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PROVISIONAL SUMMARY RECORD OF THE NINTH MEETING

Palais des Nations, Geneva
Friday, 25 May 2012, scheduled at 14:30

Chairman: Dr L.Z. DUKPA (Bhutan)

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NINTH MEETING

Friday, 25 May 2012, at 14:40

Chairman: Dr L.Z. DUKPA (Bhutan)

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Poliomyelitis: intensification of the global eradication initiative: Item 13.10 (Documents A65/20 and EB130/2012/REC/1, resolution EB130.R10) (continued)

Mrs BAMIDELE (Nigeria), speaking on behalf of the Member States of the African Region, said that, although there had been a resurgence of paralytic poliomyelitis due to wild poliovirus in some African States, progress had been achieved in many other countries of the Region. The African Region viewed completing the eradication of poliomyelitis as a global health emergency. It called on Member States to hold local authorities of key infected areas accountable for the performance and quality of supplementary immunization activities. It welcomed the efforts of countries to halt and reverse endemic and re-established transmission and encouraged them to take further measures, including strengthening accountability, evaluating eradication plans and promoting innovation, in order to interrupt transmission by the end of 2012. Continued global support should be provided to Member States where the disease remained endemic and to countries with transborder transmission. WHO and other partners should support national efforts to accelerate routine immunization and service delivery and to ensure a sustainable supply of vaccines. The African Region supported the draft resolution contained in resolution EB130.R10.

Dr MOHAMMED (Nigeria) said that the actions called for in the draft resolution were already being undertaken by his Government in the framework of its revised national poliomyelitis emergency plan. Resources would be deployed to ensure oral poliovirus vaccine coverage of all eligible children within 24 hours of crossing the border. Nigeria was committed to stopping the transmission of wild poliovirus, which had increased in 2011 as compared with 2010. A task force on poliomyelitis eradication had been established; vaccination strategies were being scaled up in high-risk areas; vigorous risk assessment methods had been developed; a revised national poliomyelitis emergency plan had been drawn up after consultation specifying the accountability of all tiers of Government, stakeholders and partners; and domestic funding for poliomyelitis eradication initiatives had been increased from US$ 17 million to US$ 30 million annually for the coming two years. Strategies had also been put in place to improve the performance of vaccination teams in order to ensure high-quality supplementary immunization. The Government was working with community, traditional and religious leaders to address population resistance to vaccination. Efforts were also being made to improve routine immunization, particularly in areas at highest risk for wild poliovirus transmission, and to ensure an uninterrupted supply of vaccines. Every effort was being made to document correctly the surveillance of acute flaccid paralysis.

He thanked WHO and other development partners for their continued support for implementation of Nigeria's emergency plan for poliomyelitis and assured Member States that his country remained committed to discharging its responsibilities.

Dr MASHAL (Afghanistan) welcomed intensification of the Global Polio Eradication Initiative and agreed that transmission of poliomyelitis should be declared a national public health emergency. Although the number of confirmed cases in his country had been reduced in 2012, challenges remained before poliomyelitis would be eradicated. Innovative strategies tailored to the needs of

populations in remaining disease-endemic areas were the key to success, and he called on national and international organizations to take appropriate action. His Government was currently preparing a national emergency action plan and working to strengthen routine vaccination, on which particular emphasis should be placed. Countries with endemic transmission should ensure an efficient link between routine vaccination and the Global Polio Eradication Initiative.

Mr FILLON (Monaco), speaking on behalf of the Member States of the European Region, said that the increasing number of cases recorded in 2011 in countries with endemic transmission was of serious concern. All children, including those in poliomyelitis-free countries and regions, would remain at risk until the disease had been eradicated. The Member States of the European Region remained committed to ensuring the immunity of populations of all ages through certified surveillance programmes, together with routine, and if necessary mass, immunization campaigns. Prevention of the importation of new cases of poliomyelitis was as important as interruption of transmission in countries where poliomyelitis remained endemic. If eradication, which was within reach, was to be achieved, systematic intervention strategies and strong national surveillance and accountability mechanisms should be established in areas where transmission persisted. Noting the financing gap with respect to the Global Polio Eradication Initiative, he said that the results achieved so far would be eroded if the necessary funds and human resources were not forthcoming. The Member States of the European Region supported the draft resolution.

Dr PRASAD (India), speaking on behalf of the Member States of the South-East Asia Region, said that the Region had been free of wild poliovirus for some time. India had succeeded in halting endemic transmission of wild poliovirus through a number of initiatives, including political commitment at the highest level and deployment of adequate resources. His Government had introduced the bivalent oral poliovirus vaccine in 2010 and, despite periodic shortages, had been able to procure sufficient quantities for national and regional supplementary immunization rounds. Special attention had been given to ensuring the vaccination of children, migrants and populations in low-coverage areas. Social mobilization, monthly village health and nutrition days and the involvement of community and religious leaders had helped to dispel fears and increase acceptance of vaccination.

Nevertheless, risks remained, and the Government was taking steps to maintain high population immunity, strong surveillance, vaccination of travellers at border crossings, preparation of an emergency preparedness and response plan and regular risk assessment. An endgame strategy, including the switch from trivalent to bivalent oral poliovirus vaccine, would also be prepared. He urged WHO to continue providing technical support at the same level until eradication of poliomyelitis had been achieved. With regard to the draft resolution, he proposed deletion of the phrase "that exploits new developments in poliovirus diagnostics and inactivated poliovirus vaccines" from subparagraph 4(3).

