EXECUTIVE BOARD
140th session

EB140/PSR/10
3 March 2017

PROVISIONAL SUMMARY RECORD OF THE TENTH MEETING

WHO headquarters, Geneva
Friday, 27 January 2017, scheduled at 09:00

Chairman: Dr R. BUSUTTIL (Malta)

CONTENTS

TENTH MEETING

Friday, 27 January 2017, at 09:05

Chairman: Dr R. BUSUTTIL (Malta)

1. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 7 of the agenda (continued)

Poliomyelitis: Item 7.3 of the agenda (document EB140/13)

2. STAFFING MATTERS: Item 15 of the agenda (continued)

Human resources: update: Item 15.3 of the agenda document EB140/46)

The CHAIRMAN recalled that the Board had agreed to consider item 7.3 of the agenda together with item 15.3. In that connection, he drew the Board's attention to the discussion by the Programme, Budget and Administration Committee of document EB140/46, which was summed up in paragraphs 62–76 of the Committee's report (document EB140/5).

He further drew attention to a draft decision on poliomyelitis proposed by Angola, Australia, Canada, Colombia, the Congo, the Czech Republic, Finland, Germany, Ireland, Japan, Mexico, Monaco, New Zealand, Norway, Pakistan, South Africa, Sweden, Switzerland, the United Kingdom of Great Britain and Northern Ireland and the United States of America, which read:

> The Executive Board, having considered the reports on poliomyelitis [1] and human resources: update;[2]
>
> (PP1) recalled resolution WHA68.3 (2015) on poliomyelitis and encouraged Member States to ensure its full implementation;
> (PP2) recalled previous discussions on the human resources aspects of the Global Polio Eradication Initiative in the Executive Board and the World Health Assembly, in particular on the issue of potential indemnities resulting from the termination of staff contracts;
> (PP3) underlined the need for continued emphasis on an effective endgame effort to eradicate polio and the importance of ensuring that the Global Polio Eradication Initiative is fit for purpose, with adequate levels of qualified staff;
> (PP4) emphasized the urgent need for effective transition planning, in line with the three main aims outlined in paragraph 19 of document EB140/13;
> (PP5) further emphasized the need to continue to provide the appropriate, situation-specific and focused interventions, in particular in human resources and budgetary requirements, to the regions and countries where transmission has not been interrupted;

[1] Document EB140/13.

[2] Document EB140/46.

(PP6) recognizing the major and systemic challenges facing WHO that will result from the current winding-down of the Global Polio Eradication Initiative;
(PP7) called for appropriate prioritization of opportunities for internal reassignment so as to reduce potential liabilities and indemnities, in particular to strengthen the WHO Health Emergencies Programme and the Expanded Programme on Immunization, with emphasis given to retaining the highest-performing staff;
(PP8) emphasized the need to accelerate opportunities to shift or reprofile the 43% of staff funded by the Global Polio Eradication Initiative who work in polio-free countries while ensuring that appropriate resources remain in place for surveillance;
(PP9) reiterated its expectation that recruitment of staff for the Global Polio Eradication Initiative be carried out without incurring any avoidable costs resulting from the foreseeable future termination of contracts, including by synchronizing contract end dates, and requested WHO to ensure that standard contracts that meet this requirement are available and are used,

(PP10) DECIDED to request the Director-General:

(1) to present to the Seventieth World Health Assembly a report which outlines the programmatic, financial, and human-resource-related risks resulting from the current winding-down and eventual discontinuation of the Global Polio Eradication Initiative, as well as an update on actions taken and planned to mitigate those risks while ensuring that essential polio-related functions are maintained, and to present a first draft of that report to a meeting of Member States before the end of April 2017;

(2) to continue reporting regularly to the Health Assembly, through the Executive Board, on the planning and implementation of the transition process.

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

Decision: Poliomyelitis	
A.	**Link to the General Programme of Work and the Programme budget**
1.	**Please indicate to which outcome in the Twelfth General Programme of Work, 2014–2019 and to which output in the Programme budget 2016–2017 this draft decision would contribute if adopted.** Twelfth General Programme of Work, 2014–2019, category 5, outcome: no cases of paralysis due to wild or type-2 vaccine-related poliovirus globally. Programme budget 2016–2017, output 5.5.4: polio legacy work plan finalized and under implementation globally.
2.	**Please provide a short justification for considering the draft decision, if there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017.** Not applicable.
3.	**Please indicate the estimated implementation time frame (in years or months) for any additional deliverables.** A 3–6 month independent study of programmatic, financial and human resource consequences of the end of the polio programme, including cessation of funding, is to be completed mid-2017. The contract is to be issued in February 2017. The results are to be fully reported in January 2018, at the 142nd session of the Executive Board; progress reports are to be given at the Seventieth World Health Assembly, in May 2017, and the Executive Board at its 141st session, following the Health Assembly.

B.	**Budgetary implications for implementation of additional deliverables**
1.	**Current biennium − estimated, additional budgetary requirements, in US$ millions:** The proposed decision would be supported within the existing Programme budget.
(i)	**Please indicate the level of available resources to fund the implementation of the proposed decision in the current biennium, in US$ millions:** **– How much are the resources available to fund the proposed decision in the current biennium?** None identified at present. US$0.6 million is needed for contracted independent study, including a consultant for 3–6 months to manage/oversee the study and travel to selected countries. **– How much would the financing gap be?** US$ 0.6 million. **– What are the estimated resources, not yet available, if any, which would help to close the financing gap?** As the study will be interprogrammatic, it should be supported from a central source or a donation specified for this purpose.
2.	**2018–2019 (if required): estimated budget requirements, in US$ millions:** The potential cost of further development and implementation of transition plans by the Secretariat and countries is to be determined.
3.	**Future bienniums beyond 2018–2019 (if required) − estimated budgetary requirements, in US$ millions:** Transition is due to be completed by 2020. Essential functions necessary to maintain a polio-free world will need to be sustained after certification of eradication. These include surveillance and laboratory function, ability to respond to any re-emergence and outbreak, continued routine immunization, and containment of poliovirus in laboratories and vaccine manufacturing plants. The costs of these essential functions will be estimated at the end of 2017.

