TENTH MEETING

Friday, 20 January 2012, at 14:45

Chairman: Dr S. OMI (Japan)

1. TECHNICAL AND HEALTH MATTERS: Item 6 of the Agenda (continued)

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: report on the work of the Advisory Group: Item 6.9 of the Agenda (Document EB130/18) (continued)

Dr DAULAIRE (United States of America) welcomed the Organization's work on the global surveillance of, and response to, pandemic influenza, particularly the Pandemic Influenza Preparedness (PIP) Framework, which he supported. Questions on its implementation and procedures would undoubtedly be raised by stakeholders until the entity-specific Standard Material Transfer Agreements 2 had been negotiated and finalized. He encouraged the Secretariat to begin negotiations on at least one or two entity-specific agreements and urged WHO to ensure that its work during the interim period did not hamper the rapid sharing of PIP biological materials. Active consultation between the Secretariat and civil society stakeholders, including industry, would be important during implementation of the PIP Framework, and he encouraged the setting up of expert working groups, as needed, in which his country would gladly participate, in order to bolster the work of the Advisory Group.

Mr OTAKE (Japan) said that it was vital to respond quickly to pandemic influenza by sharing influenza specimens, hence the importance of the Pandemic Influenza Preparedness Framework. The key to the successful implementation of the Framework lay in its details. In order to ensure its fair and transparent functioning, due consideration should be given to the views of industry. It was to be hoped that the Partnership Contributions would be based on the size and capacity of the business concerned.

A breakdown should be provided of the US$ 56.5 million operating costs for 2010 of WHO's Global Influenza Surveillance and Response System, which would help to determine its budget for 2012. Moreover, the amount of revenue from sources other than Partnership Contributions was not known. He sought further information, which would be necessary to engage other stakeholders.

He asked the Secretariat also to elaborate on the relationship between the Pandemic Influenza Preparedness Framework Advisory Group and the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009.

Dr NASHER (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that avian influenza (H5N1) virus posed a major threat for many countries in the Region, where the laboratory and surveillance facilities needed for detection purposes were either non-existent or substandard. Timely access to sufficient quantities of pandemic influenza A (H1N1) 2009 vaccines had also posed a serious challenge owing to inadequate production capacity, a problem that was compounded in some countries by a lack of the regulatory mechanisms needed to ensure the rapid approval of safe and effective influenza vaccines. The result had been a delay in use of the vaccine and a drop in vaccination rates.

Timely sharing of information on influenza surveillance, and fair access to effective vaccines, medicines and technology were important elements of pandemic influenza preparedness. The need for additional technical and financial support to build the laboratory and pandemic influenza surveillance

capacities required under the International Health Regulations (2005) was particularly urgent in those countries of the Region that were low-income or in situations of conflict.

He expressed appreciation for the positions articulated by WHO at the joint meeting of governments on pandemic influenza preparedness. He urged Member States to implement resolution WHA64.5 (Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits), in which the Health Assembly had adopted the Pandemic Influenza Preparedness Framework.

Mrs ESCOREL DE MORAES (Brazil)[1] said that the Pandemic Influenza Preparedness Framework Advisory Group had a central role in ensuring that the Framework was implemented and its regulations respected. The Group's decision to accord priority to Partnership Contributions and Standard Material Transfer Agreement 2 was sound. Half the operating costs of the Framework would be funded by the annual contribution from industry and the Advisory Group was well positioned to define the contributions to be made by individual companies and other stakeholders, and to make rules for resource allocation. Standard Material Transfer Agreement 2 formed the basis for benefit-sharing and vaccine production and should be finalized rapidly, with the Advisory Group participating directly in the negotiations. A reasonable level of benefits, including knowledge-sharing with developing countries, should be provided in order to increase and diversify vaccine-production capacity.

The Pandemic Influenza Preparedness Framework should be balanced, effective and transparent, favouring those countries that would not have the means to respond in an emergency. The negotiating process had demonstrated the importance of ensuring that decision-making at WHO was more democratic and should serve as an example for the Organization's other negotiations.

Mr GURITNO (Indonesia)[1] said that the adoption of the Pandemic Influenza Preparedness Framework with the first Standard Material Transfer Agreement in May 2011, in resolution WHA64.5, had demonstrated Member States' commitment to managing public health threats through the introduction of regulations based on fairness, equity and transparency. The projected series of meetings of the Advisory Group was welcome and Member States should do their utmost to ensure their effectiveness. Indonesia had shown its commitment to pandemic influenza preparedness by sharing its influenza A (H5N1) isolate under the Framework, which had led to the development of a vaccine. It had also provided genetic sequencing data and information for the influenza virus tracking mechanism.

