

## **ELEVENTH MEETING**

**Monday, 27 May 2013, at 09:10**

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

### **1. COMMUNICABLE DISEASES:** Item 16 of the Agenda (continued)

**Malaria:** Item 16.3 of the Agenda (Document A66/21)

Dr AL-TAAE (Iraq) said that Iraq had been free of indigenous cases of malaria for over four years. He expressed appreciation for the technical support that had been provided by the Secretariat, in particular concerning capacity-building and the exchange of expertise as part of the joint initiative involving Afghanistan, the Islamic Republic of Iran, Iraq, Pakistan and WHO. Vector surveillance had been recognized as a key element in eliminating malaria; such activities should be integrated into primary health care, using evidence-based family health practices. The target of eliminating malaria should be integrated into health promotion activities, with a focus on health education, communication, social determinants of health, risk factors, and mass gatherings.

Dr LEI Zhenglong (China) said that China was currently implementing the national action plan for malaria elimination 2010–2020. Good progress was being made in diagnosis and treatment, the number of local cases had decreased sharply, and monitoring and evaluation systems had been improved.

His Government was greatly concerned by the artemisinin resistance present in the Greater Mekong subregion of South-East Asia and had adopted several measures to contain it. China had stopped using artemisinin-based monotherapies in 2009, replacing them with artemisinin-based combination therapies. In addition to carrying out cross-border training and monitoring activities, it was paying close attention to manufacturing quality and medicine supply chains.

Malaria control must remain a key priority for global health and development efforts beyond 2015. Relevant organizations and countries should continue providing technical and financial support to African countries with heavy disease burdens, to ensure the sustainability of prevention and control measures and to consolidate the progress that had been made. WHO should also accelerate the prequalification of antimalarial drugs. Furthermore, countries in regions affected by artemisinin resistance should conduct compatibility studies on artemisinin-based combination therapies to reduce the risk of that resistance spreading.

Dr GHEBREHIWET (Eritrea) said that the report should have drawn attention to the tendency for health providers and the public to become complacent once morbidity and mortality rates had declined. It should also have mentioned that malaria would pose a more serious problem if it were to reappear after a long period of successful control, since people would have lost their immunity, and the number of people who had never had malaria would have increased. The report should also have highlighted the need for strategies to combat infection in men since, despite the fact that they were less vulnerable to malaria than children and pregnant women, men who contracted malaria could have a detrimental effect on household economies and poverty alleviation, and could infect others in the community.

Ms BENNETT (Australia) welcomed the Secretariat's work on a global technical strategy for malaria control and elimination for the period 2016–2025 and the work being done in parallel by the Roll Back Malaria Partnership to renew the Global Malaria Action Plan.

Australia's Prime Minister would be co-chairing the Asia-Pacific Leaders Malaria Alliance, the aim of which was to consolidate the political commitment to malaria control in the Region and to implement priority action with regard to financing and access to medicines. She welcomed the support provided by the Secretariat to countries in the Mekong subregion in their efforts to contain artemisinin resistance, which was a challenge not only for the subregion, but potentially for global health. Australia had pledged 5 million Australian dollars to support WHO's emergency response in that field.

Dr COOMBS (Jamaica) said that, after being declared malaria-free in 1965, Jamaica had witnessed a reintroduction of the disease in 2006, which set in motion a national emergency response, followed by an intensive prevention and control programme. Jamaica was recertified as malaria-free in 2012 but it continued to maintain a strong surveillance and vector control programme. Various factors, including inadequate resources, antimalarial drug resistance, vector resurgence, and political and social resistance, threatened to undermine the progress made to date, but that challenge could be met through increased vector control, use of artemisinin-based combination therapies, training, better diagnostic, treatment and surveillance efforts, and political alliances.

Dr FORSTER (Namibia) welcomed the 2012 global plan for insecticide resistance management in malaria vectors but would appreciate more information on progress in the development of new insecticides. Namibia regarded DDT as a key component of elimination efforts across southern Africa and would continue to use it for indoor residual spraying, provided that it was applied under careful, safe and quality-assured conditions by well trained and supervised teams.

The move from malaria control to malaria elimination implied considerable additional costs owing to the broader scope and intensity of the initiative and, to that end, substantial contributions to the fourth replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria were needed. Malaria must also remain high on the post-2015 global health and development agenda. His country had significantly increased its national budget allocation for health, including malaria, but without external support, those resources would not be sufficient.

Professor SHIRALIYEV (Azerbaijan) expressed satisfaction that US\$ 1800 million was currently allocated to the fight against malaria. Nevertheless, it was unrealistic to expect a three-fold increase in funding, so it would be necessary to step up the measures against malaria that were already in place, use existing resources rationally and efficiently, adopt innovative approaches to national epidemic surveillance, and implement strategies to combat malaria at various stages of its development.

The tasks assigned to the health sector, government bodies and voluntary associations should be set out clearly, but goals could only be achieved by fully mobilizing efforts and resources, defining priorities, and above all, through political will. Acting on those principles, Azerbaijan had made significant progress in fighting malaria and indeed had almost eliminated it. The Millennium Development Goal on the elimination of malaria in developing countries could be attained by improved interregional coordination and by building stronger partnerships between countries, international organizations and donors.

Dr ANUTTARASAKDI RATCHATATAT (Thailand) said that the emergence of artemisinin resistance in border zones was a major challenge and called for strengthening of cross-border coordination and surveillance systems. In that regard, he asked the Secretariat to organize a forum where participants could share good practices in the implementation of the "T3: Test Treat Track" initiative in countries endemic for the disease.

In many low- and middle-income countries, diagnostics, essential medicines and prevention and control instruments were unaffordable owing to market monopolies, inadequate supply, or poor

management of stockpiles. WHO and other development partners must ensure the supply of low-cost fixed-dose artemisinin-based combination therapies of good quality, sold on the open market, before requesting Member States to stop marketing artemisinin-based monotherapies.

An overall lack of technical expertise and human resources was one reason for the slow implementation of the Global Malaria Action Plan. The Secretariat must continue providing Member States with technical guidance and expertise, and support them in training human resources in malaria prevention and control. Properly functioning health systems, especially at the primary health care level, were fundamental to malaria prevention and control.

Dr SMIRNOVA (Russian Federation) said that, despite increased funding for measures to combat malaria, there was still a substantial shortfall, which might put future progress at risk. Surveillance systems in a number of countries in which malaria was endemic were failing to show the actual disease burden and were in need of improvement, while preventive chemotherapy was still being used far too infrequently to cure children and pregnant women.

The Russian Federation welcomed WHO's efforts to meet those challenges by drawing up new strategies and guidelines, such as the global plan for insecticide resistance management in malaria vectors. The Organization's reviews of national malaria prevention and control programmes were important to countries endemic for malaria. A broad range of international and regional training courses on malaria provided by the Secretariat had been helping administrators to plan and manage measures to control the disease. The Russian Federation had made substantial contributions to international initiatives, including by providing advice and practical support to countries with malaria control programmes and by training managers in countries of the Commonwealth of Independent States and the African Region.

Dr BLOKLAND (Suriname) said that his country had surpassed the Millennium Development Goal target for malaria and was now on the way to eliminating the disease entirely. However, in the Guiana Shield region, malaria was principally transmitted by mobile populations that crossed borders frequently, and strong cross-border collaboration was therefore needed. According to recent studies, *Plasmodium falciparum* malaria in Suriname was 28% less susceptible to artemisinin. Effective diagnostic, therapeutic and preventive measures were therefore urgently needed in the region, and he called on international partners to provide support in that regard. In particular, he urged the Secretariat to continue supporting the WHO office in Suriname in its efforts to prevent the reintroduction of malaria and to step up its support for early diagnosis and treatment programmes for at-risk populations and for the recently established Caribbean Epidemiology Centre.

