PROVISIONAL SUMMARY RECORD OF THE TWELFTH MEETING

Palais des Nations, Geneva
Saturday, 24 May 2014, scheduled at 14:30

Chairman: Professor PE THET KHIN (Myanmar)

CONTENTS

1. Organization of work

2. Promoting health through the life course (continued)
   - Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention (continued)
   - Contributing to social and economic development: sustainable action across sectors to improve health and health equity

3. Preparedness, surveillance and response (continued)
   - Implementation of the International Health Regulations (2005)

4. WHO reform (continued)
   - Framework of engagement with non-State actors (continued)

5. Preparedness, surveillance and response (resumed)
   - Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits

6. Organization of work

7. Promoting health through the life course (resumed)
   - Monitoring the achievement of the health-related Millennium Development Goals (continued)
     - Health in the post-2015 development agenda (continued)
   - Addressing the global challenge of violence, in particular against women and girls (continued)

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Organization of work</td>
<td>3</td>
</tr>
<tr>
<td>2. Promoting health through the life course (continued)</td>
<td>3</td>
</tr>
<tr>
<td>Public health impacts of exposure to mercury and mercury compounds:</td>
<td>3</td>
</tr>
<tr>
<td>the role of WHO and ministries of public health in the implementation of the Minamata Convention (continued)</td>
<td>3</td>
</tr>
<tr>
<td>Contributing to social and economic development: sustainable action across sectors to improve health and health equity</td>
<td>6</td>
</tr>
<tr>
<td>3. Preparedness, surveillance and response (continued)</td>
<td>10</td>
</tr>
<tr>
<td>Implementation of the International Health Regulations (2005)</td>
<td>10</td>
</tr>
<tr>
<td>4. WHO reform (continued)</td>
<td>15</td>
</tr>
<tr>
<td>Framework of engagement with non-State actors (continued)</td>
<td>15</td>
</tr>
<tr>
<td>5. Preparedness, surveillance and response (resumed)</td>
<td>17</td>
</tr>
<tr>
<td>Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits</td>
<td>17</td>
</tr>
<tr>
<td>6. Organization of work</td>
<td>20</td>
</tr>
<tr>
<td>7. Promoting health through the life course (resumed)</td>
<td>20</td>
</tr>
<tr>
<td>Monitoring the achievement of the health-related Millennium Development Goals (continued)</td>
<td>20</td>
</tr>
<tr>
<td>Health in the post-2015 development agenda (continued)</td>
<td>20</td>
</tr>
<tr>
<td>Addressing the global challenge of violence, in particular against women and girls (continued)</td>
<td>29</td>
</tr>
</tbody>
</table>
8. Preparedness, surveillance and response (resumed)
   Smallpox eradication: destruction of variola virus stocks .......................... 39
9. Progress reports .................................................................................................. 44
10. Sixth report of Committee A ........................................................................... 50
11. Closure of the meeting ..................................................................................... 50
COMMITTEE A
TWELFTH MEETING
Saturday, 24 May 2014, at 14:45
Chairman: Professor PE THET KHIN (Myanmar)

1. ORGANIZATION OF WORK

The CHAIRMAN announced that, following consultation between the President of the Health Assembly and the chairmen of Committees A and B, item 16.5 (Antimicrobial drug resistance) would be transferred to Committee B.

It was so agreed.

2. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 14 of the Agenda (continued)

Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention: Item 14.5 of the Agenda (Documents A67/24 and EB134/2014/REC/1, resolution EB134.R5) (continued from the eleventh meeting, section 2)

Dr GAMKRELIDZE (Georgia) said that his country was a signatory to the Minamata Convention on Mercury. He supported the draft resolution contained in resolution EB134.R5 and asked for Georgia to be added to the list of sponsors.

Mr ZHANG Yong (China) commended WHO’s support for the Minamata Convention. China was in the process of industrialization and had high levels of mercury pollution. The Secretariat should provide developing countries like China with timely and appropriate capacity-building support and technical guidance, including for technology transfer, as well as support in mobilizing financial resources for the implementation of the Convention.

Mr AL ATAWI (Bahrain) expressed support for the Minamata Convention and urged the Committee to approve the draft resolution.

Ms RÍOS (Argentina) agreed that plans to reduce exposure and phase out the use of mercury in the health sector should be developed. It was essential to monitor and control the risk situations that could lead to direct or indirect exposure. Argentina was committed to developing and implementing national policies aimed at prohibiting the import, extraction, production and sale of mercury and mercury-containing products and to eliminating the use of such products in the health sector. She supported the amendment proposed by the delegate of Uruguay during the previous meeting.

Mr FERDINAN TARIGAN (Indonesia) said that his country was a signatory to the Minamata Convention. It had participated in the South-East Asian subregional workshop for the ratification and
early implementation of the Convention (Kuala Lumpur, March 2014), which had recommended the elimination of mercury in products and devices by 2020. Indonesia was developing a national roadmap to eliminate mercury and mercury components from all products, with the focus in the health sector on clinical and laboratory devices, and stood ready to work with other countries and stakeholders to reduce mercury emissions and releases.

