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PROVISIONAL SUMMARY RECORD OF THE FIFTH MEETING

Palais des Nations, Geneva
Friday, 25 May 2012, scheduled at 18:30

Chairman: Professor M.H. NICKNAM (Islamic Republic of Iran)

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FIFTH MEETING

Friday, 25 May 2012, at 18:45

Chairman: Professor M.H. NICKNAM (Islamic Republic of Iran)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: report of the Working Group of Member States: Item 13.13 of the Agenda (Documents A65/23 and EB130/2012/REC/1, resolution EB130.R13) (continued)

Miss PATCHAREEWAN PHUNGNIL (Thailand) welcomed the establishment of the Member State mechanism. The fight against substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products must focus on protecting public health and improving access to efficacious, quality medical products and should not be linked to intellectual property and trade issues. Increased Internet sales of medical products and false media claims were facilitating the entry of SSFFC products into the supply chain, calling for increased public awareness-raising of the issue in order to protect consumers. Effective collaboration free from conflicts of interest among stakeholders at the country, regional and global levels was required. The objectives set out in Appendix 2 of document A65/23 should be translated into action plans with a view to their implementation and strengthening of the rapid alert system against SSFFC medical products. She endorsed the draft resolution contained in resolution EB130.R13, notwithstanding the unusual request in subparagraph 6(2), urging Member States to provide financial resources rather than requesting the Director-General to mobilize such resources.

Mrs GOONERATNE (Sri Lanka) said that the availability of quality generic medicines was crucial to her Government's ability to continue providing its population with free health care. Efforts were under way to enhance national capacity for the production of medical products with a view to reducing costs and ensuring optimum use of the health care budget. It was to be hoped that the new Member State mechanism, which her Government welcomed, would contribute to national capacity-building through the transfer of technology between countries. Further Secretariat collaboration with Member States was needed to ensure that efforts to combat SSFFC products did not result in reduced availability of legitimate, affordable generic medicines and other medical products. She supported the draft resolution.

Ms SAMIYA (Maldives), expressing support for WHO's role in the prevention and control of medical products of compromised quality, safety and efficacy, noted that patents and trade agreements might hinder the availability and decrease the affordability of medicines in countries such as hers. She urged WHO to prioritize action to ensure the availability and accessibility of safe, quality and efficacious medical products in countries that had insufficient pharmaceutical manufacturing capacity or none at all. Her Government supported the establishment of a Member State mechanism, which would establish links between pharmaceutical regulatory authorities and facilitate the exchange of important information at the regional and international levels. That, in turn, would benefit import-dependent countries. As a developing country, Maldives required guidance and capacity-building support from WHO to prevent SSFFC medical products from entering the country and to ensure the availability of safe, quality products.

Mr GARCÍA DE ZÚÑIGA (Paraguay), speaking on behalf of the member countries of the Union of South American Nations, endorsed the creation of the new mechanism to tackle the issue of SSFFC medical products and asked the Secretariat to promote Member States' active participation in the mechanism. The countries of the Union were in favour of holding the first meeting of the mechanism in Argentina. Endorsing the draft resolution, he reaffirmed his Government's commitment to regional cooperation to prevent and combat SSFFC products.

Mr PIPPO (Argentina) welcomed the creation of the Member State mechanism and called on Member States to collaborate actively in it and to make every effort to secure the necessary agreements and formulate specific proposals to enable WHO to sustain its global activities aimed at combating SSFFC medical products. He reaffirmed his Government's offer to host the first meeting of the mechanism in November 2012 in Buenos Aires. His Government wished to encourage the participation of low-income countries in the meeting and, to that end, was working with the Secretariat to facilitate the attendance of technical and regulatory experts from around the world.

Mr TOSCANO VELASCO (Mexico), underscoring the importance of international action to combat the problem of SSFFC medical products, welcomed the offer by the Government of Argentina to host the first meeting of the Member State mechanism, to be preceded by a preparatory meeting in Geneva.

Ms WISEMAN (Canada) endorsing the draft resolution, said that the new mechanism would enhance coordination of national, regional and multilateral efforts to combat the issue of SSFFC medical products. Its objectives must be clearly focused on the public health elements of such products and the scope of its activities should be appropriately scaled in view of the resource constraints facing WHO. Her country appreciated the offer by the Government of Argentina to host the first formal meeting of the mechanism, in which it looked forward to participating.

Dr SEAKGOSING (Botswana) said that registration of medicines was key to evaluating and ensuring their safety, efficacy and quality. All medicines manufactured, imported or exported, distributed or sold in Botswana had to be registered. The country had limited capacity to conduct post-market surveillance and lacked a fully functional testing laboratory, which made it difficult to detect SSFFC medical products. It was therefore imperative to strengthen enforcement capacity and ensure that law enforcement agencies had the necessary technical know-how and equipment to deal with SSFFC products, especially at points of entry, as Botswana was mainly a medicine-importing country. He strongly supported the draft resolution.

