized the need to harmonize the proposed additional core indicators and monitoring framework with existing information systems; that would limit the data collection and reporting burden on Member States. The Secretariat had taken steps to ensure that the extended nutrition indicators were in line with the equivalent indicators in the standard set and with the Global Reference List of 100 Core Health Indicators; however, it was essential to ensure that the new indicators actually did collect new information. The Secretariat would work with Member States to strengthen and align their existing data collection systems to the core indicator framework. He acknowledged the assistance provided by Canada to strengthen the monitoring frameworks of 11 countries of the African Region. WHO and other United Nations agencies would provide capacity-building assistance to strengthen national monitoring and data collection systems.

At the invitation of the CHAIRMAN, Dr ONDARI (Secretary) read out the amendment to paragraph 2 of the draft decision proposed by Canada, reading: "to recommend that Member States report on the entire core set starting in 2016, with the exception of process indicators 1, 4 and 6 and policy environment and capacity indicator 1, that will be reviewed by the Executive Board once available, for approval, and which will be reported on starting from 2018."

The draft decision contained in document A68/9, as amended, was approved.[1]

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as decision WHA68(14).

Update on the Commission on Ending Childhood Obesity: Item 13.3 of the Agenda (Document A68/10)

The CHAIRMAN drew attention to the report on the update to the interim report of the Commission on Ending Childhood Obesity[1] and invited Member States to provide any comments or suggestions using the comments form on the Commission's homepage.

Ms HARB (Lebanon), noting the role played by the private sector and the media in childhood obesity, said that countries should devise coherent policies and build strong partnerships with the private sector and nongovernmental organizations in order to reinforce healthy eating habits and lifestyles. Her country had tackled low rates of exclusive breastfeeding by strengthening national policies to prohibit the advertising of breast-milk substitutes and had promoted regular physical activity and healthy foods in schools. However, further assistance was needed to strengthen data-collection mechanisms, and she called for WHO's support in closing the gaps in data for all indicators, and, in particular, in the surveillance and monitoring of maternal, newborn and childhood diseases.

Dr KAZIHISE (Burundi), speaking on behalf of the Member States of the African Region, said that a sixth item should be added to the overarching policy considerations of the interim report of the Commission on Ending Childhood Obesity, reading "community involvement in the search for solutions to prevent and comprehensively address childhood obesity". He called for WHO's support to enable African countries to redress the lack of data on obesity and nutrition disaggregated by country, and recommended that the Commission on Ending Childhood Obesity should identify clear and effective measures to strengthen national health systems for contributing to the prevention, detection and treatment of childhood obesity and noncommunicable diseases.

Dr RONQUILLO (Philippines) said that his country paid equal attention to both childhood obesity and malnutrition and had introduced legislation regulating the marketing of unhealthy foods and non-alcoholic sweetened beverages, because the food industry had not regulated itself satisfactorily. In addition, the Philippines had agreed to test the WHO Child Obesity Toolkit in order to establish country-specific, coherent and comprehensive policy actions and needs-based interventions.

Dr ALQATTAN (Kuwait) suggested that the Ad Hoc Working Group on Science and Evidence for Ending Childhood Obesity should examine the social factors involved in childhood obesity with a view to finding appropriate solutions. She also recommended that practical ways of supporting policy-makers to raise awareness of the problem in sectors other than health should be identified in order to ensure ongoing cooperation among all sectors in tackling childhood obesity.

Ms GARCIA ARREOLA (Mexico) said that her country had implemented several measures to promote healthy lifestyles, including the introduction of a national prevention and treatment strategy for overweight, obesity and diabetes and legislation prohibiting the marketing of unhealthy foods and beverages to children.

Dr ROY (Bangladesh) emphasized the need for interventions to prevent obese children from growing into obese adults. The upturn in the Bangladeshi economy had led to a rapid rise in fast-food businesses and lifestyle changes, with a consequent increase in childhood obesity. Bangladesh called

[1] Interim Report of the Commission on Ending Childhood Obesity (document WHO/NMH/PND/ECHO/15.1). Geneva: World Health Organization; 2015 (http://www.who.int/end-childhood-obesity/commission-ending-childhood-obesity-interim-report.pdf, accessed 4 June 2015).

on WHO to take urgent action on the regulation of sugar, salt and fat in foods, and welcomed the establishment of the Commission on Ending Childhood Obesity.

Dr MUTHU (Malaysia) said that Malaysia had participated in the Western Pacific regional consultation and hearings on ending childhood obesity (Manila, 24 and 25 March 2015), at which policy options, implementation and monitoring to combat childhood obesity had been discussed. The recommendations in the Commission's final report should be practical and take into account individual national socio-cultural and political considerations.

Dr SHOHANI (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Commission's work should stress the key social determinants of childhood obesity to guarantee an effective response in the economic, social and cultural context of the country concerned, using a life-course approach, and encourage the development of coherent policies by the trade, industry and health sectors to ensure healthy food supply partnerships. He also requested more guidance on mobilizing policy-makers from non-health sectors to implement existing programme and policy recommendations on promoting a healthy diet, restricting the marketing of unhealthy foods and drinks, and promoting physical activity.

Dr CHOMPOONUT TOPOTHAI (Thailand) said that childhood obesity could not be tackled within the health system alone. Efforts should additionally focus on the social determinants of health and taking an environmental approach, as limiting the way forward to approaches aimed at the individual might not be an effective model. She called on the Commission to take account of recent scientific evidence supporting a complementary environmental approach, including legislation and regulation, when formulating its recommendations. Interventions should be of the highest technical quality and free of conflicts of interest.

Dr STEVENS (United States of America), noting the recent positive trends in her country, said that many of the success factors for reversing obesity trends lay outside the health sector. Stakeholders could contribute to creating environments that promoted a healthy weight in children. It was encouraging that the Commission had held hearings with non-State actors, and she supported its continued drawing on diverse stakeholders and expertise.

Mr MANUELLA (Tuvalu), speaking on behalf of the Pacific island countries, said that nine of the countries with the highest rates of obesity globally were in the Pacific. At a meeting in April 2015, their health ministers had emphasized the need for multisectoral action to tackle the problem. National activities were in line with the Commission's priorities, in particular health promotion, engagement of communities and primary health care.

Ms LUNA (Ecuador) highlighted the importance of the Commission's work and the need for regional and global consultations on childhood and adolescent obesity. Ecuador was keen to participate actively in those consultations. PAHO's 53rd Directing Council had approved the Plan of Action for the Prevention of Obesity in Children and Adolescents (resolution CD53.R13) in 2014, and several countries in the Region of the Americas had adopted regulations governing food labelling, food offered in schools and food advertising, and imposed taxes on sugary drinks. She stressed the need to include adolescents and children in consultations and the importance of targeting campaigns at families. She suggested an exchange between Member States of best practices, measures adopted and the outcomes of evaluations.

Dr MUSTIKOWATI (Indonesia) said that, given the alarming national prevalence of overweight children, her country had included an indicator of obesity in its 2015–2019 national mid-term development targets, regulated the implementation of guidelines on balanced nutrition and

developed guidance for primary care professionals on preventing childhood obesity. She called on the Secretariat to provide more support to and greater collaboration with Member States.

Mr DE ANDRADE FILHO (Brazil) suggested that, in addition to fostering cultural and behavioural changes, social and economic policies should be adopted in the areas of health, agriculture and education in order to combat obesity, and regulations introduced on food distribution and advertising. The Commission should take into account other existing mandates and strategies to combat poor nutrition, especially at the regional level. WHO should join the FAO Advisory Group of the Committee on World Food Security, and childhood obesity should be included on the agenda of the Sixty-ninth World Health Assembly in 2016.

Mr COLMENARES CORONA (Bolivarian Republic of Venezuela) said that his country was developing an interinstitutional plan to combat overweight and obesity, preparing a law on healthy eating covering healthy eating habits, physical activity and regulations on food labelling and advertising, and promoting exclusive breastfeeding.

Dr BELLALOUNA (Tunisia) said that her Ministry of Health had developed a programme to combat obesity in collaboration with other ministries, the food and agriculture industry, health professionals and civil society. Its five priority areas were: encouraging the production of healthy foods; promoting physical activity; raising public awareness of healthy eating habits; improving the screening and management of obesity; and promoting healthy lifestyles. The programme was currently being piloted in a town in the north east of Tunisia.

Ms HAN Jianli (China) agreed with the life-cycle approach to tackling childhood obesity, which included encouraging weight control in pregnant women to reduce the number of high-weight births, promoting exclusive breastfeeding for the first six months of life, regular monitoring of infant and child development, and promoting a healthy diet and lifestyle and physical exercise.

