

**PROVISIONAL SUMMARY RECORD OF THE NINTH MEETING**

**Palais des Nations, Geneva  
Friday, 24 May 2013, scheduled at 14:30**

**Chairman: Dr Walter T. GWENIGALE (Liberia)  
later: Dr Lester ROSS (Solomon Islands)  
later: Dr Walter T. GWENIGALE (Liberia)**

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**COMMITTEE A**

**NINTH MEETING**

**Friday, 24 May 2013, at 14:36**

**Chairman:** Dr W.T. GWENIGALE (Liberia)

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

**Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits:** Item 15.2 of the Agenda (Documents A66/17 and A66/17 Add.1) (continued)

Dr EL TAHER (Egypt) said that, ever since the outbreak of avian influenza A(H5N1), Egypt had devoted great attention to combating influenza, which had been monitored under the national disease surveillance system until the development of a specialized surveillance system for monitoring severe acute respiratory infections and influenza-like illnesses. Activities to prepare the entire health system and the public for dealing with potential epidemics had greatly contributed to the creation of health security in Egypt, which constantly reviewed and updated its influenza preparedness plans on the basis of new information provided by WHO. Full and effective implementation of the Pandemic Influenza Preparedness (PIP) Framework was vital, and support was essential for laboratory and disease surveillance systems. Technology for influenza vaccine manufacture must be transferred to as many countries as possible, and vaccines must also be fairly distributed among countries and individuals.

Dr KAMALIAH MOHAMAD NOH (Malaysia) endorsed the recommendations made by the Pandemic Influenza Preparedness Framework Advisory Group and recognized that strengthening the Global Influenza Surveillance and Response System (GISRS) through new or enhanced laboratory capacity at country level was essential for robust pandemic preparedness and response. She drew attention to the urgent need for WHO to conclude Standard Material Transfer Agreement 2s (SMTA 2s) with non-GISRS recipients of pandemic influenza preparedness biologicals and urged greater transparency in the Organization's discussions with vaccine, diagnostic and pharmaceutical manufacturers. She supported the Advisory Group's recommendation that WHO should establish a system for tracking the distribution and use of Partnership Contribution resources, in order to ensure equitable benefit-sharing with regard to the use of viruses, and that it should establish criteria for selecting countries eligible for Partnership Contribution funds.

Dr ABDULLA (Maldives) congratulated WHO and all those who had been involved in the swift response to the influenza A(H7N9) outbreak in China. The Government of Maldives was committed to maintaining an outbreak preparedness and response capability; however, the country lacked the capacity to produce influenza vaccines, diagnostics or pharmaceuticals and was heavily dependent on support from WHO and producing countries. Currently, the high cost of vaccines meant that immunization was restricted to meeting travel requirements, and timely availability of vaccines could not be guaranteed. Technical support would be needed in order to fulfil the country's plan to establish a national influenza centre and build capacity for influenza surveillance and response. Maldives also needed support in conducting disease burden studies, so as to extend provision of vaccines to high-risk groups, and in procuring and deploying vaccines in a timely manner. Regular

training was also imperative for maintaining pandemic preparedness and response. She urged WHO to accelerate completion of the SMTA 2s.

Dr MELNIKOVA (Russian Federation) said that the outbreak of pandemic influenza (H1N1) 2009 and the recent cases of influenza A(H7N9) had confirmed the importance of the PIP Framework, and the Committee had the opportunity to decide on the measures that should be taken to improve it. In that regard, she supported the strengthening of laboratory capacity and epidemiological surveillance and the establishment of an H5N1 vaccine stockpile, as well as the measures taken to make rational use of the Partnership Contribution. Technical support should continue to be provided to developing countries, including vaccine production technology transfers. She welcomed the satisfactory progress in the negotiations with representatives of the pharmaceutical industry on the first SMTA 2s, which should lead to the establishment of transparent criteria governing their participation in the Partnership Contribution scheme. She urged all Member States to take note of WHO's work in reviewing the preparedness and response guidance in the light of the lessons learnt from the previous pandemic and in the preparation of practical guidance, for national influenza centres, on epidemiological surveillance and the effectiveness of antiviral agents. She commended China's cooperation in passing on information on the outbreak of influenza A(H7N9) and in delivering the virus to the State Research Centre for Virology and Biotechnology in the Russian Federation for research purposes.

Mr OVIEDO (Costa Rica) emphasized the importance of technology transfer among Member States as a means of sharing experience and resources. He suggested that the report should refer to the actions that had been taken in connection with the emergence of the influenza A(H7N9) virus. He would also welcome a further report on any agreements that had been reached with the industry, with particular emphasis on the status of structures for virus surveillance and information transfer mechanisms.

Dr ABDULRAHIM (Bahrain) said that there was a need to ensure that countries could have rapid access to vaccines and other materials, and also clearly to identify the biological materials that would be needed to combat the virus. The Secretariat must maintain its efforts to support developing countries and help to strengthen their capacity. It was also important to ensure technology transfer from the vaccine-manufacturing pharmaceutical companies, so that equitable access to vaccines could be guaranteed all around the world. She welcomed the progress made in implementation of the PIP Framework. There had been excellent cooperation on sharing of viruses, but countries also needed to exchange scientific knowledge that would contribute to the manufacture of vaccines.

Dr RUÍZ MATUS (Mexico) said that Mexico would be willing to share circulating strains or samples of other influenza virus subtypes with pandemic potential, once the necessary capacity to use the electronic virus traceability mechanism was in place. In return, Mexico sought equitable access to vaccines and antiviral agents for use in an influenza epidemic or pandemic. It was important for WHO to conclude negotiations on SMTA 2s with non-GISRS institutions.