Mr ELMARDI (Sudan) expressed appreciation for the efforts made by the WHO Global Malaria Programme to establish the sorely needed Malaria Policy Advisory Committee, which counted Sudan's Minister of Health among its members. Sudan had made significant progress in malaria control and prevention by intensifying the action recommended by WHO, but it still faced several challenges, including parasitic resistance to insecticides. He endorsed WHO's effort to develop a global technical strategy for malaria control and elimination for the period 2016–2025, which would provide much-needed support to Member States as they continued to face that challenge.

Dr KAFA (Solomon Islands) said that the annual parasite incidence in his country had decreased four-fold in the previous decade, thanks to support from WHO and donor partners. The national malaria action plan was focused on scaling up control activities in areas of high endemicity and on implementing two pilot elimination programmes. Joint leadership by the provincial government, traditional chiefs and faith-based organizations, together with community involvement, had played an important role in reducing the malaria incidence rate to 0.1 cases per 1000 inhabitants in Isabel province. He urged the Secretariat to continue providing support to his country to ensure that its gains were not lost; in particular WHO should focus on strengthening health systems, empowering communities and bolstering social structures. His Government fully supported integrated community

case management of childhood illnesses, which gave community health workers the opportunity to diagnose and treat malaria, pneumonia and diarrhoea. Malaria control must remain a key priority for global health and development efforts beyond 2015, and WHO should maintain its leadership role in that regard.

Dr LOUME (Senegal) said that Senegal had integrated pneumonia and diarrhoea into its strategy for home-based management of malaria, which had been recently evaluated by WHO. Since 2009, more than 100 health professionals had completed malaria training courses to acquire the skills needed to manage the national malaria programme. With regard to vector control, Senegal had obtained conclusive results in areas where indoor residual spraying had been tested, and it would be pursuing that experience. It was important for neighbouring countries to develop joint malaria control strategies, to ensure that their efforts were coordinated.

Dr WAYESA (Ethiopia) said that according to the *World malaria report 2012*, 25 of the 99 countries with continuing malaria transmission were classified as being in the phases of pre-elimination, elimination or prevention of reintroduction. Unfortunately, African countries with high malaria burdens did not appear on that list of 25 countries, and they deserved more attention. He urged Member States to advocate for and contribute to the Global Fund to Fight AIDS, Malaria and Tuberculosis, in order to build on the progress made.

Dr BENSON (South Africa) commended the collective efforts that had enabled 50 countries to be close to reducing malaria incidence by 75%, in line with the Roll Back Malaria target. South Africa had reduced mortality by 89% and morbidity by 84% between 2000 and 2012. Yet it had not been classified in the *World malaria report 2012* as having entered the pre-elimination stage and, in that regard, he requested more information about the criteria to be met for inclusion in that category. He was concerned by the substantial funding shortfall predicted to occur annually up to 2020, and called for international and domestic partners to ensure that more creative and sustainable ways of raising additional funding were identified. He was also concerned about reports of mosquito resistance to insecticides and by renewed calls to phase out the use of DDT, even though it had proven to be effective for malaria vector control. He called on the Secretariat to continue its support for strengthening cross-border malaria initiatives in Africa. The global technical strategy for malaria control and elimination to be prepared by the Malaria Policy Advisory Committee would help to guide the progress of South Africa's own national malaria control strategy.

Dr ISSOUFOU (Niger), speaking on behalf of the Member States of the African Region, said that despite worldwide efforts to combat malaria, which had been successful in reducing the mortality rate, disease transmission persisted in 99 countries and territories. Furthermore, despite a substantial increase in funding in recent years, funding shortages were having a negative impact on supplies of antimalarial drugs and other materials, and on plans to broaden the scope of interventions, all of which could lead to a resurgence of malaria. The Member States of the Region were committed to preserving the gains made and achieving the global targets set, and would do so by implementing the Secretariat's proposals, including the global plan for insecticide resistance management in malaria vectors; the recommendation on seasonal malaria chemoprevention for control of *P. falciparum* malaria; the programme to support the expansion of integrated community case management of childhood illnesses; and development of new co-financing and technology transfer mechanisms and improved surveillance systems.

Dr NTAKARUTIMANA (Burundi) said that malaria continued to be a major public health problem in his country and a leading cause of morbidity and mortality. Burundi supported all the strategies that had been proposed for controlling the disease, particularly the use of indoor residual spraying, which had been tested with excellent results in one of his country's provinces. He appealed to WHO and international and local partners to increase funding for implementing that strategy.

Dr JANAIRO (Philippines) said that under its national malaria programme, his country had over the past eight years reduced the number of malaria cases by 79% and the number of deaths by 92%, thereby achieving the global targets that had been set. To preserve those gains, support from WHO and international partners was needed, in particular, to help the Philippines establish strong surveillance systems; ensure the diagnostic, treatment and vector control capabilities of all the country's regions by guaranteeing the supply of malaria commodities; carry out and sustain social mobilization activities; and foster strong coordination among government units at all levels. Funding for the national malaria programme would be increased by revenue from the country's new tax law, but continuing international support was still needed, since funding under the Global Fund to Fight AIDS, Tuberculosis and Malaria was ensured only until 2014.

Mr KLEIMAN (Brazil) said that combating malaria was a priority in Brazil. In recent years, the number of deaths had been reduced by 70%, and morbidity had also declined. That success was due to the decentralization of prevention and control activities to local and provincial governments, an improvement in patient treatment and care, and investment in and training of human resources. However, the challenge remained significant, particularly in the Amazon region. His country had been working on research into and development of vaccines and medications, for example, in cooperation with the Drugs for Neglected Diseases initiative. It was also endeavouring to cooperate in a more integrated manner with other countries in the Amazon region, particularly those on its border. The combat against malaria must remain on the post-2015 agenda, so that countries that had not yet achieved the targets would continue to receive international support, including from WHO.

Dr AFZAL (Pakistan) said that malaria had become one of the major causes of morbidity in Pakistan and controlling it was a priority. The Government had revised its malaria policy by including in it a strategy for the province of Punjab, as it moved from control to pre-elimination, and by setting targets for intensified control activities in high-burden areas along the western border. Pakistan had introduced artemisinin-based combination therapy as a first-line therapy, banned monotherapy, strengthened surveillance and developed national guidelines and a training manual, and would be working to strengthen its malaria programme even further.

Mr OVIEDO (Costa Rica) said that Costa Rica had been among the countries classified by the *World malaria report 2012* as being in the pre-elimination phase. It was cooperating with other countries in the region on a joint initiative to eliminate malaria in Central America and Hispaniola by 2025, in partnership with the Global Fund to Fight AIDS, Tuberculosis and Malaria (which planned to contribute US\$ 10 million to it), PAHO and the Bill & Melinda Gates Foundation. The final proposal for the initiative would be submitted to the Global Fund at the meeting of the Council of Ministers of Health of Central America in June 2013. He urged Member States to use an integrated approach to the prevention and control of malaria.