Dr AGUILAR (Ecuador) said that as demand for and consumption of medicines increased throughout the world, industrial and commercial interests were seeking to relax regulatory mechanisms, which could hinder efforts to control SSFFC medical products. It was important to improve access to medicines for diseases considered to be public health issues, such as malaria, HIV/AIDS and tuberculosis, however Member States' technical and regulatory capacity must be strengthened in order to ensure the safety and quality of such medicines.

Dr OPUNI (Ghana) expressed support for the establishment of a subcommittee of the WHO Expert Committee on Specifications for Pharmaceutical Preparations to give technical advice on SSFFC medical products, and the establishment of a Member State mechanism to address the problem. He encouraged Member States to prioritize and intensify post-market surveillance activities and subregional and regional collaboration in the fight against SSFFC products. The mechanism should be established as soon as possible, and the Secretariat should be responsible for convening and coordinating its meetings.

Mr MESBAH (Algeria) said that one of the most effective means of combating SSFFC medical products was to ensure access for all, especially the most vulnerable, to safe medicines. WHO had a critical role to play in that regard. Strategies to combat SSFFC products should be shaped by the way in which such products entered the supply chain. To prevent them from entering the formal market, increased surveillance and the establishment or strengthening of quality control laboratories at country level was needed. Preventing products from permeating the informal market required cooperation among the institutions and authorities concerned at the international level, and effective intersectoral law enforcement and quality control mechanisms at the national level. As for the emerging threat posed by the availability of SSFFC products via the Internet, the experiences of countries that were already grappling with the issue should be taken into account. Algeria's national pharmaceutical quality control laboratory served as a WHO collaborating centre, and his Government stood ready to share its expertise in that area with other Member States.

Dr DAOUDA (Niger) said that his Government's medicines policy focused on providing access for all to quality essential medical products and encouraging their rational use, ensuring the quality of pharmaceutical products and developing local pharmaceutical production. The national quality assurance system was based on registration, inspection and quality control. Globalization and trade growth, however, were increasing the risk that SSFFC products would find their way onto the market, and regional and subregional cooperation efforts to combat illicit trade in such products had proved insufficient. Niger therefore supported the draft resolution, which sought to protect public health and enhance access to products that were safe, efficacious and of high quality.

Dr NORHAYATI RUSLI (Malaysia), commending the work of the Working Group on SSFFC medical products, said that her Government recognized the need to strengthen its national capacity to combat such products. In 2005, Malaysia had introduced the mandatory hologram labelling of all registered medical products in order to facilitate the identification of counterfeits. She welcomed the draft resolution.

Mr NEVES SILVA (Brazil) welcomed the Working Group's decision to recommend the establishment of a Member State mechanism and its clear definition of the goal, objectives and terms of reference of the mechanism, which would ensure that it addressed the scourge of SSFFC products from a public health perspective. His Government fully supported the establishment of the mechanism and welcomed the offer by the Government of Argentina to host its first meeting. His Government was prepared to assist in organizing the event. In order to prevent and control SSFFC products effectively, the root cause of the problem – unequal access to essential medicines – had to be tackled. Trade in falsified medicines would not thrive where quality, affordable medicines were available to the entire population.

Dr Guey-Ing DAY (Chinese Taipei) said that strategies used to combat SSFFC medical products in Chinese Taipei included monitoring the supply chain and setting up pre-market registration and post-market surveillance systems. An interagency law enforcement task force had been established and national pharmaceutical legislation had been amended to impose stricter penalties on those who manufactured or imported SSFFC products. Furthermore, a public awareness campaign had been launched to inform senior citizens of the risks associated with illicit medical products. In 2011, her Government had hosted a regional workshop at which experts and officials from Asian countries had exchanged information and shared best practices. Chinese Taipei would continue striving to combat SSFFC medical products.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, expressed strong support of WHO's role in ensuring the availability of quality, safe, efficacious and affordable medical products and urged that adequate financing be provided so that the Organization could continue to fulfil that role. Special expertise and multisectoral support were required in order to deal with emerging channels for the sale of SSFFC products, such as the Internet. He therefore recommended that the new Member State mechanism should make provision for the collaboration of civil society organizations like his own, which had such expertise.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, welcomed the proposed new mechanism. The use of fake medicines could turn a treatable condition into a fatal one and could foster drug resistance. Fake versions of both generic and branded medicines had entered the supply chain in developed as well as developing countries, a trade facilitated by the Internet. In more than 50% of cases, medicines purchased over the Internet from illegal sites had been found to be counterfeit. His organization encouraged governments and other stakeholders to develop education and public awareness-raising programmes on the potential dangers of fake medicines and on ways of purchasing medicines safely. Multistakeholder and multidisciplinary collaboration were required at the local and global levels. The Federation stood ready to share its expertise on the subject.