Dr LEI Zhenglong (China) expressed appreciation of the important role played by the PIP Framework in the prevention and control of influenza and the outstanding efforts of WHO in facilitating the establishment of a transparent and equitable framework. The Chinese health authorities were playing an active role in coordinating the establishment of communication channels between vaccine manufacturers and WHO. They were also exploring the necessary steps for participation of Chinese manufacturers in the PIP Framework and providing support for the signing of SMTA 2s. After the outbreak of human cases of influenza A(H7N9) in April 2013, China for the first time had shared the isolated human strain of H7N9 with reference laboratories and WHO collaborating centres. The Chinese authorities would continue to support global influenza surveillance activities, share viruses and related benefits and contribute to international vaccine reserves. It was rigorous in

controlling outbreaks within the country. He urged WHO to find out about the overall situation of global vaccine manufacturers, in order to formulate more detailed and operable rules for the implementation of the Framework.

Mr KLEIMAN (Brazil) said that the approach outlined by the Advisory Group would ensure transparency, the sharing of information and samples, and access to benefits. He encouraged the Secretariat to explore with Member States the possibilities of using the principles of the PIP Framework to tackle other public health emergencies, such as the emergence of the novel coronavirus. He recognized the importance of the signing of the first SMTA 2 and the need for further agreements. He also acknowledged the payment of the Partnership Contribution by a section of the vaccine industry, highlighting the need to identify the beneficiaries of such contributions in a transparent manner and to determine the proportions of funds to be provided by each contributor, so that the process could be completed in 2013. Implementation of the Framework would contribute to the formulation of principles for WHO's engagement with the private sector and nongovernmental organizations in the context of WHO reform.

Dr TRIONO SOENDORO (Indonesia) requested the Secretariat to expedite the formulation of technical guidance in full compliance with the terms of reference of GISRS. Indonesia had worked with a WHO collaborating centre on the implementation of a Standard Material Transfer Agreement 1 (SMTA 1), which had resulted in the characterization of the Indonesian virus as one of the candidate influenza vaccines. He welcomed the signing of the first SMTA 2 in December 2012 with one of the three largest manufacturers of influenza vaccines and looked forward to the conclusion of similar agreements. In that connection, he requested that the benefit-sharing mechanism should be established in a timely manner and Member States informed of the procedures.

Mr THOMSON (Switzerland) welcomed the progress made on the SMTA 2 and strongly supported implementation of the PIP Framework, which would serve not only to increase global health security but also to foster international solidarity during pandemics, as well as increase equitable access to vaccines. It also illustrated the growing role of public/private sector partnerships in resolving health problems.

Dr Jen-Hsiang CHUANG (Chinese Taipei) described the steps being taken in the areas of vaccine production and immunization programmes. On 24 April 2013, Chinese Taipei had confirmed the first human case of influenza A(H7N9); the health authorities continued to exercise all precautions in order to control avian-to-human transmission. He appreciated the action of the WHO collaborating centre in Beijing for sharing the H7N9 virus.

Dr FUKUDA (Assistant Director-General) said that the comments of delegates attested to the importance attached to the PIP Framework and the need to accelerate its implementation. A number of delegates had called for transparency in terms of benefit provision and related activities.

In reply to the delegate of the United States of America, he affirmed that every effort would be made to bring about cooperative working in areas of potential overlap between the PIP Framework and other frameworks, in particular, the Global Action Plan for Influenza Vaccines and the International Health Regulations (2005). He clarified that the funding for capacity-building to which WHO had access through the PIP Framework was the Partnership Contribution, the largest percentage of which, namely 70%, was for laboratory capacity and surveillance. The Partnership Contribution would be subject to scrutiny by Member States, civil society and the pharmaceutical companies that had contributed, in order to ensure transparency in how the funds were distributed, as well as outputs and deliverables. WHO would examine the process for transparency, and the results of its work would be presented in a report. Turning to the comments made by the delegate of Paraguay, he drew attention

to the shipping fund that allowed countries to send specimens to a WHO collaborating centre free of charge. WHO also provided specific training in the packaging of specimens.

In reply to the delegate of Australia, he clarified that two SMTA 2s had been completed and five other negotiating processes were in progress. Replying to the delegate of Japan, he said that following the influenza A(H1N1) 2009 pandemic, work had begun on revising the guidance on pandemic preparedness, including pandemic phases and severity scale, with input from the Review Committee on the Functioning of the International Health Regulations (2005), as well as national experts. He hoped that the interim guidance would soon be available and requested feedback from Member States for inclusion in the final version of the guidance.

He had noted that some delegates had expressed their very helpful agreement with the recommendation of the Pandemic Influenza Preparedness Framework Advisory Group that up to 10% of the funds over a four-year period could be used to support the Secretariat.

He assured the delegate of Maldives that WHO would provide support for the development of a national influenza centre, as it had with a number of other countries. Replying to the delegate of Indonesia regarding benefit-sharing and the nature of the agreements being made with the commercial entities, he noted that one company had agreed to donate 7.5% of its vaccine production in real time to WHO in the event of a pandemic; to provide an additional 2.5% of its production at affordable prices; to donate 2 million doses of antiviral medicines to WHO; and to make 8 million courses available to WHO at affordable prices.

#### **The Committee noted the report.**

**Poliomyelitis: intensification of the global eradication initiative:** Item 15.3 of the Agenda (Document A66/18)

Ms LANTERI (Monaco), speaking on behalf of the Member States of the European Region, commended the report for accurately reflecting the comments made at the previous session of the Executive Board. Noting the ambitious nature of the polio eradication and endgame strategic plan 2013–2018, she called for it to be independently reviewed each year and for information to be supplied on how that would be carried out.

She firmly condemned the violence perpetrated against health workers, which deprived children of vaccination and could compromise earlier achievements. Expressing profound sympathy to the families of those workers, she called on the Member States concerned to ensure a safe environment as a matter of urgency, so that optimal immunization coverage could be achieved. With regard to legacy planning, she strongly supported the three main goals, in particular the integration of poliomyelitis-related work into existing public health programmes. However, financing the programme remained a concern: unless the necessary human and financial resources were made available, earlier achievements might be compromised. In that regard, she welcomed the commitments made at the Global Vaccine Summit (held in Abu Dhabi, United Arab Emirates on 24 and 25 April 2013), amounting to US\$ 4000 million of the US\$ 5500 million needed.