Ms RIGHETTI (Switzerland) said that an increase in and better use of available resources, long-term commitment from all Member States, and coordination of the stakeholders involved were essential if the fight against malaria were to be successful. Malaria control should be part of the strategy to strengthen health systems at the national level. She endorsed the appeal from affected countries for greater funding, but co-financing initiatives must be part of countries' overall health funding strategies. Community participation in malaria control programmes was vital to ensuring that prevention and treatment methods were well known, applied in an effective manner and accessible to all. Universal health coverage must include strategies for combating malaria at the community level. Better surveillance and information systems in malaria-endemic countries were needed, as were innovative approaches to vector control, monitoring of drug resistance, early diagnosis and treatment, and research relating to vector control. Alternative vector control methods should be developed so that the use of DDT could be gradually eliminated.

Mr KOLKER (United States of America) welcomed the information that malaria mortality had decreased by 25% worldwide and by 33% in the African Region between 2000 and 2010. His Government endorsed the efforts of the WHO Global Malaria Programme to strengthen its policy-making process and was concerned by the forecasted funding shortfall; it therefore encouraged all partners to renew their commitment to funding malaria prevention programmes. It was for that reason that the United States of America had proposed that malaria should be included on the agenda as a technical item.

Emerging insecticide and antimalarial drug resistance threatened the success that had been achieved. More than one third of antimalarial drugs tested in surveillance programmes in sub-Saharan Africa and South-East Asia were counterfeit or substandard. Compromised medicines could lead to resistant strains of the parasite, making the disease more difficult to treat, even with quality medicines. The United States of America was in favour of public–private partnerships for testing and identifying counterfeit or substandard antimalarial medicines, including falsified products. His country would continue to support efforts to identify and control antimalarial drug resistance and effectively manage insecticide resistance, and urged all Member States to promote the deployment of proven, effective interventions.

Dr SON Hyun-jin (Republic of Korea) said that her country aimed to reduce the incidence of malaria cases to less than one per 100 000 by 2015 and to eliminate the disease entirely by 2017, through intensive patient management focused on early detection and treatment. Only *Plasmodium vivax* malaria was prevalent in the Republic of Korea, which meant that drug resistance was not a problem. However, artemisinin resistance had been detected in neighbouring countries, and her country would be joining the cross-border efforts to contain it.

Mrs KHUMALO (Swaziland) said that malaria remained a serious public health issue and had been rightly placed on the agenda as a technical item. Donor contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria were making a difference in the lives of people in sub-Saharan Africa and replenishment of the Fund was of vital importance. It was encouraging that some countries in the African Region, including her own, were on track to meet the targets that had been set for malaria control. Nevertheless, greater South–South and cross-border cooperation was needed to achieve sustainable progress in Africa. Malaria prevention and control should remain a key priority for global health and development beyond 2015.

Dr LANE (United Kingdom of Great Britain and Northern Ireland) supported the decision to include malaria as a full technical item on the agenda. His Government welcomed the high-level political commitment to combating malaria in high-burden countries, and it intended to provide up to £500 million to help halve malaria deaths in at least 10 of those countries by 2015.

Institutions and companies in the United Kingdom of Great Britain and Northern Ireland were at the forefront of research and development to generate new tools and products for combating malaria. He welcomed the preparation of a global technical strategy for malaria control and elimination for the period 2016–2025; it should be based on the principle of evidence-based malaria programming and would help to consolidate the gains of the previous decade and accelerate progress towards the health goals on the post-2015 development agenda.

Mr ROMERO PUENTES (Cuba) said that, since eliminating malaria in 1967, Cuba had been developing a strong epidemiological and entomological monitoring system at the primary level and gaining experience in the development of human resources and environmentally friendly products, with a view to sustaining its achievements. Setting up a vector control mechanism at the primary health care level had made it possible to localize and identify malaria vectors and treat them with bolarvicides which, in addition to being effective, were not harmful to the environment and did not generate resistance in other vectors. His country was sharing its experience by transferring its

production technology and work methods to other countries and cooperating with them in general on malaria control programmes.

Mrs OGU (Nigeria) said that long-lasting insecticide-treated nets alone could not eliminate malaria. Multiple vector control strategies were needed, including indoor residual spraying, the use of larvicides, cross-border surveillance and accelerated technology transfer to build local capacities for manufacturing antimalarial products.

Mr MUKALENGE (Democratic Republic of the Congo) said that despite having the second-highest malaria mortality rate in the world, his country had nevertheless made significant progress in combating the disease in recent years, particularly through mass distribution of long-lasting insecticide-treated nets and by supplying health centres with artemisinin-based combination therapies, rapid diagnostic testing kits and sulfadoxine-pyrimethamine. Access to and use of those services remained a challenge, as did the logistics of ensuring reliable services in a country as large as his own. In the previous two years, there had been a recrudescence of malaria in districts with no prior history of cases on that scale, with a disproportionate number of young malnourished children falling ill. To make matters worse, unreliable test results were leading the health workers involved to make inappropriate treatment decisions, with sometimes disastrous consequences. He therefore wished to underline the importance of improving malaria surveillance systems in the 17 most affected countries and of providing support to them in establishing effective laboratory networks.

Ms NGARI (Kenya) said that, on the recommendation of her country's Ministry of Health, carbamates would be used for indoor residual spraying in areas with perennial malaria transmission in the 2013–2014 spraying cycle. That important policy change had been made as a result of recent findings demonstrating high-level resistance to pyrethroid-based insecticides, as opposed to organophosphate and carbamate-based insecticides. Kenya had also completed a programme of mass distribution of long-lasting insecticide-treated nets to all target areas, and rapid diagnostic test kits were being used to strengthen malaria diagnosis and management.

Ms DÁVILA CHÁVEZ (Mexico) said that Mexico had achieved good results in combating malaria but it remained a health priority in some areas of the country. Since 2004, Mexico had been using targeted approaches in order to obtain WHO malaria-free certification, especially for tourist centres and industrial development zones. Her country would be glad to share its national experiences with any country that requested it.

Mr SAMO (Federated States of Micronesia) said that his delegation had been in favour of including malaria as a technical item on the agenda. His Government appreciated the mosquito nets provided by WHO and global partners for preventing other mosquito-borne diseases.

Dr MALEFHO (Botswana) said that, through its national malaria programme, Botswana had dramatically reduced unconfirmed and confirmed malaria incidence, while deaths attributed to malaria had shown a 91.4% decrease between 2000 and 2012, leading the Government to predict that it would be able to eliminate malaria by the target date of 2015. Several initiatives undertaken by the Ministry of Health had contributed to the downward trend, including strengthening the policy-making process; providing evidence-based technical guidance; monitoring trends in malaria control and elimination; strengthening human resources; promoting technology transfer; combating insecticide resistance, and mitigating shortages in the supply of artemisinin-based combination therapy.

Challenges nevertheless remained that had the potential to reverse the gains made, the most serious being the limited resources available globally for malaria prevention and control.

Dr AL LAMKI (Oman) said that efforts to build on the tremendous progress achieved in implementing the global strategy for malaria control could be jeopardized by inadequate funding in countries that were endemic for malaria, particularly in view of growing antimalarial drug resistance. It was vital to combat malaria in those countries, in order to reduce their disease burden; that in turn would have a positive impact on the disease burden of countries with imported malaria, including by minimizing the risk of domestic transmission. Thanks to a robust malaria control programme, domestic transmission had been eliminated in Oman, which nonetheless faced the major challenge of monitoring incoming cases from nearby countries where malaria was endemic.