Mrs GROVES (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that a global, multi-stakeholder approach was essential in order to reduce the proliferation of SSFFC medical products and protect patients, especially those in the least developed countries with limited access to the necessary information to protect themselves. Her organization supported the establishment of the Member State mechanism and welcomed the inclusion among its objectives of action to strengthen regulatory capacity in developing and least developed countries, to ensure the integrity of the supply chain and to develop tools in the areas of prevention, detection and control. It was concerned, however, that the mechanism's terms of reference did not adequately provide for the participation of key stakeholders, including health professionals, regulators and patients, whose involvement was crucial to addressing the issues surrounding SSFFC products.

Ms RASMUSSEN (International Pharmaceutical Students' Federation), speaking at the invitation of the CHAIRMAN, said that innovative, simple and affordable technologies were required to detect SSFFC medical products, together with solid regulatory systems and appropriate enforcement. Methods should be developed to enable patients to verify the legitimacy of pharmacies trading via the Internet. Pharmacists should be included in the detection process. The Federation had conducted an anti-counterfeit drug campaign to educate pharmacy students, other health professionals and the wider health community. She welcomed the draft resolution which constituted a step forward in combating SSFFC medical products. Her organization would continue to support WHO's efforts to protect patients.

Ms WANIS (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, welcomed the establishment of the Member State mechanism, which was an appropriate mechanism for dealing with the problem of compromised medicines. With the establishment of the mechanism, WHO should dissociate its activities from those of the International Medical Products Anti-Counterfeiting Taskforce. She urged Member States, through the mechanism, to find solutions to the problems associated with the lack of affordable, high-quality medicines, which was one of the root causes of the proliferation of SSFFC products. The Organization should support the development of regulatory capacity at the global, regional and national levels, with particular emphasis on countries that lacked the capacity to control the quality of medicines circulating in their markets. The Organization should focus on regulation of the quality, safety and efficacy of medicines,

not on the regulation of intellectual property rights. Adequate financial resources could be ensured by increasing assessed contributions and non-earmarked funding.

Dr ETIENNE (Assistant Director-General) said that Member States clearly attached high priority to ensuring the availability of safe, quality, efficacious and affordable medical products. She welcomed the consensus reached with regard to establishing the Member State mechanism, which would be a valuable complement to WHO's existing work in relation to substandard medicines, and which also was endorsed by Member States. That work encompassed the Expert Committees, pharmacovigilance, rational use of medicines, quality and safety of medical products and regulatory capacity-building. The first meeting of the Member State mechanism had been provisionally scheduled to be held in the week beginning 19 November 2012 in Argentina. A preparatory meeting would be held in Geneva. The Member State mechanism and its associated activities would entail high costs, which could not be covered out of the current biennial budget; the Secretariat undertook to mobilize the additional funds required. The Secretariat remained committed to working with Member States in a spirit of transparency, responsiveness and accountability, using evidence-based approaches, and would focus exclusively on the public health aspects of SSFFC products.

Dr YUSUFU (Nigeria) said that resource constraints would make it difficult for representatives from the African Region to attend the first meeting of the Member State mechanism if it were held in Argentina. Since most Member States were well represented in Geneva, and since the mechanism was linked to the International Conference of Drug Regulatory Authorities, he strongly believed that the first and second meetings should be held in Geneva.

Mr CAVALERI (Argentina) said that his Government stood ready to work with the Secretariat to ensure that experts from countries with limited resources would be able to attend the meeting. Fund-raising activities were envisaged especially for that purpose. He expressed the hope that the delegate of Nigeria would thus be able to support his Government's proposal to hold the first meeting in Buenos Aires.

The CHAIRMAN said that the Secretariat would follow up on the offer by the Government of Argentina to assist in further planning of the meeting. As no amendments had been proposed, he took it that the Committee was prepared to approve the draft resolution recommended by the Executive Board in resolution EB130.R13.

The draft resolution was approved.[1]

WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies: Item 13.15 of the Agenda (Documents A65/25 and EB130/2012/REC/1, resolution EB130.R14)

Mrs HANJAM DA COSTA SOARES (representative of the Executive Board) said that the Board had considered an earlier version of the report on the item at its 130th session. Discussions had highlighted the need to support Member States in meeting needs in disaster-struck areas; strengthen local capacities to improve disaster preparedness; develop WHO's surge capacity; make better use of Member States' existing capacities and expertise and develop a mechanism for utilizing them in the event of an emergency; enhance coordination and accountability; ensure the adequacy of resources;

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA65.19.

and address the issue of health worker safety in emergencies and conflicts. The Board had adopted resolution EB130.R14, which recommended a resolution for adoption by the Health Assembly.

Mr SMIDT (Denmark), speaking on behalf of the European Union and its Member States, said that the acceding country Croatia, candidate countries Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Iceland and Serbia, the countries of the Stabilisation and Association Process and potential candidates Albania and Bosnia and Herzegovina, as well as Armenia and Georgia, aligned themselves with his statement.