The representative of the CONGO, speaking on behalf of the Member States of the African Region, expressed support for the draft decision and said that, as cases of poliomyelitis due to wild poliovirus were still being detected, vigilance was essential if eradication of the disease was to be attained. In view of the limited stock of inactivated poliovirus vaccine available worldwide, it was imperative that African States should be given priority when it came to allocating supplies of the vaccine and should receive sustained support for the practical and efficient use of intradermal fractional-dose inactivated poliovirus vaccine. In order to support polio transition planning, an independent and objective evaluation should be carried out to determine the potential impact of the transition on other national health programmes. The results of that evaluation, accompanied by a clear communication and implementation plan, should be submitted to the Board. In order to secure funding for the transition, support should also be provided for the investment scenarios being developed by Member States. Any delay resulting from a lack of funding could undermine achievements to date and raise questions about the failure to fulfil objectives. The Secretariat should therefore take a flexible and realistic approach in reviewing the transition plans of vulnerable States, and immediately finalize the post-certification strategy that was under development, to help guide the development of such plans.

The representative of CHINA said that in his country, one dose of inactivated poliovirus vaccine had been included in the national immunization plan; the switch had been made from trivalent to bivalent oral polio vaccine; and the recovery, sequestration and destruction of poliovirus type 2 strains had been actively promoted. He expressed support for WHO's polio eradication efforts and the hope

that the Organization would take into account the realities in developing countries, especially those facing a higher risk of importing the virus; put forward practical action plans; strengthen national and interregional cooperation; mitigate the global spread of the wild poliovirus; and provide effective technical and financial support in key areas.

The representative of the UNITED STATES OF AMERICA expressed appreciation for the dedication of front line workers and asked what new data would be obtained from the independent study referred to in the financial implications resulting from the draft decision under discussion. Innovations under the Global Polio Eradication Initiative – such as the establishment of emergency operations centres, evidence-based communication strategies and more sensitive disease surveillance methods – would benefit broader public health programmes. However, there were still a number of hurdles to overcome: the insufficient supply of inactivated poliovirus vaccine; outbreaks declared ended before the criteria had been met; inconsistent routine immunization and immunization campaigns, especially in insecure areas; surveillance gaps; slow containment of the type 2 serotype component of trivalent oral polio vaccine; and the effects of complacency. In addition, the extra US$ 1 billion that would be required for every year that polio eradication was delayed would place a strain on donor and country resources. Previous setbacks had largely occurred as a result of overestimated population immunity and underestimated surveillance gaps. Polio eradication assets and infrastructure should be incorporated into core public health systems. With regard to human resources, she asked for information on the Secretariat's plans to maximize opportunities for internal reassignment and to facilitate staff retention, including plans for the capacity building of staff.

The representative of THAILAND expressed serious concern about the availability of inactivated polio vaccine, despite the initial success of the trivalent to bivalent oral polio vaccine switch. WHO should expedite the process of certifying vaccines produced by manufacturers in developing countries, so as to ensure a sufficient global supply at an affordable price. Poliovirus containment under the WHO global action plan to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAPIII) was also a cause for concern, especially with regard to potentially infectious materials, as some of those materials were invaluable clinical samples that posed a much lower risk than those retained by vaccine manufacturers. The Secretariat should review and propose more options to balance the risks against the benefits and, most importantly, propose options that were technically and financially feasible for countries with limited resources and few essential facilities.

Regarding the human resources funded by the Global Polio Eradication Initiative, the indemnity forecast was significant, given the Organization's funding crisis. She expressed support for the measures recommended by the ad hoc human resource planning working group for the proactive management of human resources. Staff members had to be reassigned to other programmes of work, in order to minimize indemnity exposure.

The representative of the RUSSIAN FEDERATION expressed support for the draft decision and said that the sensitive nature of epidemiological surveillance in some countries, particularly those facing a humanitarian crisis, cast doubt on polio eradication data. In the face of generally low immunization coverage rates, the circulation of various strains, including vaccine-derived viruses, was a serious possibility. In the absence of effective response measures, the overall epidemiological situation could worsen, undermining the eradication programme. Many countries faced shortages of inactivated poliovirus vaccine. The possibility of using fractional-dose schedules to solve that problem had yet to be properly studied and was inappropriate for many countries, including the Russian Federation. The switch from trivalent to bivalent oral polio vaccine was important for polio eradication, but, given that manufacturers were unable to meet demand for inactivated poliovirus vaccine, it must be acknowledged that the risks had been underestimated when the decision on the switch had been taken. It would be better to prevent vaccine shortages, which could have a serious

impact on national immunization programmes, than issue warnings about them. She welcomed the Secretariat's efforts to prepare guidelines on the safe containment and handling of materials potentially infected with type 2 poliovirus. It was important to plan the training of Member State specialists in the certification of basic institutions working with poliovirus, so that those specialists could perform their tasks systematically and successfully. With regard to transition planning, it was essential to examine the redistribution of assets under the Global Polio Eradication Initiative, particularly human resources, and information should be provided in that regard at the Seventieth World Health Assembly.

The representative of CANADA, speaking on behalf of the Member States of the Region of the Americas, commended the bravery of the community health workers and social mobilizers who worked to reach the most vulnerable children. Commending the successful completion of the switch from trivalent to bivalent oral polio vaccine, she said that deep concern persisted given the continued shortage of inactivated poliovirus vaccine and the associated delays in introducing the vaccine globally. The Global Polio Eradication Initiative should work with the GAVI Alliance and vaccine manufacturers to minimize the impact of that shortage and maximize the use of existing supplies. The global reduction in the overall number of containment facilities maintaining poliovirus materials was commendable; however, as the world moved towards stiffer containment requirements for such facilities, it was important to balance the need for robust containment measures with the impact on vaccine production and supply. As the goal of eradication drew near, planning for the transition of polio assets, resources and infrastructure should be conducted in a timely manner.

Notwithstanding the contribution of the newly established Transition Independent Monitoring Board, the implications of the eventual discontinuation of funding under the Global Polio Eradication Initiative for WHO field capacity, including for immunization support, surveillance and emergency response, were a source of concern. WHO should engage with United Nations partner agencies and other stakeholders to address the post-eradication funding challenges that it would face, in particular the reliance on polio funding in countries that had maintained their polio-free status for several consecutive years. Such resources had to be reallocated to other health priorities. The Secretariat should continue reporting regularly to the Health Assembly, through the Executive Board, on transition planning and implementation.

The establishment of the ad hoc human resource planning working group was a welcome step towards minimizing indemnities and ensuring a more integrated approach to human resources across the Organization. Contracts and appointments should be decided with due diligence to ensure that they were synchronized with the projected end of the programme. Opportunities to transition polio resources away from countries that had been polio-free for some time should be accelerated in a way that maintained local capacity for immunization support, surveillance and emergency response. At the same time, the Global Polio Eradication Initiative must remain fit for purpose, and have the human resources it required to implement the Polio Eradication and Endgame Strategic Plan 2013–2018 and the post-certification strategy currently being developed.