Dr MUHAMMAD (Nigeria) expressed appreciation for the global solidarity shown during and after the killing of the health workers. Security remained a concern, but the Government of Nigeria was determined not to allow the incident to derail the vaccination programme. He expressed his condolences to the families of health workers elsewhere who had also lost their lives.

Nigeria continued to make progress in eradicating poliomyelitis as a result of political commitment, the establishment of national and state emergency centres, improved financial resources and additional funding pledged during the Global Vaccine Summit. There had been a 67% reduction in the number of wild poliovirus cases in Nigeria compared to 2012, and a reduction in the number of children missed during each vaccination round testified to an improvement in the quality of the campaigns. Special scaling-up strategies were being implemented, especially in the north-east of the

country; they included the use of teams to carry out vaccination at international borders, airports and other locations frequented by transient populations; supplementary immunization activities synchronized with neighbouring countries; and intensification of routine immunization and acute flaccid paralysis surveillance in poliomyelitis-free States, in preparation for the endgame.

Dr MASHAL (Afghanistan) described some of the efforts being carried out in Afghanistan to complete poliovirus eradication. So far in 2013, only two cases of poliomyelitis had been confirmed and no poliovirus had been identified in the south of the country, which had been a key reservoir. Nevertheless, access to children in unsafe areas was difficult, and a new epidemiological situation had arisen in the east of the country. He commended the polio eradication endgame strategic plan 2013–2018, in particular the emphasis it placed on routine immunization. Ensuring the availability of affordable inactivated poliovirus vaccine would help in extending coverage among target populations.

Dr NISHTAR (Pakistan) said that there had been a more than 65% reduction in cases of poliomyelitis in Pakistan between 2011 and 2012. Thus far in 2013, there had been 50% fewer cases than in the corresponding period in 2012. Those advances had taken place despite disruption caused by natural disasters and insecurity, which had resulted in the killing of Pakistani health workers by terrorists. To build on the achievements to date, a number of measures had been taken, including establishing a monitoring system and vaccination points in locations extensively used by people in transit, ensuring that children were vaccinated inside all international airport departure lounges, and putting border coordination mechanisms in place for synchronized immunization activities. The Government had drawn up a national emergency action plan following a broad consultative process. It had also created channels of accountability, in order to secure performance and delivery, and routine immunization would be further strengthened. The media would be fully involved in efforts to counter negative propaganda, and civil society would be mobilized in an attempt to overcome parental opposition to vaccination. She paid tribute to the bravery of the health workers who continued to carry out their work despite the danger, adding that the Government was working with law enforcement agencies to ensure security for the large numbers of health workers involved in immunization days. Efforts were also being made to engage the support of religious scholars so that the importance of poliomyelitis eradication and the right of children to health care was made known at grass roots level.

Dr AL-TAAE (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed support for the polio eradication and endgame strategic plan 2013–2018 and highlighted the importance of tracing other potential areas at risk of an outbreak, following the recent discovery of a case in Somalia. Iraq was participating in international efforts to combat any obstacles to poliomyelitis eradication and was working to increase routine immunization and surveillance of acute flaccid paralysis. Noting that further efforts were being carried out with Afghanistan, Iran, Pakistan and WHO to enhance all poliomyelitis eradication activities, he called on stakeholders to continue to support such initiatives, in particular in countries with re-established transmission.

Professor BAGGOLEY (Australia) commended the progress made so far against poliomyelitis and expressed support for intensification of efforts to reach the eradication goal. He also commended the emergency actions being taken by the Governments of Afghanistan, Nigeria and Pakistan to avert risks to health workers, as well as the efforts of international partners, particularly UNICEF, to reach the least accessible children and to train health workers in service delivery.

Ms REITENBACH (Germany) said that at the Global Vaccine Summit Germany had contributed a significant amount towards the more than US\$ 4000 million that had been pledged in support of the Global Polio Eradication Initiative. However, it still remained to interrupt transmission in poliomyelitis-affected countries before the end of 2014 and to maintain the gains made thus far. Serious consideration should be given to vaccinating all travellers from poliomyelitis-affected

countries. In order to ensure the sustainability of the Initiative, the medium-term goal should be to move from poliomyelitis vaccination campaigns to routine immunization.

She expressed support for WHO's efforts, following the tragic incidents in December 2012 and February 2013, to reinforce the safety of health workers and said that Germany would pledge an additional €5 million over and above the €100 million already committed, to be used for relevant measures.

MR ÁLVAREZ LUCAS (Mexico) said that his country agreed that the eradication of poliomyelitis was a worldwide health priority. For as long as the disease existed anywhere in the world, for as long as there was a risk of imported cases, it was necessary to maintain and even step up immunization.

Dr USHIO (Japan), commending both the Global Polio Emergency Action Plan 2012–2013 and the polio eradication and endgame strategic plan 2013–2018, said that effective implementation would be needed and progress should be regularly monitored and evaluated by an independent evaluation committee. With regard to the transition to bivalent oral poliovirus vaccine and the introduction of inactivated poliovirus vaccine, adequate steps, including risk assessment, must be taken to avoid confusion in countries where trivalent oral poliovirus vaccine was currently in use. He hoped that the discussions on legacy planning would be widely applied to other areas of public health.

Dr MELNIKOVA (Russian Federation) emphasized that implementation of the Global Polio Emergency Action Plan 2012–2013 in support of national emergency plans in poliomyelitis-affected countries had shown the effectiveness of such joint efforts. She expressed support for the polio eradication and endgame strategic plan 2013–2018 and drew attention to the legacy element, which required the transfer of relevant capacities, processes and assets. The Russian Federation was making a specific contribution to the Global Polio Eradication Initiative by providing support to countries of the Commonwealth of Independent States.