Mr DARR (United States of America) expressed support for the draft resolution. He appreciated the Secretariat’s commitment to raising awareness of the health risks of mercury exposure and encouraged Member States to take the necessary domestic steps to implement the Minamata Convention.

Ms ALGOE (Suriname), speaking on behalf of the members of the Union of South American Nations, welcomed the involvement of WHO in the negotiations on the Minamata Convention and the inclusion in the Convention of a specific article on health aspects. As health ministries would be pivotal to implementation of the Convention, the Secretariat should provide advice and technical cooperation to support Member States in their strategies and programmes and continue to cooperate closely with the Intergovernmental Negotiating Committee, the Conference of the Parties to the Convention and other international bodies. Multilateral instruments were important tools for promoting convergence between the environmental and health dimensions, and WHO’s engagement in work done under international agreements with an impact on health and the environment should be strengthened.

Dr ABUGALIA (Libya) expressed support for the draft resolution, and the Minamata Convention on Mercury, noting the extreme danger that mercury posed to human health.

Ms JIMÉNEZ VALDEZ (Mexico) welcomed WHO’s contribution to developing the Minamata Convention. Her Government had already begun to implement the provisions of the Convention. Consideration should be given to the problems associated with mercury exposure among mine workers and their families and to the development of health and environmental surveillance systems. The draft resolution should make reference to financing mechanisms intended to facilitate implementation of the Convention, and the Secretariat should call on those States with the necessary resources to provide technical support and assistance to facilitate ratification. All States should develop a plan of action tailored to their circumstances.

Dr REDDY (India) expressed support for the report and the Minamata Convention.

Ms LUNA (Ecuador) recalled that, in the negotiation of the Minamata Convention, Ecuador had led the discussions resulting in the inclusion of Article 16 on health aspects and had been a sponsor of resolution EB134.R5. She supported the amendment proposed by the delegate of Uruguay.

Ms HALÉN (Sweden) expressed support for the draft resolution, as amended by Uruguay. She also welcomed the Secretariat’s proposal in the report (paragraph 22) to consult Member States on identifying a set of core priority actions for the health sector.

Ms GONÇALVES (Brazil) said that important roles of health ministries in implementing the Convention would include building and strengthening national capacities for prevention and treatment of exposure to mercury; WHO’s support and an intersectoral approach would be crucial. She expressed support for the draft resolution and highlighted the need for WHO to cooperate with UNEP and other entities for implementation of the health-related aspects of the Convention.
Ms NURHUSSIEN (Eritrea) said that her country supported the implementation of the Minamata Convention and would work towards the achievement of its health-related goals by 2020.

Dr MONTECILLO NARVAEZ (United Nations Environment Programme) welcomed the continued strong political support for the Minamata Convention on Mercury, an instrument that had 97 signatories and had been ratified by one country. The Convention was unique among multilateral environmental agreements as it contained a specific article on health aspects. She praised WHO’s involvement in the development of the Convention and its support for global action on mercury, and called for strong political and financial engagement in implementing the Convention and cooperation at the national, regional and international levels to maximize the impact of action. She fully supported the draft resolution.

Ms SCHÜLKE (CMC – Churches’ Action for Health), speaking at the invitation of the CHAIRMAN, called upon countries with small-scale gold mining to act immediately to reduce the health threats of mercury – paying particular attention to children, who were unaware of its dangers – through monitoring mercury concentrations in mining communities and capacity-building. She welcomed the adoption of the Minamata Convention, noting the crucial role of the health sector in its implementation. WHO’s strong support for the Convention was encouraging, and she urged health ministries to do more to prevent, diagnose, treat and monitor the health effects of mercury.

Dr BUSTREO (Assistant Director-General) thanked Member States for their support of the report and the draft resolution and for the actions they had already initiated to implement the essence of the Minamata Convention. The Secretariat would continue to provide scientific evidence and technical advice and engage in awareness-raising concerning the public health impact of mercury. She acknowledged the leadership of Uruguay and the sponsors of the draft resolution.

The CHAIRMAN invited the Secretary to read out the proposed amendment to the draft resolution contained in resolution EB134.R5.

Dr ARMSTRONG (Secretary) recalled that the proposed addition of a new subparagraph 3(4) read: “to report to the Seventieth World Health Assembly in 2017 on progress in the implementation of this resolution.”

Mr SAMAR (Algeria) said that the report to be submitted to the Seventieth World Health Assembly should focus on health issues, rather than issues relating to the mandates of other organizations.

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

The draft resolution, as amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee’s sixth report and adopted as resolution WHA67.11.
Contributing to social and economic development: sustainable action across sectors to improve health and health equity: Item 14.6 of the Agenda (Documents A67/25 and EB134/2014/REC/1, resolution EB134.R8)

Ms KAIRMAMO (Finland) acknowledged the difficulty of translating into practice the knowledge that the environment, which was shaped by societal policies, had an important influence on health and health equity. A “health in all policies” approach was necessary, and the health sector had to act strategically and help other sectors to recognize the potential impact of their policies on population health and health equity. The focus of the 8th Global Conference on Health Promotion (Helsinki, June 2013) had been on how to implement a “health in all policies” approach, and the draft resolution contained in resolution EB134.R8 called for implementation of the outcome document of the conference. She expressed her gratitude to the sponsors of the draft resolution.