Dr PORNTHIP CHOMPOOK (Thailand) congratulated India for its success in halting virus circulation. India's experience showed that a high level of routine vaccination coverage coupled with high-quality supplementary immunization activities were essential, as were a sound cold chain and community engagement. Evidence showed that eradication was compromised by lack of commitment of leaders and shortages of funding. Although the inactivated poliovirus vaccine would have an increasing role to play, particularly in the post-eradication era, its high cost and limited supply were obstacles to its use in developing countries. She asked the Director-General, the vaccine industry and development partners, including the GAVI Alliance, to take concrete steps to ensure that inactivated poliovirus vaccine was affordable.

She supported the draft resolution contained in resolution EB130.R10, as amended by India. She also proposed the addition of a preambular paragraph 6bis reading: "Concerning the current high cost and limited supplies of inactivated vaccine that are hampering the introduction and scaling up of inactivated poliovirus vaccine, resulting in major programmatic and financial implications to

developing countries". Subparagraph 4(4) should be amended to read "to coordinate with all relevant partners, including vaccine manufacturers, to promote the research, production and supply of vaccines, in particular inactivated polio vaccine, to enhance their affordability, effectiveness and accessibility".

Dr DECOCK (United States of America) said that the eradication of poliomyelitis was feasible, but if countries in which the virus was endemic and WHO did not make eradication a priority, a tremendous investment in public health would be wasted. The challenges faced by countries experiencing outbreaks required more attention, and countries in which the disease was endemic must make eradication a national priority and ensure accountability for eradication activities. Member States should work together to mobilize the necessary human and financial resources to achieve global eradication. Poliomyelitis was a disease requiring immediate notification under the International Health Regulations (2005), and he urged all Member States to adhere to that reporting requirement and to remain vigilant for cases caused by imported wild poliovirus.

WHO was proposing a comprehensive approach for reducing to the lowest possible level the risk associated with ceasing use of oral poliovirus vaccine and for managing residual risk. It was in the interest of all Member States to support that effort and to coordinate implementation of the medium-term and endgame strategy being prepared by the Strategic Advisory Group of Experts on immunization. Turning to the draft resolution, he proposed replacing the term "epidemic" in subparagraph 3(4) with "epidemiologic".

Dr CORTEZ (Philippines) expressed strong support for the intensification of poliomyelitis eradication efforts. Eradication of poliomyelitis and other vaccine-preventable diseases remained the highest public health priority in his country, and a comprehensive, mandatory, sustainable immunization programme had been approved in 2011. The Philippines had remained poliomyelitis-free for the previous 12 years; however, a risk of reintroduction of wild poliovirus through importation persisted, because of increased local and international travel and low population immunity in some areas. The Government was seeking to strengthen surveillance and oral poliovirus vaccine coverage. A national poliovirus importation preparedness and response plan had been drawn up to encourage the preparation of subnational plans for sustaining poliomyelitis-free certification and ensuring that the country met its goals for the elimination of other vaccine-preventable diseases. Sustainable financial assistance was needed to support active surveillance.

Dr HIRAOKA (Japan) said that further effort would be needed in order to ensure effective implementation of the Global Polio Emergency Action Plan 2012–2013 and asked why proven new strategic approaches for eradicating poliovirus were not being fully applied. It was essential to reach unvaccinated children and to strengthen outreach strategies. Immunization and seroprevalence rates should be monitored carefully in designated pilot areas over the crucial next few years. His Government supported the draft resolution and would continue to provide technical and financial support and collaborate with international partners such as WHO and UNICEF in order to achieve eradication.

Dr HUSAIN (Bahrain) said that her country had taken a number of steps to control vaccine-preventable diseases and had been free of poliomyelitis since 1994. A programme was in place for the detection of suspected new cases, and national campaigns to increase immunization against poliomyelitis had resulted in over 90% coverage. Vaccination strategies were continuously evaluated, and introduction of bivalent oral poliovirus vaccine was foreseen. She was confident that, as a result of local, regional and national activities, Bahrain would remain free of the disease. She emphasized the importance of the strategies recommended by WHO for completing the eradication of poliomyelitis and expressed support for the draft resolution.

Dr AL-TAAE (Iraq) said that his country had remained free of poliomyelitis for 12 years. He emphasized the importance of comprehensive coverage with services at primary, secondary and tertiary health care levels in order to reach populations in remote areas; the active participation of all sectors; and partnerships with other countries. Afghanistan, the Islamic Republic of Iran, Iraq and Pakistan, in collaboration with WHO, were promoting cooperation with neighbouring countries for the eradication of poliomyelitis, including the use of active surveillance as recommended by WHO.

Mr LASKAR (Bangladesh) said that significant progress had been made towards eradication of poliomyelitis in the South-East Asia Region over the previous 24 months and that the Region hoped to be certified as poliomyelitis-free in January 2014. India had succeeded in halting endemic transmission as a result of concerted efforts, including strong government ownership, close partnerships, a focus on quality, and programme accountability. Member States of the Region recognized the importance of achieving a high level of population immunity in order to remain free of poliomyelitis and to mitigate the risk of importation. A careful review of the use of oral and inactivated poliovirus vaccines, including adequate regional consultations, would be needed as part of the endgame strategy.

Bangladesh had been free of poliomyelitis since 2006, and current vaccination coverage stood at 95%. National poliomyelitis immunization days were held each year and would continue until the Region had been certified as poliomyelitis-free. Bangladesh supported the draft resolution.