Dr DAKULALA (Papua New Guinea) said that although malaria was one of the most important public health problems in Papua New Guinea, morbidity, mortality and parasite prevalence had all declined considerably between 2000 and 2011. In addition, malaria was no longer one of the top three causes of hospital admission for children, owing to the widespread use of insecticide-treated bed nets, of which 5.1 million had been distributed free of charge in the previous 10 years. Artemisinin-based combination therapy had been introduced as the first-line treatment in 2009. Rapid diagnostic tests were being introduced in all health facilities, and testing and treatment coverage was expanding through community-based case management. Under the country's policy of free primary health care, efforts would be made to increase equity and access to diagnosis and treatment.

Strong public-private partnerships and collaboration with WHO, research institutions and nongovernmental organizations had enabled the country to expand its malaria programme, and malaria control was included in its national health plan 2011-2020 as a priority objective. Nevertheless, diagnostic capacity and laboratory quality assurance remained key challenges, and the supply of artemisinin monotherapies by the private sector meant that staff did not always comply with treatment guidelines. Furthermore, the quality of the malaria programme and its potential for expansion were likely to be jeopardized by the health workforce crisis in his country, which must be tackled immediately. The progress that had been made was a result of international efforts to combat malaria, and he therefore supported the call for sustained financial and technical support.

Mr EMANUELE (Ecuador) said that his country's firm political commitment to combating malaria had led to significant improvements in diagnosis, treatment and follow-up of cases, thus eliminating local transmission. In November 2012, PAHO had named Ecuador a "champion in the fight against malaria", in recognition of the work done by the country's national service for control of vector-borne diseases, which had reduced the incidence of malaria by 70% in the previous two years. It was important to promote and disseminate good practices, since that would foster international cooperation and help other countries to achieve similar results. Despite the significant progress that had been made towards attaining the Millennium Development Goals, the control of communicable diseases like malaria must continue to rank high on the post-2015 development agenda, to ensure the sustainability of what had already been achieved.

Dr WIDIYARTI (Indonesia) said that global and national investments in malaria control had yielded significant results in decreasing the disease burden in Indonesia, and districts where malaria had previously been endemic were moving towards elimination of the disease.

The country's health system was being strengthened using an integrated health services approach that had resulted in an increase in coverage with long-lasting insecticidal nets, a decline in the annual parasite index and improved access to treatment. The Government was committed to increasing community access through campaigns to distribute more long-lasting insecticidal nets, and establish village malaria posts and mobile clinics in remote areas. Artemisinin resistance was being dealt with by efforts to promote a standardized treatment regimen, in conjunction with professional organizations. Continued technical support from WHO, other international organizations and development partners would be welcome.



Mr Chin-Shui SHIH (Chinese Taipei) said that malaria had been eradicated in Chinese Taipei in 1965, as a result of a control and eradication programme launched in 1945. Chinese Taipei was currently in a maintenance phase of sustained control and was malaria-free. Chinese Taipei strongly supported the WHO Global Malaria Programme's new initiative "T3: Test Treat Track". Chinese Taipei had been collaborating with WHO and other partners on malaria prevention and control in countries endemic for the disease and welcomed the opportunity to do so in the future.

Dr NAKATANI (Assistant Director-General), said that the world was, overall, on track to reach the Millennium Development Goal target on malaria. However, an estimated 660 000 lives were still lost to malaria each year, mostly in sub-Saharan Africa, a figure almost double that attributed to maternal deaths. Drug and insecticide resistance still presented considerable challenges, although existing tools had generally been effective in many countries. Unnecessary deaths could be avoided through further expansion of evidence-based interventions, such as the use of long-lasting insecticidal nets, indoor residual sprays, diagnostic tests and artemisinin-based combination therapies for uncomplicated cases.

Delegates had expressed their views on four broad areas: the post-Millennium Development Goal strategy; artemisinin resistance; insecticide resistance; and funding. Many delegates had expressed full support for the development of a post-2015 global technical strategy for malaria control and elimination, to be overseen by the Malaria Policy Advisory Committee. The new strategy would be based on a comprehensive evidence review and regional consultations, and would be submitted for consideration to the Sixty-eighth World Health Assembly in May 2015. The strategy would cover the period 2016–2025 and provide a solid technical foundation for the second version of the Roll Back Malaria Partnership's Global Malaria Action Plan.

Member States had referred to artemisinin resistance and the need for closer cross-border collaboration, including strengthened surveillance, since maintaining the efficacy of artemisinin-based combination therapy was critical for malaria control. Resistance to artemisinins had first been detected in the border area between Thailand and Cambodia and had then spread to the Greater Mekong area. On World Malaria Day 2013, WHO had introduced its emergency response to artemisinin resistance in the Greater Mekong subregion, which included a regional framework for action for 2013–2015. The framework would be assessed from the perspective of the countries affected. The data on weakened efficacy of artemisinin-based combination therapy had been reviewed by the Malaria Policy Advisory Committee which, following further study, would be issuing recommendations in that regard.

Insecticide resistance remained a major threat to malaria control efforts, and in response WHO had launched a global plan for insecticide resistance management in 2012. The plan called for increased monitoring efforts and the development of a country-specific response, as well as for the intensification of research to identify new insecticides and new approaches to vector control.

In respect of funding, Member States had acknowledged the importance of the Global Fund to Fight AIDS, Tuberculosis and Malaria, since it represented about 60% of international resources. Nevertheless, it was satisfying to note that domestic resources were increasing. He called on all partners to work together to ensure funding for malaria control until the disease had been fully eliminated.

**The Committee noted the report.**

**2. NONCOMMUNICABLE DISEASES:** Item 13 of the Agenda (continued)

**Draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases:** Item 13.1 of the Agenda (Documents A66/8 and A66/8 Add.1) (continued from the first meeting, section 3)

**Draft action plan for the prevention and control of noncommunicable diseases 2013–2020:** Item 13.2 of the Agenda (Documents A66/9 and A66/9 Corr.1) (continued from the first meeting, section 3)

The CHAIRMAN drew attention to a revised draft resolution that had been prepared by a drafting group set up at the Committee's first meeting. The revised draft resolution, proposed by the delegations of Australia, Bahrain, Barbados, Belgium, Brazil, Canada, China, Colombia, Costa Rica, Côte d'Ivoire, Denmark, Djibouti, Finland, Ghana, Iraq, Libya, Malaysia, Mexico, Monaco, Mongolia, Nigeria, Norway, Pakistan, Panama, Russian Federation, Singapore, South Africa, Spain, Suriname, Sweden, Switzerland, Thailand, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America, Uruguay, and Zimbabwe, read:

The Sixty-sixth World Health Assembly,

PP1 Having considered the reports by the Secretariat to the Sixty-sixth World Health Assembly on noncommunicable diseases;<sup>1</sup>

PP2 Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases,<sup>2</sup> which acknowledges that the global burden and threat of noncommunicable diseases constitutes one of the major challenges for development in the twenty-first century and which also requests the development of a comprehensive global monitoring framework, including a set of indicators, calls for recommendations on a set of voluntary global targets, and requests options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership;

PP3 Welcoming the outcome document of the United Nations Conference on Sustainable Development (Rio de Janeiro, 20–22 June 2012), entitled "The future we want",<sup>3</sup> which commits to strengthen health systems towards the provision of equitable, universal health coverage and promote affordable access to prevention, treatment, care and support related to noncommunicable diseases, especially cancer, cardiovascular diseases, chronic respiratory diseases and diabetes, and commits to establish or strengthen multisectoral national policies for the prevention and control of noncommunicable diseases;

PP4 Taking note with appreciation of all the regional initiatives undertaken on the prevention and control of noncommunicable diseases, including the Declaration of the Heads of State and Government of the Caribbean Community entitled "Uniting to stop the epidemic of chronic noncommunicable diseases", adopted in September 2007, the Libreville Declaration on Health and Environment in Africa, adopted in August 2008, the statement of the Commonwealth Heads of Government on action to combat noncommunicable diseases, adopted in November 2009, the declaration of commitment of the Fifth Summit of the Americas, adopted in June 2009, the Parma Declaration on Environment and Health, adopted by the Member States of the WHO European Region in March 2010, the Dubai Declaration on Diabetes and Chronic Noncommunicable Diseases in the Middle East and Northern Africa Region, adopted in December 2010, the European Charter on Counteracting Obesity, adopted in

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<sup>1</sup> Documents A66/8 and A66/9.