Ms MVILA (Congo), speaking on behalf of the Member States of the African Region, welcomed the outcomes of the 8th Global Conference on Health Promotion and expressed support for the measures envisaged in the draft resolution. The Member States of the Region recognized the need to meet their responsibilities as identified in the Regional Health Promotion Strategy (resolution AFR/RC51/R4). Health systems strengthening in Africa must be tailored to the needs of the population, especially the poor and vulnerable, through a primary health care approach. In order to achieve universal health coverage, several obstacles would have to be overcome, including the inequitable allocation of resources and the absence of coherent health financing policies, weak and fragmented health systems and the lack of access to high-quality medicines, and poor coordination of the growing number of global health initiatives. The Member States were committed to accelerating action to achieve universal health coverage.

Dr AL-JALAHMA (Bahrain) asked the Secretariat to provide the necessary guidance and technical assistance to Member States in order for them to be able to build their capacities for taking appropriate “health in all policies” initiatives and for protecting the most vulnerable groups, especially in emergency situations and conflict areas. He supported the draft resolution.

Mr MÜHLBACHER (Austria), welcoming the draft resolution, said that the 8th Global Conference on Health Promotion had provided a useful opportunity for the exchange of experience and best practice. As part of the national health reform process in Austria, efforts were being made to promote health equity and literacy and to focus on social determinants of health. The country also aimed to formulate and implement a “health for all” strategy.

Ms RÍOS (Argentina) noted that governments could only fulfil their responsibility for the health of their peoples through the adoption of appropriate health and social measures. The health sector must work with and coordinate policy-making with other sectors in order to improve water and sanitation, food safety and security, air quality and other social determinants of health, in keeping with the recommendations of the Commission on the Social Determinants of Health on action to reduce inequalities and achieve health equity. She supported the draft resolution, welcoming in particular the reference to the post-2015 development agenda.

Ms CHEN Ningshan (China) expressed appreciation of the efforts of the Secretariat to encourage intersectoral action for health promotion. China had been pursuing a multisectoral approach since the launch of its health campaign in the 1960s. Although the health of the population had improved, challenges remained with regard to sustainable action across sectors. She endorsed the draft resolution and supported the action suggested. She called upon the Secretariat to strengthen guidance and technical support to Member States, further enhance cooperation with other United Nations bodies
and international organizations, and raise awareness among decision-makers in other sectors with a view to ensuring that health became a core issue in major decisions at the global and country levels.

Dr FEISUL IDZWAN MUSTAPHA (Malaysia) welcomed the development of the Framework for Country Action to support Member States in implementing a “health in all policies” approach, which should include indicators agreed across all United Nations bodies working on social determinants of health. He supported the draft resolution and urged that it build on prior instruments, including resolutions of both the Health Assembly and the United Nations General Assembly, and avoid duplication.

Mr FERDINAN TARIGAN (Indonesia) said that health equity was a shared goal and responsibility requiring multisectoral and multistakeholder commitment at the highest level. The “health in all policies” approach would promote achievement of the Millennium Development Goals and should be considered in the post-2015 development agenda. The Secretariat should provide technical support to enable countries to implement that approach and increase their commitment to integrate a health perspective into the policies in other sectors. He supported the draft resolution.

Dr AL-TAAE (Iraq), expressing support for the draft resolution, said that health development must be fully integrated with economic and social development and further that the Millennium Development Goal indicators should also be integrated in order to further social development. He also highlighted the importance of community engagement and community-based initiatives in scaling up health development at the community level.

Ms SAIZ MARTÍNEZ-ACITORES (Spain) said that action across sectors was essential to improve health and health equity. Given the link between social determinants and health, the health sector must lead the effort to ensure the adoption of the “health in all policies” approach. Noting that Spain had sponsored the draft resolution, she said that her country had already been working for some time along the lines suggested in the text.

Dr GALINDEZ (Philippines), commending the leadership of Finland in promoting the “health in all policies” approach, drew attention to some of the multisectoral initiatives being undertaken by his country to encourage the participation of other stakeholders in the health agenda and promote health equity. The Philippines supported the draft resolution and would welcome guidance from the Secretariat on capacity-building and engagement with other sectors and advocacy for the improvement of health and the achievement of health equity.

Dr MAHIPALA (Sri Lanka), speaking on behalf of the Member States of the South-East Asia Region, welcomed the draft resolution, which was of great importance to the Region. Many countries in the Region already had long experience of intersectoral action to promote better health outcomes. The Framework on Health in All Policies for South-East Asia identified four strategic directions, including national, local and issue-specific strategies for promoting health in all policies, intersectoral collaboration on health concerns and health equity. The “health in all policies” approach could be facilitated through common initiatives, such as the Millennium Development Goals, national health reform, national and international legislative frameworks for health and intersectoral and financial mechanisms.