In her capacity as the representative of Canada, she said that the draft decision underscored the serious financial, human resource and programmatic risks facing WHO as the Global Polio Eradication Initiative was wound down, and the importance of timely action by the Secretariat to counter those risks. The report and update requested in the draft decision were considered to be part of the Secretariat's ongoing work on transition planning and human resource management, and should be performed using existing resources; the aim had not been to add to the budgetary pressure on the Organization.

The representative of BAHRAIN stressed the importance of pursuing efforts to combat poliomyelitis, tackling the global shortage of inactivated poliovirus vaccine by continuing to cooperate with manufacturers, and engaging with Member States to study the possibility of using fractional-dose vaccines. She emphasized the need to maintain support for countries that remained affected by

poliovirus, draw up response and preparedness plans for all contingencies, and establish oversight regulations on virus containment. She thanked partners and the WHO Regional Office for the Eastern Mediterranean for their support in national efforts towards improving immunization coverage and preparedness.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND commended efforts towards global polio eradication, which should continue until eradication was achieved. Despite the successful global switch from trivalent to bivalent oral polio vaccine in April 2016, success would ultimately depend on reaching all missed children, including those in hard-to-reach and conflict-affected areas. He called on all governments at the highest level to ensure that their countries contributed to the global eradication of polio in 2017. His Government, for its part, was providing £300 million for the period 2013–2019.

The representative of MEXICO said that effective surveillance and reporting mechanisms were fundamental to polio eradication. As long as the poliovirus continued to circulate, with the risk of importation, it was essential for Member States to maintain oral poliovirus vaccination in systematic immunization programmes, and ensure the surveillance and monitoring of cases of acute flaccid paralysis. Once eradication had been certified, it would be important to plan the sustainable replacement of the Sabin polio vaccines by inactivated poliovirus vaccine and WHO should provide the support needed to obtain unbroken continuous supply of poliovirus vaccines. Expressing support for the draft decision, he said that his country would continue to contribute to the Global Polio Eradication Initiative.

The representative of PAKISTAN said that progress had been made in stemming uncontrolled transmission and tackling the underlying challenges to virus interruption and eradication in his country, including improved vaccination coverage and attitudes to vaccination. Key areas of the national emergency action plan included surveillance, immunization campaigns, risk assessment, and at-risk populations. Pakistan was close to interrupting indigenous transmission and his Government would remain committed to addressing residual risks until the virus was eradicated. The switch from trivalent to bivalent polio vaccine had been implemented successfully in his country, and was being monitored. The Government of Pakistan had made a significant financial and in-kind contribution to the polio campaign, and he urged others to continue to support efforts to ensure access to inactivated poliovirus vaccine in Pakistan and other tier 1 countries.

The representative of the NETHERLANDS expressed concern about indemnity costs and the effect of transition on other surveillance, preparedness and response programmes, as referred to in the human resources update. He asked the Secretariat to clarify the human and financial impact of discontinuing the Global Polio Eradication Initiative, and how that impact could be mitigated. He also asked for further information about the scope of the essential polio-related functions to be maintained. He supported the draft decision and timely action.

The representative of the DEMOCRATIC REPUBLIC OF THE CONGO said that, although the situation was currently stable, the risk factors had not been eliminated. Reinforced surveillance, routine immunization, and the introduction of new vaccines would be needed to safeguard what had been achieved to date. Action to that end would require resource mobilization, and finance ministers should be made aware of those needs. Each country should allocate budget lines to the purchase of vaccines and counterpart funding, for the introduction of new vaccines. In his country, the GAVI Alliance had absorbed staff from the Global Polio Eradication Initiative, who would work to maintain surveillance activities.

The representative of KUWAIT commended the work of health professionals and the progress made towards polio eradication; however, efforts should continue until that goal was reached, particularly in areas where the virus was still circulating. All stakeholders should take part in health surveillance and vigilance, and the International Health Regulations (2005) must be fully implemented. Member States should support one another in improving health sector training, and funds should be earmarked for that work. She encouraged WHO to use health professionals in other areas once polio eradication had been achieved.

The representative of BHUTAN, speaking on behalf of the Member States of the South-East Asia Region, said that although his Region had been certified polio-free in 2014, the importation of wild poliovirus from other countries was still a concern. All of the region's countries had switched from trivalent to bivalent oral polio vaccine and had successfully introduced inactivated polio vaccine, although there was concern over its reduced supply. Regional efforts to contain wild poliovirus type 2 were progressing in line with GAPIII. Some Member States in the Region faced challenges in implementing a practical transition plan. He expressed concern that developing countries would face a reduction in human and financial resources following eradication, which could hinder ongoing surveillance and endanger progress achieved thus far.

The representative of SWEDEN welcomed the establishment of the WHO-wide Post-Polio Transition Planning Steering Committee and supported the consequence analysis to be undertaken within the country offices that had staff funded by the Global Polio Eradication Initiative. He looked forward to receiving the report requested under the draft decision.

The representative of JORDAN said that national vaccination campaigns aimed to reach all sectors of the population, including those in refugee camps, despite the challenges faced by increasing numbers of refugees arriving from Syria. The purchase of lower-cost vaccines had been made possible with the support of the GAVI Alliance.

The representative of COLOMBIA said that progress had been made in the Region of the Americas as a result of its poliomyelitis immunization strategy, which had strengthened overall immunization programmes. However, challenges remained in implementing resolutions WHA68.3 (2015) on poliomyelitis and WHA68.6 (2015) on the global vaccine action plan. Progress had also been made in the switch from trivalent to bivalent oral polio vaccine; however, the short supply of the latter, and of inactivated polio vaccine, was a cause for concern.

The representative of NEPAL noted that several steps had been taken in her country to improve vaccination, including against poliomyelitis, and to switch successfully to bivalent oral polio vaccine.

The representative of LIBYA commended global and regional efforts towards polio eradication, but said that it was difficult for national vaccination programmes to reach all citizens in his country, particularly children and refugees. He thanked WHO and other partners for support in improving vaccination coverage and surveillance.

The representative of MONACO[1] agreed with the comments made by members of the Board on the need to ensure the interruption of transmission, the maintenance of a surveillance framework and the monitoring of child immunization, particularly in Nigeria. She expressed concern about outbreaks of circulating vaccine-derived poliovirus and the shortage of injectable vaccines. Regarding the

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

financial and administrative implications of the draft decision, she reiterated that the measures requested should be carried out using existing resources within the Organization.

The representative of INDIA[1] supported the full implementation of resolution WHA68.3 (2015) and the Polio Eradication and Endgame Strategic Plan 2013–2018. Having introduced inactivated polio vaccine into the national routine immunization programme and having switched from trivalent to bivalent oral polio vaccine, there was an acute shortage of inactivated polio vaccine in India. Fractional-dose schedules had been adopted to ensure sufficient quantities for ongoing vaccination. WHO had to determine how to ensure affordable and continued access to that vaccine. He supported the draft decision, in order to prevent a resurgence of the disease.