Professor ARSLAN (Bangladesh) noted that considerable progress had been made in eradicating poliomyelitis in the South-East Asia Region. The last case linked to wild poliovirus had been reported in January 2011 and the Region was on track to achieve poliomyelitis-free certification in February 2014. A total of 30 countries remained at high risk of importation of poliovirus and would need to carry out supplementary immunization activities, in order to make the concerted global achievement permanent. Although Bangladesh had been free of poliomyelitis since 2006, it continued to hold national immunization days. The withdrawal of type 2 oral poliovirus vaccine and its replacement with inactivated poliovirus vaccine would necessitate having an adequate global supply of the latter. He therefore appreciated the initiative to make the latter available at an affordable price. Bangladesh had experience in maintaining its poliomyelitis-free status through its skilled workforce, which it would be willing to share with other Member States in order to keep the world free of poliomyelitis.

Dr YILMAZ (Turkey) said that poliomyelitis eradication should be high on the public health agenda: the longer the goal of eradication was delayed, the more difficult it would be to reach. High-level political commitment would be essential. The new polio eradication and endgame strategic plan 2013–2018 would reinforce the Global Polio Eradication Initiative, and countries in which poliomyelitis remained endemic should focus on the issues raised in it. Commitment to preparing and implementing national emergency plans would be the key to future success.

Dr DARIN AREECHOKCHAI (Thailand) said that having reviewed the strategic plan, she recognized that a number of major steps would have to be taken during the coming six years. In particular, countries using trivalent oral poliovirus vaccine would need to have bivalent oral poliovirus

vaccine licensed by the national drug regulatory authority, and the availability and affordability of inactivated poliovirus would have to be guaranteed. She called on the Secretariat to support Member States in the effective and timely implementation of the six-year strategic plan, particularly in connection with the poliovirus vaccine transition phases.

Dr DAULAIRE (United States of America) praised the report on poliomyelitis eradication as a critical measure of WHO's ability to contribute to global health. The recent reduction in the number of cases of poliomyelitis was encouraging. Noting that the polio eradication and endgame strategic plan 2013–2018 had been strongly endorsed during the Global Vaccine Summit, and that an impressive level of financial support had been pledged, he said that his President had proposed to donate US\$ 165 million to poliomyelitis eradication in 2014.

The recent discovery of imported poliomyelitis cases in Somalia and northern Kenya reinforced the urgency of containing and eradicating poliomyelitis. While he acknowledged the problems caused by the violence against health workers, it was crucial to improve the management of immunization programmes, as highlighted in the recommendations of the Independent Monitoring Board. The Executive Board at its 132nd session had reached consensus on the Independent Monitoring Board's recommendation to promote the vaccination of travellers to and from remaining poliomyelitis-affected countries. He congratulated Pakistan on the leadership shown in ensuring that travellers provided proof of vaccination and vaccinating children on departure from Pakistan. He also welcomed Nigeria's action in setting up vaccination posts along its land borders and its intention to do the same at international airports.

He called on WHO to ensure that countries implemented immediately and fully the existing WHO recommendations on vaccination of travellers; to urge countries to reach agreement with their neighbours on denying transit to travellers who refused vaccination at border crossings; and to consider additional measures as needed to ensure that wild poliovirus transmission was halted by December 2014.

He supported the call by the Independent Monitoring Board for the Review Committee on the Functioning of the International Health Regulations (2005) to raise the question of vaccinating travellers, and to consider issuing a standing recommendation from the beginning of 2015 in the event of any ongoing transmission of poliomyelitis after the end-2014 target date.

Dr LANE (United Kingdom of Great Britain and Northern Ireland) said that his country remained deeply committed to the goal of poliomyelitis eradication and had pledged £300 million at the Global Vaccine Summit. The new endgame strategy was ambitious and would require rigorous, transparent monitoring and the provision of evidence of progress against milestones, with course corrections as new evidence became available. Member States would want their investments to go beyond poliomyelitis eradication campaigns and be used to strengthen routine immunization and the health services that hardest-to-reach populations most needed. He welcomed the determination and commitment shown by the remaining poliomyelitis-affected countries.

Dr LEI Zhenglong (China) congratulated WHO on its efforts to eradicate poliomyelitis, as well as the Governments of Afghanistan, Nigeria and Pakistan on their progress towards that goal. In pursuit of the efforts to achieve global eradication, he made the following suggestions: coordination of all available resources in order to provide technical and financial support for interrupting transmission in poliomyelitis-affected countries; strengthening of surveillance and risk assessment services in those countries; and creation of conditions conducive to, and reinforcing of, cooperative vaccination efforts across national borders.

Dr SADRIZADEH (Islamic Republic of Iran) commended the polio eradication and endgame strategic plan 2013–2018. The four major objectives and associated milestones were realistic and achievable by the defined target date, provided that the availability of inactivated poliovirus vaccine

was enhanced and the transfer of new production technology for it guaranteed. Attaining the goals of the strategic plan would require sustained political commitment at all levels, accountability, and adequate funding throughout its duration. Strengthening cooperation between poliomyelitis-affected countries and their neighbours, and generous financial support from donor countries, would be important factors in eradicating the disease. Such partnerships were being rigorously developed in a subregional initiative, in which the Regional Office for the Eastern Mediterranean was playing a catalytic role.

Dr EL TAHER (Egypt) said that survival of the virus in any part of the world meant that no one was safe, as demonstrated by Egypt's detection, through its environmental surveillance system, of wild poliovirus from Pakistan in sewage samples taken from two areas of Cairo in December 2012. A vaccination programme had been introduced, reaching 100% coverage, and as a result no cases had occurred in children. While the final phase of the new strategic plan entailed the withdrawal of the type 2 component of oral poliovirus vaccine and the introduction of a dose of inactivated poliovirus vaccine, some countries might not be in a position to take on the high costs that would be associated with the Expanded Programme on Immunization during that phase. WHO must also support developing countries in acquiring vaccines at affordable prices.