Dr MELNIKOVA (Russian Federation) said that poliomyelitis remaining endemic in some countries demonstrated that the measures being taken were insufficient, and additional action plans were needed. The Russian Federation supported implementation of the Global Polio Emergency Action Plan 2012–2013 and welcomed the efforts of WHO to raise awareness of the issue among the leaders of all countries. Financing was essential, and her Government was committed to meeting its international obligations under the Global Polio Eradication Initiative. It was also providing additional support to countries of the Commonwealth of Independent States to strengthen their network of laboratories and had provided vaccines for supplementary immunization of children. Further steps to build capacity and improve epidemiological surveillance in the Region would be taken in 2012. Her Government had provided financial resources for diagnosis of cases at the WHO Regional Polio Reference Laboratory. It welcomed the WHO initiative to devise new strategic approaches, including to prevent cases due to vaccine-derived poliovirus, and would be willing to participate in those efforts. She endorsed the draft resolution.

Dr ALLENDE (Paraguay), noting that circulation of wild poliovirus had last been recorded in his country in 1985, said that the delay in achieving global eradication of the disease was seriously compromising the actions taken in some regions, necessitating the continuation of vaccination and epidemiological surveillance for an indefinite period. The increase in incidence of cases due to vaccine-derived poliovirus in areas with high HIV prevalence was especially worrying. Steps should be taken to accelerate the administration of inactivated poliovirus vaccines to all affected age groups in such areas. Teams of international health workers had played an important role in reducing the number of cases in countries where poliomyelitis remained endemic, and the Health Assembly should promote such horizontal cooperation. The threat of resurgence of poliomyelitis was a matter of global security, and WHO and related organizations and agencies must adopt a strong position to tackle the problems standing in the way of eradication. He endorsed the draft resolution.

Ms GOLBERG (Canada) said that Canada remained firmly committed to poliomyelitis eradication and had made significant technical and financial contributions to that end. Her Government supported the proposed Global Polio Emergency Action Plan 2012–2013 and believed that it was critical to intensify collective activities in the three countries in which poliomyelitis remained endemic. She praised the commitment of those countries to pursue aggressive eradication

campaigns. A stronger communication strategy was needed under the emergency action plan to increase the engagement of different constituencies and sustain momentum. The financial gap must be bridged to eradicate poliomyelitis, and Canada urged all Member States and funding partners to consider contributing to eradication efforts. Her Government also called on countries involved in the Partnership for Maternal, Newborn and Child Health to consider supporting immunization activities under that initiative.

Dr RAFEEG (Maldives) said that India's success was a landmark in global efforts to eradicate poliomyelitis. Maldives had remained free of indigenous poliomyelitis since 1982, a significant achievement for a nation with such a widely dispersed population and frequent foreign visitors. Vaccination had begun in 1967; high coverage had been achieved and maintained with the use of mobile vaccination teams, mandatory vaccination for school entry and advocacy and awareness-raising. Considerable effort, including continued surveillance, was being made to maintain the status of Maldives as poliomyelitis-free. She highlighted the importance of improved cross-border collaboration among neighbouring countries and called on WHO to continue to support the countries of the South-East Asia Region in order to ensure that the gains they had made were not lost. Maldives fully supported the draft resolution.

Mrs REITENBACH (Germany) observed that poliomyelitis was endemic in only parts of three countries and that the number of cases due to wild poliovirus type 3 was at its lowest level ever. Global eradication of poliomyelitis was therefore within reach, but only with continued financial, political and technical support from all governmental and nongovernmental bodies concerned. The Global Polio Emergency Action Plan 2012–2013, which Germany supported, was essential in order to complete poliomyelitis eradication. The considerable financing gap remained a serious concern, however, and could be bridged only by concerted effort from all partners of the Global Polio Eradication Initiative. Germany remained actively engaged in the Initiative and would fulfil its commitment to make available €100 million for the fight against poliomyelitis between 2009 and 2013.

Dr MOHAMED (Oman) said that, despite the tireless efforts of the Director-General, the Regional Director for the Eastern Mediterranean and the technical and financial support provided to countries for poliomyelitis eradication, cases in the three countries in which wild poliovirus remained endemic had increased in 2011 and there was a danger that transmission could spread to other countries. It was unclear from the Arabic translation of the report whether the situation constituted a global health emergency and what time frame for global eradication was being proposed. Oman welcomed the transparent reports provided by the Independent Monitoring Board and thanked the Strategic Advisory Group of Experts on immunization for its work.

Dr WU Liangyou (China) agreed that poliomyelitis was a global health emergency. Although eradication was possible, the Global Polio Eradication Initiative was facing severe challenges; China therefore supported the draft resolution. The persistence of wild poliovirus in some countries posed a threat to their neighbours. His Government had responded rapidly to importation of wild poliovirus in August 2011 by conducting intensive immunization programmes and strengthening surveillance. No further cases had been recorded since August 2011, and China had been removed from the list of countries in which poliomyelitis remained endemic.

He called on Member States to devise mechanisms for rapidly sharing information and urged the countries in which the disease was endemic to implement prevention and control activities with their neighbours. A staged plan should be prepared to promote technology transfer for the production of inactivated poliovirus vaccine, and special attention should be given to the use of that vaccine in developing countries. The Director-General should coordinate support to the countries in which the

disease was endemic to prevent transmission, conduct risk assessment to identify areas with weak immunization coverage, and take steps to rectify the situation.

Professor BAGGOLEY (Australia) said that his Government strongly supported the global eradication of poliomyelitis and had committed to provide 50 million Australian dollars for the purchase and delivery of poliovirus vaccines. He congratulated India on remaining poliomyelitis-free for more than one year and welcomed the emergency action plans prepared by Nigeria and Pakistan. His Government urged all Member States to embrace the Global Polio Eradication Initiative, strengthen their immunization systems and support WHO in eradicating the disease. Australia endorsed the draft resolution.