Dr GALVEZ (Panama), noting the impact of public policies on health and health equity, said that governments must redouble their efforts to implement coordinated action across sectors and countries in order to protect health and endow health systems with the necessary capacity to respond to health needs. Sustainable action across sectors was a core element in the management of his country’s
health policies and constituted the cornerstone for improvement of health indicators, particularly among the most disadvantaged people in society.

Miss ORRATAI WALEEWONG (Thailand) observed that it was not always easy to put the “health in all policies” approach into practice. In her country’s experience, key success factors were engagement and ownership of all stakeholders from policy formulation to implementation, as well as institutional capacity, transparency and accountability. She welcomed the Helsinki Statement on Health in All Policies and the paper on the Framework for Country Action. She supported the draft resolution, and her delegation would be pleased to participate in consultations on the Framework.

Ms DOAN PHUONG THAO (Viet Nam) said that her country recognized the important role of non-health sectors and the need for action across sectors to improve health equity. She supported the adoption of the draft resolution in principle; as all Member States must commit to developing sustainable institutional capacity, she recommended that subparagraph 2(3) be amended to begin: “to develop sustainable institutional capacity with adequate knowledge and skills in assessing health impacts of policy initiatives in all sectors, identifying solutions …”. In subparagraph 2(5) “and monitoring” should be replaced with “, monitoring and supervision” in order to highlight the role of civil society in supervising policies across sectors.

Mr ESPINOSA SALAS (Ecuador) said that his country wished to be added to the list of sponsors of the draft resolution.

Ms GONÇALVES (Brazil) said that the World Conference on Social Determinants of Health and the United Nations Conference on Sustainable Development had reaffirmed the importance of both health as an engine of sustainable socioeconomic development and intersectoral action in health policy-making. The Helsinki Statement on Health in All Policies identified actions to foster synergy between the health, economic and environmental sectors with a view to promoting equity. In the interests of advancing the achievement of that objective, Brazil had wished to join the list of sponsors of the draft resolution.

Ms Yu-Hsuan LIN (Chinese Taipei) agreed that health and health equity should be achieved through sustainable action across sectors. Implementing a “health in all policies” approach required political commitment from leaders at all levels, dissemination of evidence to guide policy-making and assessment of the health impacts of all policies of all sectors. In Chinese Taipei the health and social welfare systems had been integrated with a view to promoting synergies, enhancing the accountability of policy-makers for health impacts and enhancing health equity.

Ms BILAL (International Federation of Medical Students’ Associations), speaking at the invitation of the CHAIRMAN, said that the Health in All Policies Framework encouraged equity through the promotion of intersectoral collaboration and should ensure that the well-being of peoples was not considered a matter for the health industry only. However, the absence of a specific statement facilitating institutionalized accountability was a concern. She called on Member States to translate the “health in all policies” approach into effective legislation, in order to ensure that public health and equity were promoted in a sustainable manner and that health was prioritized in the post-2015 development agenda.

---

Dr LAU (International Society of Radiology), speaking at the invitation of the CHAIRMAN, said that more than two thirds of the global population had no access to basic radiology, even though that underpinned much of patient care and could contribute to the achievement of at least four Millennium Development Goals. He urged the Health Assembly to adopt a resolution reinstating a coordinating radiologist position in the Secretariat and initiating programme funding to increase access to safe and appropriate basic radiology in order to improve health and health equity.

Dr BETTCHER (Prevention of Noncommunicable Diseases), thanking delegates for their valuable comments and feedback, said that the Secretariat was fully committed to implementing the resolution and, in particular, to preparing, in consultation with Member States, United Nations organizations and other relevant stakeholders, a practical Framework for Country Action, for adaptation to different contexts, taking into account the Helsinki Statement on Health in All Policies. It would also collaborate with partners and Member States to build and maintain adequate and sustainable institutional capacity and skills at the regional and country levels in order to improve health and health equity outcomes through action across sectors. He looked forward to receiving ongoing guidance and support from Member States in that regard. He expressed special appreciation to the Government of Finland for its leadership in the domain of “health in all policies” and thanked the many sponsors of the draft resolution.

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

Mr ROBERTS (Assistant Secretary) said that Viet Nam had proposed that in subparagraph 2(3) the words “as appropriate, and maintain adequate” be removed, that “with adequate knowledge” be inserted after “capacity”, that “implications” be replaced by “impacts”, and that “exploring” be replaced by “identifying”, such that the subparagraph would read: “to develop sustainable institutional capacity with adequate knowledge and skills in assessing health impacts of policy initiatives in all sectors, identifying solutions …”. Viet Nam had also proposed that “implementation and monitoring” in subparagraph 2(5) be replaced with “implementation, monitoring and supervision”.

Professor HALTON (Australia), recalling that the draft resolution had been the subject of lengthy debate and compromise by the Executive Board, asked whether the delegate of Viet Nam might demonstrate flexibility and retain the existing text. She had difficulties with the proposed amendments, in particular the deletion of “as appropriate” in subparagraph 2(3), which could pose problems for some developed countries which already had in place some of the mechanisms called for, and the addition of “and supervision” in subparagraph 2(5).