WHO played a crucial role, including as global health cluster lead, in coordinating with numerous national, multilateral and nongovernmental health actors to respond to and prepare for growing humanitarian health needs in emergencies. Close cooperation under the leadership of the United Nations Office for the Coordination of Humanitarian Affairs, and with other relevant partners, was essential for strengthening the international humanitarian architecture and improving the efficiency and effectiveness of response. He therefore welcomed the Director-General's firm commitment to implement the Inter-Agency Standing Committee's humanitarian reform agenda.

WHO reform was on the right track towards improving governance, leadership and transparency in humanitarian assistance. However, some challenges remained, a key one being enhancement of the Organization's field-level response, notably in preventing and mitigating excess mortality and morbidity through effective coordination and leadership. WHO's surge capacity should be strengthened, which required pre-established arrangements between the different levels of the Organization. Sufficient numbers of qualified senior health cluster coordinators and other humanitarian experts needed to be immediately available, especially for sudden-onset emergencies. Further policy and technical guidance was required, and a means of ensuring the rapid availability of reliable epidemiological data, including in transition periods, needed to be in place. The European Union offered to support WHO in implementing its new corporate approach and emergency response framework and urged all Member States and other partners to increase the predictability and flexibility of their funding for WHO's humanitarian work in order to bridge the current funding gap.

Bangladesh, Canada, Mexico, Monaco, Republic of Moldova, Russian Federation, Switzerland and Turkey had joined as cosponsors of the resolution EB130.R14 since its adoption by the Board. Several amendments had been proposed, namely: in the fifth preambular paragraph, the words "and the guiding principles thereof" should be deleted, and "in full respect of the guiding principles therein" should be added after "by humanitarian emergencies"; a new subparagraph 1(5) should be inserted, to read: "to establish health response teams on a voluntary basis and develop a mechanism for deployment in case of humanitarian emergencies, depending on the choice of each Member State"; subparagraph 2(2) should be replaced with: "To strengthen WHO's surge capacity with global health cluster partners and Member States, including developing standby rapid-response arrangements and mechanisms to deploy and sustain response teams with appropriate resources in response to humanitarian emergencies"; and in subparagraph 2(8), the words "the International Committee of the Red Cross" in line 4 should be replaced with "other relevant actors".

Dr SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, said that the Region faced an increasing number of crises and natural disasters, causing population displacements, destruction of health facilities and disruption of services. In 2010, 69 catastrophes had occurred, affecting 9.9 million people.

Since the roll-out of the United Nations cluster approach in 2006, WHO, in collaboration with health ministries and other partners, had significantly improved health coordination and management of humanitarian response in the African Region. Strong sectoral and intersectoral collaboration at country level had improved response efficiency and increased resource mobilization, while capacity-building had empowered health ministries. WHO had also forged strategic alliances with key partners, especially among United Nations agencies and international nongovernmental organizations.

Although the approach was having a positive impact, some aspects could be improved. The multiplicity of humanitarian actors present during crises made joint planning and consensus-building a challenge. It resulted in weak inter-cluster information management; lack of a common framework for gap analysis; difficulties in working effectively with host governments owing to weak capacity and skills; and lack of meaningful participation by national and local nongovernmental organizations. Lack of cohesion and communication among donors often resulted in coordination difficulties, and low levels of funding had led to the closure of health clusters in a number of countries still afflicted by crises. Finally, the health clusters were meant to be temporary structures, yet had no defined exit strategies and no clear role in initiating transition and early recovery within the health sector.

Dr THITIKORN TOPOTHAI (Thailand) thanked the Secretariat and fellow Member States for their humanitarian support during the severe flood in his country in 2011. He welcomed the WHO emergency response framework, which would serve as a common operational platform for the Organization's work. However, there was an urgent need to define the term "humanitarian emergencies" and the scope of WHO's role and response in such situations. Greater clarity was needed concerning the roles and responsibilities of the new Department of Emergency Risk Management and Humanitarian Response and its relationship with other internal departments and with external agencies. It was critical to ensure the timeliness of support. Rapid response was a core principle of the South-East Asia Regional Health Emergency Fund, which Thailand had helped to establish. The Fund's experience had demonstrated the importance of effective management, sustainability and a demand-driven approach.

Mr PRASAD (India) expressed appreciation of WHO's role, as health cluster lead, in meeting growing health demands in humanitarian emergencies and welcomed the proposed emergency response framework, which would strengthen the Secretariat's internal capacity for a sustained response to protracted emergencies. The proposed assessment of local capacities to support the framework would not only give WHO the opportunity to judge the level of intervention required but could also help regional or inter-country support systems to mount an effective response. WHO's response to emergencies should reflect the need to increase community resilience and should incorporate a primary health care approach.