Dr SLAMET RIYADI YUWONO (Indonesia) welcomed the draft resolution, which would increase global activities for poliomyelitis eradication. His Government was encouraged by the 99% decline in cases of paralytic poliomyelitis due to wild polioviruses since the Global Polio Eradication Initiative had been launched. It also recognized the need for a comprehensive endgame strategy as well as the importance of a post-eradication strategy. His country's success in eradicating poliomyelitis was attributable to the effectiveness of the trivalent oral poliovirus vaccine, and use of bivalent vaccine would complement eradication activities. The introduction into routine immunization programmes of inactivated poliovirus vaccine, however, would have financial implications and could undermine programme delivery. He therefore strongly supported the amendment proposed by the delegate of India to subparagraph 4(3) of the draft resolution.

Professor TRAORÉ (Mali) said that Mali remained at risk of wild poliovirus importation from Nigeria and the security situation in the northern part of the country could decrease the momentum of poliomyelitis eradication efforts. After a period of interruption in the circulation of the virus in 2004, one case of poliomyelitis due to wild poliovirus had been reported in 2008 and others between 2009 and 2011, demonstrating the persisting threat of international transmission. Repeated outbreaks of poliomyelitis in Mali were due not only to population movements but also to poor vaccination coverage, which had been estimated at only 74% in 2009.

Mali had carried out 16 rounds of supplementary immunization activities in 2009 and 2010, which had been synchronized with those in 19 countries, resulting in vaccination of 85 million children under five years of age. New approaches had been introduced to reduce the number of children missed during such campaigns. Despite those efforts, seven cases had occurred in 2011, the last case in October. In order to consolidate the progress made so far, five national poliovirus vaccination days had been planned for 2012. The major challenge for his country was to synchronize supplementary immunization activities in 2012 with those of other countries of West Africa, despite the security situation.

Dr DÍAZ (Chile) said that eradication of poliomyelitis was indeed a global public health emergency. Significant progress had been made under the Global Polio Eradication Initiative Strategic Plan 2010–2012, despite the difficulties encountered. He welcomed the Global Polio Emergency Action Plan and its emphasis on the need for new diagnostic tests for vaccine-derived polioviruses, the availability of bivalent oral poliovirus vaccine and the use of inactivated poliovirus vaccine. Careful planning for phased achievement of the Plan's objectives would be key to its success. His Government was considering changing its immunization strategy by replacing the oral vaccine with inactivated poliovirus vaccine, probably before global eradication had been achieved. Member States should take into account the risks associated with the use of oral poliovirus vaccine, particularly after eradication, when all oral vaccine should cease to be used. Meanwhile, a switch from trivalent to bivalent oral poliovirus vaccine would make vaccination more effective. Wild poliovirus type 2 was no longer circulating and was therefore unnecessary in vaccine used for routine immunization. His Government

urged the Secretariat to design an integrated strategy to complete the eradication of poliomyelitis and endorsed the draft resolution.

Mr LAHLOU (Morocco) said that his country had recorded its last case of poliomyelitis in 1998. It had continued to carry out vaccination campaigns, and coverage in 2009 had been well over 90%. A national plan for the eradication of poliomyelitis had been submitted in 2010. To mitigate the risk of importation and re-establishment of transmission of poliovirus, his Government was working with neighbouring countries to strengthen their vaccination campaigns. It urged the Regional Office for the Eastern Mediterranean and the Regional Office for Africa to work together to draw up a plan for reducing the risk of cross-border transmission. The countries in which the disease was endemic should be given greater support in order to prevent the virus from spreading to neighbouring countries. Social, economic and political factors should be taken into account in designing immunization campaigns in those countries. Technical and financial support was essential to enable all countries to prepare national strategies, undertake surveillance and ensure that the achievements made thus far were not eroded. Countries that were poliomyelitis-free must invest the resources needed to prevent re-emergence of the disease. To that end, more effective resource mobilization policies were needed.

Dr GONÇALVES (Mozambique) said that any cases of acute flaccid paralysis in children under 15 years of age in her country were detected by passive surveillance in national health facilities or by active surveillance at community level. Surveillance performance indicators had improved between 2009 and 2011. Despite increased coverage with trivalent oral poliovirus vaccine, there remained health areas with low coverage. In 2011, four cases caused by vaccine-derived poliovirus had been detected, and the Government, with the support of partners, had instituted a mass emergency vaccination campaign. In order to be certified as poliomyelitis-free, Mozambique had to enhance surveillance and improve immunization coverage with trivalent oral poliovirus vaccine. Substantial efforts were being made to strengthen its immunization programme, despite financial constraints, and a national campaign would be conducted later in the year targeting susceptible groups.

Dr KIMANI (Kenya) said that an outbreak of wild poliovirus type 1 in his country in 2011 had been detected and investigated within four days. Six rounds of supplementary immunization had been conducted in selected districts within the year, some synchronized with those of neighbouring countries. A high-level coordination committee had been appointed to monitor poliomyelitis eradication activities and to mobilize resources. Kenya was not yet ready to switch from the oral to the inactivated poliovirus vaccine, as wild poliovirus was still circulating. In addition, the switch would entail logistics problems and have budgetary implications. His delegation therefore supported the amendment proposed by the delegate of India to subparagraph 4(3) of the draft resolution.

Mr KLEIMAN (Brazil), noting that use of oral poliovirus vaccine had been one of the keys to his country's success in achieving poliomyelitis-free status, said that his delegation also supported the proposed amendment to subparagraph 4(3) of the draft resolution. His Government stood ready to collaborate on initiatives for poliomyelitis eradication in the framework of South–South cooperation.