The representative of NIGERIA[1] drew attention to his Government's aggressive outbreak response following the confirmation in 2016 of three new cases of paralytic poliomyelitis due to wild poliovirus type 1 in Borno State, north-eastern Nigeria. The Government had carried out additional rounds of immunization activities, including in hard-to-reach areas, and had agreed to increase funding, strengthen routine immunization and surveillance, and rebuild health infrastructure, particularly in areas affected by insurgency. He supported the draft decision and called for targeted financial and in-kind contributions in countries and regions experiencing ongoing transmission.

The representative of GERMANY[1] said the Global Polio Eradication Initiative had to remain sufficiently funded until the goal of eradication was reached. That said, transition planning should be accelerated in order to mitigate the structural and financial risks faced by the Organization, which included ensuring that human resources financed from polio-specific funds were aligned with countries' needs. Given that over 50% of polio-related resources were used for health activities not related to polio, countries in the African Region, the Region of the Americas and the South-East Asia Region would be adversely affected when that funding was discontinued. He urged WHO to assign resources from polio-funded programmes to national health system strengthening, making use of synergies with other programmes. He asked how much polio funding was foreseen in the draft proposed programme budget 2018–2019 for polio-free countries.

The representative of KENYA[1] drew attention to polio immunization campaigns, laboratory polio containment activities and the destruction of all stored circulating vaccine-derived polioviruses type 2 and wild polioviruses in her country. Supporting the draft decision, she said that continued support was needed for polio eradication activities and surveillance strengthening in countries that had yet to eradicate polio.

The representative of PANAMA[1] said that her Government's commitment to polio eradication was reflected in the introduction of inactivated polio vaccine and the switch from trivalent to bivalent oral poliovirus. Adequate preparedness and response plans, sustainable immunization campaigns and strengthened surveillance would mitigate the risk of outbreaks of vaccine-derived poliomyelitis type 2 and the importation of wild poliovirus from endemic countries. She supported the draft decision and efforts to tackle human resources concerns in an integrated manner.

The representative of DENMARK[1] said that she welcomed the establishment of the Post-Polio Transition Steering Committee, and looked forward to the consequence analysis, requested by that Committee, that would be considered at the Seventieth World Health Assembly. Member State collaboration was essential for the full implementation of GAPIII. As one of few polio vaccine

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

manufacturing countries, Denmark called on WHO to ensure that the requirements placed on national authorities by the comprehensive GAPIII Containment Certification Scheme were not unnecessarily burdensome. In that regard, she welcomed the planned training for auditors to be held in Copenhagen in early 2017.

The representative of AUSTRALIA[1] said that the implementation of the Polio Eradication and Endgame Strategic Plan 2013–2018 must continue, as the risk of resurgence from cases of circulating vaccine-derived poliovirus persisted. Strong immunization systems, sustained immunization coverage and adequate surveillance systems to support early detection and transparent reporting were needed to ensure that countries and regions remained polio-free. The continued reliance on polio funding for human resources in countries where polio had been eliminated posed serious financial, organizational and programmatic risks to WHO, especially given the expected reduction in polio funding in the coming years. She urged the Secretariat to cooperate closely with Member States on transition planning to ensure that essential disease prevention programmes were maintained as polio resources declined. Recommending that, where possible, polio-related human resources, assets and infrastructure should be redeployed for the benefit of broader public health activities, she called on the Secretariat to act to limit the significant liabilities arising from staff separations. Supporting the draft decision, she requested the Secretariat to report on progress in implementing polio transition activities.

The representative of BANGLADESH[1] said that immunization campaigns and extensive surveillance activities were being maintained to mitigate the risk of the resurgence or importation of poliomyelitis. Inactivated polio vaccine had been introduced nationwide in 2015 and WHO's efforts to ensure supply and affordability were commendable. The Organization provided crucial technical support to vaccine manufacturers and regulatory authorities in developing countries. The immunization workforce in Bangladesh stood ready to support global polio eradication efforts.

The representative of JAPAN[1] commended the rapid response to the polio outbreak in Nigeria in August 2016 and Member States' efforts to implement an effective switch from trivalent to bivalent oral polio vaccine. As the Global Polio Eradication Initiative was gradually scaled down, polio-related assets needed to be transferred for the benefit of broader health objectives. Given some countries' inability to sustain high levels of immunity, Member States may need to verify the status of population immunity under the new protocols for detecting vaccine-derived poliovirus. With the global transition to inactivated polio vaccine, capacity and availability were of increasing concern. Sabin-inactivated polio vaccine had been introduced into the immunization schedule in Japan as an option for dealing with supply shortages. Japan worked to increase the capacity of poliovirus-essential facilities, but could not guarantee virus containment without leveraging other facilities as well. He invited the Secretariat to share relevant good practices with Member States.

The representative of INDONESIA[1] said that the Polio Eradication and Endgame Strategic Plan 2013–2018 should be fully implemented in all countries. She shared information about measures taken in her country with respect to surveillance and response, the switch from trivalent to bivalent oral polio vaccine and the planned introduction of inactivated polio vaccine. The shortage of the latter hindered progress towards eradication and WHO should urge manufacturers to improve their production capacities by facilitating advanced technology transfer. Like other Member States, Indonesia was seeking to meet the poliovirus containment requirements described in GAPIII. In order to ensure that the lessons learned from successes in polio eradication were used for the benefit of other health programmes, transition planning needed to be institutionalized in all Member States.

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

The representative of NORWAY[1] said that Norway wished to associate itself with the statement made by the representative of Canada on behalf of the Region of the Americas. He welcomed transition planning for assets under the Global Polio Eradication Initiative, including the many staff members who provided a major contribution to WHO's work in respect of health systems, emergency response and vaccination other than polio. The cessation of funding at the end of the Initiative posed a systemic risk to WHO's delivery in the field. That vulnerability should be discussed by the governing bodies, and solutions sought, and the Secretariat should prepare a report to facilitate those discussions. He recalled his comments regarding indemnity costs made during the Programme, Budget and Administration Committee meeting in January 2017.