Ms SMIRNOVA (Russian Federation)[1] welcomed WHO's leadership in pandemic influenza preparedness. The Advisory Group provided the Director-General with access to expert advice and helped countries to implement or step up their vaccination programmes and to develop influenza vaccines. It was incumbent on Member States to cooperate with each other on pandemic influenza preparedness and the importance of the Organization's work, particularly its collaboration with industry, should not be underestimated. The Russian Federation was eager to work with WHO on implementing the recommendations of the Advisory Group.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand)[1] pointed out that practical action and positive outcomes were crucial to inspiring trust. The Framework's initial successes, such as sub-licensing agreements for the manufacture of oseltamivir, commitments from influenza vaccine manufacturers, and transfer of technology to developing countries, should be pursued and strengthened. The Framework was the foundation for promoting and sustaining virus-sharing activities

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

by offering incentives and differential pricing to the partners involved. Inclusion of manufacturers from developing countries in the manufacturing base would help to ensure an adequate supply of vaccines at affordable prices.

Mr DURISCH (Stichting Health Action International), speaking at the invitation of the CHAIRMAN and also on behalf of Third World Network and the Berne Declaration, said that the Advisory Group should be guided in its work by the principles of equity and transparency. It should, for example, make available information pertaining to the process of determining Partnership Contributions, the terms and conditions of the Standard Material Transfer Agreements and the background of its members. Documents relating to the Advisory Group should be made public. Furthermore, commercial entities should be prevented from exercising undue influence on the Advisory Group, and public-interest nongovernmental organizations should be consulted at all stages of the decision-making process. Standard Material Transfer Agreements should be implemented immediately. According to media reports, efforts were allegedly under way to limit the sharing of data from research on influenza A (H5N1) virus that had produced a highly contagious strain. Such a move could affect the PIP Framework.

Dr FUKUDA (Assistant Director-General) confirmed that in 2012 work would focus on implementing the Standard Material Transfer Agreement 2 and agreeing on the use and distribution of Partnership Contributions. The Advisory Group's report had focused on its formation and first meeting; future reports would focus on a wider range of activities. Members of the Advisory Group, summaries of whose backgrounds and declarations of interest had already been published on the Internet, had been appointed in an individual capacity as experts rather than as country representatives.

Responding to the member for Japan, he explained that out of the US$ 56.5 million annual running costs of the WHO Global Influenza Surveillance and Response System, Member States spent about US$ 22 million on maintaining their National Influenza Centres and US$ 18 million for maintaining WHO Collaborating Centres on Influenza. Other expenses, such as shipping costs and the cost of maintaining the WHO H5 Reference Laboratories, accounted for the rest. A summary of the data was available in a separate document on technical studies following resolution WHA63.1.[1]

The International Health Regulations (2005) Emergency Committee concerning Influenza Pandemic (H1N1) 2009 was convened, as needed, to help to determine whether an emergency situation existed and to provide advice on dealing with it. The Advisory Group had a different function: to provide guidance to the Director-General on the implementation of the Framework and to advise, for example, on the use of Partnership Contributions.

Turning to the comments made by the representative of Brazil, he said that Partnership Contributions were cash donations from industry to the Organization and were calculated on the basis of half the running costs of the Global Influenza Surveillance and Response System. The Advisory Group provided guidance to the Director-General on how the funds should be spent, but the Contributions were intended to be used mainly to help countries to prepare for and deal with pandemic influenza outbreaks. Under the Framework, the Advisory Group was mandated to consult with industry and other stakeholders and would do so in 2012.

The DIRECTOR-GENERAL said that she appreciated the efforts made by the Member States and industry partners in the negotiations. She highlighted the importance of transparency within the Pandemic Influenza Preparedness Framework and explained that before the appointment of the members of the Advisory Group, lengthy consultations had been held with the regional directors, who

[1] Document A/PIP/OEWG/3/2, Annex 1, Section 1.2, Table A1.9.

had drawn up a list of nominees. Appendix 2 of document EB130/18 stated that all members had completed the Declaration of Interest. Those declarations had been reviewed by the Legal Counsel who had found no conflicts of interest.

The CHAIRMAN took it that the Board wished to note the report on pandemic influenza preparedness contained in document EB130/18.

The Board noted the report.

Poliomyelitis: intensification of the global eradication initiative: Item 6.10 of the Agenda (Documents EB130/19 and EB130/19 Add.1)

The CHAIRMAN drew attention to the draft resolution contained in paragraph 10 of document EB130/19 and its financial and administrative implications for the Secretariat (document EB130/19 Add.1).

Mr PRADHAN (India) announced that no case of poliomyelitis had been reported in India during the previous 12 months. That success resulted from various initiatives that had been introduced by the Government over the years, and sustained political will. In 2010, India had been one of the first countries to introduce the bivalent oral polio vaccine, and despite periodic shortages it had been able to procure sufficient quantities of the vaccine for national and regional supplementary immunization rounds. Improving supplementary immunization activities and coverage had been a key part of the fight against poliomyelitis. Plans to ensure immunization of migrant and mobile populations and populations in low-coverage areas had been implemented. A multipronged strategy involving improvement of routine coverage, sanitation and hygiene had been used in high-risk areas.