Dr AXELROD (Russian Federation) advised the Commission to pay attention to the prenatal and postnatal predisposition for development of the metabolic syndrome in babies who were premature and/or had suffered delayed intrauterine development. To reduce childhood and adolescent obesity, it was important to provide healthy food in schools and use online and peer-to-peer methods to educate adolescents.

Dr KREMER (Argentina) urged the Health Assembly to continue paying close attention to childhood obesity. Promoting individual responsibility was important, but there was a vital need for further policies and regulations on promoting healthy eating, food labelling and healthy environments, and for greater intersectoral efforts, especially collaborative working between the health, education and labour sectors.

Ms PEARCE (Nauru) said that the high prevalence of childhood obesity would have devastating consequences without urgent action. The lure of technology, competing with physical activity as a way for children to spend their time, should not be ignored as a potential culprit, alongside clever marketing that influenced eating habits. However, she acknowledged that it might be impossible to solve the problem completely.

Ms Miao-Ching CHEN (Chinese Taipei) said that Chinese Taipei had developed a surveillance system for 25 noncommunicable disease indicators and had prohibited the advertisement and promotion of unhealthy foods. Chinese Taipei had also implemented the WHO's Global School Health Initiative and Baby-friendly Hospital Initiative, adopted legislation on breastfeeding in public and preventing childhood obesity, introduced regulations on food sold inside and outside educational

establishments, and promoted the importance of healthy lifestyles and physical exercise. Chinese Taipei was willing to share its experiences with other Member States.

Ms KUSANO (International Council of Nurses), speaking at the invitation of the CHAIRMAN, highlighted the valuable role of nurses in health promotion and disease prevention. Nurses' interventions covered all aspects of prenatal and postnatal nutrition for both mothers and children. Systematic, integrated intervention could prevent not only childhood obesity but also noncommunicable diseases and birth-related complications. As providers of primary health care, nurses could capture quantitative and qualitative data to inform policy development and implementation mapping; WHO should, therefore, involve nurses in the planning of relevant policies and strategies.

Ms SINCLAIR (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN, said that strong evidence indicated that overweight and obesity were associated with at least 10 cancers. Excessive sugar consumption was a factor in overweight and obesity, and, in order to help countries to meet WHO's guidelines on sugar intake, the nongovernmental organization World Cancer Research Fund International had developed a policy brief called *Curbing global sugar consumption: Effective food policy actions to help promote healthy diets & tackle obesity*. It proposed actions in four areas that influenced sugar consumption – availability, affordability, acceptability and awareness – which Member States could adapt to their national contexts.

Mr MWANGI (World Heart Federation), speaking at the invitation of the CHAIRMAN, said that the report should place more emphasis on children living in low- or middle-income countries and on those living with disabilities. In that respect, he noted that children with certain noncommunicable diseases were unable to be physically active, which led to obesity. The report should include a more extensive analysis of the risks of childhood obesity across the life course and concrete policy recommendations relating to urbanization and the development of obesity. It overlooked the direct role of industry in promoting the current obesogenic environment. It should call for policies to manage conflicts of interest, as part of the WHO framework for engagement with non-State actors.

Dr SLAMA (International Society of Environmental Epidemiology), speaking at the invitation of the CHAIRMAN, highlighted the possible impact of exposure to environmental contaminants on childhood overweight and obesity. Evidence increasingly indicated that childhood overweight might be associated with early life exposure to endocrine disruptors, including persistent organic pollutants and brominated flame retardants. Member States should thus consider targeting chemical contaminants in food, air, water, and consumer products such as cosmetics, as well as physical activity and nutrition in order to reduce the occurrence of childhood obesity.

Ms CHING (International Baby Food Action Network), speaking at the invitation of the CHAIRMAN, said that public policy should protect and promote healthy, diversified diets and restrict the promotion of commercial formula milks. "Growing-up" milks for toddlers had high concentrations of sugar yet there were currently no restrictions on their promotion. Member States should provide objective, consistent information and ensure appropriate labelling, and prohibit advertising of the products to the public, industry contact with parents, donations or low-cost sales to health-care providers, distribution of free samples and company sponsorship of health workers or programmes.

Dr CHESTNOV (Assistant Director-General) thanked participants for their comments, which he would pass on to the Commission on Ending Childhood Obesity.

The Committee noted the report.

Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases: Item 13.4 of the Agenda (Document A68/11)

Dr KESKİNKILIÇ (Turkey) said that it would be difficult to achieve the noncommunicable disease targets by 2025. However, the implementation of the International Health Regulations (2005) had shown that local efforts could lead to global results. Management of risk factors was essential, and global initiatives to address tobacco use, alcohol misuse and obesity were needed on the part of all international organizations, not only those of the United Nations system. Such initiatives should facilitate local action, as well as the documentation and sharing of failures – from which much could be learned – and successes. Universal health coverage was a key element in the fight against noncommunicable diseases. An online database for the sharing of success stories should be rapidly set up.

Ms LANTERI (Monaco) said that, as a Chair of one of the two working groups established under the global coordination mechanism on the prevention and control of noncommunicable diseases, her country aimed to transmit the group's recommendations to the Director-General by the end of 2015. The working methods of the groups gave an interesting insight into the way that the Secretariat might well be called upon to work with Member States and other actors in the future. In the context of setting the post-2015 development agenda and the sustainable development goals, it was essential that prevention and control of noncommunicable diseases be integrated into both national development policies and international cooperation frameworks. She supported the proposed work plan for the global coordination mechanism covering the period 2016–2017 (document A68/11, Annex 3) and the proposed modalities for the general meeting in 2017 – which should, however, be as informal as possible.

Mr KASEM (Jordan) affirmed his country's commitment to continuing and expanding its efforts to prevent and control noncommunicable diseases, with priority given to minimizing risk factors, providing appropriate health care and carrying out surveillance. National goals had been set accordingly for 2025 and indicators prepared on the basis of the nine voluntary global targets for noncommunicable diseases. Steps would also be taken to strengthen the multisectoral plan for attaining those targets. Existing noncommunicable disease services had been integrated into primary health care and a national survey of risk factors was to be conducted later in 2015. Arrangements were furthermore in place for receiving technical assistance from the Inter-Agency Task Force, which was expected to complete its mission in June 2015.

Mr AL MANDHARI (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the Secretariat's commitment to publishing the technical note on how WHO would report to the United Nations General Assembly in 2018 on progress in fulfilling the commitments made in the Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. The alignment of regional and national indicators to facilitate the reporting of Member States' work was practical. The Member States of the Region had already adopted the monitoring framework proposed in the technical note, and remained committed to engaging in global efforts to implement the Political Declaration's commitments.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) said that the United Kingdom was committed to tackling noncommunicable diseases as the leading causes of mortality and morbidity both at home and globally. The report's emphasis on achieving the original intentions of the Political Declaration was welcome; "scope-creep" should be avoided. Sharing of best practice and research findings and rigorous evaluation of interventions remained important areas where international collaboration could amplify national efforts. The United Kingdom was willing to share

its experiences of working to change behaviour through voluntary partnerships, as part of its wide-ranging approach to tackle noncommunicable disease risk factors.

Dr LAHTINEN (Finland) supported the proposed work plan (document A68/11, Annex 3). The European Union, and Finland in particular, had repeatedly pointed out that global targets could only be achieved if country-level efforts were pursued across all sectors of government, not only through health systems. With the support of WHO and other United Nations organizations, work to combat noncommunicable diseases should intensify. Finland welcomed the launch of the European Region's project on the prevention and control of noncommunicable diseases. WHO's engagement with non-State actors was particularly important in view of the diversity of commercial interests in the area of noncommunicable diseases. Regulation alone would not produce results; WHO must engage with non-State actors, while maintaining the independence of its normative and policy-making functions. In that regard, it remained of concern that the Secretariat repeatedly spoke about the risk associated with *trans*-unsaturated fatty acids, but never referred to saturated fats. WHO's approach to such a complex, multidimensional problem must be balanced.

The global monitoring framework indicators were not helpful: process indicators were needed, as it might be years before results of countries' actions were evident in health outcomes. The technical note on how WHO would report on progress to the United Nations General Assembly contained concrete, measurable and relevant process indicators – it was praiseworthy and illustrative of why technical work should be left to the Secretariat.