<sup>2</sup> United Nations General Assembly resolution 66/2.

<sup>3</sup> United Nations General Assembly resolution 66/288.

November 2006, the Aruba Call for Action on Obesity of June 2011, and the Honiara Communique on addressing noncommunicable disease challenges in the Pacific region, adopted in July 2011;

PP5 Acknowledging the Moscow Declaration adopted by the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, 28–29 April 2011), endorsed by the Sixty-fourth World Health Assembly (resolution WHA64.11), which requests the Director-General to develop, together with relevant United Nations agencies and entities, an implementation and follow-up plan for the outcomes of the Conference and the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases (New York, 19–20 September 2011) for submission to the Sixty-sixth World Health Assembly;

PP6 Acknowledging also the Rio Political Declaration on Social Determinants of Health adopted by the World Conference on Social Determinants of Health (Rio de Janeiro, 19–21 October 2011), endorsed by the Sixty-fifth World Health Assembly in resolution WHA65.8, which recognizes that health equity is a shared responsibility and requires the engagement of all sectors of government, all segments of society, and all members of the international community, in an “all-for-equity” and “health-for-all” global action;

PP7 Recalling resolution EB130.R7, which requests the Director-General to develop, in a consultative manner, a WHO global action plan for the prevention and control of noncommunicable diseases for 2013–2020 and decision WHA65(8)<sup>1</sup> and its historic decision to adopt a global target of a 25% reduction in premature mortality from noncommunicable diseases by 2025;

PP8 Reaffirming WHO’s leading role as the primary specialized agency for health, including its roles and functions with regard to health policy in accordance with its mandate, and reaffirming its leadership and coordination role in promoting and monitoring global action against noncommunicable diseases in relation to the work of other relevant United Nations agencies, development banks and other regional and international organizations in addressing noncommunicable diseases in a coordinated manner;

PP8*bis* Recognizing the primary role and responsibility of governments in responding to the challenges of noncommunicable diseases;

PP8*ter* Recognizing also the important role of the international community and international cooperation in assisting Member States, particularly developing countries, in complementing national efforts to generate an effective response to noncommunicable diseases;

PP9 Stressing the importance of North–South, South–South and triangular cooperation in the prevention and control of noncommunicable diseases, to promote at the national, regional and international levels an enabling environment to facilitate healthy lifestyles and choices, bearing in mind that South–South cooperation is not a substitute for, but rather a complement to, North–South cooperation;

PP10 Noting that noncommunicable diseases are often associated with mental disorders and other conditions and that mental disorders often coexist with other medical and social factors as noted in resolution WHA65.4 and that, therefore, the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020 is expected to be implemented coherently and in close coordination with the WHO global mental health action plan 2013–2020 and other WHO action plans at all levels;

PP11 Welcoming the overarching principles and approaches of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020,<sup>2</sup> and calling for their application in the implementation of all actions to prevent and control noncommunicable diseases;

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<sup>1</sup> Decision WHA65(8), WHA65/2012/REC/1.

<sup>2</sup>As detailed in paragraph 18 of the action plan.

PP12 Recognizing that the United Nations Secretary-General, in collaboration with Member States, WHO and relevant funds, programmes and specialized agencies of the United Nations system is to present to the United Nations General Assembly at its sixty-eighth session a report on the progress achieved in realizing the commitments made in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, in preparation for a comprehensive review and assessment in 2014 of the progress achieved in the prevention and control of noncommunicable diseases,

DECIDES:

OP1 to endorse the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020;<sup>1</sup>

OP2 to adopt the comprehensive global monitoring framework for the prevention and control of noncommunicable diseases, including the set of 25 indicators capable of application across regional and country settings to monitor trends and to assess progress made in the implementation of national strategies and plans on noncommunicable diseases, as detailed in Appendix 1 of document A66/8;

OP3 to adopt the set of nine voluntary global targets for achievement by 2025 for the prevention and control of noncommunicable diseases, as detailed in Appendix 2 of document A66/8, noting that the target related to a 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases concerns premature mortality from noncommunicable diseases between ages 30 and 70, in accordance with the corresponding indicator;

OP4 URGES Member States:<sup>2</sup>

(1) to continue to implement the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, strengthening national efforts to address the burden of noncommunicable diseases, and continuing to implement the Moscow Declaration;

(2) to implement, as appropriate, the action plan and to take the necessary steps to meet the objectives contained therein;

(2bis) to enhance the capacity, mechanisms and mandates, as appropriate, of relevant authorities in facilitating and ensuring action across government sectors;

(3) to accelerate implementation by Parties of the WHO Framework Convention on Tobacco Control, including through adopted technical guidelines; other countries to consider acceding to the Convention, as well as to give high priority to the implementation of the Global Strategy on Diet, Physical Activity and Health endorsed in resolution WHA57.17, the global strategy to reduce the harmful use of alcohol endorsed in resolution WHA63.13, and the recommendations on the marketing of foods and non-alcoholic beverages to children endorsed in resolution WHA63.14, as being integral to making progress towards the voluntary global targets and realizing the commitments made in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases;

(4) to promote, establish, support and strengthen engagement or collaborative partnerships, as appropriate, including with non-health and non-State actors, such as civil society and the private sector, at the national, subnational and/or local levels for the prevention and control of noncommunicable diseases, according to country circumstances, with a broad multisectoral approach, while safeguarding public health

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<sup>1</sup> See WHA66/2013/REC/1, Annex 4.