Given the risks that still existed, his country had developed an emergency preparedness and response plan. Surveillance of acute flaccid paralysis had been stepped up in all states sharing borders with other countries. He urged the Secretariat to continue providing technical support to India's Pulse Polio Programme until the disease had been eradicated.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, congratulated India for being free of poliomyelitis for a year and called upon the remaining countries where the disease was endemic to make long-term political and financial commitments to global eradication; failure to step up efforts towards eradication would erode the results achieved thus far.

In view of the financial constraints faced by WHO, the financial and administrative implications of the draft resolution should be further clarified. How would the Global Polio Eradication Initiative Strategic Plan, launched in 2010, meet the challenges that the current strategy had failed to surmount?

Dr DANKOKO (Senegal), speaking on behalf of the Member States of the African Region, said that the unprecedented commitment of African leaders to poliomyelitis eradication and their success in conducting synchronized vaccination campaigns during the period 2009–2011 had dramatically reduced the number of poliomyelitis cases. Recent outbreaks in some countries and re-establishment of poliovirus transmission in others were nevertheless causes for concern and had prompted the Regional Committee for Africa to adopt, in August 2011, resolution AFR/RC61/R4 on poliomyelitis eradication in the African Region, the aim of which was to interrupt transmission of wild poliovirus as rapidly as possible.

In its most recent report, the Independent Monitoring Board had drawn attention to the various obstacles to reaching the milestones under the Strategic Plan which, if not attained, could lead to a global catastrophe. He was convinced that such a scenario could be avoided if measures were taken to remove those obstacles, including labelling the fight against poliomyelitis as a global programmatic

public health emergency and making a political commitment to mobilize national resources as a supplement to donor contributions. Some countries in the Region had already introduced supplementary measures, such as providing additional resources, increasing the frequency of national immunization days and stepping up surveillance activities.

He endorsed the draft resolution.

Dr TAKAOKA (Japan) regretted that the deadline for eradication had been extended to the end of 2013 and wondered why that decision had been made. Her Government was fully committed to achieving poliomyelitis eradication and, to that end, had agreed in 2011 to lend Pakistan US$ 650 million to fund poliomyelitis vaccination campaigns under the new loan conversion system. The draft resolution failed to reflect a sense of urgency about eradication and she therefore proposed three amendments. In paragraph 2, the words "making polio eradication a national priority programme and" should be inserted after "national public health emergency". In the first line of subparagraph 4(1), the word "continued" should be replaced by "renewed". The words "including the establishment of a special polio programme within the Organization" should be inserted at the end of that same subparagraph.

Dr PE THET KHIN (Myanmar) said that Myanmar was one of the Member States in the South-East Asia Region that was at moderate risk of wild poliovirus importation. The recent outbreak in China sparked by a virus originating in Pakistan had shown that poliomyelitis eradication was not only a national issue but also a regional and global concern. His Government was fully committed to implementing the Global Polio Eradication Initiative Strategic Plan 2010–2012 and, following the re-emergence in Myanmar of vaccine-derived polioviruses in 2006 and the introduction of wild poliovirus in 2007, had developed an emergency response action plan, which was updated every two years. It regarded routine and supplementary immunization as the single most important eradication strategy but was experiencing difficulties in achieving broad vaccination coverage as a result of limited access to services. It had therefore launched a national plan for intensification of routine immunization, to be headed by state and regional authorities, and would in 2012 be implementing the "Reaching Every District Strategy" in hard-to-reach areas, despite a significant funding shortfall.

Full implementation of the Strategic Plan 2010–2012 required all countries to accord priority to eradication activity funding. He was in favour of extending the Plan to 2018.

Mr LEI Zhenglong (China) said that the outbreaks of poliomyelitis in China in 2011 had highlighted the importance of continuing eradication efforts even after poliomyelitis-free status had been certified. In the draft resolution, he proposed that in subparagraph 3(1), the words "to eliminate the 'blank immunization' areas and" be inserted before "to maintain very high population immunity". At the end of subparagraph 3(2), the words "and regular risk assessment" should be inserted after "sustaining certification-standard surveillance for polioviruses" and a new subparagraph 3(4) should be inserted, to read "to engage in multilateral and bilateral cooperation, including exchanging epidemic information, laboratory monitoring data, and carrying out the supplementary immunization activities simultaneously as appropriate;". A new subparagraph should follow subparagraph 4(3), to read "to coordinate the relevant partners to promote the research, production and supply of vaccines, to enhance its affordability, effectiveness and accessibility;".

Dr DAULAIRE (United States of America) said that India's laudable achievement demonstrated that eradication was feasible but the unique challenges faced by the countries remaining endemic for poliomyelitis called for a new approach. He applauded the recommendations made by the Independent Monitoring Board, which had set a new standard for honest and straightforward programme evaluation. As human and financial resources were vital to the eradication strategy, the United States Centers for Disease Control and Prevention had recently launched an emergency

operations centre to consolidate and leverage resources for polio eradication and would be scaling up its assistance to priority countries in the areas of outbreak prevention and control, bolstering management capacity, disease surveillance and vaccination campaigning. He urged all Member States to comply with the requirement for immediate notification under the International Health Regulations (2005).