Ms MNISI (South Africa) particularly looked forward to completion of the work in the area of policy briefs on noncommunicable disease prevention and control, the electronic learning platform for policy-makers, the "One-WHO Noncommunicable Disease Work Plan", mobile technologies, and the activities of the working groups of the global coordination mechanism. South Africa was preparing to establish a national health commission, and would welcome advice from other countries that had set up intersectoral structures for the prevention of noncommunicable diseases. She welcomed the proposed work plan, but called for the work on the inclusion of noncommunicable disease prevention and control in communicable disease programmes, and on health education about noncommunicable diseases, to be brought forward. Furthermore, the Director-General's report to the United Nations General Assembly in 2017 should include baselines, in addition to process indicators, to illustrate better the progress made.

Mr GHEBRETINSAE GHILAGABER (Eritrea), speaking on behalf of the Member States of the African Region, said that, as the nine voluntary global targets focused on a limited set of noncommunicable disease outcomes, national targets, policies and interventions were important for monitoring progress at the country level. The development of process indicators that could be applied in different country contexts would be valuable. The African Region still had much work to do on communicable diseases, and thus shouldered a double burden. He appealed to WHO and other international organizations to mobilize more resources to support the Region in its fight against both communicable and noncommunicable diseases.

Mr PETERSEN (Denmark), expressing wholehearted support for WHO's work on noncommunicable diseases, said that the previous year his Government had launched a new health strategy to improve conditions for patients with noncommunicable diseases, a key objective of which was earlier detection, with greater support for the most vulnerable patients and care in the community to the extent possible. A new plan for continuity of care for patients with chronic diseases was also being launched. The work of the global coordination mechanism underlay the facilitating and enhancing coordination of activities, multistakeholder engagement and action across sectors at the local, regional and global levels, thereby contributing to the implementation of WHO's Global Action Plan for the Prevention and Control of Noncommunicable Diseases. He welcomed the emphasis on people-centred primary care and universal health coverage in the proposed work plan for 2016–2017.

Mr MOHAMED (Egypt) welcomed the comprehensive report. He outlined his country's work on prevention and control of noncommunicable diseases, including in particular finalization of a national plan in collaboration with the WHO country office and academic institutions that included roles for the private sector, revision of protocols and guidelines for cancer, diabetes and hypertension, and integration of prevention and control activities into primary health care. The health ministry was working towards achieving the nine voluntary targets and using several country-level indicators in line with national priorities and in collaboration with the WHO country office. Those and other initiatives were part of a long-term commitment to tackling noncommunicable diseases.

Dr AXELROD (Russian Federation) welcomed the follow-up activities to the high-level meeting and supported the proposals in the report. Her Government was hosting and supporting the Regional Office for Europe's recently opened geographically dispersed office in Moscow for noncommunicable diseases. Over several years, through provision of free medical care and prioritizing noncommunicable disease at the highest political level, a sustained decrease in mortality and increased life expectancy had been seen in the country. Work was in hand to create a database to track progress on the indicators established by WHO.

Mrs UTEEM (Mauritius) welcomed the clear report and the Secretariat's provision of technical assistance to Member States to deal with the issues associated with noncommunicable diseases, formulate a Framework for Country Action, and publish regular global status reports. Her country was collaborating with WHO on a mobile technology project to stop tobacco use. As many Member States did not have surveillance systems that could monitor noncommunicable diseases and their risk factors, she requested that they be given technical assistance to enable them to report on progress. She supported the holding of a second ministerial conference on healthy lifestyles and noncommunicable diseases. Mauritius had adopted bold policies to tackle noncommunicable diseases and achieved some success in several fields, including falls in tobacco use and alcohol consumption and increases in physical activity. A new noncommunicable disease survey would be carried out later in the year.

Dr ALQATTAN (Kuwait) emphasized the importance of WHO providing countries with guidance and assistance in achieving the targets by 2017; monitoring systems were still inadequate in some countries. She also stressed the need to focus on tackling noncommunicable diseases in special circumstances such as emergencies and disasters, when the Secretariat should provide support to Member States on remedial measures.

Dr YANG Taeun (Republic of Korea) welcomed the progress that had been made in tackling noncommunicable diseases; further progress would require greater cooperation. Her country was planning to amend its national plan to reflect the voluntary global targets. It had already raised the price of cigarettes by 80%. She commended the various kinds of technical support provided by the Secretariat and called for greater use of platforms such as the joint WHO-ITU programme "Be he@lthy, be mobile" in order to share the progress and strategies of all Member States.

Dr THITIKORN TOPOTHAI (Thailand) supported the comments of the delegate of Finland about managing conflicts of interest. He made several observations on the proposed work plan. The report to the General Assembly in 2017 should reflect the progress made by Member States at grassroots level; the backbone of the report should be how they had devised the best-buy, cost-effective policy interventions referred to in the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 (document A68/11, Annex 3). Furthermore, as noncommunicable diseases were a cross-cutting issue, there must be a mechanism whereby they were seamlessly integrated with other relevant programmes, in particular maternal, infant, and young child nutrition, childhood obesity, health promotion and control of tobacco use and alcohol consumption. While the single WHO work plan was appreciated, it would be useful to know how that would help to promote the integration of many programmes. Thailand was concerned that financial commitment to

noncommunicable disease prevention and control was inadequate at all levels; in that respect, he asked whether WHO had a clear mechanism to strengthen resource mobilization to facilitate implementation of the global action plan and promote the achievement of the global voluntary targets.

Dr BANDARA (Sri Lanka), speaking on behalf of the Member States of the South-East Asia Region, recalled the regional flagship programme on the prevention and control of noncommunicable diseases. Member States appreciated the Regional Office's provision of much-needed technical and financial support for the programme. Most countries were on target in establishing and implementing multisectoral plans for noncommunicable diseases. Action was being taken to tackle childhood obesity and to reduce risk factors such as use of tobacco and smokeless tobacco, most countries in the region having adopted appropriate tax policies. Policies to control smokeless tobacco seemed inadequate, however, and he called on WHO to place the issue high on the agenda. He also urged the Secretariat to strengthen technical assistance at the regional and country levels so that Member States could accelerate progress.

Dr STEVENS (United States of America) agreed with the United Nations General Assembly that progress in tackling noncommunicable diseases had thus far been too slow and uneven. She supported most of the actions described in the draft work plan 2016–2017, including the establishment of working groups on focused issues for action, and the need to study features of the burden and economic aspects of noncommunicable diseases at the regional level. She broadly supported the proposed modalities for the General Meeting of the global coordination mechanism in 2017, but wanted further opportunities for dialogue among Member States and other stakeholders, including civil society and commercial entities. It was too early to set the specific meeting format and round table topics, for which she recommended flexibility and further refinement.

Ms RANDBY (Norway) said that her country was encouraged by the results of the Secretariat's work in accelerating action, but further technical support by WHO and the Interagency Task Force was needed to strengthen national efforts. She also welcomed the work of the global coordination mechanism on multistakeholder engagement, which was particularly important for tackling the social determinants of noncommunicable diseases. Engagement with non-State actors required caution and clearly defined terms but, if managed appropriately, could usefully add to the efforts of public health authorities; her country was beginning to see positive results of collaboration with non-State actors. She supported the draft work programme for the working groups of the global coordination mechanism for 2016–2017, including the proposed modalities for the General Meeting in 2017, but that should be convened at technical rather than political level.

Ms GARCIA ARREOLA (Mexico) considered that the review of progress and the work plan were important for assessing areas of opportunity for national strategies. She outlined some of the measures taken to implement her country's national strategy for the prevention and control of overweight, obesity and diabetes, which was consistent with the objectives of WHO's Global Action Plan and focused on risk factors. At the federal, intersectoral level, an impartial, nongovernmental noncommunicable disease observatory had been set up to monitor implementation of the national strategy against set indicators, and to provide input into decision-making and policies. She urged all Member States to continue to work to reduce the burden of noncommunicable diseases.

Dr MUTHU (Malaysia) noted that WHO was on track to meet all major commitments arising from the high-level meetings held in 2011 and 2014, and was satisfied with the Secretariat's efforts to support Member States in achieving their commitments. The increased allocation to noncommunicable diseases in the Programme budget 2016–2017 should result in further progress. He supported the proposed work plan and accepted the sequencing of reports, surveys and evaluations.

Mr ZHANG Yong (China) said that China had already incorporated the prevention and control of noncommunicable diseases in its national economic and social development programme, and relevant departments had launched joint actions to tackle many of the risk factors. In line with the requirements of the global surveillance framework, China was gradually extending surveillance. At the global level, WHO should continue to play the leading role, with enhanced coordination with other international organizations. The Secretariat should provide technical assistance to Member States, accelerate the renewal and dissemination of chronic disease-related technologies, and increase response capacity and efficiency in noncommunicable disease prevention and treatment through technological means.

The meeting rose at 17:30.