Ms DOAN PHUONG THAO (Viet Nam) said that she could agree to withdraw her proposed amendment to subparagraph 2(5). As to subparagraph 2(3), she wished to add the words “with adequate knowledge” after “capacity”. In response to a clarification from the DIRECTOR-GENERAL, she agreed to retain the words “as appropriate”.

The CHAIRMAN said that, in the absence of any objection, he would take it that the Committee wished to approve the draft resolution, as amended.
The draft resolution, as amended, was approved.1

3. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 16 of the Agenda (continued)


Mr FERDINAN TARIGAN (Indonesia), speaking on behalf of the Member States of the South-East Asia Region, said that significant progress had been made in the Region in the detection and reporting of public health events and strengthening of core capacities since the revised International Health Regulations (2005) had come into force. All Member States of the Region had requested a two-year extension for implementation of core capacities. Two countries had already declared full compliance, but progress was uneven. He therefore called for increased efforts to support countries in establishing and maintaining core capacities; strengthen intersectoral collaboration at the international, national and subnational levels with all concerned stakeholders; and facilitate the mobilization of financial and technical resources for the establishment of core capacities. He welcomed the conclusion of the Strategic Advisory Group of Experts on immunization that a single dose of yellow fever vaccine was sufficient to confer life-long protection against the disease. He supported the draft resolution contained in resolution EB134.R10.

Dr AL-TAAE (Iraq), noting that important issues to be considered within the framework of the International Health Regulations (2005) included poliomyelitis, infections with the Middle East respiratory syndrome coronavirus (MERS-CoV), food safety and mass gatherings, highlighted the need for intersectoral and intercountry collaboration in applying the Regulations, and drew attention to collaboration between Afghanistan, the Islamic Republic of Iran, Iraq, Pakistan and WHO. He also noted the importance of the Secretariat’s role in capacity-building.

Dr GAMKRELIDZE (Georgia) noted with satisfaction that Georgia was among the countries that had met the core capacity requirements of the Regulations by 2012. He welcomed the Global Health Security Agenda launched in February 2014, which provided a global framework for detecting and responding to emerging health threats, and expressed support for the draft resolution.

Mr LUTNÆS (Norway) said that, despite the progress made, it was worrying that many countries had not yet established the core capacities under the International Health Regulations (2005). Norway supported the establishment by the Secretariat of a country-twinning programme to facilitate the exchange of best practices. It was working to identify areas in low- and middle-income countries that could be improved through bilateral and multilateral initiatives such as the Global Health Security Agenda, which involved 34 countries, including Norway. Such initiatives must, however, be consistent with the principles of the Regulations and reinforce WHO’s efforts to improve core capacities. He supported the draft resolution.

Mr KRANIAS (Greece), speaking on behalf of the European Union and its Member States, Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova, Armenia and Georgia, said that recent outbreaks of disease underlined the importance of the full implementation of the International Health

---

1 Transmitted to the Health Assembly in the Committee’s sixth report and adopted as resolution WHA67.12.
Regulations (2005). The Union’s Decision on serious cross-border threats to health would help to strengthen preparedness and response, and all international initiatives to strengthen the implementation of the Regulations, including the Global Health Security Agenda, were welcome. The Secretariat’s coordination of international efforts was crucial. The Regulations would remain a major component of preparedness and response as well as health system strengthening, and the Secretariat should intensify its work on putting resolution WHA65.23 into practice and its support for Member States in their implementation of the Regulations. Welcoming the technical briefing on strengthening health security by implementing the Regulations held during the current Health Assembly, he called on States to renew their commitment to the implementation of the Regulations.

Dr AMMAR (Lebanon) said that, for some of the Member States requesting extensions, civil unrest and political instability were the biggest obstacles to establishment of the core capacities. In Lebanon, for example, armed conflict and mass migration had hindered capacity-building and enforcement of the Regulations at points of entry and led to human resources shortages. As that situation was unlikely to improve in the near future, the June 2016 deadline might not be realistic for some countries unless exceptional measures were taken. Recent experiences had revealed weakness in coordination between National IHR Focal Points, notification of WHO, and sending of specimens to reference laboratories. Coordination mechanisms should be reviewed and Focal Points better trained in communication.

Ms CHO Soo-nam (Republic of Korea) said that recent health threats from avian influenza A(H7N9) and MERS-CoV had made the International Health Regulations (2005) more important than ever. Extensions should be granted for the implementation of core capacities under the Regulations, but great efforts by both States Parties and the Secretariat would be needed in order to meet the 2016 deadline. The Republic of Korea planned to establish an emergency committee, in accordance with the amended Regulations. Her Government would conduct research to determine whether it would apply the proposed amendment to the Regulations (2005) regarding yellow fever vaccination.

Ms GURBANOVA (Azerbaijan) said that monitoring infectious diseases had become increasingly important in the face of outbreaks and threats of potential pandemics associated with globalization, increased transport and increasing migration. Modern electronic disease surveillance systems were needed for that purpose. Azerbaijan had recently introduced such a system in order to improve data collection and analysis, and provide real-time information for analysis and decision-making. The system also facilitated information-sharing with other countries and with the Regional Office for Europe. Azerbaijan was prepared to share its experience with interested countries and partners.