In preambular paragraph 8 of the draft resolution, the words "and that some countries, such as the Kingdom of Saudi Arabia, require poliovirus vaccination for travellers coming from polio-infected areas, including administration of an additional dose of vaccine upon arrival," should be inserted after "interrupted globally". A new subparagraph 3(2bis) should be inserted, to read: "to review and, if necessary, align national guidelines and practice with WHO recommendations for the vaccination of travellers to and from polio-infected areas; countries at particular risk of recurrent importation and spread of poliovirus may consider additional steps to promote vaccination". In the first line of subparagraph 4(3) the words "scientific vetting" should be inserted after "development"; the words "inactivated poliovirus" should be inserted after "poliovirus diagnostics and"; and the words "that include risk management;" should be inserted after "the end of 2018.".

Dr GULLY (Canada) agreed that poliomyelitis should be regarded as a global health emergency. He urged Member States, previous funding partners of the Global Polio Eradication Initiative and others that had yet to support the Initiative to give immediate consideration to contributing to it. It was essential to prevent the reintroduction of poliovirus in poliomyelitis-free areas, and the determined efforts in that regard of some Member States, such as Saudi Arabia, merited recognition. He endorsed the amendments proposed by the members for China, Japan and the United States of America.

Dr LARSEN (Norway) praised India's success in achieving a poliomyelitis-free 12-month period, which proved that eradication was possible. He urged the remaining countries where poliomyelitis was endemic to draw on the lessons learnt in India.

Dr ABD JALIL (Brunei Darussalam) welcomed the significant progress made by many countries, and India in particular, towards poliomyelitis eradication. Nevertheless, outbreaks in regions that had previously been declared poliomyelitis-free and their impact on other poliomyelitis-free countries still caused concern. His country, which had been poliomyelitis-free for more than a decade, had drawn up guidelines on response in the event of the import of wild poliovirus and an outbreak contingency plan. Aware that a high-quality surveillance system and ensuring population immunity from an early age were key strategies in controlling and eradicating poliomyelitis, his Government was continuing its acute flaccid paralysis surveillance activities and, in April 2012, would switch to the inactivated poliovirus vaccine. He endorsed the draft resolution.

Mrs BAMIDELE (Nigeria) said that, following the introduction of the Global Polio Eradication Initiative Strategic Plan in 2010, Nigeria had made significant advances towards poliomyelitis eradication by using multisectoral and innovative approaches, including increasing the number of immunization days and supplementary immunization activities in target areas, and by looking at the effects of political, economic and sociocultural factors on eradication efforts. Traditional leaders and faith-based organizations had been encouraged to become involved in those efforts, which had resulted in unprecedented community participation in the campaign. Nevertheless, in 2011, poliovirus transmission had continued during unsettled times in the northern areas of Nigeria and the number of cases had increased four-fold in comparison with the previous year. In response, 10 targeted national immunization-plus days had been held, resulting in 100% coverage in some affected areas. Following the adoption of resolution AFR/RC61/R4 on poliomyelitis eradication by the Regional Committee for Africa in September 2011, the President had made a commitment to increase funding for poliomyelitis

eradication to US$ 30 million annually and approved the establishment of a presidential taskforce. Action committees had subsequently been set up at the central, local and community levels, and a plan was being finalized for providing incentives to both mothers and children and using new social mobilization strategies for hard-to-reach communities. The presence of type 2 poliovirus meant the continued use of trivalent polio vaccine.

The amendments proposed by the member for the United States of America were, in her view, unnecessary in the light of the efforts being made by her Government, with the support of the Regional Office for Africa and other Member States. She could not support the draft resolution as she needed more time to study the proposed amendments.

Mr MANCHA MOCTEZUMA (Mexico) agreed that poliomyelitis should be regarded as a global health emergency. The implementation of eradication strategies and development of effective surveillance and accountability mechanisms were essential. India's achievement of one poliomyelitis-free year showed that eradication was possible. Poliomyelitis vaccination campaigns should be pursued as the disease remained endemic in some countries, threatening reintroduction of the virus elsewhere. As part of its poliomyelitis eradication programme his Government had set up a high-quality epidemiological surveillance system. It was maintaining high levels of vaccination coverage despite budgetary constraints, taking immediate control measures in suspected cases of acute flaccid paralysis, and monitoring signs of wild poliovirus transmission, from which the country had been free since 1990. He endorsed the draft resolution and welcomed the amendments proposed by the member for Japan and the amendment concerning vaccination of travellers proposed by the member for the United States of America.

Dr DANKOKO (Senegal), speaking on behalf of the Member States of the African Region, reiterated his earlier position that, while it was possible to bring an end to the transmission of poliovirus rapidly, there was no need at that stage to restrict movement by requiring a vaccination certificate for travellers from polio-endemic countries. Instead, the international community should demonstrate its solidarity by providing as many financial, technical and human resources as possible to help countries to eradicate endemic poliomyelitis.