Mr PLAVČAN (Slovakia) said that his country continued to carry out immunization and other activities to maintain its polio-free status in accordance with the approach of the Regional Office for Europe. Recognizing the importance of maintaining eradication activities at the global level, Slovakia was providing financial support to the Global Polio Eradication Initiative for 2013 to help provide vaccines for Afghanistan.

Dr TRIONO SOENDORO (Indonesia) acknowledged the need for a comprehensive endgame strategy and a strong post-eradication strategy. Switching from trivalent to bivalent oral polio vaccines would present programmatic and financial challenges, particularly when the shift would include the introduction of inactivated polio vaccine, with its sophisticated and costly production technology. Indonesia was in the process of analysing the situation, taking into account the country's current epidemiological scenario, clinical and financial aspects and production capability. He requested the Secretariat and other relevant stakeholders to provide support to Member States, to encourage manufacturers to provide sufficient quantities of vaccines at affordable prices, including inactivated poliovirus vaccine, and to facilitate access for developing countries to production technologies.

Dr ABDULRAHIM (Bahrain), welcoming the efforts made by WHO to intensify the eradication campaign, said that despite the problem of propagation of the virus in the three countries where poliomyelitis was still endemic, significant progress had been made towards eradicating poliomyelitis through the implementation of WHO global strategies. Global eradication would require commitment at all levels, together with an assessment of capacities and of needed improvements. She urged the Secretariat and its partners to continue their consultations with pharmaceutical companies in order to improve capacities and address the cost of vaccines and immunization campaigns.

Professor PRASAD (India), acknowledging that the polio eradication and endgame strategic plan 2013–2018 had to be carefully executed to manage the risks associated with its implementation, said that his country would hold consultations with relevant experts at the national level in order to identify the technical and financial implications. India was supporting global eradication efforts by sending technical and medical officers to provide support in interrupting transmission in Afghanistan, Nigeria and Pakistan and was committed to strengthening routine immunization. There had been no case of poliomyelitis in India since 2011, and the Government was coordinating with state governments to provide information to the Global Commission for the Certification of the Eradication of Poliomyelitis; it was hoped that the South-East Asia Region would be certified as polio-free in early

2014. Legacy planning activities were also being undertaken, including measures to improve vaccination coverage.

Dr WAMAE (Kenya) said that as long as the wild poliovirus was still in circulation, no country was completely safe. Routine coverage with oral poliovirus vaccine stood at 85% in her country; however, in May 2013 there had been a confirmed report of wild poliovirus in a neighbouring country and shortly afterwards, two persons in the Daadab refugee camp who had come into contact with a young girl with acute flaccid paralysis had tested positive for type 1 wild poliovirus. Kenya had accordingly activated its polio outbreak preparedness and response plan and raised the vaccination target age to 15 years; it would shortly be initiating a number of vaccination campaigns, including a cross-border campaign. The Ministry of Health was also working with partners, including WHO, to respond to the outbreak; further support was needed in that regard. In addition, as countries began to change from using oral poliovirus vaccine to inactivated poliovirus vaccine, there was a need to look at the challenges involved, particularly with regard to cost and logistics.

Dr ABDULLA (Maldives) said that her country, together with other countries in the South-East Asia Region, was strengthening its surveillance and response strategy against a possible reintroduction of poliovirus in the country. Some difficulties remained with regard to surveillance and vaccination refusal, particularly as a result of misinformation spread by the anti-vaccination lobby. Maintaining polio-free status required continued preparedness, through surveillance and rapid response, as well as high immunization coverage. Improved cross-border collaboration was also important.

Ms GOLBERG (Canada) said that significant progress had been made since the declaration of poliomyelitis as a global health emergency at the Sixty-fifth World Health Assembly, and the recent Global Vaccine Summit had successfully galvanized a significant proportion of the financial resources needed for a final push towards eradication. She urged all donors who had pledged funds to turn them into contributions, programmes and activities. However, major challenges still existed, including security and the fostering of local acceptance of vaccination. She commended the commitment of the three remaining countries endemic for the disease and the courage of their local health workers. It was vital that governments and religious and community leaders promote science-based information and ensure safe access for health workers; the efforts made by the Regional Office for the Eastern Mediterranean to engage Islamic scholars and leaders should be particularly noted. In addition, it was crucial that the polio eradication and endgame strategic plan 2013–2018 be closely aligned with the goals of the Global Vaccine Action Plan 2011–2020.

Dr GOERENS (Luxembourg) said that the recent cases reported in Kenya and Somalia made it necessary to multiply global efforts to eradicate poliomyelitis. He paid tribute to Afghanistan, Nigeria and Pakistan for their efforts but acknowledged that new challenges were appearing, particularly with regard to security; increased protection for immunization campaigns was vital, and national and regional security cooperation mechanisms should be strengthened in that regard. He welcomed the success of the Global Vaccine Summit; failing to protect future generations because of a budget deficit would be unacceptable. Luxembourg would continue to contribute funding beyond 2013, to enable attainment of the goals of the polio eradication and endgame strategic plan 2013–2018.

Dr FIKRI (United Arab Emirates) said that his country was committed to fulfilling its commitments to WHO and other partners and favoured intensification of current efforts to eradicate poliomyelitis. He welcomed the comments made regarding the World Vaccine Summit and thanked all Member States that had participated.

Ms VALLINI (Brazil) said that her country's experience had shown that eradication of poliomyelitis could be achieved through a combination of strong epidemiological surveillance and

decentralized immunization activities throughout the country. With health authorities playing a leading role, it was also important for communities, families and civil society to participate actively in national vaccination campaigns. Cessation of oral poliovirus vaccine use after certification of global eradication should continue to be the objective of an inclusive debate with the participation of all stakeholders.