EIGHTH MEETING

Tuesday, 26 May 2015, at 09:00

Chairman: Mr M. MALABAG (Papua New Guinea)

1. NONCOMMUNICABLE DISEASES: Item 13 of the Agenda (transferred from Committee A) (continued)

Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases: Item 13.4 of the Agenda (Document A68/11) (continued)

Mr DE ANDRADE FILHO (Brazil) expressed the hope that the comprehensive review by the United Nations General Assembly in 2018 would include information on strengthening of national capacities and stepping-up of efforts to develop national targets, implementation of cost-effective interventions, evaluation of results and progress in multilateral action beyond the health sector and promotion of international cooperation and coordination. The consistency and complementarity among the 25 indicators and also the nine voluntary global targets of the Global Monitoring Framework on Noncommunicable Diseases should be maintained. New indicators did not need to be created. He commended the work of the Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases, which was an important tool for the implementation of the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020, and endorsed the related work plan covering the period 2016–2017.

Mr CONCEIÇÃO FREITAS (Timor-Leste) emphasized that noncommunicable diseases were not just a health issue but also a social and development issue that needed to be addressed through multisectoral approaches. In Timor-Leste, a national multisectoral action plan had been developed in line with the 2011 United Nations High-Level Meeting on Prevention and Control of Non-communicable Diseases, the Global Action Plan 2013–2020, and the nine voluntary global targets. With support from WHO, his Government had made progress in implementing noncommunicable disease-related initiatives, such as the organization of a risk factor survey in 2014 and the launch of an anti-tobacco campaign.

Mrs BANDAZI (Malawi) drew attention to several strategic actions by her Government to combat the high burden of noncommunicable diseases in Malawi, such as the inclusion of noncommunicable diseases as part of the essential health care package in the Health Sector Strategic Plan and the establishment of a noncommunicable diseases and mental health unit within the Ministry of Health. Consultations on Malawi's accession to the WHO Framework Convention on Tobacco Control were at an advanced stage. Her country looked forward to receiving technical assistance from the Secretariat to move forward with the noncommunicable diseases agenda.

Dr MUSTIKOWATI (Indonesia) said that in the light of the insufficient and highly uneven progress in the prevention and control of noncommunicable diseases underlined in the report, stronger efforts were required to enable Member States to apply the 25 indicators and achieve the nine voluntary targets. Her Government had included indicators on smoking, obesity and hypertension in its National Medium Term Development Plan 2015-19. For the purpose of the 2018 comprehensive review, the Secretariat should develop a monitoring framework using the existing tools of Member

States. WHO should also enhance mechanisms to strengthen technical assistance on noncommunicable diseases and capacity-building at country level, as well as global coordination and the sharing of experiences.

Dr KABIRU (Kenya) drew attention to numerous actions undertaken in her country to address noncommunicable diseases and their underlying social determinants, including establishment of mechanisms to reduce risk factors through the implementation of interventions and policy options to create health-promoting environments, application of the guidance in Appendix 3 of the Global Action Plan 2013–2020 and acceleration of the implementation of the WHO Framework Convention on Tobacco Control. She applauded the efforts of WHO and the international community to ensure that such diseases were comprehensively incorporated into the post-2015 development goals.

Dr MOUNTAKA BOUARE (Mali), speaking on behalf of the Member States of the African Region, said that in his country, a multisectoral strategy to prevent and control noncommunicable diseases had been adopted as part of the National Health and Social Development Programme, and that a research centre had been established. However, Member States in the Region still faced many challenges in implementing such initiatives, including the lack of reliable statistics on morbidity, funding, trained human resources and adequate equipment.

Ms LEWIS (Trinidad and Tobago) described several actions taken by her Government to implement the resolutions of the United Nations High-level Meeting on Noncommunicable Diseases, such as the establishment of a multisectoral Partners' Forum for action on noncommunicable diseases, and the implementation of the Chronic Disease Assistance Programme, which had resulted in a decrease in mortality from cardiovascular disease. Work had also been carried out on tobacco control legislation and guidelines on foods offered to children in schools. For further progress, more technical assistance was needed to build capacity including in noncommunicable disease surveillance; work should be carried out with the food production sector to reduce sugar, salt and fat contents; and access to resources should be enabled to transform commitment into action. Legislation on the prevention and control of noncommunicable diseases also needed to be strengthened, and a supportive international environment should be created to bolster action. She looked forward to active involvement and support from WHO through its regional offices to strengthen national capacities in order to address the remaining challenges.

Ms CHEN Miao-Ching (Chinese Taipei) highlighted some activities carried out in Chinese Taipei to apply the Political Declaration and the Global Action Plan, including the implementation of the WHO Framework Convention on Tobacco Control through relevant legislation, which had led to a decline in the adult smoking rate, and measures to promote healthy eating. A comprehensive data collection and surveillance system had also been established to continuously monitor the 25 indicators and nine targets. She supported the 2016–2017 work plan.

Ms SÉVERIN (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN and with specific reference to the first Dialogue on noncommunicable diseases and development, highlighted the importance of forums that allowed for a fruitful exchange of opinions and experiences among a wide range of stakeholders, encouraging the development of web-based platforms and communities of practice. To facilitate the review of policy options and cost-effective interventions to be conducted by WHO in 2015, Member States should support robust epidemiological data-collection efforts in their own countries. Global and national surveillance of oral diseases, which were the most prevalent noncommunicable diseases worldwide, should be an integral part of routine epidemiological surveillance. Monitoring risk factors and oral health needs was fundamental to developing appropriate oral health interventions and programmes and to evaluating their effectiveness.

Ms BAILEY (IntraHealth International Inc.), speaking at the invitation of the CHAIRMAN, said that reducing the human and economic toll of noncommunicable diseases hinged on strengthening health systems and the health workforce. The chronic nature of noncommunicable diseases meant that new models of care were needed, including more effective use of health care teams, community-based prevention approaches and new cadres of health workers. Member States should finalize a robust Global Strategy on Human Resources for Health for 2016, as agreed in the Sixty-seventh World Health Assembly, and collaborate in building a global workforce trained and equipped to address changing disease burdens. WHO should also invest in expanded training programmes for health workers to build new skill sets and incorporate noncommunicable diseases into all curricula. Each country should implement evidence-based policies and plans that built on the expertise of nongovernmental organizations. Without such efforts, health workers worldwide would not be able to meet the demand created by a growing burden of noncommunicable diseases.

Mrs PUNZO (Medicus Mundi International), speaking at the invitation of the CHAIRMAN, remarked that the report did not address the structural determinants of noncommunicable diseases, and that constant high-level meetings and endless indicators were diverting attention from the real priorities. WHO needed to focus more on the influence of trade and investment agreements on health, and prioritize the protection of policy space for noncommunicable disease prevention in the face of investor-state dispute settlement provisions in such agreements. WHO should also provide more active support for the use of flexibilities in the TRIPS agreement to ensure affordable access to medicines, and call for a halt to the inclusion of TRIPS-plus provisions in trade agreements. The exorbitant prices being charged for biotherapeutic medicines resulted in part from the regulatory barriers to the entry of generics. She reminded delegates that the Sixty-seventh World Health Assembly had resolved to ensure that the introduction of new national regulations did not constitute a barrier to access to safe, effective and affordable biotherapeutic products. Further attention should be paid to move the research and development system away from the intellectual property-protected monopoly that was making noncommunicable disease treatments too absurdly expensive for public procurement programmes to offer. Owing to the growing influence of the pharmaceutical and food and beverages industries on WHO and United Nations policy-making, a robust framework was required to govern WHO's engagement with private sector entities.

Mr COTTERELL (Australia), expressing appreciation for the report and support for the draft work plan 2016–2017, said that WHO leadership in the prevention and control of noncommunicable diseases had been vital and, further to the comments of previous speakers on the importance of tobacco control to their prevention policies, he announced that Australia's pioneering and highly effective plain packaging measure, introduced in 2012, was facing a legal challenge at WTO, with the first hearings due to begin the following week. His Government remained committed to defending that crucial public health measure, and looked forward to the continuing support of fellow Parties to the WHO Framework Convention on Tobacco Control.

Dr BELLALOUNA (Tunisia) said that, bearing in mind the nine indicators to inform reporting on progress in implementing the Action Plan, and in the light of Tunisia's commitment to prioritizing measures in the areas of governance, prevention and reduction of risk factors, health care and surveillance, over the period 2015–2016, her Government had taken stock of the current situation and realigned its national strategy for prevention and control of noncommunicable diseases. That exercise had included actions to boost intersectoral collaboration, encourage the participation of nongovernmental organizations and the private sector, incorporate the new strategy into the five-year public health plan, improve access to welfare and encourage research to develop evidence-based practices. The national obesity prevention and control programme was taking steps to reduce salt, sugar and trans-fatty acid contents, in close collaboration with the food-processing industry. As part of its efforts to combat chronic noncommunicable diseases associated with tobacco use, Tunisia had

applied to serve as the pilot site for the first French-language version of the mobile phone-based mCessation initiative.