Ms QUACOE (Cote D'Ivoire)[1] said that, despite significant advances towards eradication of poliomyelitis, the fact that some countries had recently experienced outbreaks was cause for concern. To meet that challenge, equitable access to the poliomyelitis vaccine should be ensured, particularly for children under the age of five years living in underserved rural areas, impoverished urban zones, unstable countries and marginalized communities. Efforts should also be made to strengthen the monitoring and detection of cases of acute flaccid paralysis, ensure the availability of effective vaccines and bolster cross-border cooperation. She commended the Organization's efforts to provide technical support under the Global Polio Eradication Initiative.

Ms LANTERI (Monaco)[1] said that her Government accorded priority to poliomyelitis eradication and had been a partner in the Global Polio Eradication Initiative for 10 years. The section of the report on the recommendations, conclusions and concerns of the Independent Monitoring Board, whose transparency had been exemplary, were of particular interest. She welcomed India's success in interrupting transmission of poliovirus, but expressed concern at the increase in the number of cases in Africa in 2011. All countries should acknowledge the importance of keeping poliomyelitis

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

eradication high on the global health agenda. Adoption of the draft resolution would facilitate that process.

Mrs ESCOREL DE MORAES (Brazil)[1] said that, in the framework of the STOP Polio Initiative of the United States Centers for Disease Control and Prevention, her Government had been working to build national capacity by training specialized teams to provide assistance to poliomyelitis-endemic countries, starting with Angola. Assisting in planning, implementation and evaluation activities, providing complementary immunization activities, developing data-management plans for national programmes, and preparing outsourcing information on the poliomyelitis and smallpox vaccination programmes were top priorities in that regard. Brazil had been poliomyelitis-free since 1989. Regular vaccination campaigns were conducted in order to prevent reintroduction of the disease.

Mrs MELNIKOVA (Russian Federation)[1] welcomed WHO's efforts to raise awareness of the need for poliomyelitis eradication, particularly in countries where the disease was endemic. Her Government supported the independent monitoring of eradication activities and supported the call for poliomyelitis eradication to be treated as a global health emergency. Funding for polio eradication should be increased but spending should be strictly monitored through regular accountability reports. As part of its commitment to global eradication efforts, her Government had taken the following steps: cooperated with other countries in the Commonwealth of Independent States on strengthening their network of laboratories, purchased and provided equipment and vaccines for additional and supplementary vaccination campaigns in those countries, and entered into an agreement for monitoring the effective use of those resources. It would continue to provide such assistance.

She encouraged the Secretariat to develop new strategic approaches to poliomyelitis eradication and endorsed the draft resolution.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)[1] welcomed the Secretariat's frank and accurate summary of the situation and, in particular, the hard work of the Independent Monitoring Board over the past year. The widespread gains that had been made in poliomyelitis eradication should be protected and built on. The tiny percentage of countries that had not yet eliminated the disease were, however, the most intractable cases, in part because of their complex situations. The international spread of poliomyelitis to other countries through importation remained a concern.

India's recent achievement deserved special mention. Other affected countries would do well to follow its lead, for example by expanding their national immunization programmes.

Despite challenging economic conditions, a strong case could be made for supporting the Global Polio Eradication Initiative. In her country that investment had proved to be cost-effective and her Government would be doubling its financial commitment to the Initiative over the next two years. The funding shortfall was nonetheless a substantial obstacle to progress and there was consequently an urgent need to broaden the donor funding base.

She endorsed the draft resolution and the work plan underpinning it.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand)[1] said that Thailand, which had had been free of poliomyelitis since 1998, remained committed to global eradication. She commended the efforts of the Global Polio Eradication Initiative, development partners, Member States, in particular India, and WHO. Nevertheless, global eradication meant that all countries endemic for poliomyelitis

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must comply with the recommendations of the Independent Monitoring Board. The swift action of countries to contain outbreaks of imported wild poliovirus was greatly appreciated.

The draft resolution should place greater emphasis on the importance of adequate resources and the need to identify areas where routine immunization coverage was low or surveillance systems were not functioning well, so that appropriate action could be taken.

Mr CHIKH (Organisation of Islamic Cooperation), speaking at the invitation of the CHAIRMAN, said that the Organisation had recently stressed the urgency of stopping transmission of wild poliovirus by the end of 2012 and had called for political commitment and high-level oversight of vaccination campaigns. It had also urged its member countries and those of the G8 and G20 to provide emergency funding to the Global Polio Eradication Initiative. Most of the Organisation's members had succeeded in eradicating poliomyelitis, with the exception of Afghanistan, Nigeria and Pakistan, where the increase in cases presented a major national and global threat, made even more complex by the scarcity of vaccination coverage in conflict zones where cases among children had risen sharply. Following an appeal by the President of Afghanistan, the Taliban had agreed not to hinder immunization campaigns in conflict zones.