Dr Yi-Chun LO (Chinese Taipei) said that strong political commitment was essential in the fight to eradicate poliomyelitis and minimize the risks of reintroduction and re-emergence. A standardized immunization record system introduced in 1983 to monitor the immunization status of each child had contributed to eradication of poliomyelitis from Chinese Taipei. Chinese Taipei welcomed the new strategy endorsed by the Strategic Advisory Group of Experts on immunization regarding the introduction of inactivated polio vaccine in place of the traditional oral poliovirus vaccine and would continue to collaborate with all countries in order to achieve a polio-free world.

Ms DIETTERICH (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, paid tribute to the health workers from the Afghanistan Red Crescent Society mobile health team who had lost their lives in recent months. Although tragic, such incidents only served to strengthen her organization's resolve to ensure that every child and every adult had access to an essential package of health services, including immunization. The national societies of her organization served as vital health auxiliaries to the governments of affected countries, from which the members and volunteers usually came. Civil society organizations delivered as much as 60% of health services in some developing countries and required the support and resources to do so.

Mr STENHAMMAR (Rotary International), speaking at the invitation of the CHAIRMAN, said that the progress made since eradication of poliomyelitis had been declared a programmatic emergency had been remarkable, in part as a result of the introduction of new strategies including mapping using global positioning system technology and the expansion of outreach to migrant and nomadic populations. Nevertheless, accountability, management and supervision of vaccination campaigns in the three countries endemic for the disease needed to be strengthened still further to stop transmission of wild poliovirus. The recent outbreak in Somalia highlighted the significant risk to children in all countries until poliomyelitis was eradicated. Welcoming the significant commitments made at the Global Vaccine Summit, he urged implementing entities to use the funds judiciously, in order to take advantage of the global investment in the eradication of poliomyelitis. Member States should maximize their political and financial support to provide the remaining US\$ 1500 million needed to achieve the objectives outlined in the Strategic Plan. Rotary International had committed more than US\$ 1000 million to polio eradication over the years and stood ready to help further.

The CHAIRMAN, acknowledging the many statements of concern, expressed sympathy on behalf of all the members of the Committee for the deaths of poliomyelitis workers at the hands of terrorists in Nigeria and Pakistan. He extended the Committee's condolences to their families, and its support to the Governments of the two countries for their efforts to improve security for such workers.

Dr AYLWARD (Assistant Director-General) said that the eradication efforts were on an emergency footing; more than 2500 new personnel had been recruited and deployed to the most difficult areas in the remaining countries to help governments implement their emergency plans. Those efforts had resulted in real progress; for the first time in history, six months had passed without the detection of type 3 virus anywhere in the world. Key reservoirs of the virus in southern Afghanistan and Pakistan had also been quiescent for the same period. The World Vaccine Summit had seen the finalization of the endgame plan, and he thanked Member States for their contributions to and endorsement of the plan. He also thanked all who had made financial pledges, expressing appreciation

to the Government of the United Arab Emirates for hosting the Summit and encouraging Member States to translate the pledges into funding as soon as possible. However, despite the generous pledges made, there was still a funding shortfall of US\$ 1500 million.

There were still several concerns, particularly with regard to the security of health workers; attacks continued to happen in some countries and additional measures were being taken at country and regional levels to restructure operations and help build a safe environment. In addition, although cases of poliomyelitis were at their lowest number in history, the virus was still being found, namely in Cairo at the end of 2012 and recently in northern Kenya and Somalia. As the virus was continuing to move, one element of the polio eradication and endgame strategic plan was to address reservoirs. In addition, the plan included activities to boost global immunity as much as possible through the introduction of inactivated poliovirus vaccine. That would be a huge task as 127 countries were still only using oral poliovirus vaccine. WHO was working hard to develop supply and financing strategies to ensure rapid implementation, starting with the highest-risk countries.

Responding to the questions and comments by Member States, he explained that the Global Polio Eradication Initiative was committed to using its substantial assets on the ground to work with the GAVI Alliance in boosting routine immunization; the polio eradication and endgame strategic plan contained several firm commitments and concrete actions in that regard, in line with the Global Vaccine Action Plan. With regard to the need for rigorous monitoring, he explained that the Independent Monitoring Board had agreed, at the request of the Director-General, to extend its mandate to the end of 2015; moreover the Strategic Advisory Group of Experts on immunization had agreed to oversee the second objective of the plan on a biannual basis, and the Global Commission for the Certification of the Eradication of Poliomyelitis would be responsible for the third objective. WHO was already starting the process of legacy planning through regional committee meetings; the plan was then to engage with a broader range of stakeholders and present a report to the Sixty-seventh World Health Assembly. He acknowledged that there had been shortages of bivalent and trivalent vaccines during 2012 as a result of the exit of two key manufacturers from the oral poliovirus vaccine market. However, thanks to the efforts of UNICEF and other partners, more manufacturers had been brought on line and it was hoped that by October 2013, supply would meet demand. He thanked the Member States for their patience during the vaccine shortage and for amending their immunization plans to ensure that the vaccines went where they were most needed. The Director-General was considering convening a meeting of the Review Committee of the International Health Regulations (2005) to study the potential role of a standing recommendation on the vaccination of travellers from 2015 if needed. With regard to ensuring the availability and affordability of inactivated poliovirus vaccine, he said that there were currently sufficient stocks of the vaccine to implement the endgame plan and that there had been a 65% reduction in price over the previous 12 months. In addition, WHO had been working on technology transfer to six vaccine manufacturers in developing countries and was looking to develop additional capacity for more manufacturers during 2013. At the same time, a global vaccine supply and financing strategy for inactivated poliovirus vaccine was being developed to ensure that vaccination continued to move forward. He expressed appreciation for the support, solidarity and condolences expressed by Member States and thanked those countries that had announced additional funding to help ensure that vaccination activities were as safe as possible as efforts continued.