Dr AL-JALAHMA (Bahrain) thanked the Strategic Advisory Group of Experts on immunization and the Director-General for providing support to countries in their implementation of the International Health Regulations (2005). Bahrain had robust surveillance and reporting mechanisms and a good system for capacity-building. Recent evaluation, with the assistance of six WHO experts, of the plan of action that had been prepared for applying the Regulations had concluded that the country could build up its capacities in order to apply the Regulations and that it did not need to request any extension of the deadline. She supported the draft resolution.

Dr MANAMOLELA (Lesotho), speaking on behalf of the Member States of the African Region, noted the exemplary response to MERS-CoV and the importance of the International Health Regulations (2005) as the main legal framework for responding to such epidemics. The Member States had taken note of the recommendation of the Strategic Advisory Group of Experts on immunization regarding yellow fever vaccination and would implement measures to accept vaccination certificates from travellers vaccinated at least 10 days before arrival. They recommended vigilance, however, and...
the establishment of early warning systems to contain any infections that might occur. She supported the draft resolution.

Dr FEISUL IDZWAN MUSTAPHA (Malaysia), acknowledging the Secretariat’s response to the emergence of MERS-CoV, expressed concern that even after two years many questions about the virus and its transmission in humans remained unanswered. The recent increase in reports of cases, including imported and travel-associated cases, was also of great concern. The Secretariat should intensify efforts to improve knowledge about the virus.

Mr ZHANG Yong (China) expressed appreciation of the Secretariat’s coordination of the response to MERS-CoV and other public health risks. Following the detection of cases of human infection with avian influenza A(H7N9) virus in April 2013, his Government had strengthened information-sharing and technical cooperation, as well as sharing of virus strains with WHO and relevant countries. Chinese health authorities and other relevant bodies were cooperating to build core public health capacities in order to meet the targets for 2014. Building core capacities was a long-term, sustained process, and the Secretariat should therefore continue to provide technical support to enable countries to fill gaps. He endorsed the proposed revisions to Annex 7 to the Regulations regarding yellow fever vaccination.

Mr BOISNEL (France), expressing support for the draft resolution, said that the International Health Regulations (2005) had proved their value as an international framework for responding to health threats associated with globalization and drew attention to the need for States Parties to have core capacities in place. Full implementation of the Regulations was an ongoing objective for France. The Secretariat must continue to support States Parties in implementing the Regulations. He welcomed initiatives aimed at accelerating that work, such as the Global Health Security Agenda. One component of preparedness and response in the context of the Regulations was the Pandemic Influenza Preparedness Framework, which he fully supported.

Dr HANSA RUFSAKOM (Thailand) supported the proposed revisions to Annex 7 of the Regulations. The large number of States Parties that had requested extensions of the deadline for establishing the core capacities demanded urgent attention from all relevant national and international actors. A clear and adequately funded capacity-building plan was needed; however, it remained the responsibility of States Parties to fill gaps and strengthen core capacities. Successful implementation of the Regulations hinged on the capacity of the National IHR Focal Points, which should receive sustained political and financial support, in particular to facilitate cross-sectoral collaboration. That was an important support role for the Secretariat.

Dr REDDY (India) said that India remained committed to the implementation of the International Health Regulations (2005) and had made good progress in establishing the core capacities. Having completed a self-assessment questionnaire in 2013, the country had requested an extension to 2016. He supported the draft resolution and agreed with the revised recommendations on yellow fever vaccination for travellers from countries where the disease was endemic. However, the proposal regarding revaccination of travellers from countries where yellow fever was not endemic should be reviewed, given that immunity levels in travellers from such countries, including India, would be lower because they would not have been frequently exposed to the virus. The Secretariat should continue to support national plans for the implementation of the Regulations.

Ms BONNER (Germany), noting that Germany had provided laboratory experts and financial support to help to contain the Ebola virus outbreak in Guinea, said that global health depended on global implementation of the International Health Regulations (2005), whose application must be a continuous process. Even after putting the core capacities in place, countries would need to maintain
and further develop them in order to keep up with new threats and technologies. The exchange of information and alerts on threats to public health was the backbone of the Regulations, and she called on all Member States to continue to share timely and relevant information. She supported the draft resolution, which would strengthen cooperation and improve application of the Regulations.

Mr CANDIA (Paraguay), speaking on behalf of the members of the Union of South American Nations, welcomed the report on the status of implementation and the proposed draft resolution. He proposed that an additional function of the IHR Review Committee be to advise the Director-General on how to support Member States requesting extensions of the deadline to establish core capacities and recommended a comprehensive evaluation of existing capacities and gaps. Self-assessment was vital to continuously improving core capacities. With regard to port and airport certification, he asked the Secretariat for the latest working versions of the relevant guidelines.

He supported the recommendation to eliminate the requirement for revaccination against yellow fever, but requested that an updated map be produced that reflected Member States’ assessments of the areas at risk. The content and scope of Annex 7 should then be revised on that basis. He also requested that progress in implementing the Regulations be reviewed by the Executive Board at its 136th session, in January 2015.