Dr HEMMATI (Islamic Republic of Iran) pointed out that cross-border traffic could adversely affect the poliomyelitis-free status of countries such as his own, which had borders with two of the countries in which poliomyelitis remained endemic. In his country, more than one million people were vaccinated each year, while no significant increase in vaccination rates had occurred in the neighbouring countries. His Government was willing to provide those countries with technical support for vaccination and surveillance, especially in border areas. The support of other neighbouring countries and the Regional Office for the Eastern Mediterranean in those efforts would be much appreciated. His country had achieved close to 100% coverage with routine vaccination and conducted supplementary immunization, had improved its system for surveillance of acute flaccid paralysis and

had instituted a national poliomyelitis laboratory proficiency test. All stored specimens of infectious and potentially infectious materials in the national poliomyelitis laboratory had been destroyed in 2006. He endorsed the recommendations in the draft resolution and supported the proposed amendment to subparagraph 4(3).

Dr WILLIAMS (Jamaica) said that her country had eradicated wild poliovirus in 1982 and had been certified as free of poliomyelitis in 1994. Vaccination coverage was high and the Government conducted active surveillance for cases of acute flaccid paralysis. In order to lower the risk for re-importation of wild poliovirus, developed countries should share best practices and provide technical cooperation. Technical guidance from WHO would be needed as countries prepared for the shift to bivalent oral poliovirus vaccine and then from oral vaccine to inactivated vaccine. She endorsed the draft resolution.

Ms MEDINA (Ecuador) observed that her country had been free of poliomyelitis for 19 years. Vaccination coverage for the country as a whole had been above 95% since 2005, and most municipalities had achieved about 80% coverage. A national campaign had been carried out to ensure immunization of all children under seven years of age, concentrating on areas without adequate coverage. Laboratories in which wild poliovirus was stored had been assessed, and active surveillance of acute flaccid paralysis continued. She supported the draft resolution.

Dr MMBANDO (United Republic of Tanzania), expressing support for the draft resolution, said that his country continued to implement poliomyelitis eradication initiatives, with emphasis on regions and districts with low vaccination coverage and those at risk for wild poliovirus importation. Routine immunization was a core strategy, and 91% coverage with three doses of oral poliovirus vaccine had been achieved nationally. The "reaching every district" approach had contributed to that result. The last poliomyelitis case had been detected in 1996, but acute flaccid paralysis surveillance continued nationally. He drew attention to the cost and logistical implications of switching from oral to injectable poliovirus vaccine and expressed support for the amendment to the draft resolution proposed by the delegate of India. He welcomed the support provided by WHO, the GAVI Alliance and UNICEF and urged WHO to continue mobilizing resources to support the required response to outbreaks of poliomyelitis.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that his delegation agreed with the conclusion of the Strategic Advisory Group of Experts on immunization that failure to eradicate poliomyelitis would lead to a public health emergency of global proportions and was not acceptable. Cuba had eradicated wild poliovirus in 1962, but a vaccination campaign was still conducted every year. WHO was conducting research on the circulation of vaccine-derived polioviruses in Cuba, in collaboration with the Instituto Pedro Kouri. Cuba had started using inactivated poliovirus vaccine, as recommended by WHO. He supported the draft resolution.

Dr SIA (Brunei Darussalam) expressed concern over the recent outbreaks of poliomyelitis in regions and countries that had previously been free of the disease. Although there had been no poliomyelitis cases in her country since 2000, surveillance for acute flaccid paralysis continued, as maintaining high-quality, case-based surveillance and ensuring that a high proportion of the population was immunized at an early age were key strategies for controlling and eradicating poliomyelitis. In line with global recommendations, Brunei Darussalam had begun using inactivated poliovirus vaccine. She welcomed the work of the Global Polio Eradication Initiative and WHO towards the goal of eradication, which was achievable, and congratulated India on its success in combating poliomyelitis.

Dr BROU (Côte d'Ivoire) said that, despite the progress made towards the eradication of poliomyelitis, 36 cases due to imported poliovirus type 3 had been recorded in Côte d'Ivoire in 2011. Given the mobility of populations and the upheavals in his country and elsewhere in West Africa, maintaining surveillance in accordance with international recommendations was crucial. Nine supplementary vaccination campaigns, synchronized with campaigns in other countries, had been carried out in 2011 and 2012, and no cases of poliomyelitis had been recorded since July 2011. The use of different types of poliovirus vaccine by neighbouring countries was a problem in cross-border vaccination campaigns, and he asked whether individuals vaccinated with bivalent poliovirus vaccine who entered a country in which the trivalent vaccine was used should be re-vaccinated. Despite the technical difficulties, the goal of poliomyelitis eradication had been shown to be achievable. He called for renewed efforts and adequate financing from Member States and local and international partners, and welcomed the new strategies proposed in the report. His country had recently experienced a serious political crisis and needed WHO support in order to strengthen its health system, particularly for routine vaccination.

Mr ÁLVAREZ LUCAS (Mexico) said that universal vaccination was essential and agreed that completing poliomyelitis eradiation should be recognized as a global health emergency. The establishment of eradication strategies and effective surveillance were crucial. As long as poliovirus continued to circulate and the risk of importation persisted, oral poliovirus vaccine should continue to be used in regular immunization campaigns; surveillance for acute flaccid paralysis should be maintained and the capacity of laboratories to analyse samples, particularly from mobile populations, should be strengthened.