In the present economic climate, it was heartening to learn that WHO had managed to double the funding received through the Consolidated Appeal Process from 2006 to 2010. The Regional Emergency Response Fund might be further strengthened by establishing clear norms and procedures for equitable assessment, transfer and disbursement to support timely response. He endorsed the draft resolution with the amendments proposed by the delegate of Denmark, but would like to know the precise meaning of "surge capacity".

Mr SMIDT (Denmark), speaking on behalf of the European Union, said that it was his understanding that "surge capacity" meant the capacity to swiftly deploy experienced and coordinated experts in an emergency.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland) said that he welcomed WHO's support of the Inter-Agency Standing Committee's transformative agenda and the new emergency response framework. The Organization should promptly establish the capacity it would need to fulfil its leadership role in health emergencies, particularly at country level. It was urgent to take steps to strengthen WHO's surge capacity. Recent experience in health emergencies, particularly in the Horn of Africa and Somalia, underlined the need for the reforms identified in the report contained in document A65/25 and envisaged under the emergency response framework. The draft resolution outlined some of the mechanisms that would enable the Secretariat to establish stronger accountability mechanisms for the health cluster at all three levels. The suggested year-end review of the new corporate approach to humanitarian response should be as broad as possible in its scope.

Strongly condemning all attacks on humanitarian workers, he welcomed WHO's efforts to develop methods for systematic collection and dissemination of data on attacks on health facilities, health workers and patients in emergencies, in coordination with other relevant bodies, including the International Committee of the Red Cross.

Dr SHOHANI (Iraq), emphasizing the importance of WHO's technical role and of the sharing of expertise between WHO regions, said that steps should be taken to put in place a common work strategy in which all regions could participate, engage with the international community and create an interregional fund for promoting the common work strategy. It was important to prioritize action in humanitarian emergencies and to ensure that strategies were results-based to allow for performance assessments and also to contribute to the development of the countries concerned.

Mr KAZI (Bangladesh) said that his country had experienced first-hand the benefits of the health cluster approach in recent humanitarian emergencies and that the health cluster had also been helpful in assessing Bangladesh's health sector preparedness in normal times. The emergency response framework should enable WHO to deliver an effective, speedy and predictable response to humanitarian and public health emergencies. Its efficacy, however, would depend on increased investment in resources and trained personnel. His delegation requested that the Secretariat consult Member States with respect to the two processes to be undertaken in 2012 – development of a corporate approach to humanitarian emergencies and of a comprehensive work programme for emergency risk management – and report to the Sixty-sixth World Health Assembly through the Executive Board on their progress and outcomes. He would also like regular updates on progress made and challenges encountered in streamlining WHO's emergency humanitarian response through the new Department of Emergency Risk Management and Humanitarian Response.

Dr HAO Yang (China) conveyed China's appreciation of WHO's support following two major earthquakes in recent years, which had killed and injured many people. His Government had taken a number of actions in response to those events and had carefully analysed the lessons learnt in order to prepare for and mitigate the effects of future disasters. To enhance its response and role in meeting growing health-related demands in humanitarian emergencies, the Organization should strengthen reserves of medical supplies and step up capacity-building efforts in emergency-affected regions, including strengthening the capacity of health ministries to provide technical advice, public information, and communicable disease surveillance and control. WHO should evaluate countries' emergency response capacity and make recommendations for improvement, and should continue to promote the construction of disaster-resilient hospitals. The Organization should convene an annual meeting for health ministries to share their emergency response experiences.

Mr BLAIS (Canada) expressed strong support for the efforts of the Inter-Agency Standing Committee to strengthen overall humanitarian response through improved coordination, leadership, accountability, preparedness and advocacy. He welcomed the creation of the Emergency Risk Management and Humanitarian Response Department and encouraged WHO, as the lead agency of the health cluster, to continue providing strong support for leadership and coordination efforts in the health sector at both global and country levels, and to work with relevant health actors, including the International Red Cross and Red Crescent Movement and nongovernmental organizations.

Mr KOLKER (United States of America) said that his Government strongly supported the Organization's efforts to improve its response to humanitarian emergencies. At a time of change within the Organization, the draft resolution was a timely reaffirmation of the commitment of the Secretariat and Member States to meeting health needs in humanitarian emergencies. He urged the Secretariat to further hone its role as the health cluster lead and to clearly define and harmonize its role and that of the regional and country offices vis-à-vis partners. His Government supported the

resolution and particularly appreciated its inclusion of the issue of health worker safety. WHO, in cooperation with partners and governments, had an important role to play in ensuring that health care providers could work in safety and in documenting threats to and violations of their security.

Ms SANDHU (Australia), welcoming WHO's efforts to better fulfil its health cluster lead role and its commitment to work with the United Nations Office for the Coordination of Humanitarian Affairs on system-wide reform of humanitarian activities, said that she supported the draft resolution. She particularly welcomed efforts to boost the capacity of country offices and urged the Secretariat to move quickly to implement that aspect of the emergency response framework. The Secretariat should remain focused on the twin objectives of supporting emergency response and empowering countries and regions through capacity-building. Progress in implementing the framework should be measured against performance benchmarks.