Mrs SHEEHY-CHAN (Global Diagnostic Imaging, Healthcare IT and Radiation Therapy Trade Association), speaking at the invitation of the CHAIRMAN, said that concerted action to confront the challenge of noncommunicable diseases made economic sense, as was demonstrated by the fact that a decrease in the mortality rate from noncommunicable diseases reduced economic loss. She therefore supported WHO's call on all Member States to implement national plans by 2016, urging a whole-of-government approach to ensure that an effective and sustainable delivery framework was developed to address noncommunicable diseases, and for progress to be monitored by each country. In addition, she urged that the attainment of universal health coverage should remain a key priority, and pledged her organization's support to work with WHO to develop solutions to the problem of noncommunicable diseases.

Mr MWANGI (World Heart Federation), speaking at the invitation of the CHAIRMAN, expressed his deep concern at the insufficient and uneven progress made in preventing and controlling noncommunicable diseases, as shown by the 2014 United Nations comprehensive review and assessment. As the deadline approached for fulfilling the commitments made at the related high-level meeting, he urged Member States to accelerate progress at country level by fully implementing the time-bound measures defined at that meeting, which entailed establishing national targets, multisectoral plans and commissions to address the issue of noncommunicable diseases. He stressed the importance of prioritizing the commitments to reduce risk factors and strengthen health care systems, and pledged the support of his organization to that end. It was also important to establish greater accountability prior to the next follow-up meeting in 2018. He called for full leverage of the global coordination mechanism, and for the delivery of actionable recommendations from national working groups related to it.

Ms TASKER (Handicap International Federation), speaking at the invitation of the CHAIRMAN, drew attention to the close relationship among noncommunicable diseases, ageing and disability. The issues of morbidity and disability, which had recently been introduced to the agenda on noncommunicable diseases, should be taken into consideration when measuring progress. In order more meaningfully to address the challenges faced by persons with disabilities, those living with noncommunicable diseases, and older persons, a broader range of subjects, including mental health and musculoskeletal disorders, should be taken into account when reviewing progress. Universal access to comprehensive health services should be promoted, and the compatibility and interplay of policies concerning noncommunicable diseases and those on ageing and disabilities should be enhanced.

Professor ZHANG Xin-Hua (World Hypertension League), speaking at the invitation of the CHAIRMAN, highlighted the fact that cost-effective interventions for hypertension were often inaccessible to the most disadvantaged sectors of society. WHO's Package of essential noncommunicable disease interventions for primary health care provided a set of protocols for diagnosis and treatment of noncommunicable diseases and had been implemented in China with the aim of managing diabetes and hypertension. Results had revealed a consistent improvement in hypertension control, illustrating that the set of protocols constituted an effective tool for primary care providers in low-resource settings involved in the long-term management of major noncommunicable diseases. Her organization supported implementation of the Package as an equitable means of controlling hypertension in the context of other noncommunicable diseases.

Mr BALASUBRAMANIAM (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, said that the inclusion of new and expensive medicines on the WHO Model List of Essential Medicines signalled that clinical need – not cost – would henceforth determine the essentiality of a medicine. With a view to putting into effect the Global Action Plan, the international community needed to face up to the problem of the cost of the new medicines in order to render them affordable for persons in need. To that end, all countries should be encouraged to seek WHO's technical assistance in ensuring legal access to treatment by regulating and eliminating monopolies. Furthermore, he proposed that a round table should be convened to discuss cost-management approaches relating to noncommunicable diseases. The round table should consider ways of achieving increased transparency regarding the true cost of researching and developing cancer medicines, and mechanisms to dissociate that cost from the cost of cancer treatment, with the aim of providing life-saving medicines to cancer patients in all countries.

Mr MELLO (International Federation of Medical Students Associations), speaking at the invitation of the CHAIRMAN, recommended, in the light of the increase in young people's behaviours that led to noncommunicable diseases, that interventions to reduce the burden of noncommunicable diseases should take into account risk factors during childhood and adolescence. He urged that horizontal primary care approaches be designed with a focus on prevention and treatment of noncommunicable diseases and that the issue of noncommunicable diseases be integrated into health-in-all-policies with intersectoral planning. He commended the implementation of the Global Coordination Mechanism, but urged WHO to prioritize policy coherence across sectors with a focus on trade and investment. He recommended that governments ensure the participation of young people in awareness-raising activities aimed at preventing noncommunicable diseases.

Dr CHESTNOV (Assistant Director-General) said that, at the 2014 United Nations high-level meeting to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases, the work of WHO since the 2011 Political Declaration had been highly commended. With the cooperation of the Member States, the Organization had fulfilled almost all its commitments, established a comprehensive Global Monitoring Framework and designed a Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. Measures should be established to maintain that progress.

He had noted that some Member States had expressed concern regarding the development of measures that would ensure progress at country level. In that regard, the Organization and all stakeholders should not wait until the political landscape would facilitate implementation of national strategies but should take action by adopting a multisectoral approach. While countries could look to WHO for guidance, it was also essential to implement national plans to prevent and control noncommunicable diseases, covering initiatives such as those to reduce salt intake and smoking, and there had been a significant increase in the number of Member States that had designed and applied national policies and plans. He acknowledged that workshops on the practical application of international instruments were also essential to ensure those instruments fulfilled their purpose. More than 65 countries were presently seeking assistance in putting those instruments into effect. The global coordination mechanism on the prevention and control of noncommunicable diseases also had an important role to play, but the efforts of governments, nongovernmental organizations, civil society and the private sector were equally fundamental to ensure successful implementation of plans at the national level. In addition, discussions on the proposed work plan of the global coordination mechanism required the active engagement of civil society and the private sector and much work lay ahead in that regard. The input of highly competent personnel would contribute to ensuring that the work plan was a success.

Furthermore, the work of the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases was bearing fruit and the number of agencies involved had risen to more than 20. He thanked Member States for their financial contributions to projects on noncommunicable diseases, adding that until universal coverage was achieved at primary level such

support could not falter. He underscored the importance of exchanging information and best practices through appropriate mechanisms, and of raising awareness of the impact of noncommunicable diseases on the economy and on all aspects of people's lives. The eradication of polio demonstrated that similar achievements in the field of noncommunicable diseases were possible, even if those diseases posed greater challenges as they affected all populations.

Preparedness for dealing with noncommunicable diseases remained the next major challenge. Member States needed to be technically and financially equipped and WHO also needed to mobilize resources at country level in order to achieve real results in the area of prevention and control of noncommunicable diseases. He called upon Member States to finalize their national plans and targets relating to noncommunicable diseases and, for those seeking WHO's support, to present a needs-based budget in order to obtain the funding required. The implementation of the post-2015 development agenda would call, once again, for WHO to take a leadership role with a view to effectively achieving the goals set.

The Committee noted the report.

Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications: Item 13.5 of the Agenda (Documents A68/12 and EB136/2015/REC/1, resolution EB136.R8)

Mr CORRALES HIDALGO (Panama), commending the Secretariat for its work on epilepsy, drew attention to the multiple impacts that the condition had on sufferers as a result not only of the cost of treatment but also of discrimination and inequality of opportunities. Basic antiepileptic medicines were provided at all three levels of his country's health system, although there were sometimes shortages of them. Skilled diagnosis, in most cases, took place only at the tertiary level, in response to which his Government had prioritized the enhancement of epilepsy prevention and control in primary health care, backed by public awareness-raising and cooperation with civil society and other partners. Panama asked to be added to the list of sponsors of the draft resolution contained in resolution EB136.R8.

Dr SHOHANI (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed appreciation for the report and the technical assistance provided by the Secretariat to bridge the epilepsy treatment gap. Epilepsy was a multifaceted mental health and neurological disorder that disproportionately affected the most disadvantaged and vulnerable groups. It was satisfactory to note that epilepsy was among those disorders considered by the WHO Mental Health Gap Action Programme (mhGAP) to be priorities for treatment in general health care settings. States in the Region were committed to promoting the requisite legislative and regulatory action, awareness-raising and cost-effective heath interventions to ensure the prevention and control of epilepsy at the national, community and health care system levels.