<sup>2</sup> And, where applicable, regional economic integration organizations.

interests from undue influence by any form of real, perceived or potential conflict of interest;

(5) to consider the development of national noncommunicable disease monitoring frameworks, with targets and indicators based on national situations, taking into consideration the comprehensive global monitoring framework, including the 25 indicators and a set of nine voluntary global targets, building on guidance provided by WHO, to focus on efforts to prevent and address the impacts of noncommunicable diseases, to support scaling up effective noncommunicable disease actions and policies, including technical and financial aspects, and to assess the progress made in the prevention and control of noncommunicable diseases and their risk factors and determinants;

(6) to establish and strengthen, as appropriate, a national surveillance and monitoring system to enable reporting including against the 25 indicators of the comprehensive global monitoring framework, the nine voluntary global targets, and any additional regional or national targets and indicators for noncommunicable diseases;

(7) to recommend that the United Nations Economic and Social Council considers the proposal for a United Nations Task Force on Noncommunicable Diseases, which would coordinate the activities of the United Nations organizations in the implementation of the WHO global noncommunicable disease action plan before the end of 2013, which would be convened and led by WHO and report to ECOSOC, incorporating the work of the United Nations Ad Hoc Interagency Task Force on Tobacco Control while ensuring that tobacco control continues to be duly addressed and prioritized in the new task force mandate;

(8) to support the work of the Secretariat to prevent and control noncommunicable diseases, in particular through funding relevant work included in the programme budgets;

(9) to continue to explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms and to increase, as appropriate, resources for national programmes for prevention and control of noncommunicable diseases;

#### OP5 REQUESTS the Director-General:

(1) to submit the detailed and disaggregated information on resource requirements necessary to implement the actions for the Secretariat included in the global action plan for the prevention and control of noncommunicable diseases 2013–2020, including information on the financial implications of the establishment of a global coordination mechanism for the prevention and control of noncommunicable diseases, to the first financing dialogue convened by the Director-General and facilitated by the Chairman of the Programme, Budget and Administration Committee of the Executive Board, on the financing of the Programme budget 2014–2015, with a view to ensuring that all partners have clear information on the specific funding needs, available resources and funding shortfalls of the actions for the Secretariat included in the action plan at the project or activity level;

(2) to develop draft terms of reference for a global coordination mechanism, as outlined in paragraphs 14–15 of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, aimed at facilitating engagement among Member States, United Nations funds, programmes and agencies, and other international partners and non-State actors, while safeguarding WHO and public health from undue influence by any form of real, perceived or potential conflicts of interest, without pre-empting the results of ongoing WHO discussions on engagement with non-State actors;

- (3) to develop the draft terms of reference referred to in paragraph 5.2 through a formal Member States'<sup>1</sup> meeting in November 2013, preceded by consultations with:
- (i) Member States,<sup>1</sup> including through regional committees;
  - (ii) United Nations agencies, funds and programmes and other relevant intergovernmental organizations;
  - (iii) nongovernmental organizations and private sector entities, as appropriate, and other relevant stakeholders;
- and to be submitted, through the Executive Board, to the Sixty-seventh World Health Assembly for approval;
- (4) to develop, in consultation with Member States and other relevant partners, a limited set of action plan indicators to inform reporting on progress, which build on the work under way at regional and country levels, are based on feasibility, current availability of data, best available knowledge and evidence, are capable of application across the six objectives of the action plan, and minimize the reporting burden on Member States to assess progress made in 2016, 2018 and 2021 in the implementation of policy options for Member States, recommended actions for international partners, and actions for the Secretariat included in the action plan, and to submit the draft set of action plan indicators, through the Executive Board, to the Sixty-seventh World Health Assembly for approval;
- (5) to work together with other United Nations funds, programmes and agencies to conclude the work, before the end of October 2013, on a division of tasks and responsibilities for United Nations funds, programmes and agencies and other international organizations;
- (6) to provide technical support to Member States, as required, to support the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020;
- (7) to provide technical support to Member States, as required, to establish or strengthen national surveillance and monitoring systems for noncommunicable diseases to support reporting under the global monitoring framework for noncommunicable diseases;
- (8) to provide technical support to Member States, as required, to engage/cooperate with non-health government sectors and, in accordance with principles for engagement, with non-State actors,<sup>2</sup> in the prevention and control of noncommunicable diseases;
- (9) to submit reports on progress made in implementing the action plan, through the Executive Board, to the Health Assembly in 2016, 2018<sup>3</sup> and 2021,<sup>2</sup> and reports on progress achieved in attaining the nine voluntary global targets in 2016, 2021 and 2026;
- (10) to propose an update of Appendix 3 of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, as appropriate, to be considered, through the Executive Board, by the World Health Assembly, in the light of new scientific evidence and to continue to update, as appropriate Appendix 4.

Mr McIFF (United States of America), speaking in his capacity as co-chair of the drafting group established by the Committee at its first meeting, said that the drafting group had been open to all Member States and had held nine meetings. The drafting group had reached consensus on several new tasks to be assigned to the Secretariat, including the provision of technical support to Member States with implementation of the revised global action plan; the development of terms of reference for a

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<sup>1</sup> And, where applicable, regional economic integration organizations.

<sup>2</sup> Without prejudice to ongoing discussions on WHO engagement with non-State actors.

<sup>3</sup> The progress reports in 2018 and 2021 should include the outcomes of independent evaluation of the implementation of the global action plan conducted in 2017 and 2020.

global coordination mechanism; the development of a limited set of action plan indicators to be used in reporting on progress to the governing bodies; and the updating of a menu of policy options and cost-effective interventions for the prevention and control of noncommunicable diseases.

He wished to highlight several events that had taken place during the meetings of the drafting group. First, the Secretariat had assured Member States that the participation of non-State actors in the proposed global coordination mechanism would be in line with the principles concerning the Organization's engagement with non-State actors, to be considered by the Sixty-seventh World Health Assembly. Secondly, Member States had agreed that the Secretariat would make document A65/7 and United Nations General Assembly document A/67/373 available as background documents during the consultations prior to the formal meeting to complete work on terms of reference for the global coordination mechanism. Thirdly, the delegate of Mongolia had requested the Secretariat to begin work on an instrument relating to the harmful use of alcohol, similar in nature to the Framework Convention on Tobacco Control. However, it had become clear in recent years that, although Member States agreed on the objective of reducing the harmful use of alcohol, not all supported the idea of a convention. The Secretariat could not therefore start work on a convention until a consensus had been reached. Fourthly, the Secretariat had assured Member States that it would pursue its efforts to explore informal collaborative arrangements regarding palliative care and pain management with the United Nations Office on Drugs and Crime and the International Narcotics Control Board. Fifthly, the Secretariat had given its assurances that it would include an update on the progress made in completing the tasks assigned to the Organization in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, and in the present draft resolution, in the report of the Director-General of WHO that would serve as input for a comprehensive review and assessment of the prevention and control of noncommunicable diseases, to be conducted by the United Nations General Assembly in 2014.

Dr AHMED ELBASHEER (Sudan), endorsing the draft global action plan and the draft comprehensive global monitoring framework, said that she was pleased that the drafting committee had taken into consideration the reservations expressed by her delegation, so that children were now taken into account in both drafts.

Dr SON Hyun-jin (Republic of Korea) welcomed the draft action plan and the draft monitoring framework. Her country had high expectations for the interim reports that would be issued in 2015 and 2020 and the final report in 2025.

The Republic of Korea, which was currently serving as Chair for the Conference of the Parties to the WHO Framework Convention on Tobacco Control, considered that the Convention had been producing visible and tangible results for which WHO should be credited. It might be possible to envisage a similar initiative in the area of alcohol.

Given the potential for friction between health and commerce, the Secretariat should be encouraged to strengthen dialogue and collaboration with economic organizations such as WTO and WIPO.

Professor MESBAH (Algeria) emphasized the importance that his country attached to access to affordable medicines, particularly in light of the high cost of medicines for noncommunicable diseases. He looked to WHO for support in establishing mechanisms for bulk procurement of medicines and in promoting local production through intercountry cooperation, which was particularly important for countries such as his own with emerging pharmaceutical industries.

Ms DÁVILA CHÁVEZ (Mexico) said that Mexico's national strategy to tackle its serious problem of overweight and obesity and to reduce the preventable and avoidable burden of morbidity, mortality and disability due to noncommunicable diseases was focused on three major areas: health promotion and prevention, effective access to health services, and public policy. That approach was fully in line with the overarching principles of the draft global action plan. To enable Member States

to make realistic commitments, the voluntary global targets set out in the plan should take national conditions into account.