**The Committee noted the report.**

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## 2. COMMUNICABLE DISEASES: Item 16 of the Agenda

### Global vaccine action plan: Item 16.1 of the Agenda (Document A66/19)

Dr DAHL REGIS (Bahamas) welcomed the leading role being played by WHO in the coordination of partner agencies with regard to activities under the global vaccine action plan and the integration of the recommendations of the Strategic Advisory Group of Experts on immunization into the work of the Secretariat. Maintaining measles elimination was a particular challenge for the Region of the Americas, and she was concerned that the targets contained in the global vaccine action plan would not be sufficient to address importation of the disease into regions that had already eliminated it. More efforts were needed to encourage privileged sectors of society to value immunization and to support the vaccination of hard-to-reach and vulnerable populations.

#### Dr Ross took the Chair.

Dr AL-TAAE (Iraq) said that through the Expanded Programme of Immunization, rotavirus and *Haemophilus influenzae* type b vaccines had been introduced in his country, and it was hoped to introduce conjugated pneumococcal and human papillomavirus vaccines in future. Introduction of new vaccines should be based on evidence and community needs and be consistent with epidemiological and demographic variables. Introduction of inactivated poliovirus vaccine would present many challenges, and support was needed from WHO and other organizations in areas such as capacity-building for health personnel and institutions. Vaccination of high-risk groups and mass gatherings also needed to be addressed. WHO should work to enhance integrated activities between countries and regions. Advocacy, communication and social mobilization were important tools that should be strengthened and implemented as part of a primary health care approach.

Dr ALHAJERI (Bahrain), welcoming the efforts to establish a global plan and mechanisms for the inclusion of all social groups in the Expanded Programme on Immunization, said that Bahrain, as part of its ongoing support for that Programme, had participated in the activities marking Vaccination Week ever since it had first been launched by the Regional Office for the Eastern Mediterranean. WHO must support Member States in drawing up their national plans in line with the global vaccine action plan and strengthen their implementation capacities. Guidelines should also be provided for alignment of the monitoring, evaluation and accountability processes at national level with those at regional and global levels. Bahrain endorsed the proposed framework for those processes.

Mrs CARTER TAYLOR (Barbados) said that her country was seeking to address vaccine-preventable diseases through interventions including measures aimed at achieving high routine immunization coverage, surveillance activities and the introduction of new vaccines where applicable. The Secretariat should continue to work with Member States over the Decade of Vaccines in order to implement the global vaccine action plan. Barbados was honoured to have been selected to serve on the Strategic Advisory Group of Experts on immunization to monitor the progress on the action plan.

Dr DOGBE (Togo), speaking on behalf of the Member States of the African Region, said that despite numerous difficulties, those countries had made significant progress in vaccination coverage; however, countries affected by conflict were facing a number of challenges in that regard. He welcomed the support of the GAVI Alliance and the international community for the introduction of new vaccines in the African Region. However, given the situation of countries in the Region, it should be adequately represented in the Strategic Advisory Group of Experts on immunization. Although the African Region greatly appreciated the initiative to monitor the commitment of various partners with regard to immunization, such monitoring should be part of the Accountability Framework for the

United Nations Secretary-General's Global Strategy for Women's and Children's Health and the Global Fund to Fight AIDS, Tuberculosis and Malaria. National bodies should document best practices and develop recommendations on how to improve immunization services. At the country level, work should concentrate on strengthening targeted communication strategies, intensifying community and government commitment, advocating for lowered vaccine costs, and promoting research on vaccines and immunization, including against those illnesses that contributed to the burden of noncommunicable disease.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand) said that the introduction of new vaccines required an evidence-based decision mechanism and depended on epidemiology, efficacy, cost-effectiveness, budgetary impact, cold chain capacity and health systems' scale-up capacity. In the action plan's proposed indicator on the introduction of new or underutilized vaccines, the phrase "based on adequate evidence and the context of the country" should be inserted after "new or underutilized vaccines". The insertion would provide flexibility to countries that were not eligible for GAVI support, enabling them to make the best decision based on their national situation. A new indicator should also be added to the final strategic objective and should read "Progress towards institutional capacity to generate evidence to inform the introduction of new and underutilized vaccines". In addition, the indicator for the first strategic objective, "Domestic expenditures per person targeted", should be replaced by the existing indicator used by WHO and UNICEF, namely "Percentage of routine EPI vaccines financed by government", which provided a better representation of the financial investment by a country in immunization activities. In order to achieve strategic objectives 3 and 5, global expansion of vaccine production capacities was key; therefore an additional strategic-level indicator was required, reading "Number of WHO prequalified vaccine manufacturers in developing countries".

Dr ABANIDA (Nigeria) said that the cost of the basic package to vaccinate a child had risen rapidly and that there was minimal global information to enable tracking of vaccine prices. Monitoring vaccine prices and setting global norms for the cost of vaccines were important tools that would enable countries to accurately plan and prepare funding for immunization programmes, especially for countries that were ceasing to be eligible for GAVI support. He urged WHO to continue its work to develop indicators to track vaccine prices as part of the action plan's monitoring, and evaluation and accountability framework.

Dr DA COSTA SARMENTO (Timor-Leste) said that the global vaccine action plan provided a strategic framework to guide vaccination priorities during the Decade of Vaccines 2011–2020 and for the annual World Immunization Week. She expressed appreciation to the Regional Director for South-East Asia for declaring 2013 to be the Year of Intensification of Routine Immunization in the Region, as that had enabled Timor-Leste to identify critical areas for action. In collaboration with WHO, the GAVI Alliance and other relevant partners, Timor-Leste had been able to introduce a pentavalent vaccine in 2012. Developing countries, in particular, should have the opportunity to introduce vaccinations for other vaccine-preventable diseases, such as pneumococcus and rotavirus infections, at low prices.

Dr MELNIKOVA (Russian Federation), welcomed the work being done by the Strategic Advisory Group of Experts on immunization to develop indicators to monitor the progress being made at the country and global levels. Those indicators provided a useful basis but might have to be revised in future. She also welcomed the revision of the WHO/UNICEF guidance on developing national plans that took into account the targets and goals of the global vaccine action plan. The guidance would aid Member States in developing procedures for monitoring, evaluation and accountability at national level and would make it easier to agree on corresponding procedures at regional and global levels.