The representative of SWITZERLAND[1] expressed concern that the Global Polio Eradication Initiative was financing health personnel in countries where there had been no cases of polio for 10 years. She asked the Secretariat to provide a detailed explanation of that statistic, and information on the risks associated with WHO staff positions losing their funding at the end of the Initiative in 2019. WHO's value rested in its capacity to develop, manage and transfer knowledge; the knowledge acquired in the global fight for polio eradication must not be lost. The Secretariat should step up its efforts to integrate skilled staff members into other WHO programmes or transfer them to other institutions that were working to strengthen national health systems. Solutions must be holistic and the Secretariat should report back regularly to the governing bodies on progress in transition planning and implementation.

The representative of PERU[1] said that due consideration must be given to the recommendations made by the Strategic Advisory Group of Experts on Immunization regarding the fractional-dose administration of inactivated polio vaccine to address supply shortages. Relevant studies had confirmed the effectiveness of fractional-dose schedules. He supported the draft decision.

The representative of the BOLIVARIAN REPUBLIC OF VENEZUELA[1] said that inactivated polio vaccine had been introduced into the routine immunization schedule in his country and the switch from trivalent to bivalent oral polio vaccine had been completed successfully. A national polio outbreak preparedness and response plan had been developed with the support of PAHO.

The representative of ANGOLA[1] said that surveillance, response to outbreaks, and access to vaccines were crucial. All stages of transition planning should be fully implemented, with a view to improving national capacity and with due regard to available human and financial resources.

The representative of ARGENTINA[1] said that polio eradication could be effective only if measures were applied comprehensively. In Argentina, a national polio eradication programme and a laboratory containment programme of wild polioviruses were in place. The transition to inactivated polio vaccine and the switch from trivalent to bivalent oral polio vaccine had taken place in 2016. In order to prevent new outbreaks, polio eradication strategies in affected areas and temporary recommendations issued under the International Health Regulations (2005) should be fully implemented, surveillance should be strengthened, and national polio outbreak preparedness and response plans should be developed.

The representative of UNICEF recalled UNICEF's long-standing commitment to the Global Polio Eradication Initiative. Emphasis must be on eradicating polio, while planning for a smooth transition so that neither the gains of polio eradication nor the broader immunization agenda were

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

jeopardized. UNICEF was pleased to participate in the Polio Legacy Management Group and in developing post-certification transition strategies. It would also conduct a polio-related human resource mapping exercise within UNICEF to help mitigate the risk of a negative impact on its broader immunization activities as polio-related funding was gradually reduced.

The observer of the INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES highlighted the important role of community volunteers in polio eradication. The recent detection of wild poliovirus in north-eastern Nigeria had shown that more needed to be done to reach high-risk communities and address the risk of poliovirus importation into neighbouring countries. Sustained investment was required in Afghanistan, Pakistan and the Lake Chad Basin to address the ongoing challenges to eradication. Elsewhere, the planned reduction in polio funding should trigger a review of overall government financing strategies for immunization, as polio funding played a key role in countries' broader immunization platforms.

The representative of the GLOBAL HEALTH COUNCIL, speaking at the invitation of the CHAIRMAN, said that the loss of polio infrastructure and funding would pose a significant risk to broader public health goals in many countries. While focusing on achieving polio eradication, transition planning must be made a priority, and should include the development of costed transition plans. The realignment of public health efforts, which was complex, required sustainable funding.

The representative of ROTARY INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that the resurgence of polio in Nigeria was a reminder that constant vigilance was required to achieve global eradication. In that regard, he acknowledged the dedication of frontline workers in reaching every child. In order to protect gains, sustain immunity levels and monitor virus transmission, financial commitment from stakeholders would be critical. The polio eradication infrastructure, resources and expertise had made valuable contributions to other health priorities and needed to be transferred effectively.

The DIRECTOR (Polio Eradication) said that, despite the very small number of cases in 2016, the switch from trivalent to bivalent oral polio vaccine and the improved responses to polio outbreaks, the progress made towards eradicating poliomyelitis remained fragile. There could be no rest until eradication was complete, and the 2016 outbreak in Nigeria was a reminder not to be complacent. The global shortage of inactivated poliovirus vaccine affected all countries – both industrialized and those where the virus was still endemic. WHO was working with its partners to prioritize access to that vaccine for countries at the highest risk of outbreaks of circulating vaccine-derived poliovirus type 2. However, the best tool for interrupting outbreaks was monovalent oral polio vaccine type 2, and the Director-General had authorized use of the latter in five cases in Nigeria and Pakistan.

WHO, together with PAHO and UNICEF, was working with existing and emerging manufacturers of inactivated poliovirus vaccine to improve the global supply of that vaccine, as future suppliers – including those using Sabin strains – would not be able to provide sufficient additional quantities before 2020. Until then, the existing supply must be managed responsibly, with monovalent oral vaccines used to respond to cases of type 2 poliovirus. Member States should prepare to introduce a vaccination schedule based on fractional-dose inactivated poliovirus vaccine, as recommended by the Strategic Advisory Group of Experts on Immunization. WHO had developed the GAPIII Containment Certification Scheme, and was working on related technical guidance to improve containment plans, recognizing the need for a balance between safety and feasibility.

While many concerns had been expressed regarding transition planning, the first priority remained the eradication of poliovirus. To do so, strong capacities and staffing were needed as stated in the Polio Eradication and Endgame Strategic Plan 2013–2018 and by the Transition Independent Monitoring Board. It was important not to limit the Global Polio Eradication Initiative prematurely, and that should be kept in mind during transition planning. Of the 16 countries supported by the

Global Polio Eradication Initiative, 14 were preparing national transition priority plans that would be ready in mid-2017.

Transition planning would include a consequence analysis for areas including emergency response, surveillance and routine immunization, particularly in countries that relied on the Initiative for other capacities. That could include transferring polio-related capacities to the WHO Health Emergencies Programme, which did not yet have sufficient capacity at the country level. The Secretariat would provide more details to the Seventieth World Health Assembly, in May 2017 on the possibility of reassigning staff with transferrable skills. Surveillance had to remain a priority during the transition phase, to avoid the risk of poliovirus passing undetected in hard-to-reach areas. The African Region and the South-East Asia Region already had plans in place to ensure that essential functions were maintained post-eradication.

The Secretariat was committed to reporting to Member States every six months. The WHO-wide Post-Polio Transition Planning Steering Committee would examine human-resources and other implications of the eventual closure of the Global Polio Eradication Initiative, and would provide the governing bodies with a strategic road map and a report on progress made, including with regard to staff indemnity.

The DIRECTOR-GENERAL reiterated her commitment to regular reporting as requested in the draft decision. As the experience of eradicating smallpox had proven, the last mile would be the most difficult and costly, but eradication of poliomyelitis would be a gift to future generations. It was time to redouble efforts.

The CHAIRMAN took it that the Executive Board agreed to take note of the reports contained in documents EB140/13 and EB140/46.