Dr SEAKGOSING (Botswana) said that his country had remained free of poliomyelitis since certification in 2005; it continued to conduct surveillance for wild poliovirus through reporting and laboratory confirmation of all suspected cases of acute flaccid paralysis and quarterly risk assessments. Botswana had achieved routine poliomyelitis immunization coverage of over 90% and had used numerous strategies to ensure that all children were immunized. In response to the outbreak in Angola in 2011, Botswana had conducted a house-to-house campaign to strengthen immunity among children under five years of age. He endorsed the draft resolution.

Ms KOBELA (Cameroon), noting that her country bordered Nigeria, said that her Government had recently implemented a contingency plan to scale up its poliomyelitis eradication activities and interrupt transmission, including increasing routine vaccination coverage to at least 88% and accelerating vaccination against other vaccine-preventable diseases, strengthening communication about the benefits of vaccination and ensuring the availability of oral poliovirus vaccine. Despite the burden they represented, Cameroon continued to conduct vaccination campaigns, particularly against poliomyelitis.

Professor Shan-Chwen CHANG (Chinese Taipei), commending the draft resolution, said that the introduction of a system to monitor the immunization status of all children in Chinese Taipei had contributed to poliomyelitis eradication. He recognized the importance of documenting vaccination, of surveillance for acute flaccid paralysis and of strong political commitment in order to ensure that countries remained free of poliomyelitis and supported the recommendation by the Strategic Advisory Group of Experts on immunization to remove Sabin polioviruses from immunization programmes. Chinese Taipei stood ready to share its experience as part of ongoing efforts to eradicate poliomyelitis.

Dr TOURE (UNICEF) welcomed the progress made globally in eradicating poliomyelitis. Millions of children were now protected against the threat of death or paralysis as a result of effective vaccination initiatives. The threat of poliomyelitis would, however, continue until eradication was complete. The number of cases reported globally was now at its lowest level, and it was essential to eliminate remaining pockets of poliomyelitis transmission. She welcomed the draft resolution and said that UNICEF was committed to continuing to work with WHO and other partners to support governments and communities in eradicating poliomyelitis globally.

Dr BELL (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that the Federation was committed to working closely with its partners in the Global Polio Eradication Initiative. She fully supported global endeavours to eradicate wild poliovirus in the three countries that remained endemic and support certification activities thereafter. The Federation would sustain such efforts through its global network of national societies and over 13 million community-based volunteers.

Mr STENHAMMAR (Rotary International), speaking at the invitation of the CHAIRMAN, expressed support for the draft resolution. Eradication was closer than ever, but ongoing transmission in Afghanistan, Nigeria and Pakistan continued to threaten children and adults everywhere. Interruption of transmission in India was proof that eradication strategies worked when fully implemented, and the Global Polio Emergency Action Plan should therefore be fully implemented and progress reviewed by the Executive Board at its 132nd session. He noted that activities in 24 countries had been reduced or cancelled in 2012 because of a shortage of funds. Therefore, in addition to increased efforts by the countries concerned, financial support was required from the global community, including the G8 and G20 groups of countries, the European Commission and development banks, and through innovative funding mechanisms.

Dr AYLWARD (Assistant Director-General), replying to points raised by delegates, apologized for the lack of clarity in the Arabic version of the report referred to by the delegate of Oman and assured delegates that the current situation indeed constituted an emergency. After 20 years of eradication efforts, the situation had now reached a tipping point. It was clear that failure would have horrific consequences for both children and adults, as had been demonstrated when outbreaks had occurred in areas that had long been free of the disease; mortality rates in those cases had been extremely high in recent outbreaks. At the same time, India's success had demonstrated that poliomyelitis could be eradicated. A time line had been agreed with the countries in which transmission remained endemic and the Global Polio Emergency Action Plan 2012–2013 prepared, although it was recognized that activities would have to continue through 2018. The Emergency Action Plan had already been implemented in all countries. Under the Plan, responsibility for eradication programmes would extend beyond the health sector to include governments and society as a whole in the effort to ensure that all children in all countries were immunized. The approach involved innovative tools and strategies, with emphasis on improving routine immunization and on enhanced accountability and monitoring frameworks.

The heads of Government in the countries with ongoing transmission of wild poliovirus were regularly updated on the progress of the initiative. At the request of the governments of those countries, WHO was deploying nearly 2500 additional people to subdistrict level to support implementation and monitoring of activities, while UNICEF was recruiting more than 5000 additional community mobilizers to improve communication. Regular risk reviews in poliomyelitis-free areas were included in the Emergency Action Plan. The Director-General and the Regional Directors regularly discussed the poliomyelitis programme during Global Policy Group meetings and had made cross-regional coordination a priority. Thousands of hours of technical support had been provided by the regional offices. He thanked delegates for their offers of additional support.

Availability of the bivalent oral poliovirus vaccine would be somewhat limited initially, but the situation should stabilize within six months as new suppliers began production. Clearly, international spread would remain a threat until poliomyelitis had been eradicated everywhere. The goal was to conduct additional campaigns in areas at highest risk, although financing continued to be a problem. Despite the progress achieved and the evidence that the consequences of failure would be horrific, campaigns in 24 high-risk countries had had to be abandoned already in 2012 because of lack of funding. The financing prospects for the second half of 2012 were even worse, and activities would have to be curtailed in some affected areas if the funding gap could not be filled. Indeed, the availability of sufficient financing would make the difference between success and failure. Implementing the Emergency Action Plan would require at least an additional US$ 150 million in 2012 alone.