Ms ST. LAWRENCE (Canada) welcomed the emphasis in the report on the need to integrate epilepsy management into primary health care and, concurring with the view that such a step had the potential to help to reduce the treatment gap, noted that it would also require adequate training for health care professionals. Her Government continued to invest in epilepsy research and had conducted its first national population study of neurological conditions to gain insight into how they affected people's lives. Canada supported efforts to tackle epilepsy at the global and country levels as part of the noncommunicable disease and mental health agendas, and requested to be added to the list of sponsors of the draft resolution.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) highlighted the progress made by the National Health Service towards enabling people with long-term conditions including epilepsy to understand and manage their own condition, in partnership with clinicians. This included

monitoring indicators specific to reducing unplanned hospital admissions, with the aim of improving the care being offered outside the hospital. Efforts were also in hand to improve data collection on prevalence, drug management and patient outcomes, which would help to promote best practice and reduce variation in service provision nationwide. The United Kingdom wished to be added to the list of sponsors of the draft resolution.

Dr AL MOSAWI (Bahrain) expressed strong support for the actions suggested in paragraphs 22–30 of the report for improving epilepsy care. In Bahrain, the epilepsy treatment gap was small. The country already trained non-specialist primary care providers in order to assist diagnosis and treatment in primary health care facilities and provided treatment with first- and second-line antiepileptic medicines without charge.

Mrs GYANSA-LUTTERODT (Ghana) recommended, based on the results of an epilepsy care project launched in Ghana in 2012, adoption of a multi-stakeholder approach, development of a global drug facility to improve access to medicines, increased involvement of civil society in public education to foster synergies in information-provision and communication at the community level and improvements to the information management systems to feed data into national surveillance systems. Ghana wished to be added to the list of sponsors of the draft resolution.

Mr COTTERELL (Australia), commending WHO on its work to address the challenges in epilepsy care, stressed that it was important for Member States to strengthen leadership and governance while ensuring appropriate assistance and support for vulnerable people with epilepsy. It was also important to address the stigma associated with epilepsy. Thanking China for its leadership in developing the draft resolution, which Australia supported and wished to cosponsor, he requested clarification on whether the costs of implementation of the resolution had been taken into account in the Programme budget 2016–2017.

Dr JAMALUDIN (Malaysia) expressed support for the draft resolution, which Malaysia wished to cosponsor, and noted the need for a global action plan to guide especially low- and middle-income countries in the areas of prevention, control and monitoring. Phased implementation of the resolution should be considered to allow for the capacity-building needed to ensure the effective implementation of national epilepsy programmes and services.

Dr BUSUTTIL (Malta) said that the findings presented in the report accurately reflected the situation in Malta and elsewhere in regard to misdiagnoses of epilepsy, treatment gaps and discrimination against sufferers, predominantly as a result of a lack of understanding of the condition. There was an urgent need to promote awareness-raising in order to remove stigmatization, to prioritize research into the causes and means of prevention and control and to strengthen international collaboration to tackle the challenges. Malta strongly supported and wished to cosponsor the draft resolution.

Ms SAMIYA (Maldives) commended China on its leadership in developing the draft resolution, of which Maldives was a cosponsor. Her country's mental health policy included an integrated approach to prevention and control that, inter alia, sought to increase access to medicines and decrease disparities among those in need of treatment. It was important for Member States to implement policies on mental health and noncommunicable diseases that considered the specific needs of people with epilepsy. Key steps included integrating epilepsy management into primary health care, raising public awareness, conducting more extensive research, strengthening surveillance systems and fostering partnership with civil society.

Ms GURBANOVA (Azerbaijan), welcoming the attention paid to the important and highly complex problem of epilepsy, drew attention to the medical and social benefits of her Government's increased efforts to improve diagnosis and treatment by ensuring that people with epilepsy had access to free first-line antiepileptic medicines, a disability allowance and services provided by specialist health professionals. In addition, doctors took courses on epilepsy and diagnostic tools as part of their basic training, support was provided to families and plans were being made to establish an epilepsy research centre in Baku.

Dr AXELROD (Russian Federation) recognized that, in most cases, epilepsy could be treated with inexpensive medicines, and that people with epilepsy could live normal lives, but acknowledged that more than 90% of people with epilepsy in developing countries did not receive adequate treatment. The Decade of Action on Epilepsy and the Organization's priorities on noncommunicable diseases, maternal and child health and access to medicines sought to address the challenge of epilepsy, which was an international and multidisciplinary problem, with social implications. The Russian Federation had developed national standards and clinical recommendations on epilepsy, and most antiepileptic medicines were on its Essential Medicines List. Other national measures included comprehensive epidemiological research, analysis of the economic burden of epilepsy, studies of stigmatization of people with epilepsy, and developing measures to improve epilepsy care, particularly through improving competencies of specialists in that regard. She recognized the need for WHO to address epilepsy, and urged development of a WHO global plan of action on epilepsy, which her country would be ready to implement. Finally, she requested that her country be added to the list of sponsors of the draft resolution.

Mr GWIAZDA (Poland), recognizing the need for coordinated action to address stigmatization, discrimination and other impacts of epilepsy, welcomed implementation of the mhGAP, especially in low- and middle-income countries, and looked forward to the results of pilot initiatives. Poland was coordinating the EPISTOP Programme, which sought to better understand the pathophysiology of epilepsy and its consequences, based on expertise gathered from around the world.

Mr KRANIAS (Greece) acknowledged the global impact of epilepsy and its prevention and treatment possibilities. National efforts sought to improve the quality of life of people with epilepsy, promote social awareness, and build an effective system of prevention, early detection and long-term care. Under a new universal health coverage framework in Greece, people with epilepsy would be eligible for antiepileptic medicines and health care. His country wished to be added to the list of sponsors of the draft resolution.

Ms KIPIANI (Georgia), supporting the draft resolution, asked that her country be added to the list of sponsors.

Ms STRESINA (Romania) said action plans to increase awareness and access to medicines would ensure treatment for people with epilepsy. At the same time, she recognized treatment gaps, discrimination and stigmatization. Various national initiatives had sought to improve public knowledge of epilepsy, and provide better services and care for people with the disorder. While in general patients had access to medicines, she recognized that more could be done to increase public awareness and improve training of health professionals. Supporting the draft resolution, she requested that her country be added to the list of sponsors.

Dr MUKENGESHAYI KUPA (Democratic Republic of the Congo) recognized the impact of epilepsy in his country, including stigmatization of sufferers. Progress had been made in managing the disease, particularly in community actions; however, further steps had to be taken, to produce conclusive data on morbidity and mortality. Member States should integrate management of epilepsy into national strategic and operational plans, and establish coordination mechanisms. WHO should

continue to coordinate stakeholders in order to mobilize resources for awareness-raising, monitoring, research and medicine procurement. He supported the draft resolution.

Dr MAGAGULA (Swaziland), noting the increasing prevalence of epilepsy, drew attention to the lack of specialized caregivers for epilepsy and similar conditions in his country. Failure to provide epilepsy-sufferers with appropriate treatment led to increased risk of death. He encouraged the Secretariat and the Member States to ensure that people with epilepsy received adequate treatment, and proposed that neurology scholarships be offered to African doctors. He drew attention to the need for increased education on epilepsy, and on living with the disease, which could be undertaken by community support groups and in schools. He thanked Chinese Taipei for its support in providing specialized doctors to Swaziland to fill gaps in epilepsy care.

Mr AMOUSSOU (Benin), speaking on behalf of the Member States of the African Region, recognized the prevalence and social and economic burden of epilepsy, particularly in low- and middle-income countries, which included countries from his Region. Almost 90% of cases of epilepsy occurring in resource-poor or rural settings, which were common in Africa, were not diagnosed or treated. Limited health systems, lack of trained personnel, and poor access to medicines were elements that contributed to the treatment gap. Several countries in the Region had participated in technical committees and pilot programmes aimed at reducing that gap. He supported the draft resolution, and encouraged coordinated efforts to lobby pharmaceutical companies in order to reduce the cost of antiepileptic medicines.

Dr CHOMPOONUT TOPOTHAI (Thailand) commended China's leadership in preparing the draft resolution, requesting that her country be added to the list of sponsors. However, she expressed concern regarding ways of improving access to care, with particular regard to availability and accessibility of antiepileptic medicines in countries where health care was financed through user charges. Context-specific measures had to be taken to remove all barriers to services and care. In addition, she drew attention to the lack of provision in the draft resolution for a monitoring and evaluation tool, and hoped it would be included in the technical recommendations to be produced by WHO pursuant to operative paragraph 3(2) of the draft resolution. Such a tool should include indicators on availability of antiepileptic medicines at primary health care centres, and percentage of patients with access to those medicines. Treatment outcomes should also be assessed in line with country contexts.