Dr NORHAYATI RUSLI (Malaysia) congratulated the Secretariat on its strong leadership and persistence in building consensus on health priorities, policies and best practices in humanitarian emergencies and in strengthening the capacity of all health sector stakeholders to deliver effective and predictable responses in humanitarian emergencies. She endorsed the draft resolution, particularly its emphasis on strengthening national-level risk management, health emergency preparedness and contingency planning processes, and disaster management units in health ministries. Lessons could be drawn from the experience of nongovernmental organizations in responding to humanitarian emergencies, especially the use of local resources and capacities. It was important to encourage active participation by the local community in response activities and to respect local customs and culture. Further efforts should be made to reduce vulnerability to public health emergencies.

Mr THOMSON (Switzerland), noting that his country had a long tradition of working to ensure respect for international humanitarian law, said that he fully supported the draft resolution. Although WHO had limited operational capacity, it must carry out its role in leading and providing technical support to the health cluster. Recruitment and deployment of health cluster coordinators, technical experts and support teams would be key to fulfilling that role, as would mobilizing the necessary financial resources. He drew attention to WHO's duty to protect humanitarian response personnel, including its own staff, in line with international humanitarian law.

Dr SIMSEK (Turkey) expressed appreciation for the Organization's decisive role as the health cluster lead in humanitarian emergencies. The Organization's surge capacity could be strengthened by putting in place a mechanism to ensure rapid mobilization of global health cluster partners and Member States in humanitarian emergencies. National capacities and expertise should be identified and security issues, such as the system for issuing visas, should be resolved in advance in order to ensure a rapid, effective response. A shift system should be implemented for field staff in order to ensure the continuity of response operations. Education and training programmes should be provided at the country level in order to strengthen capacity; such programmes should be administered and coordinated by an office set up specifically to deal with issues relating to the health sector response in humanitarian emergencies. His Government stood ready to collaborate with Member States in the event of humanitarian emergencies. It had considerable experience in managing disaster and emergency response operations and could play a leading role in training and research related to disaster risk reduction. he supported the draft resolution with the amendments proposed by the delegate of Denmark.

Mr BEN AMMAR (Tunisia) said that in 2010 his Government had grappled with a range of humanitarian emergency situations as a result of the influx of some one million refugees from Libya and natural disasters in the north of the country. It had been able to provide an effective response to those emergencies with technical support from WHO. The capacity of the national health ministry had been strengthened as a result, in particular its capacity to deal with large numbers of refugees. A national strategic centre had been established in 2010 to deal with health needs in humanitarian disasters. He encouraged WHO to continue its capacity-building efforts and to promote knowledge-sharing activities in order to strengthen national capacity.

Dr YEHYA ELABASSI (Sudan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Region had endured numerous natural and man-made disasters and therefore had considerable experience of WHO-supported humanitarian response. Despite the efforts of bilateral and multilateral partners, the response provided had fallen short of what had been needed, particularly in terms of funding and technical preparedness. The Secretariat and Member States needed to make additional efforts and strategic investments that took into account community involvement, which was crucial to an effective response. Member States should share experience with one another. WHO needed support to be prepared financially, technically and culturally to lead and coordinate response.

Dr Tsung-Hsi WANG (Chinese Taipei) said that in the wake of a devastating earthquake in 1999, Chinese Taipei had set up disaster medical assistance teams, which could perform triage, on-site first aid, emergency resuscitation, field medicine and outbreak monitoring in a disaster area. It had also established an international health action team, which participated in international emergency relief efforts. In addition, many nongovernmental organizations from Chinese Taipei provided humanitarian medical assistance in other regions and countries.

Mr RUBENSTEIN (The World Medical Association, Inc), speaking at the invitation of the CHAIRMAN on behalf of the World Health Professions Alliance, said that health workers were on the front line during conflicts and other humanitarian emergencies and deserved protection. In crises, health workers were at high risk of assault, arrest, obstruction of their duties, kidnapping and even death. Health facilities and ambulances were also at risk of attack. Information was the foundation for protection and prevention of attacks on health workers. WHO had a unique role to play in collecting and disseminating data on such attacks, as described in subparagraph 2(8) of the draft resolution. Adoption of the resolution by the Health Assembly would be an affirmation of Member States' commitment to safeguard health workers, facilities and patients.