The ongoing outbreak of poliomyelitis on the border between Kenya and Uganda was of great concern, especially as all polioviruses imported into African countries had been found to be linked genetically with a virus originating in northern Nigeria. It was vital to involve religious and community leaders in the eradication campaign as they could help to ensure broader vaccination coverage in troubled regions. India's success should lead the countries with endemic transmission of wild poliovirus to intensify their eradication efforts.

His Organisation had been cooperating closely with the Global Polio Eradication Initiative and was involved in awareness raising and mobilization of political support at the highest level for vaccination campaigns. It would be stepping up its political advocacy to ensure that the necessary action was taken in the three Member States where poliovirus was still endemic.

Mr STENHAMMAR (Rotary International), speaking at the invitation of the CHAIRMAN, said that the success of the global eradication campaign would depend on unwavering commitment from partners providing political, financial and technical support, extraordinary determination by countries that were still affected by poliomyelitis, and rigorous action to reverse the continued lack of progress in some countries. Because the Global Initiative was currently facing a funding crisis, stakeholders must ensure accountability at all levels with regard to immunization coverage, surveillance activities and resource management. Priorities for 2012 included responding to the recent increase in the number of poliomyelitis cases in Nigeria and ensuring that Pakistan's strong commitment at the highest level to improve vaccination coverage and its revised national emergency plan translated into practical measures.

Recent achievements such as India's declaration of a poliomyelitis-free year and Rotary International's attainment of its fund-raising goal of US$ 200 million, bringing its total investment in poliomyelitis eradication to more than US$ 1000 million, should renew resolve in the international community's efforts to eradicate poliomyelitis.

Dr AYLWARD (Assistant Director-General), responding first to the points made by the member for Estonia on the financial implications of the draft resolution, said that the Secretariat would shortly issue a text revised in the light of the comments made.

The current failure to meet targets meant that eradication activities would continue until 2013 and the budget allocated to them would be increased to more than US$ 935 million. Furthermore, eradication efforts would henceforth be based on continuation of existing core strategies, more widespread use of best practices such as those seen in India, and an expansion of routine immunization programmes. The key to the plan would, however, be its oversight function. The Independent

Monitoring Board did valuable work in that regard at the international level and in recent months Nigeria and Pakistan had also established reporting mechanisms for their eradication programmes.

With regard to the proposed one-year extension to the action plan for eradication mentioned by the member for Japan, he explained that such an extension would give countries another 24 months to interrupt poliovirus transmission. The action plan, which would be supported by emergency provisions during those 24 months, would incorporate the lessons learnt from India's recent experience. All the partners involved would endeavour to increase their technical and financial support to the countries where it was needed, particularly Nigeria and Pakistan.

Regarding guidelines on inactivated poliovirus vaccine, the Strategic Advisory Group of Experts on immunization had set up a working group to provide advice to the Director-General and immunization partners, and final recommendations would be available before the end of the year on long-term use of the inactivated poliovirus vaccine in eradication and post-eradication risk management.

The DIRECTOR-GENERAL affirmed her own commitment and that of the regional directors to eradicating poliomyelitis and expressed appreciation for the financial and technical support of the partners involved in that effort.

She acknowledged the work of the Independent Monitoring Board and welcomed its transparent, honest and sometimes hard-hitting reports. Such frankness, however difficult it was to accept, was essential if all the countries concerned were to meet the target of eradicating poliomyelitis. Despite their best efforts, many countries still faced difficulties, but the example of India should serve as inspiration: just two years previously India had been regarded as having insurmountable obstacles to eradicating poliomyelitis, owing to its high population density, sanitation problems and migrant populations, yet it had just announced that it had been free of poliomyelitis for one year. Other countries should strive to reproduce that success through strong political leadership at all levels, government ownership of eradication programmes, investment by government and development partners, and adequate planning, oversight and accountability mechanisms.

Intensified cross-regional cooperation was essential to the eradication of poliomyelitis in the remaining affected countries. Failure to achieve that goal would be the most expensive and devastating of all public health failures and she appealed to Member States to do what was necessary to attain the target.

She informed the Board that she had requested a meeting with the Prime Minister of Pakistan during the World Economic Forum in Davos, Switzerland, later in the month in order to discuss the particularly worrying situation in his country.

The CHAIRMAN took it that the Board would at a subsequent meeting review the revised version of the draft resolution incorporating the amendments made.

It was so agreed.

Mrs BAMIDELE (Nigeria) requested the Director-General to arrange a meeting with her country's President, who would also be attending the forthcoming World Economic Forum.

The DIRECTOR-GENERAL said that she would endeavour to arrange such a meeting and requested the assistance of the Nigerian delegation to that end.

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

Elimination of schistosomiasis: Item 6.11 of the Agenda (Documents EB130/20 and EB130/20 Add.1)

The CHAIRMAN drew attention to the draft resolution contained in paragraph 9 of document EB130/20 and its financial and administrative implications for the Secretariat (document EB130/20 Add.1).