The Board noted the reports.

The CHAIRMAN further took it that the Executive Board agreed to adopt the draft decision on poliomyelitis.

The Board adopted the decision.[1]

3. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 7 of the agenda (continued)

Review of the Pandemic Influenza Preparedness Framework: Item 7.5 of the agenda (documents EB140/16 and EB140/16 Add.1)

Implementation of the International Health Regulations (2005): Item 7.4 of the agenda (continued)

- **Public health implications of the implementation of the Nagoya Protocol** (document EB140/15)

The CHAIRMAN recalled that the Board had agreed to consider item 7.5 together with the second part of item 7.4. He drew attention to the report contained in document EB140/16, which the Board was invited to consider, and the draft decision on extending the application of decision EB131(2)

[1] Decision EB140(4).

(2012), contained in Annex 2 thereto. The financial and administrative implications of that draft decision were contained in document EB140/16 Add.1. He further drew attention to the report contained in document EB140/15. The Board was invited to note the report and give guidance.

The MEMBER OF THE PANDEMIC INFLUENZA PREPAREDNESS (PIP) FRAMEWORK REVIEW GROUP said that the PIP Framework was a bold and innovative tool that had been well implemented, and its founding principle of increasing health equity through the sharing of viruses and other pathogens was as relevant as ever. He drew attention to the recommendations made in the report of the Review Group, referring in particular to the need to react to technological change, such as the ability to use genetic sequence data as a substitute for actual viruses. In view of the possible impact of the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from Their Utilization to the Convention on Biological Diversity, the Framework needed to be recognized as a specialized international instrument under the Nagoya Protocol. Other recommendations covered the possible inclusion of seasonal influenza in the Framework, efforts to build on the success of Standard Material Transfer Agreements 2, means of improving the predictability of yearly partnership contributions, the identification of aspects of the global action plan on influenza vaccines that could support the Framework's implementation, the alignment of activity under the Framework with capacity-building efforts under the International Health Regulations (2005) and efforts to broaden WHO's engagement with stakeholders – including laboratories – on the Framework.

Although change could be challenging, it was vital in order to ensure that the Framework remained a nimble and relevant legal instrument that evolved in response to changes in technology. The ongoing need for better surveillance, diagnostics and national capacities in case of an influenza pandemic meant that investment in the Framework was as critical as ever.

The representative of MALTA, speaking on behalf of the Member States of the European Union, proposed two amendments to the draft decision contained in document EB140/16. In the final sentence of the preambular paragraph, before the word "decided" the words "having further considered documents EB140/15 and EB140/16" should be added. She also proposed the insertion of new paragraph 2*bis*, which should read: "to request the Director-General to continue consultations with the secretariat of the Convention on Biological Diversity and other relevant international organizations, as appropriate, on access to pathogens, and fair and equitable sharing of benefits, in the interests of public health, and to report thereon to the Seventieth World Health Assembly."

The representative of BAHRAIN praised efforts to coordinate the exchange and monitoring of viruses and the formulation and manufacturing of vaccines, which had led to progress on pandemic influenza preparedness. She expressed support for the draft decision on extending the application of decision EB131(2) (2012). The Government of Bahrain had made considerable efforts to prepare for a possible pandemic and improve its laboratory and surveillance capacities.

The representative of LIBERIA, speaking on behalf of the Member States of the African Region, commended the WHO Regional Office for Africa for providing support to strengthen laboratories in that Region. She noted the recommendations of the Review Group and urged WHO to strengthen national capacities in the five core areas of the PIP Framework. The timely sharing of viruses, contributions to the benefit-sharing programme and provision of resources to strengthen national regulatory authorities should be encouraged. She welcomed the recommendation on the integration of the Framework in capacity-building under the International Health Regulations (2005) and in regional efforts to build capacity on emergency preparedness and response. She enquired about the implications of the Framework becoming a legal instrument independent of the Nagoya Protocol.

The representative of NEW ZEALAND, expressing support for a number of the recommendations by the Review Group, said that the Nagoya Protocol had implications for public health responses and could result in delayed medical countermeasures, since it could complicate the process of sharing influenza viruses between global influenza surveillance and response system laboratories. To address the issue, the Framework should be considered a specialized international access and benefit-sharing instrument under the Nagoya Protocol. As such, and in line with recommendation 36 of the report, WHO should engage with the secretariat of the Convention on Biological Diversity on the matter and report on progress to the Seventieth World Health Assembly.

Turning to the draft decision contained in Annex 2 of document EB140/16, she proposed that the final clause of the preambular paragraph, in addition to the proposal by Member States of the European Union, should be amended to read: "having further considered documents EB140/15 and EB140/16 and the recommendations, in particular recommendation 36 of the 2016 Pandemic Influenza Preparedness (PIP) Framework Review Group contained in EB140/16, decided the following". Moreover, in paragraph 1, the date of extension should be changed to 28 February 2018, to enable the application of decision EB131(2) (2012) to be discussed at the 142nd session of the Executive Board, in January 2018.

The representative of CANADA, welcoming the proposed inclusion of genetic sequence data in the PIP framework and the suggestion that the Framework should be considered a specialized international instrument under the Nagoya Protocol, said that, although the Framework could be used as a model for other pathogens, its scope should continue to be focused on pandemic influenza. She expressed support for ongoing collaboration between the Secretariat of WHO and the secretariat of the Convention on Biological Diversity to consider the results of the report and other potential implications of the Protocol for public health. Further analysis was needed of a number of questions raised by the report, including the impact of the Protocol on the sharing of pathogens for public health research and development and whether it had delayed access to and the sharing of samples for seasonal influenza, Ebola virus and Zika virus.

The representative of MEXICO, underscoring the importance of the Framework for strengthening preparation, surveillance and response activities, said that it was important to maintain collaboration and technical support between laboratories and vaccine manufacturers in order to enable the timely and sufficient production of vaccines and antiviral medications in response to a potential pandemic. With regard to concerns about the scope and application of the Nagoya Protocol, he said that WHO should endeavour to ensure that the exchange of genetic material could continue without impeding established channels of cooperation. Distribution of information on the proper use of biological resources was also key for the harmonization of the Protocol and existing pathogen exchange systems. As President of the Thirteenth meeting of the Conference of the Parties to the Convention on Biological Diversity, Mexico supported the incorporation of biodiversity in all policies; as such, he encouraged WHO to continue discussions on the issue and coordinate with the secretariat of that Convention to identify challenges in that regard.

With respect to the draft decision, he proposed that in new paragraph 2*bis*, the phrase "in the context of the existing international commitments" should be inserted after "and other relevant international organizations, as appropriate".