Dr VALVERDE (Panama), noting that Panama belonged to the National IHR Focal Points network, which facilitated timely sharing of public health information, echoed the call for a review of the yellow fever risk map, as the current map did not reflect the fact that some countries had been free of the disease for more than 40 years.

Ms VACA (Colombia) supported the draft resolution and the recommendation that the validity of a certificate of vaccination against yellow fever after a single dose of vaccine extend for the life of the person vaccinated. The risk map for yellow fever, however, should be reviewed. A complete review of Annex 7 should be considered and the possibility of including requirements concerning other vaccines and risk areas be examined.

Ms CAMERON (United States of America) said that global collaboration and transparency were imperative in responding to global health threats and commended the efforts of the Secretariat and States Parties to ensure that the International Health Regulations (2005) continued to be used as intended: a legally binding global framework for detecting and responding to diseases and public health risks and emergencies. In line with resolution WHA65.23 and its call for increased collaboration among States Parties, her Government had championed the development of the Global Health Security Agenda to identify, refine and focus actions to accelerate the implementation of the Regulations. States Parties should prioritize their commitment to the Regulations in order to ensure introduction and maintenance of the required core capacities by 2016. Her country continued to maintain its core capacities. She supported the draft resolution.

Ms JIMÉNEZ VALDEZ (Mexico) affirmed her country’s commitment to implementation and maintenance of the required core capacities; it would not be requesting an extension of the deadline. Mexico maintained close communications with WHO regional offices to share information and respond to emerging issues. The experience of its National IHR Focal Point, which was in constant contact with PAHO, could be shared with others in the Region of the Americas. Mexico would continue to participate actively in regional and global meetings and workshops on matters relating to implementation of the Regulations.

Ms DOAN PHUONG THAO (Viet Nam) welcomed the Secretariat’s leadership in the response to MERS-CoV and other public health threats and its support for strengthening core capacities. The updated Event Information Site for National IHR Focal Points had improved access to information on
emerging public health events. The recently established public health emergency operations centre network promoted collaboration between Member States and international organizations. The Secretariat should continue to support the transfer of technology, knowledge and skills in priority areas. She had no objection to the proposed revision of Annex 7 of the Regulations and supported the draft resolution.

Ms IBRAHIM (Maldives) said that, although her country had made some progress, particularly in laboratory capacity and infection control, capacities relating to public health legislature, preparedness and surveillance needed further strengthening. Like many small countries, Maldives had limited human resources, and needed cross-sectoral, regional and intercountry collaboration to augment their numbers to an appropriate size. Adequate resources must be allocated for the implementation of the core capacities in order to ensure global health security.

Ms GONÇALVES (Brazil) welcomed the improvements to the Event Information Site for National IHR Focal Points, which was a fundamental tool in multilateral cooperation, and commended the work of the Strategic Advisory Group of Experts on immunization. She supported the draft resolution and the proposed revisions to Annex 7. Brazil would continue to support other countries in implementing the Regulations through South–South cooperation and support for the Secretariat’s work.

Mr MERCADO (Argentina) requested a longer period for consideration of the guidelines relating to port and airport certification, which should be discussed and approved by Member States. He also requested that the Secretariat make available information on all initiatives by Member States, other organizations and WHO to implement the International Health Regulations (2005).

Mr AGAFONOV (Russian Federation) congratulated the Secretariat for its work on the outbreaks of MERS-CoV, including the development of protocols and response plans and the provision of support to affected countries. The preparation of technical guidelines for assessing and managing the risks associated with international mass gatherings was an important aspect of the Secretariat’s work in relation to the Regulations. He thanked the Secretariat for its support of a seminar recently held in the Russian Federation to train ship inspectors from various countries on the issuance of ship sanitation certificates. Technical guidelines for land-based points of entry should be developed and made available as soon as possible. Although the Russian Federation had met the deadline for implementation of the core capacities under the Regulations, many countries had been unable to do so, and he supported the proposal to extend the deadline where necessary. He supported the draft resolution.

Ms NURHUSSIEN (Eritrea), affirming her Government’s support for full implementation of the International Health Regulations (2005), thanked the Secretariat for its prompt responses in emergency situations and for its capacity-building support.

Dr DAHL-REGIS (Bahamas), speaking on behalf of the member countries of the Caribbean Community, thanked the Secretariat and the Regional Office for the Americas for their continued efforts to support small island countries with limited ability to meet the core capacity requirements. The new flexibilities in the Regulations that allowed countries to partner with other countries to ensure needed capacities, in particular with respect to radiological and chemical preparedness, were welcome. She sought continued support from the Secretariat and the Pan American Sanitary Bureau in strengthening the newly established Caribbean Public Health Agency. She supported the draft resolution.
Dr Kuy-Lok TAN (Chinese Taipei), expressing support for the draft resolution, said that Chinese Taipei had met the core capacity requirements. Two international airports and ports had been evaluated by international experts in 2011 and 2013 and five more were being evaluated in 2014. She welcomed the Event Information Site for National IHR Focal Points, which had provided current information on MERS-CoV and human infection with avian influenza A(H7N9). Chinese Taipei would continue to contribute to global public health security under the framework of the International Health Regulations (2005).