Mr BENMAMOUN (Morocco) welcomed WHO's continued support for activities to control or eliminate schistosomiasis, which remained a serious public health problem in many countries. Morocco had successfully eliminated schistosomiasis under a national plan between 1994 and 2004. That experience had served as a guide for other national disease control programmes, including for trachoma.

Many countries had launched programmes to eliminate schistosomiasis, which would undoubtedly increase their motivation to consolidate gains and intensify efforts to prevent and control the disease. His country was ready to share its experience. He endorsed the draft resolution, which could serve as a springboard for discussion on elimination mechanisms and certification procedures.

Dr DAULAIRE (United States of America) affirmed his Government's support for schistosomiasis control, given the detrimental socioeconomic impact of the disease, especially in developing countries. Despite the failure to achieve the objectives set out in resolution WHA54.19 by the target year of 2010, Member States that had made progress in controlling the disease were to be commended. Progress had been made in increasing the availability of praziquantel and national programmes should be expanded to meet the growing demand for that medicine.

It was premature to call for elimination of schistosomiasis in all countries in the draft resolution. He proposed the deletion in paragraph 1 of the words "with the aim of eliminating the disease" and in paragraph 2 of the words "with the goal of elimination of the disease". In subparagraph 3(1), the words "to proceed towards the elimination of schistosomiasis" should be replaced with "and water, sanitation, and hygiene interventions, to intensify control programmes in most endemic countries and initiate elimination campaigns, where appropriate" and in subparagraph 3(2) the word "appropriate" should be inserted before "countries". A new subparagraph 3(3) should be inserted, to read "to prepare guidance for Member States to determine when to initiate elimination campaigns, along with methods for implementation of programmes and documentation of success.".

Mr LEI Zhenglong (China) said that the report contained inaccurate information on the situation in China (paragraph 5); in fact, among the 12 provinces that had been endemic for schistosomiasis, five had eliminated the disease and three more had recently achieved the targets set for its control. The target year for controlling schistosomiasis nationwide was 2015. China actively supported control and elimination efforts in African countries and would continue to cooperate with international partners to promote global targets for elimination.

In order to strengthen the draft resolution, he proposed that in paragraph 1 the words "to intensify control interventions and strengthen surveillance, with the aim of eliminating the disease" be deleted, and three subparagraphs be added: "1(1) to attach importance to prevention and control of schistosomiasis, analyse and develop applicable plans with progressive targets, intensify control interventions and strengthen surveillance, with the aim of eliminating the disease; 1(2) to take full advantage of non-health programmes to improve the environment, in order to cut the transmission of schistosomiasis and accelerate the elimination of the intermediate host; and 1(3) to ensure the provision of essential drugs;".

In subparagraph 3(1), the words "by setting up a special programme" should be inserted after "particularly medicines,", and in subparagraph 3(2) the word "countries" should be replaced with "Member States,", immediately after which the words "to analyse the global schistosomiasis prevention and control status, epidemic model and key challenges so as to provide targeted recommendations and guidance," should be inserted.

Dr ABDI (Somalia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that with an estimated 200 million people infected worldwide, schistosomiasis remained a clear public health concern, not least because of failures to meet the targets set in resolution WHA54.19. Nevertheless, some progress had been made: 32 million people had benefited from preventive chemotherapy with praziquantel in 2010, several countries in the Region had reported no new case in recent years and others had attained low levels of endemicity which, in some cases, was a substantial achievement in view of the original breadth of the problem. South Sudan, Sudan, Yemen and, to a lesser extent, Somalia had the highest prevalence rates in the Region. In Yemen, a national schistosomiasis control programme, backed by WHO and the World Bank, had been launched in 2010 and would continue until 2015. He endorsed the draft resolution.

Dr SHEKU DAOH (Sierra Leone), speaking on behalf of the Member States of the African Region, affirmed that schistosomiasis remained a major public health concern, especially in sub-Saharan Africa, which accounted for more than 85% of the overall disease burden. Progress towards control and elimination had been insufficient; the target defined in resolution WHA54.19 had not been reached and expansion of treatment had been slow. However, access to praziquantel and other resources needed for schistosomiasis control was increasing and many countries endemic for the disease had strengthened surveillance systems and reported only a few cases.

The Regional Office had developed a draft strategic plan for schistosomiasis elimination, which would provide guidance to Member States for the development of their own national plans, but challenges remained, including inadequate funding, lack of cooperation among sectors and inadequate coordination among partners. He therefore recommended that the Secretariat continue to provide technical and financial support to countries and encourage Member States to commit themselves to making available the medicines needed for treatment. It should also support the work being done by a team of Senegalese researchers to assess the therapeutic efficacy of the schistosomiasis vaccine Bilhvax 3. He supported the draft resolution.

Dr JESSE (Estonia), referring to subparagraph 3(2) of the draft resolution, in which the Director-General was requested to report regularly to the Health Assembly, asked the Secretariat how often the reports would be provided.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland)[1] said that effective tools for the elimination of schistosomiasis were available and intensified efforts towards that objective should be supported. The timing of the draft resolution was appropriate, as it coincided with increased global commitment to the control of schistosomiasis and other neglected tropical diseases. Ensuring access to adequate and safe water supplies and sanitation facilities was an essential component of control and elimination programmes and, although resolution WHA54.19 had recognized that, the report and the draft resolution had failed to do so.