The representative of THAILAND, expressing support for the draft decision, said that although the Standard Material Transfer Agreements 2 signed to date had enabled access to 350 million doses of vaccine during an influenza pandemic, that amount was far below global demand in the event of a worldwide pandemic. She strongly supported the expansion of the benefit-sharing system to include genetic sequence data and seasonal influenza viruses. Moreover, the Framework could provide support to strengthening pandemic vaccine production capacities as part of its inter-pandemic preparedness

measures. The Framework should be recognized as a specialized international instrument under the Nagoya Protocol.

The representative of the RUSSIAN FEDERATION echoed the findings of the Review Group on the need for closer cooperation on pandemic influenza preparedness, links with other programmes and legal instruments, and improved communication with all interested parties on the aims of the PIP Framework and progress made. The issues of handling genetic sequence data and increasing virus sharing were complex but must be discussed, particularly with regard to the Nagoya Protocol. The PIP Framework could not function without the full coordination of all elements of the Global Influenza Programme, particularly the WHO collaborating centres. The possibility of including seasonal influenza viruses under the Framework must be approached with great caution, as should applying the Framework to other pathogens. The Russian Federation would participate in any preparatory work on those issues, including by joining a dedicated working group if one was to be set up. He expressed support for extending the application of decision EB131(2) to 31 December 2017, as suggested in the draft decision.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, welcoming the possibility of further discussion of the topic at the Seventieth World Health Assembly, said that it was important to improve coordination between the PIP Framework, the International Health Regulations (2005) and the Global Health Security Agenda and to ensure that preparedness benefit was realized from the proportional division of the partnership contribution funds. Moreover, care should be taken to ensure that the important work on seasonal influenza by the Global Influenza Programme was not inappropriately subordinated to emergency response work.

The representative of the UNITED STATES OF AMERICA, expressing support for the draft decision, called for an external review of the expenditure of partnership contribution funds and a more transparent decision-making process for the use of those funds. The inclusion of seasonal influenza material in the PIP Framework would have operational implications and should be considered carefully. Moreover, documents should be drafted to provide greater clarity on virus sharing, particularly for novel viruses. His country did not support the incorporation of genetic sequencing data in the Framework. Assessments of how such data would be handled should be completed before a final decision was made. He encouraged WHO to hold consultations with, among others, experts in public health law, WHO collaborating centres for influenza and the private sector to further discuss protecting access to pathogens and promoting benefit sharing. The Nagoya Protocol was not applicable to influenza viruses with pandemic potential; he therefore encouraged the Secretariat to continue to provide support to Member States with a view to developing domestic legislation that facilitated rapid access to pathogens that threatened human health while ensuring the equitable sharing of benefits.

The representative of CHINA, drawing attention to his country's actions with regard to the implementation of the PIP Framework, expressed support for the draft decision. WHO should continue efforts to strengthen the overall capacity of the global influenza surveillance and response system and promote the implementation of the PIP Framework. The Nagoya Protocol played an important role in responding to epidemics and promoting the fair and equitable sharing of benefits and he encouraged all Member States to strengthen implementation of the Protocol through the harmonization of its provisions in domestic legislation. WHO should develop more detailed rules and standards in that regard.

The representative of PAKISTAN, highlighting the steps taken in her country with regard to the Nagoya Protocol, said that the Protocol would ensure more predictable access to genetic resources and the more equal sharing of benefits when genetic resources left the country of origin. International and

regional cooperation on biodiversity conservation should be strengthened, including through targeted financial support for capacity-building and development initiatives through the Global Environment Facility.

The representative of FINLAND[1] said that the PIP Framework should be considered a specialized international instrument under the Nagoya Protocol; he urged the Secretariat to continue in-depth discussions with the secretariat of the Convention on Biological Diversity and other relevant stakeholders on the subject and to report back to the Seventieth World Health Assembly and the 141st session of the Executive Board. There should be careful consideration of the need for amendments to the PIP Framework and their potential impact on access to influenza viruses and genetic sequence data; preliminary information in that regard was needed prior to the Seventieth World Health Assembly. He expressed support for the draft decision, as amended.

The representative of NORWAY[1] expressed support for the Review Group's recommendation not to expand the scope of the Framework to include other pathogens. In order to facilitate further discussions on that issue and on the increasing use of genetic sequence data in the context of the Framework, WHO should prepare a comprehensive report on the potential implications of the use of digital sequence information on genetic resources and access and the sharing of benefits for those resources. The report should take into account decision XIII/16 of the Conference of the Parties to the Convention on Biological Diversity and decision 2/14 of the Meeting of the Conference of the Parties to the Convention on Biological Diversity Serving as the Meeting of the Parties to the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of the Benefits Arising from Their Utilization. WHO should also engage with the secretariat of the Convention on Biological Diversity through the exchange of information on issues relevant to the PIP Framework. He expressed support for the draft decision, as amended.

The representative of MONACO,[1] expressing support for the amendments to the draft decision proposed by the representative of Malta, said that it was vital to remove doubts about the application of the Nagoya Protocol for all pathogens; further collaboration with the Convention on Biological Diversity was needed in that regard. Moreover, the PIP Framework should be recognized as a specialized international instrument under article 4.4 of the Nagoya Protocol.

The representative of BELGIUM[1] said that, in order to ensure that public health remained a priority, WHO should be actively involved in the relevant processes and deliberations under the Convention on Biological Diversity. It was the role of WHO to guarantee access at the global level to emerging pathogens to enable the prompt development of medical responses and ensure the fair and equitable sharing of benefits in collaboration with all relevant partners.

The representative of PANAMA,[1] reiterating her country's position on the draft global implementation plan for the International Health Regulations (2005), said that coordination and cooperation with all relevant stakeholders were indispensable for the implementation of the Nagoya Protocol.

The representative of GERMANY[1] said that the PIP Framework, while generally well implemented, might benefit from enhanced monitoring of key areas. Animal influenza viruses, as potential influenza viruses with human pandemic potential, should be included in its scope. Expanding the Framework to include seasonal influenza viruses, however, would have consequences that required

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

thorough consideration to avoid undermining the global influenza surveillance and response system and the public health response to seasonal influenza viruses. As such, the Framework should remain focused on pandemic influenza for the time being.

Any decision on amending the definition of pandemic influenza preparedness biological materials to include genetic sequence data should take place through an analytical and consultative process that assessed the potential consequences of such a decision. Further clarification was needed of realistic approaches to monitoring the use of such data and on models for sharing the benefits thereof. He welcomed the Review Group's recommendations that activities of the global influenza surveillance and response system and the PIP Framework should remain closely aligned with and integrated in the Global Influenza Programme and that capacity-building activities under the PIP Framework should be further aligned with implementation activities for the International Health Regulations (2005).