Mr O'BRIEN (Trinidad and Tobago) said that his country wished to sponsor the draft resolution under consideration. The Heads of Government of the countries of the Caribbean Community (CARICOM) had worked very hard to place noncommunicable diseases on the United Nations development agenda and he urged the Secretariat to ensure that the item would continue to have priority on that agenda.

Dr AL-TAAE (Iraq), confirming the agreement that had been reached within the Eastern Mediterranean Region concerning the draft global action plan, said that Iraq's strategic plan for the prevention and control of noncommunicable diseases had been incorporated into its national development plan. All the relevant ministries were working in partnership with the private sector to achieve the goals relating to noncommunicable diseases, and a national committee had been set up to monitor and evaluate progress towards those goals, for which a time limit had been set. The strategic plan had also been incorporated into primary health care and family medicine. Surveillance of noncommunicable and communicable diseases had been linked, and efforts had been made to incorporate noncommunicable diseases into other health strategies to ensure that account was taken of them in programme implementation mechanisms at the district and community levels.

Mr ZITKO (Slovenia) said that noncommunicable diseases and related health inequalities posed a growing challenge for his country. His Government had begun reforming the primary health care system with a view to strengthening prevention, detection and case management of noncommunicable diseases. The draft comprehensive global monitoring framework and the 25 indicators it contained would serve as a guide for national efforts to reduce health inequalities.

Slovenia had spearheaded the efforts to launch the European Partnership on Action Against Cancer and was particularly concerned by diseases attributable to preventable environmental factors, including exposure to chemicals. Resolution WHA63.26 on the improvement of health through sound management of obsolete pesticides and other obsolete chemicals reflected the resolution adopted by the International Conference on Chemicals Management at its first session in February 2006, and implementation of both resolutions was crucial for easing the burden of noncommunicable diseases. He endorsed the recent appeal of the UNEP Governing Council that WHO continue to provide health expertise within the secretariat of the Strategic Approach to International Chemicals Management.

Ms LANGEROCK (Belgium), welcoming the draft global action plan, said that the social determinants of health should be kept in mind when adapting the plan to national realities, in order to reduce inequalities between and within countries as much as possible. Multisectoral action at the global and national levels was essential, and she therefore endorsed the proposed global coordination mechanism. The agreements reached in respect of the draft global action plan and the draft comprehensive global monitoring framework were balanced compromises, and her country was proud to be a sponsor of the draft resolution. The next step in facing the global public health challenge presented by noncommunicable diseases was to implement the measures set out in the action plan.

Ms GÓNGORA TORRES (Colombia) said that the population of Colombia suffered disproportionately from noncommunicable diseases, particularly cardiovascular disease, which was the principal cause of morbidity and mortality. Her Government endorsed the request in the draft resolution that the Director-General develop terms of reference for a global coordination mechanism because, under a "health-in-all-policies" approach (which Colombia supported), as it was important to establish objectively the contributions of "all" to health. The social, economic and environmental aspects of health, as well as the risks of co-morbidity, should be kept in mind during implementation of the global action plan, which should be adapted to the contexts of individual countries.



Ms WISEMAN (Canada) commended all those who had been involved in drafting the global action plan. The plan was comprehensive and would engage all stakeholders and sectors, under the leadership of WHO, in the task of reducing the global burden of noncommunicable diseases. The draft global action plan and the draft comprehensive global monitoring framework had her delegation's full support.

Dr ALOMARI (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that the International Federation had developed a framework for noncommunicable disease prevention and control. Prevention started at the community level, where Red Cross and Red Crescent Societies played a critical role in helping people to become better informed, and better equipped to take care of their own health. His organization was leading a process of developing harmonized evidence-based tools for healthy lifestyles, which would be adapted by national branches to local contexts. Member States should strike a balance between care and prevention; ensure that prevention approaches were at the centre of all strategies; and ensure that universal health coverage and noncommunicable diseases were included in the post-2015 development agenda.

Ms Yu-Hsuan LIN (Chinese Taipei) said that Chinese Taipei had a highly efficient universal health coverage system that produced results comparable to those of the developed countries. Ensuring the sustainability of health care systems required health promotion, prevention and equitable social development. Furthermore, political engagement and social mobilization were crucial to implementing a "health-in-all-policies" approach and achieving health targets. Chinese Taipei had used benchmarking and monitoring as tools for fostering political commitment. It had included health on the development agenda, with the specific goals of reducing cancer mortality and smoking prevalence and increasing physical activity, and efforts to do so were being supported with revenue from a tobacco tax.

Ms MORTON DOHERTY (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN, commended the Organization's leadership in mobilizing action to fulfil the commitments of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (General Assembly resolution 66/2). She called on Member States to: adopt the draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases, including the 25 indicators and nine voluntary global targets, in order to ensure accountability among all stakeholders; determine action for the next phase of the global response to noncommunicable diseases by adopting the draft global action plan; agree to set up a global coordination mechanism to fill what had been a critical weakness in the response to noncommunicable diseases; integrate the global noncommunicable disease architecture into global health and development agendas, including the post-2015 framework; and ensure long-term, predictable and sustainable funding for noncommunicable disease efforts nationally and internationally.

Mr STEWART (Corporate Accountability International), speaking at the invitation of the CHAIRMAN, endorsed the draft global action plan. Powerful corporations contributed significantly to the noncommunicable disease burden, and he therefore encouraged those working to reduce the burden to continue to focus their efforts on accelerating implementation of the WHO Framework Convention on Tobacco Control and of WHO's recommendations on the marketing of foods to children. Member States should not be encouraged to enter into partnerships or accept funding from the food, tobacco and alcohol industries, in view of potential conflicts of interest and the efforts of those industries to undermine progress on the prevention and control of noncommunicable diseases. High-quality, independent research must be safeguarded, and dietary and food policy should include recommended language and codes of conduct, in order to guard against undue commercial influence.

Marketing recommendations must be backed up by statutory regulations, and actions by the private sector to self-regulate or interfere with public health policy should be monitored.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, welcomed the emphasis in the draft global action plan on health system strengthening as essential to achieving the voluntary global targets and expressed satisfaction that counselling had been included under voluntary global target 8 as a factor in preventing heart attacks and strokes, since counselling would help to maximize the effect of medicines and other technologies and reduce costs. Pharmacists should be included in paragraph 30(h) of document A66/9 concerning the health workforce, since their advice often had a strong impact on patients. His organization, in collaboration with WHO and other stakeholders, had been assessing the status of the pharmacy workforce and working to reform pharmacy education.

Mr COLLINSWORTH (The International Association for the Study of Obesity), speaking at the invitation of the CHAIRMAN, welcomed the draft global action plan and called on Member States to adopt it. He endorsed the objective of reducing modifiable risk factors for noncommunicable diseases and welcomed the voluntary global targets relating to diet. Member States should endorse the full range of policy and regulatory options for promoting a healthy diet, as set out in paragraphs 37 to 39 of the draft global action plan. Among the actions proposed for the Secretariat in the action plan, he welcomed in particular its policy guidance role, in which it would, inter alia, provide guidance to countries concerning management of conflicts of interest at national level, and its work on developing technical tools for implementation of cost-effective interventions. He also supported the division of labour set out in Appendix 4, under which the United Nations Standing Committee on Nutrition would facilitate harmonization of action for the reduction of dietary risk of noncommunicable diseases.