With regard to the poliomyelitis endgame strategy and barriers to use of inactivated poliovirus vaccine, there was strong collaboration with countries, including Cuba, India, Indonesia and Oman, and with vaccine manufacturers to ensure that the problems were addressed. Research was under way on reducing the number of doses needed, optimizing the antigen content, fractional dosing and technology transfer. Major breakthroughs had been made that would bring product costs down, probably by more than 50% or in some cases 75%. Nevertheless, inactivated poliovirus vaccine would always be more expensive than the oral vaccine. WHO, with the GAVI Alliance, UNICEF and other partners, was exploring potential financing options to ensure a smooth transition from trivalent to bivalent oral poliovirus vaccine for routine immunization in countries using oral poliovirus vaccine, coupled with the use of inactivated poliovirus vaccine in countries that deemed it necessary to vaccinate against type 2 poliovirus. Those issues would be addressed in the 2014–2018 endgame strategy, which was being prepared for consideration in regional consultations before being submitted to the Strategic Advisory Group of Experts on immunization in November 2012 for an initial review. He thanked all partners for their technical and financial support and commended the efforts of countries with endemic transmission of wild poliovirus to achieve eradication.

The DIRECTOR-GENERAL said that progress in eradicating poliomyelitis had been made thanks to the combined efforts of countries with endemic transmission of wild poliovirus, partners and experts, in particular the Independent Monitoring Board, the Strategic Advisory Group of Experts on immunization, the United States Centers for Disease Control and Prevention, and the Bill & Melinda Gates Foundation. Political commitment to, and ownership of, eradication efforts in countries with endemic transmission of wild poliovirus was encouraging and was essential to eradication, as had been demonstrated in India. Poliomyelitis eradication had reached a point where failure was not an option, as the cost in human terms would be disastrous, and the credibility of public health would be undermined. She therefore urged all partners to ensure that lack of funding did not lead to failure. All those concerned must redouble their efforts and their accountability for delivering results. It was to be hoped that declaring the situation a programmatic emergency would tip the scales towards success.

The CHAIRMAN invited the Secretary to read out the proposed amendments to the draft resolution.

Dr DAYRIT (Secretary) said that the delegate of Thailand had proposed an additional preambular paragraph 6bis, which would read: “Having noted the current high cost and limited supplies of inactivated polio vaccine that are hampering the introduction and scaling-up of inactivated polio vaccine, resulting in major programmatic and financial implications to developing countries”. In subparagraph 3(4), the delegate of the United States of America had proposed that the word “epidemic” be replaced by “epidemiologic”.

In subparagraph 4(3), the delegate of India had proposed deletion of the phrase "that exploits new developments in poliovirus diagnostics and inactivated poliovirus vaccines". Lastly, the delegate of Thailand had proposed two amendments to subparagraph 4(4), which would thus read: "to coordinate with all relevant partners, including vaccine manufacturers, to promote the research, production and supply of vaccines, in particular inactivated polio vaccines, to enhance their affordability, effectiveness and accessibility".

Dr KIMANI (Kenya) observed that much of the progress achieved towards the goal of eradication was due to use of the trivalent oral vaccine. A switch to the injectable inactivated vaccine would be more expensive for developing countries, with no guarantee that it would be as effective. The live attenuated oral vaccine had many advantages in countries where environmental sanitation conditions were poor. Member States should be made fully aware of all the implications before making the switch. He supported the amendment proposed by the delegate of India.

The CHAIRMAN said that, in the absence of any objections, he took it that the Committee wished to approve the draft resolution, as amended.

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

Nutrition: Item 13.3 of the Agenda (continued)

- **Maternal, infant and young child nutrition** (Documents A65/11, A65/11 Corr.1) (continued from the eighth meeting, section 4)

Ms WISEMAN (Canada) said that, following informal consultations, it was proposed to amend the draft resolution presented during the previous meeting such that subparagraph 2(1) would read: "developing or, where necessary, strengthening nutrition policies so that they comprehensively address the double burden of malnutrition and include nutrition actions in overall country health and development policy, and establishing effective intersectoral governance mechanisms in order to expand the implementation of nutrition actions with particular emphasis on the framework of the global strategy on infant and young child feeding."

A new subparagraph 2(4) would read: "implementing a comprehensive approach to capacity building, including workforce development."

Subparagraph 3(1) would read: "to provide clarification and guidance on the inappropriate promotion of foods for infants and young children as mentioned in resolution WHA63.23, taking into consideration ongoing work of the Codex Alimentarius."

Subparagraph 3(3) would read: "to develop risk assessment, disclosure and management tools to safeguard against possible conflicts of interest in policy development and implementation of nutrition programmes consistent with WHO's overall policy and practice."

A new subparagraph 3(4) would read: "to report to the Sixty-seventh World Health Assembly through the Executive Board on progress in the implementation of the comprehensive implementation plan together with the report on implementation of the Code of Marketing Breast-milk Substitutes and related WHA resolutions."

Dr ZWANE (Swaziland), speaking as a cosponsor of the draft resolution, thanked the Committee for its enthusiastic response and urged Member States to continue to support the Secretariat in its work.

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA65.5.

The CHAIRMAN said that, in the absence of any objections, he took it that the Committee wished to approve the draft resolution, as amended.

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

Monitoring of the achievement of the health-related Millennium Development Goals: Item 13.5 of the Agenda (Documents A65/14, A65/15 and EB130/2012/REC/1, resolution EB130.R3)

- **Progress in the achievement of the health-related Millennium Development Goals, and global health goals after 2015**

- **Implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health**

Dr LARSEN (representative of the Executive Board), introducing the item, said that the Board at its 130th session had adopted resolution EB130.R3 on monitoring of the achievement of the health-related Millennium Development Goals: implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health, which recommended a resolution for adoption by the Health Assembly.