Professor MAGIMBA (United Republic of Tanzania), acknowledging the high burden of epilepsy in sub-Saharan Africa, drew attention to national efforts to address mental health and epilepsy, including development of a mental health programme, provision of district mental health coordinators, inclusion of antiepileptic medicines in the country's Essential Medicines List, improved engagement with relevant professional bodies and the inclusion of epilepsy and mental diseases on educational curricula. Cultural beliefs at community level remained an obstacle, hindering epilepsy diagnosis and management, and limiting numbers of trained health professionals in primary care centres and referral hospitals.

Dr MUSTIKOWATI (Indonesia) recognized the burden of epilepsy globally and in her country, and the need for a comprehensive action plan for epilepsy to include promotion of neurological health, prevention, provision of medical and social epilepsy services in community settings, and strengthening of information systems, research, leadership, and governance. Nationally, essential antiepileptic medicines had been added to the Essential Medicines List, but epilepsy diagnosis and management capacity required further strengthening. She supported the draft resolution, and called for continued support from WHO and other United Nations agencies in that regard.

Mr BERTONI (Italy) supported the draft resolution, which would not only provide for a review of national health policies on epilepsy, particularly in low- and middle-income countries, but also defined priority areas for intervention, recognized the need for further research on more efficacious and disease-modifying treatments and acknowledged the central role of all stakeholders. He asked that Italy be added to the list of sponsors.

Mr COLMENARES CORONA (Bolivarian Republic of Venezuela) expressed his support for the draft resolution, which his country wished to cosponsor. His country had continued to develop a new understanding of mental health, built on health promotion and disease prevention, emphasizing early diagnosis and community action in order to improve services and care of people with epilepsy in primary health care facilities. With a view to improving quality of life and ensuring adequate treatment, the Government was strengthening policies on provision of antiepileptic medicines, increasing investment in epilepsy treatment, improving multidisciplinary training of health workers on mental health, and educating patients in order to improve adherence to treatment.

Dr HINOSHITA (Japan) agreed that the treatment gap could be reduced by strengthening diagnostic and treatment capacity at the primary health care level, alongside increased coordination with specialized institutions. WHO's Comprehensive Mental Health Action Plan 2013–2020 was relevant to the prevention of epilepsy, and he therefore encouraged WHO to strengthen epilepsy care in line with that plan. Due to limited medical facilities and health care workers in low- and middle-income countries, particularly in their rural areas, a comprehensive approach to mental health was required, to include action on epilepsy. He asked that his country be added to the list of sponsors.

Mr CONCEIÇÃO FREITAS (Timor-Leste) said that the national mental health strategy included an epilepsy programme, considered one of the country's priorities. The programme concentrated on managing severe epilepsy cases and provided training and support to other agencies for managing less severe conditions. With WHO's support, the Ministry of Health had conducted a pilot project on reducing epilepsy treatment gaps, and he hoped that further support in that area would be forthcoming. He endorsed the draft resolution.

Mr KOLKER (United States of America), welcoming the draft resolution, encouraged the Secretariat to provide guidance and technical assistance to Member States for implementing their prevention and treatment programmes. In the poorer parts of the world there was an enormous treatment gap, highlighting a key aspect of the problem of access to medicines. Despite having existed for decades and being available globally as generic medicines, medications for treating epilepsy were often highly priced or not available to patients. He therefore called for enhanced multisectoral action to implement, disseminate and evaluate effective prevention and treatment programmes in health care settings, in communities, and by patients themselves in order to reduce the epilepsy burden.

Ms VILAS (Argentina) said that despite the existence of national legislation in Argentina under which essential medicines for treating epilepsy were available free of charge, discrimination was illegal and information about the condition was disseminated, lack of access to medicines and treatment, as well as stigmatization in the workplace and at school, persisted, often amounting to a violation of human rights. She placed emphasis on providing proper training for health professionals working at primary care level, and urged Member States to develop strategies in line with the Strategy and Plan of Action on Epilepsy 2012–2021 being implemented in the Region of the Americas and to make discrimination illegal. She therefore called on WHO to take the lead in drawing up a global plan of action on epilepsy and expressed support for the draft resolution.

Mr ZHANG Yong (China) said that in many low- and middle-income countries, where there was a shortage both of doctors specializing in epilepsy and of antiepileptic medicines, sufferers often did not receive appropriate treatment. However, the experience of some developing countries,

including China, had shown that coordinated action at country level made it possible to manage epilepsy with limited funds, significantly improving people's lives as a result. The draft resolution reflected the importance of such coordinated action and recognized that access to essential medicines was a human right.

Mr Chin-Shui SHIH (Chinese Taipei) outlined the measures being taken in Chinese Taipei to manage epilepsy and recalled that the revision of its disability legislation had been carried out in accordance with the WHO International Classification of Functioning, Disability and Health.

Mr BALASUBRAMANIAM (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, underscored the importance of the draft resolution given that neurological disorders such as epilepsy were not included in WHO's Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. Highlighting the difficulties experienced by people with epilepsy in low- and middle-income countries in securing the necessary medicines, usually because of high cost, he pointed to the need for research in order to understand the barriers to treatment, and also for governments to do more to ensure that antiepileptic medicines were both available and affordable for all who needed them. Adopting the resolution in its entirety would be an important first step in that direction.

Dr COVANIS (International Bureau for Epilepsy), speaking at the invitation of the CHAIRMAN, said that in high-income countries, 30% of people with epilepsy continued to have seizures despite existing antiepileptic medicines, while in middle- and low-income countries, where at least 42 million people with epilepsy lived, up to 90% did not receive medical treatment for the reasons mentioned in the report. He supported the draft resolution and expressed his organization's willingness to work with Member States, the Secretariat and other stakeholders to encourage its global implementation.

Professor PERUCCA (International League against Epilepsy), speaking at the invitation of the CHAIRMAN, said that the draft resolution was fully aligned with the sustainable development agenda and provided the basis for synergistic actions at country level to reduce the burden of epilepsy. In order to fulfil the commitments contained in the draft resolution, she called on the Health Assembly to enhance the Secretariat's capacity by allocating an adequate budget for action on epilepsy. Her organization was eager to work with WHO to implement the recommendations contained in the draft resolution through fostering capacity building, promoting collaboration, training health care professionals and developing cost-effective programmes for epilepsy care.

Dr SHAKIR (World Federation of Neurology), speaking at the invitation of the CHAIRMAN, stressed the need for pragmatic measures to ensure that the commitments in the draft resolution were translated into real action, such as increasing capacity in the Secretariat and ensuring an adequate budgetary allocation. Epilepsy was preventable and treatable, yet the majority of the 50 million people affected did not receive basic affordable medications. It was the duty of governments and health authorities to remove the stigma often associated with the condition.

Dr SAXENA (Mental Health and Substance Abuse Department) expressed appreciation for the strong support shown by Member States for the work on epilepsy. Within the category of noncommunicable diseases, epilepsy was a condition where cost-effective interventions had long been available, but progress in widening access to them had been slow. The resolution, if adopted, would be implemented in coordination with the Comprehensive Mental Health Action Plan 2013–2020 and the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020. The inclusion of epilepsy in the mhGAP Intervention Guide had further served to promote activities on epilepsy. Work would be carried out with the relevant departments to facilitate access to essential medicines and address the issue of cost. Monitoring and evaluation would be an important part of the

process. He confirmed that provision had been made for epilepsy in the Programme budget 2016–2017, adding that additional internal adjustments would be made, as needed, to ensure adequate funding for implementing the resolution.

The draft resolution contained in resolution EB136.R8 was approved.[1]

2. FOURTH AND FIFTH REPORTS OF COMMITTEE B

Dr FONES (Chile), Rapporteur, read out the draft fourth and fifth reports of Committee B.

The reports were adopted.[2]

3. CLOSURE OF THE MEETING

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

The meeting rose at 11:50.

[1] Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA68.20.

[2] See pages 368 and 369.

PART II

REPORTS OF COMMITTEES

In the following sections, information has been drawn from the relevant Health Assembly report. That report is identified by its document number and publication date, which are provided in square brackets under each subheading. Square brackets have also been used in the reports of Committee A and Committee B to indicate where the text of resolutions and decisions recommended and subsequently adopted by the Health Assembly has been replaced by the respective resolution or decision number (see document WHA68/2015/REC/1). The verbatim records of the plenary meetings at which these reports were approved are available on the WHO website, official records page (http://apps.who.int/gb/or/).

COMMITTEE ON CREDENTIALS

Report[1]

[A68/63 – 19 May 2015]

The Committee on Credentials met on 19 May 2015. Delegates of the following Member States were present: Belgium; Colombia; Djibouti; Gabon; Guinea-Bissau; Singapore; Switzerland; Tajikistan; Timor-Leste; Tonga.