The representative of BRAZIL,[1] highlighting the complexity of the issue, said that consideration of the possibility of establishing the PIP Framework as a specialized international instrument under the Nagoya Protocol should be led by the States parties to the Convention on Biological Diversity, in line with their December 2016 decision to study what would constitute such a specialized international instrument. The PIP Framework should evolve to include genetic sequence data, with a workable system for tracking access and use, so as to ensure that virus genetic sequence data could be shared rapidly and equitably.

Given that viruses could be synthesized from genetic sequence data, it would not be viable for the PIP Framework to be based on biological materials alone in the long term. The implications of the existence of large databases and biobanks outside the global influenza surveillance and response system should be studied. Extending the PIP Framework to cover seasonal influenza viruses and other pathogens would enhance its complexity but should be considered further in view of the potential benefits. He expressed support for holding consultations on the public health, operational and legal aspects of the issue before the Seventieth World Health Assembly.

The representative of AUSTRALIA[1] welcomed the findings and recommendations of the Review Group and drew attention to the need for further work on the reasons for the decline in virus sharing and on enabling the PIP Framework to keep pace with advances in technology, including with respect to genetic sequence data. Although the Framework should continue to focus on pandemic influenza, the implications of including seasonal influenza viruses in its scope should be studied carefully, with particular consideration being given to the potential impact on the work of the global influenza surveillance and response system.

He welcomed the Secretariat's analysis as an important first step towards understanding the public health implications of implementing the Nagoya Protocol, but expressed concern that uncertainty over the legal obligations implementation entailed could delay virus sharing and lead to suboptimal viruses being used in the production of vaccines or to delays in manufacturing. He expressed support for the PIP Framework being listed as a specialized international instrument under the Nagoya Protocol. He also expressed support for the draft decision contained in Annex 2 to document EB140/16, as amended.

The representative of JAPAN[1] said that swift virus sharing during a pandemic was indispensable to vaccine development and manufacture. The implementation of the PIP Framework should not be impeded by the Nagoya Protocol, and the Organization should play a leading role in international coordination in that regard. Work on pandemic influenza preparedness and response

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

should continue to occupy a prominent place within the WHO Health Emergencies Programme. The Global Influenza Programme must not be adversely affected by the reforms proposed by the Independent Oversight and Advisory Committee.

The representative of INDONESIA[1] said that it was essential to ensure that Member States' capacity to detect potentially pandemic influenza as early as possible was strengthened in line with the PIP Framework, including through benefit sharing. It was critical for the Framework to adapt to technological developments. The PIP Advisory Group should consider seeking information from WHO collaborating centres on how genetic sequence data were handled in reality, which could then inform its recommendations on the optimal handling of such data under the PIP Framework. By clarifying and harmonizing the access and benefit-sharing obligations associated with the sharing of pathogens, the Nagoya Protocol could support the promotion of timely sharing and accelerate risk assessment and the development of measures to counter disease.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, noted that the PIP Framework placed virus sharing and benefit sharing on an equal footing. He expressed concern at several of the Review Group's recommendations on genetic sequence data. Such data should be treated in the same way as the viral isolate under the PIP Framework. Access to and use of genetic sequence data should trigger benefit sharing. Databases that wished to host sequence data should implement a standard user agreement that applied the Framework's benefit-sharing obligations to users accessing sequence data and allowed such users to be tracked. The Organization should be guided by the outcome of studies and deliberations under the Convention on Biological Diversity on the criteria and process for recognizing specialized international instruments for access and benefit sharing.

The partnership contribution paid by manufacturers should be updated, given the current running costs of the global influenza surveillance and response system, and Member States should create a new instrument to govern the sharing of seasonal influenza virus, rather than taking action that might undermine the PIP Framework. Further discussion was needed on how the Organization's other research and development activities intersected with the Convention on Biological Diversity and the Nagoya Protocol.

The representative of the INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS AND ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, expressed full support for the objectives of the Convention on Biological Diversity and the Nagoya Protocol, but urged Member States to give careful consideration to the public health implications of any legislation intended to implement the Protocol, particularly if it might affect the timely and comprehensive sharing of pathogens. The WHO Secretariat should produce a follow-up report reviewing all existing international pathogen sharing mechanisms. Where such mechanisms resulted in public health or societal benefits, Member States should formally recognize them as specialized access and benefit-sharing instruments under the Protocol. The same applied to the WHO Research and Development Blueprint. The Organization should support calls to elevate the PIP Framework and the global influenza surveillance and response system to the status of specialized international instruments under the Protocol as soon as possible.

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

The EXECUTIVE DIRECTOR (WHO Health Emergencies Programme), responding to the points raised, said that many lessons had been learned that had relevance beyond the PIP Framework itself. Some had already been applied in other areas of the Organization's work. Member States had commented on all three of the major issues covered by the report: areas for further study, process improvements and, most importantly, complex policy issues. The last included the overlap with the International Health Regulations (2005), the implementation of the PIP Framework and the WHO Research and Development Blueprint. Close review of those aspects and further discussion with Member States would be needed, particularly with regard to genetic sequence data and the potential expansion of the PIP Framework to cover seasonal influenza.

Although there was, as yet, no established process for designating specialized international institutions under the Nagoya Protocol, the possibility of the PIP Framework becoming such an institution should be explored. He acknowledged the requests made for close cooperation with the secretariat of the Convention on Biological Diversity in that area, which would build on efforts already being made by the PIP Framework team and the Office of the Legal Counsel. An inter-agency coordinating mechanism was being discussed. He was not aware of any instances of the implementation of the Nagoya Protocol having a negative impact on pathogen sharing to date; work would continue to identify any such events. The Secretariat and Member States had a critical role to play in determining the public health implications of the implementation of the Nagoya Protocol. Full use should be made of the flexibilities set out in the Protocol, particularly article 8 thereof, and all government ministries should be encouraged to take an active role in the process. The reform of the WHO Health Emergencies Programme meant that the matter would continue to be of high priority.

The CHAIRMAN took it that the Executive Board wished to take note of the reports contained in documents EB140/15 and EB140/16.

The Board took note of the reports.

The CHAIRMAN took it that the Board wished to adopt the draft decision contained in Annex 2 to document EB140/16, as amended.

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

Responding to a proposal by the DIRECTOR-GENERAL, the CHAIRMAN said he took it that the Board wished the Secretariat to work on consolidating and combining the various regular reports submitted in relation to the agenda items under discussion, which had become rather numerous.

It was so agreed.

The meeting rose at 12:30.

= = =

[1] Decision EB140(5).