Ms STIRØ (Norway) said that, although the Millennium Development Goals and targets had not yet been fully achieved and progress was uneven, many were on track. The United Nations Secretary-General's Global Strategy for Women's and Children's Health had given new impetus to efforts to achieve Goals 4 and 5. The Strategy had had significant mobilizing power, and more than US$ 40 billion had been committed so far. The main goal was to save 16 million lives by 2015. The need to track commitments had led to establishment of the Commission on Information and Accountability for Women's and Children's Health. The aim of the draft resolution contained in resolution EB130.R3 was to build on the recommendations in the Commission's final report for effective institutional arrangements for national and global reporting, oversight and accountability on women's and children's health. With regard to the post-2015 development agenda, the formidable task of eradicating extreme poverty, hunger and maternal and child mortality would require intensified efforts. In view of the growing epidemic of noncommunicable diseases, the focus should be on prevention and on health system strengthening. Health challenges were closely linked to food security, nutrition, energy, clean air, sanitation and safe drinking-water. The new agenda should therefore include the security aspects of development, linked to the rule of law, human rights and good governance. Changing geopolitical and economic realities that affected the political balance between countries should also be taken into account. Most importantly, the future development agenda must be clear and retain the mobilizing power of the present Goals.

Dr HUSAIN (Bahrain), noting that the draft resolution did not mention the threat posed by chronic noncommunicable diseases, said that health systems should have the capacity to provide high-quality services to everyone. The existence of a health infrastructure providing health care services at various levels had contributed towards the progress made by Bahrain in achieving the health-related Millennium Development Goals. For example, the country had seen a decrease of more than two thirds in infant mortality and rates of HIV infection and tuberculosis had fallen. The country had been free of malaria since 1988. The Millennium Development Goals could not be achieved without cooperation between governments and nongovernmental organizations. The WHO reform process

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA65.6.

should enable the Organization to face the numerous challenges and also undertake the actions required.

Dr McMILLAN (Bahamas) said that uneven progress among and within countries suggested that much remained to be done, both before and after 2015. While childhood malnutrition was not a serious problem in her country, overweight and obesity were increasingly prevalent among children. A multisectoral initiative was addressing the problem. To further progress in reducing child mortality, five new antigens would be introduced into the national immunization programme within two years. In that connection, she wished to highlight the need for urgent attention to the issue of vaccine availability for developing countries that were not eligible for support from the GAVI Alliance but did not have the means to introduce expensive new vaccines on their own.

The small island States of the Caribbean remained concerned about the method used to calculate maternal mortality ratios. A denominator of 100 000 was too large for countries with small populations and yielded ratios that were higher than the true values. Small nations were often able to report actual numbers, which might better reflect the current situation. Her Government supported the recommendations contained in document A65/14 and looked to the Secretariat and to the Regional Office for the Americas for continued support of Member States' efforts to achieve the Millennium Development Goals.

Mr SMIDT (Denmark), speaking on behalf of the European Union and its Member States, the acceding country Croatia, the candidate countries Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Iceland and Serbia, the countries of the stabilization and association process and potential candidates Albania and Bosnia Herzegovina, as well as Ukraine, the Republic of Moldova, Armenia and Georgia, said that those countries welcomed the progress made towards the health-related Millennium Development Goals and in implementing the United Nation's Secretary-General's Global Strategy for Women's and Children's Health. They were concerned, however, that many developing countries, particularly in sub-Saharan Africa, were unlikely to achieve Goals 4 and 5. Major efforts were therefore required to close the gaps in access to reproductive health services between regions and between and within countries. The Secretariat should analyse the uneven progress in order to identify the factors responsible and possible solutions. Health systems should be further strengthened and actions to prevent child and maternal mortality enhanced through, inter alia, programmes aimed at removing obstacles to women's health, including discriminatory laws and practices. Attainment of the health-related Millennium Development Goals depended on enhancing gender equality and the empowerment of women.

It was of particular concern that most young people had limited access to sexual and reproductive health programmes that provided gender-specific information, including comprehensive sexuality education, as well as contraceptives and social support. Access to treatment for sexually transmitted infections was also inadequate. He welcomed the momentum created by the Political Declaration of the United Nations High-level Meeting on HIV/AIDS in 2011 and emphasized the pressing need to eliminate mother-to-child transmission of HIV and achieve universal access to interventions for prevention and treatment of HIV infection.

A more comprehensive approach to global health goals after 2015 should be encouraged, one that emphasized the right to health, universal coverage, social protection and social determinants of health. WHO should highlight the role of health not just as a goal in itself but as an indicator of sustainable development. He urged Member States to engage in discussions before the global consultation on the health-related Millennium Development Goals with a view to establishing a coordinated, coherent review. The European Union was pleased to have been one of the cosponsors of the draft resolution contained in resolution EB130.R3 and looked forward to its adoption.

Dr NOZAKI (Japan) expressed support for the various strategies and initiatives aimed at achieving the Millennium Development Goals, including the Global Strategy for Women's and Children's Health and the 2011 Political Declaration on HIV/AIDS. He welcomed the recommendations of the Commission on Information and Accountability for Women's and Children's Health and the recently developed accountability framework. He emphasized the role of intersectoral collaboration in maximizing the effectiveness of interventions. His Government had undertaken studies of cooperation between the health, water and social security sectors in several countries and had found the intersectoral approach useful in identifying vulnerable groups requiring support. The discussions on global goals after 2015 should not adversely affect the momentum towards achieving the current Goals. There should be continuity between the new goals and current ones. He encouraged WHO to continue its leadership role after 2015.

The meeting rose at 17:30.

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