The Committee elected the following officers: Mrs Muriel Peneveyre (Switzerland) – Chairman; Dr Médard Toung Mve (Gabon) – Vice-Chairman.

The Committee examined the credentials delivered to the Director-General in accordance with Rule 23 of the Rules of Procedure of the World Health Assembly. It noted that the Secretariat had found these credentials to be in conformity with the Rules of Procedure.

The credentials of the delegates of the Member States shown below were found to be in conformity with the Rules of Procedure as constituting formal credentials; the Committee therefore proposed that the World Health Assembly should recognize their validity.

States whose credentials it was considered should be recognized as valid (see fourth paragraph above and decision WHA68(6)):

Afghanistan; Albania; Algeria; Andorra; Angola; Antigua and Barbuda; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Benin; Bhutan; Bolivia (Plurinational State of); Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cabo Verde; Cambodia; Cameroon; Canada; Central African Republic; Chad; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Guinea-Bissau; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Libya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia;

[1] Approved by the Health Assembly at its sixth and eighth plenary meetings.

Maldives; Mali; Malta; Mauritania; Mauritius; Mexico; Monaco; Mongolia; Montenegro; Morocco; Mozambique; Myanmar; Namibia; Nauru; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Serbia; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; South Sudan; Spain; Sri Lanka; Sudan; Suriname; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Thailand; The former Yugoslav Republic of Macedonia; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Vanuatu; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe.

GENERAL COMMITTEE[1]

Report[2]

[A68/64 – 21 May 2015]

Election of Members entitled to designate a person to serve on the Executive Board

At its meeting on 20 May 2015, the General Committee, in accordance with Rule 100 of the Rules of Procedure of the World Health Assembly, drew up the following list of 12 Members, in the English alphabetical order, to be transmitted to the Health Assembly for the purpose of the election of 12 Members to be entitled to designate a person to serve on the Executive Board: Canada, Congo, Dominican Republic, France, Jordan, Kazakhstan, Malta, New Zealand, Pakistan, Philippines, Sweden and Thailand.

In the General Committee's opinion these 12 Members would provide, if elected,[3] a balanced distribution of the Board as a whole.

COMMITTEE A

First report[2]

[A68/65 – 21 May 2015]

Committee A held its fifth meeting on 20 May 2015 under the chairmanship of Dr Eduardo Jaramillo Navarrete (Mexico).

In accordance with Rule 34 of the Rules of Procedure of the World Health Assembly, the Committee elected Ms Dorcas Makgato (Botswana) and Dr Bahar Idreiss Abugarada Abulgassim (Sudan) Vice-Chairmen, and Dr Liis Rooväli (Estonia) Rapporteur.

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[1] See decision WHA68(4) for establishment of the Committee.

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

[3] The Health Assembly considered the list at its eighth plenary meeting and elected the 12 Members (see decision WHA68(7)).

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

12. Programme and budget matters
    12.2 Proposed programme budget 2016–2017
        Programme budget 2016–2017 [WHA68.1]
16. Communicable diseases
    16.2 Malaria: draft global technical strategy: post 2015
        Global technical strategy and targets for malaria 2016–2030 [WHA68.2].

Second report[1]

[A68/67 – 22 May 2015]

Committee A held its sixth meeting on 21 May 2015 under the chairmanship of Dr Eduardo Jaramillo Navarrete (Mexico).

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

15. Preparedness, surveillance and response
    15.2 Poliomyelitis [WHA68(9)].

Third report[1]

[A68/69 – 23 May 2015]

Committee A held its eighth and ninth meetings on 22 May 2015 under the chairmanship of Dr Eduardo Jaramillo Navarrete (Mexico).

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

15. Preparedness, surveillance and response
    15.2 Poliomyelitis [WHA68.3]
    15.3 Implementation of the International Health Regulations (2005)
        Yellow fever risk mapping and recommended vaccination for travellers [WHA68.4]
        The recommendations of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation [WHA68.5].

[1] Approved by the Health Assembly at its ninth plenary meeting.

Fourth report[1]

[A68/71 – 25 May 2015]

Committee A held its eleventh meeting on 23 May 2015 under the chairmanship of Dr Eduardo Jaramillo Navarrete (Mexico).

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

16. Communicable diseases
    16.1 2014 Ebola virus disease outbreak and follow-up to the Special Session of the Executive Board on the Ebola Emergency [WHA68(10)].

Fifth report[1]

[A68/73 – 26 May 2015]

Committee A held its twelfth and thirteenth meetings on 25 May 2015 under the chairmanship of Dr Eduardo Jaramillo Navarrete (Mexico).

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

16. Communicable diseases
    16.4 Global vaccine action plan [WHA68.6]
15. Preparedness, surveillance and response
    15.1 Antimicrobial resistance
        Global action plan on antimicrobial resistance [WHA68.7].

Sixth report[1]

[A68/75 – 27 May 2015]

Committee A held its fourteenth and fifteenth meetings on 26 May 2015 under the chairmanship of Dr Eduardo Jaramillo Navarrete (Mexico).

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

14. Promoting health through the life course
    14.6 Health and the environment: addressing the health impact of air pollution [WHA68.8]
11. WHO reform
    11.2 Framework of engagement with non-State actors [WHA68.9].

[1] Approved by the Health Assembly at its ninth plenary meeting.

COMMITTEE B

First report[1]

[A68/66 – 21 May 2015]

Committee B held its first meeting on 20 May 2015 under the chairmanship of Mr Michael Malabag (Papua New Guinea).

In accordance with Rule 34 of the Rules of Procedure of the World Health Assembly, the Committee elected Dr Raymond Busuttil (Malta) and Mr Khaga Raj Adhikari (Nepal) Vice-Chairmen, and Dr Guy Fones (Chile) Rapporteur.

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

20. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan [WHA68(8)].

Second report[2]

[A68/68 – 22 May 2015]

Committee B held its second and third meetings on 21 May 2015 under the chairmanship of Mr Michael Malabag (Papua New Guinea) and Dr Raymond Busuttil (Malta).

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

21. Financial matters
    - 21.1 Financial report and audited financial statements for the year ended 31 December 2014 [WHA68.10]
    - 21.2 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution [WHA68.11]
    - 21.4 Scale of assessments for 2016–2017 [WHA68.12]
22. Audit and oversight matters
    - 22.1 Report of the External Auditor [WHA68.13]

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

[2] Approved by the Health Assembly at its ninth plenary meeting.

22.3 Appointment of the External Auditor [WHA68.14].

Third report[1]

[A68/70 – 25 May 2015]

Committee B held its fourth and fifth meetings on 22 May 2015 under the chairmanship of Dr Raymond Busuttil (Malta).

It was decided to recommend to the Sixty-eighth World Health Assembly the adoption of one resolution and two decisions relating to the following agenda items:

17. Health systems
    - 17.1 Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage [WHA68.15]
    - 17.2 WHO Global Code of Practice on the International Recruitment of Health Personnel [WHA68(11)]
    - 17.3 Substandard/spurious/falsely-labelled/falsified/counterfeit medical products [WHA68(12)].

Fourth report[1]

[A68/72 Rev.1 – 26 May 2015]

Committee B held its sixth and seventh meetings on 25 May 2015 under the chairmanship of Mr Michael Malabag (Papua New Guinea).

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

23. Staffing matters
    - 23.3 Amendments to the Staff Regulations and Staff Rules
        - Salaries of staff in ungraded posts and of the Director-General [WHA68.16]
        - Amendments to the Staff Regulations [WHA68.17]
    - 23.5 Appointment of representatives to the WHO Staff Pension Committee [WHA68(13)]

17. Health systems
    - 17.5 Global strategy and plan of action on public health, innovation and intellectual property [WHA68.18]

13. Noncommunicable diseases
    - 13.1 Outcome of the Second International Conference on Nutrition [WHA68.19]
    - 13.2 Maternal, infant and young child nutrition: development of the core set of indicators [WHA68(14)].

[1] Approved by the Health Assembly at its ninth plenary meeting.

Fifth report[1]

[A68/74 – 27 May 2015]

Committee B held its eighth meeting on 26 May 2015 under the chairmanship of Mr Michael Malabag (Papua New Guinea).

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

13. Noncommunicable diseases
    13.5 Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications [WHA68.20].

[1] Approved by the Health Assembly at its ninth plenary meeting.

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COMPOSITION DE L'ASSEMBLÉE DE LA SANTÉ

LIST OF DELEGATES AND OTHER PARTICIPANTS
LISTE DES DÉLÉGUÉS ET AUTRES PARTICIPANTS

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