Mr TOBON GARCÍA (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, welcomed the draft global action plan and the draft comprehensive global monitoring framework. Nevertheless, despite promoting a social determinants approach to noncommunicable diseases, the action plan failed to provide for specific actions to be undertaken in that regard. In implementing the plan and framework, WHO should ensure transparency, establish policies regarding conflicts of interest, and develop guidelines restricting private sector involvement in policy-making. With regard to the risk factors associated with noncommunicable diseases, the Organization should support the right of Member States to regulate trade of unhealthy products, and encourage the development of incentives for the production and consumption of healthy food and drink. Government subsidies of products that were harmful to health should be eliminated. The draft global monitoring framework placed too much emphasis on outcome indicators and would benefit from a focus on input and process indicators.

Mrs PARISOTTO (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that the narrow focus of the draft global action plan on four specific diseases might give rise to a vertical approach that disregarded the influence of many social, environmental and economic determinants of health. Furthermore, the global action plan explicitly called for the involvement of the private sector and failed to mention how potential conflicts of interest might be managed. Another concern was how various industries endeavoured to influence the public health agenda. To combat that, it was crucial for Member States to conduct independent analyses and evaluations of the efficacy, safety, cost-effectiveness and feasibility of public health measures, including pharmaceutical interventions. She called on Member States to take concerted action and draw up effective policies at the global and national levels to address the underlying causes of noncommunicable diseases and the structural determinants created by the current model of global economic governance.

Ms SAMSON (European Society for Medical Oncology), speaking at the invitation of the CHAIRMAN, said that with respect to cancer care, she welcomed the focus in the draft global action plan on moving beyond prevention and ensuring a full continuum of care, including early detection, treatment and palliative care. Yet, there was a risk that the action plan could increase the cancer care gap between high- and low-income countries if Member States failed to implement a comprehensive response to noncommunicable diseases. Such a response would include linking screening and early detection to an increase in health systems' treatment capacity; providing treatment options beyond the primary health care level; prioritizing the availability of basic treatment options for cancer patients in low- and middle-income countries; and including palliative care interventions and the use of morphine for pain relief in national cancer care plans. She therefore supported the call for a draft resolution on palliative care to be submitted for consideration to the Sixty-seventh World Health Assembly.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the draft global action plan was a pragmatic document that recognized the extent of the challenge posed by noncommunicable diseases and proposed tangible measures for achieving results. Strategies that involved multiple stakeholders, were fully integrated into health care systems, and extended beyond the health sector, were needed at all levels. The pharmaceutical industry was helping to reduce the noncommunicable disease burden by developing new medicines (thousands of which were currently under study) to treat those diseases safely and effectively, and it would be glad to contribute its expertise to preparation of the proposed global coordination mechanism. On the question of conflicts of interest, the industry took the view that competing interests could be managed through declarations of interests and appropriate safeguards. The industry was working to ensure that medicines for noncommunicable diseases were available in resource-poor settings. In addition, under a recent agreement between the International Federation of Pharmaceutical Manufacturers and Associations and the International Federation of Red Cross and Red Crescent Societies, the two parties would work together to develop a behaviour change toolkit for broad distribution, which would give people the skills they needed to reduce their risk of developing noncommunicable diseases.

Ms SLOATE (GAVI Alliance), speaking at the invitation of the CHAIRMAN, said that her organization encouraged countries to work towards the voluntary global target of a 25% relative reduction in noncommunicable diseases by 2025. Evidence-based tools and interventions were needed to reach that goal, especially in resource-poor settings where access to screening and treatment was limited. Immunization had become a critical preventive factor and, in that regard, the inclusion of hepatitis B and human papillomavirus vaccines under the global monitoring framework was welcome since those vaccines, given at an early age, provided protection later on from liver cancer and cervical cancer, two of the leading causes of mortality in developing countries. The battle against noncommunicable diseases required strong partnerships and, in that framework, the GAVI Alliance would continue to broaden the reach of vaccine delivery in low-income countries.

Dr CHESTNOV (Assistant Director-General) said that adoption of the action plan would take the political process to the next level: all participants should "roll up their sleeves" and begin to put it into effect. Noncommunicable diseases provided the opportunity to improve international cooperation. Universal forces, including globalization, urbanization, poverty and population ageing, were responsible for the sudden increase in noncommunicable diseases and risk factors. The global coordination mechanism that would be developed in the coming months would reinforce the importance of international cooperation for the prevention and control of noncommunicable diseases. Ongoing research on noncommunicable diseases provided Member States with evidence-based tools and an assortment of best practices, which had been included in Appendix 3 to the draft action plan, and he urged Member States to make use of that precious resource. There was still a need for tools to support Member States' efforts to elaborate national goals for the prevention and control of noncommunicable diseases, taking account of the two global objectives included in the draft action

plan. The Secretariat was hard at work on that assignment and planned to involve Member States, research institutions, nongovernmental organizations and other partners in the process.

With regard to improving access to medical treatment for noncommunicable diseases in the developing world, he was strongly in favour of providing support to countries with developing market economies, especially through competitive pricing of quality generics. The issue was being taken up by foreign ministries and health ministries in both traditional donor States and others, including Brazil, the Russian Federation, India, China and South Africa. He urged Member States to help one another in achieving by 2025 the nine voluntary global targets included in the global action plan. For its part, WHO would provide technical support.

The DIRECTOR-GENERAL said that the consensus at which Member States had arrived with regard to the draft global monitoring framework for the prevention and control of noncommunicable diseases and its voluntary global targets represented a milestone for the Organization. In conjunction with the framework, the draft global action plan would be critical for translating political vision and commitment into action. Coordination was another essential element in implementing the global action plan at the international and country levels. Global health in the twenty-first century was a matter of multisectoral and multi-stakeholder participation. In the case of noncommunicable diseases, which was a vast field, the question was, what contributions could individual stakeholders make? Was the food industry prepared to reformulate its products to produce healthy food and to refrain from marketing unhealthy foods to young children? Above all, was the food industry prepared to refrain from interfering with government efforts to protect the public? Ministers worldwide had informed her that they were under great pressure from industry lobby groups. Engagement, participation and contributions from all sources were always welcome, but interference definitely was not. A monitoring framework and action plan for the prevention and control of noncommunicable diseases had been agreed upon by the Member States. Partners that wished to be part of that process had to operate transparently, honestly, and in full compliance with the regulations.

The Organization would strengthen its capacity, ensure that its work was based on science and technical excellence, and focus its attention on supporting countries in the implementation of the policies and the action plan. Noncommunicable diseases must be integrated with the Millennium Development Goals and with communicable diseases; otherwise the work would not be cost-effective. An integrated approach based on people-centred primary health care that addressed the social determinants of health was the way forward. Implementation was the difficult part, and the Organization needed the Member States' continued support, guidance and funding, as well as patience and understanding. She pledged to collaborate closely with other organizations in the United Nations system and with other sectors. Noncommunicable diseases threatened the development of many countries if appropriate action was not taken.

Ms JACOB (Ireland), speaking on behalf of the Member States of the European Union, expressed her appreciation to the chair of the Member States' meeting on the global monitoring framework and to the co-chairs of the drafting group for their unceasing energy and positive outlook throughout those processes. She also wished to thank the Member States and the Secretariat for their hard work and commitment. The adoption of the global action plan and the comprehensive global monitoring framework would be a milestone in WHO's collective response to the challenge posed by noncommunicable diseases.

**The meeting rose at 12:10.**