Mr LUCHESI (World Vision International), speaking at the invitation of the CHAIRMAN, said that his organization had a long history of responding to major emergencies and was a partner of the global health cluster. WHO's role in leading the health cluster and in providing technical support before and during crises was increasingly important as disasters became more frequent and the number of people affected by humanitarian emergencies increased. WHO played an important role in gathering and disseminating information and in monitoring, which enabled an effective, efficient and targeted humanitarian response and helped in the protection of health workers. Building resilient communities with local capacities to respond to disasters was crucial. The central principles of national ownership and accountability should be strengthened through investment in human resources and technologies in areas at risk of disasters. The draft resolution represented an opportunity to build stronger accountability mechanisms at all levels, ensuring that emergency actors were compliant with the highest standards of practice. World Vision International encouraged Member States to approve the resolution and to fully fund the reforms it outlined, which would require significant investment.

Dr AYLWARD (Assistant Director-General), thanking delegates for their expressions of support for WHO's humanitarian response work, said that the preceding 12 months had seen major structural reform of the Organization's policies and approaches in relation to emergencies, with the aim of improving the predictability, effectiveness and speed of response. Those changes had been fully in line with the reforms and recommendations of the Inter-Agency Standing Committee's transformative agenda and had focused on improving leadership, coordination and accountability. The process had also been in line with the WHO reform goals and principles, with special emphasis on improving country outcomes and cross-organizational coherence. He agreed that there was a lack of clarity in the area of cluster transitions and exit strategies. Addressing that issue was a major part of the Inter-Agency Standing Committee's reform agenda, which was being reviewed by the global health cluster partners. A number of suggestions had been made as to how the emergency response framework could be improved, and he assured Member States that all guidance received would be taken fully on board.

WHO had been working closely with the Emergency Relief Coordinator on reforms aimed at increasing accountability. The emergency response framework laid out specific commitments and benchmarks; recording and reporting performance transparently would be a key part of the reform process. A number of delegates had made suggestions in relation to broadening the year-end review and expanding participation in it. He would welcome specific proposals in that regard.

Ensuring that WHO had adequate surge capacity was one of his greatest concerns. To that end, a four-pronged approach had been adopted, which included repurposing country offices, which were the front line for any response; improving the Secretariat's internal surge capacity, both within the new Emergency Risk Management Department and in regional offices; cooperation with global health cluster partners to combine surge capacities; and a new standby arrangements policy that would enable much faster and more effective deployment. Performance in emergency response ultimately depended on a good state of readiness and preparedness. With the new emergency response framework in place, the target for 2012 was to develop a companion framework for emergency risk management that clearly laid out roles, commitments and mechanisms for enhancing readiness and preparedness.

He wished to assure Member States that the Secretariat was moving quickly to implement the reform measures and build capacities. New leadership of the Emergency Risk Management Department was in place, and a major cross-organizational simulation had been held in April 2012, involving all levels of WHO. That exercise had confirmed the soundness of the new response framework and pointed up areas where improvement was needed. The Secretariat was dealing with those areas. The framework had also been tested practically by the situations in the Syrian Arab Republic and in the Sahel, and those experiences had yielded valuable lessons. While the Secretariat could accelerate the implementation of the reforms needed to fulfil its role as a global health cluster lead, it would require greater funding in order to do so. Thanking Member States for the support received thus far, he appealed for their continued support as the Secretariat worked to make the emergency risk framework fully operational and developed the emergency risk management framework.

The CHAIRMAN said that, in the absence of any objection, he took it that the Committee wished to approve the draft resolution contained in resolution EB130.R14, as amended.

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

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA65.20.

Elimination of schistosomiasis: Item 13.11 of the Agenda (Documents A65/21 and EB130/2012/REC/1, resolution EB130.R9)

Mrs HANJAM DA COSTA SOARES (representative of the Executive Board) said that, at its 130th session in January 2012, the Executive Board had considered a report on the elimination of schistosomiasis and had adopted resolution EB130.R9, in which it recommended a draft resolution for adoption by the Health Assembly. The draft resolution incorporated several amendments proposed by Member States reflecting the view that the call for elimination of the disease in some countries was premature and that control interventions, including sanitation and hygiene education, should be strengthened, and elimination activities launched only where appropriate. The Board had agreed that progress should be reported every three years.

Dr EL MENZHI (Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed WHO's continued support for activities aimed at controlling and eliminating schistosomiasis, which remained a serious public health concern in the Region. Many countries, including his own, had launched programmes to eliminate schistosomiasis and had made significant headway. The implementation of a well-defined procedure for certifying the interruption of transmission would encourage the countries concerned to redouble their efforts to prevent and control the disease. The draft resolution could provide a useful basis for the discussion of mechanisms and procedures for the elimination of schistosomiasis, a goal which he considered feasible. It could be strengthened, however, through the addition of two new subparagraphs under paragraph 3, to read: "to elaborate a procedure to evaluate the interruption of transmission in the countries concerned with a view to certifying that transmission has been eliminated in these countries" and "during the post-elimination phase, to support countries that have been certified free of schistosomiasis to pursue preventive actions designed to avoid the reintroduction of transmission of the disease".