Where possible, schistosomiasis control measures should be integrated into other disease control programmes and into health systems in general as that would make the use of resources more efficient and optimize programme benefits. Progress towards control and elimination was likely to vary both between and within countries. Several countries with a high disease burden had yet to initiate sufficiently broad programmes to have a meaningful impact. Some countries had “hotspots” of infection, which were difficult to control. Targets for elimination should take account of those differing circumstances.

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

Dr NIPUNPORN VORAMONGKOL (Thailand)[1] emphasized the public health burden of schistosomiasis, a disease for which 800 million people were at risk and which caused the loss of more than 70 million disability-adjusted life years. The groups most at risk of infection included school-age children and individuals in particular occupational categories such as fishing, most of whom were from poor backgrounds. The international community had failed to achieve the target set in resolution WHA54.19 to ensure the regular administration of chemotherapy to at least 75% and up to 100% of all school-age children at risk of morbidity by 2010. Lessons learnt from that public health failure should influence future treatment strategies. Anthelminthic agents such as praziquantel were highly effective, but could not prevent reinfection; at-risk populations required repeated rounds of treatment.

The draft resolution was not a good road map for the future; rather than continuing with the same measures as used previously, future action should be oriented towards increased resource mobilization and support from partners, better education about schistosomiasis, and improved sanitation facilities. She called on the Director-General to endorse a programme of work encompassing those elements in order to eliminate schistosomiasis as rapidly as possible.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the pharmaceutical industry had contributed actively to the control and elimination of neglected tropical diseases by increasing access to treatment through medicine-donation programmes. In the case of schistosomiasis, one member company of the Federation, Merck KGaA, had been donating 25 million praziquantel tablets annually, had recently doubled that contribution, and would shortly announce a further increase. Yet, even greater quantities of praziquantel were needed in order for elimination targets to be attained over the next decade and, to that end, the Federation encouraged donors to increase their commitments.

The pharmaceutical industry was only one global partner among many. All stakeholders should be involved in schistosomiasis prevention and control efforts, which included improving sanitation facilities, increasing access to safe water, enhancing capacity building and preventive education, and strengthening health systems. The Federation also pledged to continue research and development in the area of neglected tropical diseases.

Dr NAKATANI (Assistant Director-General) thanked the members for Morocco and Somalia for sharing their experience in controlling schistosomiasis, the member for Sierra Leone for her recommendations, and the members for the United States and China for their amendments to the draft resolution. Replying to the question raised by the member for Estonia, he said that, were the draft resolution to be adopted, the Secretariat would report every three years on its implementation.

The donation of medicines was essential to schistosomiasis control, as were improved standards of hygiene. Moreover, as the representative of the United Kingdom had suggested, schistosomiasis control measures should be integrated into other disease control programmes.

Responding to the DIRECTOR-GENERAL's suggestion that the Board consider adopting the draft resolution, as amended, Dr DAULAIRE (United States of America) drew attention to the potentially contradictory nature of the amendment proposed by the member for China to subparagraph 3(1) and his own amendment to that same subparagraph.

The DIRECTOR-GENERAL asked the member for China if he would be willing to accept subparagraph 3(1) without the words "setting up a special programme".

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

Dr NIE Jiangang (China) agreed to that request.

Dr JESSE (Estonia) requested that subparagraph 3(2) of the draft resolution be amended to include the information that the Director-General would report every three years on progress in implementing the resolution.

The CHAIRMAN took it that the Board wished to take note of the report contained in document EB130/20 and to adopt the draft resolution on the elimination of schistosomiasis, as amended.

The Board took note of the report and adopted the resolution, as amended.[1]

2. WHO REFORM: Item 5 of the Agenda (Documents EB130/5, EB130/5 Add.1 to Add.9) (continued from the seventh meeting)

Dr GULLY (Canada), speaking in his capacity as chairman of the drafting group on WHO reform (programmes and priority setting), said that the draft decision drawn up by the drafting group would be distributed to the Board members as soon as possible. Under the decision, the Executive Board would: (1) define the scope of work for the Member State-driven process established to provide recommendations on programme and priority-setting methods to the Sixty-fifth World Health Assembly, (2) fix the objectives of the process and (3) set up a meeting at the end of February 2012 to provide Member States with the opportunity to give further consideration to the proposed categories, methodology, criteria and timeline for programmes and priority setting. The Board would also request the Secretariat to identify and provide, before the February meeting, materials that would facilitate discussion at the meeting, at which the participants would decide whether further work was needed before a report could be prepared and transmitted to the Sixty-fifth World Health Assembly.

(For adoption of the draft decision, see the summary record of the thirteenth meeting, section 2.)

The meeting rose at 17:30.

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[1] Resolution EB130.R9.