Dr DAULAIRE (United States of America) agreed with the proposed incorporation of multi-year costed immunization plans within broader national health system planning processes. High-level national commitment to collect accurate data and report annually was critical to monitoring and evaluating progress towards the goals and strategic objectives of the global vaccine action plan. While expressing support for the tracking of countries' national immunization expenditures, and encouraging opportunities for synthesis and the leveraging of funds across broader national health system budgets, he suggested that some components of the implementation plan and indicators would require further refinement. For example, it would be important to identify how countries would use the results and how regional committee recommendations would be implemented. Standardization within and across countries would also be necessary, to allow for analyses over time and across different countries. For low- and middle-income countries that were not eligible for GAVI Alliance support, identifying financial resources would be critical for the implementation of the proposed framework. He encouraged WHO to be more ambitious in its goal to develop and introduce improved vaccines and technologies by 2020 and to concentrate more closely on issues related to the cost-effective delivery and affordability of the entire vaccination package. The Decade of Vaccines had reinvigorated the discussion on the need for robust routine immunization programmes; he also commended its inclusion of the eradication of poliomyelitis and the accelerated progress it had generated towards the global goals of elimination of measles, rubella and neonatal tetanus.

Dr RATIH (Indonesia) said that, although the global vaccine action plan was an excellent strategic framework, guidance on monitoring, evaluation and accountability was vital to ensure its implementation by Member States. High immunization coverage and strong surveillance activities would contribute to achieving regional targets on the eradication of poliomyelitis and the elimination of maternal and neonatal tetanus and measles. There was increasing demand for new vaccines as a result of the Decade of Vaccines, and she urged manufacturers to provide vaccines at affordable prices, particularly for developing countries, and to facilitate access to production technologies.

Professor ARSLAN (Bangladesh) said that Bangladesh had achieved most of the global targets for routine immunization and vaccine-preventable disease control, with the introduction of vaccines against hepatitis B, *Haemophilus influenzae* type b and rubella; the pneumococcal vaccine would be introduced in August 2013 with the support of the GAVI Alliance. Several pharmaceutical companies were planning to produce vaccines in Bangladesh, and efforts were in hand to enhance the capacity of the national regulatory authority to monitor domestic production. As it would be difficult for Member States to obtain data on the strategic objective-level indicators on, for example, domestic expenditure per person targeted or confidence in vaccination at the subnational level, WHO should develop measurement tools and provide support to Member States in their use. He supported the proposed framework for monitoring, evaluation and accountability Framework but suggested that WHO should refine the indicators to make them measurable by Member States.

Dr SEAKGOSING (Botswana) said that his country had developed a multiyear plan for the Expanded Programme on Immunization, aligned with the six guiding principles of the global vaccine action plan. The strategies and activities in the national plan included child health days, African Vaccination Week, supplementary measles immunization activities and the introduction of pentavalent, rotavirus and pneumococcal vaccines. He encouraged WHO, the GAVI Alliance and other stakeholders to continue providing support to Botswana and other countries by bringing about lower vaccine costs in order to ensure the sustainability of immunization programmes.

Dr YILMAZ (Turkey) said that despite measles elimination programmes, many countries, including developed ones, were encountering difficulties in eliminating the disease as a result of low vaccination coverage rates; anti-vaccine groups were having a significant impact on those rates. WHO

should launch an initiative to combat the influence of anti-vaccine groups; measles elimination could only be achieved if everyone played his or her part.

**Dr Gwenigale resumed the Chair.**

Dr ABDULLA (Maldives) said that the global vaccine action plan was an important strategic document that would shape attainment of the goals of the Decade of Vaccines. Her country was committed to achieving global polio-free status and measles elimination in the next biennium. Monitoring of immunization coverage and preparedness against reintroduction of those diseases would be of utmost importance in that regard. The South-East Asia Region was actively working to achieve the goals of the global vaccine action plan, and all Member States had developed focused plans to reach the targets and increase immunization coverage. A regional immunization strategic plan would be finalized by the end of 2013. Significant resources at country level, often through external funding, and strong international support would be needed to implement that plan. The main challenge for Maldives, as a small, import-dependent country, was the procurement of vaccines; the rising costs and limited accessibility of some vaccines threatened successful implementation of its immunization programme. She hoped that the global vaccine action plan would help to improve availability through appropriate price monitoring and controls.

Dr MARTÍNEZ DE CUELLAR (Paraguay) said that immunization was a priority in her country; in recent months, four new vaccines had been introduced, against varicella, hepatitis A, diphtheria, tetanus and pertussis, and human papillomavirus infection. Her country had gathered significant experience using a coordinated, multisectoral approach, working with the education sector to give the human papillomavirus vaccine to schoolchildren; a strategy had also been developed to reach children who did not attend school. Storage and transport capacity had been strengthened and a national registry developed. No case of measles, rubella or congenital rubella syndrome had been identified in the last 10 years. However, weaknesses persisted, and she requested the Secretariat to continue providing support to Paraguay and other countries for strengthening the monitoring of epidemiological and laboratory trends and enhancing community-based activities, so that immunization was recognized as a right and areas at risk were reached.

Professor MESBAH (Algeria) said that a workshop had been held in his country the previous month on updating the immunization schedule, so that the planned introduction of four new vaccines would be in line with WHO's recommendations. It was important that vaccines, including the most modern ones, were made available at a reasonable price. He was not seeking a charitably subsidized price, just a fair one; a vaccine supply mechanism for medium-income countries should be developed.

Dr RUÍZ MATUS (Mexico) said that when the vaccination scheme had started in his country, six vaccines had been included; that number currently stood at 14. It was important that WHO should urge Member States to continue strengthening mechanisms for ensuring safe vaccination practices.

**The meeting rose at 17:30.**

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