Dr SUPATRA CHADBUNCHACHAI (Thailand), noting that schistosomiasis remained a significant public health problem, although it was largely preventable, said that her delegation supported the draft resolution. Many countries lacked the technical capacity to develop effective surveillance programmes that dealt not only with the risks to human health but also the environmental aspects of the disease; the Organization should support countries in enhancing that capacity. Both natural and human-made environmental changes could affect the transmission of schistosomiasis. Thailand carried out sentinel surveillance activities every three years in high-risk areas and was investigating the contamination risks posed by a variety of animals, including dogs. A comprehensive impact assessment should be carried out prior to the commencement of any project that could have a detrimental effect on health and well-being, and mechanisms should be strengthened to ensure that the evidence provided by such assessments were communicated to all relevant sectors and policy-makers.

Dr DIAKHABY (Guinea), speaking on behalf of the Member States of the African Region, said that schistosomiasis remained a serious problem in sub-Saharan Africa, which accounted for 90% of all schistosomiasis cases in the world. Significant progress had been made, however, in controlling the disease; several African countries had substantially lowered transmission levels and some had reported no new autochthonous cases in recent years. The interruption of transmission thus appeared feasible. To that end, interventions should be strengthened in countries with high endemicity and the availability of praziquantel ensured. The Member States of the African Region considered that the goal of elimination as envisaged in the draft resolution could be achieved in some epidemiological settings, provided that there was strong political commitment, adequate supplies of antihelminthic medicines, and support for hygiene, sanitation and water supply measures by Member States. She endorsed the draft resolution.

Dr DECOCK (United States of America) said that while the goals set out in resolution WHA54.19 had not been fully achieved, commendable progress had been made towards control and elimination of schistosomiasis. While noting the advances made to increase the availability of praziquantel, including the ongoing efforts of private-sector pharmaceutical partners, he stressed the need for Member States and the international community to focus on ensuring the medicine's availability and to employ a multisectoral approach to schistosomiasis control programmes, including post-treatment surveillance. He supported the draft resolution.

Mr NEVES SILVA (Brazil) observed that there was a clear and direct link between schistosomiasis and social determinants of health, as evidenced by its concentration in poor areas with deficient sanitation. His country was committed to eliminating schistosomiasis and other neglected diseases and strongly endorsed the draft resolution. He suggested that the topic of neglected diseases should be discussed during the Sixty-sixth World Health Assembly with a view to strengthening action and adopting a coordinated approach to the control and elimination of such diseases, with due attention to their relationship with poverty and other social determinants of health. A coordinated approach and the efforts and commitment of all Member States were essential if schistosomiasis was to be eliminated.

Dr SAKAMOTO (Japan) said that adoption of the draft resolution would send a message highlighting the importance of increasing access to medicines for schistosomiasis and provide an impetus for the development of guidelines and policy measures in respect of the disease. Comprehensive measures, including vector control and health system strengthening, were needed to eliminate schistosomiasis and other neglected tropical diseases. Insufficient progress had been made in developing medicines to combat such diseases, and public–private partnerships for that purpose should be encouraged.

Dr YU Jingjin (China) said that of the 12 provinces in his country that had been endemic for schistosomiasis, five had eliminated the disease and the remaining seven had set control targets. His Government had implemented a plan to control schistosomiasis nationwide by 2015. Its cross-cutting approach focused on four areas: health, agriculture, irrigation and forestry. China would continue to cooperate with WHO and other international partners to achieve the elimination of schistosomiasis. He supported the draft resolution.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the pharmaceutical industry, which had long been engaged in the fight against neglected tropical diseases, had recently pledged 14 billion treatments annually until 2020 to control or eliminate nine major diseases responsible for 90% of the overall burden of neglected diseases. One company had increased its annual donation of praziquantel from 20 million to 250 million tablets. He acknowledged, however, that much larger quantities of praziquantel would be required over the coming decade in order to eliminate schistosomiasis. An essential prerequisite for increasing supplies of the medicine was ensuring the availability, in sufficient quality and quantity, of the active ingredient. In addition, appropriate dosage forms for very young children were needed. The targets set by WHO were clear and could be achieved through a concerted and dedicated multistakeholder approach.

Dr NAKATANI (Assistant Director-General) said that he had taken careful note of all comments and suggestions made. He welcomed the proposals by the delegate of Morocco regarding procedures for certification of the interruption of transmission and support for schistosomiasis-free countries to prevent reintroduction of the disease. With respect to the suggestion by the delegate of Brazil regarding the inclusion of neglected tropical diseases in the agenda of the Sixty-sixth World Health Assembly, he noted that the subject had been discussed at a technical briefing held earlier in

the week and suggested that Member States should confer among themselves in order to advise the Secretariat on the approach they wished to take to the topic.

Dr ONDARI (Secretary) said that the amendments to the draft resolution proposed by the delegate of Morocco would become subparagraphs 3(4) and 3(5) and the existing subparagraph 3(4) would become paragraph 3(6).

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

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

The meeting rose at 21:35.

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[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA65.21.