Dr NUTTALL (Global Capacities, Alert and Response) acknowledged the comments and commended Member States’ efforts in developing and maintaining the core capacities, noting in particular the various initiatives mentioned and the bilateral support provided for the implementation of the Regulations. The Secretariat would continue to support States Parties in tracking specific events, monitoring and providing appropriate guidance. In response to specific questions and requests, she said that the Strategic Advisory Group of Experts on immunization had considered that the current recommendations were adequate for travellers from countries in which yellow fever was not endemic. The yellow fever risk map was regularly updated by an expert group as additional information became available. The Review Committee on the Functioning of the International Health Regulations (2005) would advise the Director-General on how best to support States Parties in implementing the Regulations. The guidelines on port and airport certification would be circulated to all Member States through their National IHR Focal Points, in collaboration with the regional offices. Guidelines on ground crossings were being developed and were expected to be available in early 2015.

The CHAIRMAN said that, in the absence of any objection, he took it that the Committee wished to approve the draft resolution contained in resolution EB134.R10.

The draft resolution was approved.¹

4. WHO REFORM: Item 11 of the Agenda (continued)

Framework of engagement with non-State actors: Item 11.3 of the Agenda (Documents A67/6 and A67/54) (continued from the tenth meeting, section 1)

The CHAIRMAN drew attention to a revised version of the draft decision on the framework of engagement with non-State actors reflecting the amendments agreed during the tenth meeting. The text read:

The Sixty-seventh World Health Assembly,
Having considered the report on the framework of engagement with non-State actors;² welcoming the progress made on the draft framework of engagement with non-State actors by the Sixty-seventh World Health Assembly; underlining the importance of an appropriate framework for engagement with non-State actors for the role and work of WHO; and recognizing that further consultations and discussions are needed on issues including conflict of interest and relations with the private sector,

¹ Transmitted to the Health Assembly in the Committee’s sixth report and adopted as resolution WHA67.13.
² Document A67/6.
(1) **called upon DECIDED that** Member States **should** submit their specific follow-up questions to the Director-General by 6 17 June 2014;

(2) **REQUESTED** the Director-General:
   (1) to prepare a comprehensive report in response to the Health Assembly’s comments and the follow-up questions raised, including clarification thereon from the Secretariat, by the end of July 2014;
   (2) to consult further with Member States during the regional committees, in 2014 on the basis of the draft framework of engagement with non-State actors and the report referred to in subparagraph (2)(1) above;
   (3) to submit an account of the further consultations undertaken in 2014 and the proposed way forward to the Executive Board at its 136th session in January 2015.

(3) **DECIDED that** the regional committees in 2014 should discuss this matter, with reference to the draft framework of engagement with non-State actors (A67/6) and the report referred to in subparagraph (2)(1) above; and requested that regional committees submit a report on their deliberations to the Sixty-eighth Health Assembly, through the Executive Board;

(4) REQUESTED the Director-General:
   (1) to submit a paper to the 136th session of the Executive Board in January 2015, ensuring that Member States receive it by mid-December 2014, to allow them sufficient time to study the paper and be better prepared for the discussions and deliberations.

Dr VALLEJO (Ecuador) proposed that in order to better reflect the discussions that had taken place in earlier meetings, in paragraph (1) “comments and” should be inserted between “follow-up” and “questions” and that subparagraph (2)(1) should be amended to read: “to prepare a comprehensive report of the comments made by Member States during the Sixty-seventh World Health Assembly and the follow-up comments and questions raised, including clarification thereon from the Secretariat in response by the end of July 2014.”

Dr REDDY (India), Mr MERCADO (Argentina), Mr ROSALES LOZADA (Plurinational State of Bolivia), Ms JIMÉNEZ VALDEZ (Mexico), Mr MATUTE HERNANDEZ (Colombia), Ms GONÇALVES (Brazil) and Dr COITIÑO (Uruguay) supported the amendments proposed by the delegate of Ecuador.

Ms BLACKWOOD (United States of America) asked the Secretariat to reread the amendments proposed by the delegate of Ecuador. In addition, she asked whether an account of the discussions that had taken place in the drafting group would be included in the Director-General’s comprehensive report.

Professor HALTON (Australia) asked the Secretariat to clarify the amendments proposed by the delegate of Ecuador.

Dr MCLELLAN (Assistant Secretary), in response to a request from the CHAIRMAN, said that with the amendments proposed by the delegate of Ecuador paragraph (1) would read: “DECIDED that Member States should submit their specific follow-up comments and questions to the Director-General by 17 June 2014” and subparagraph 2(1) would read: “to prepare a comprehensive report of the comments made by Member States during the Sixty-seventh World Health Assembly and the follow-up
up comments and questions raised, including clarification thereon from the Secretariat in response by the end of July 2014;”.

Dr DAHL-REGIS (Bahamas) said that the proposed amendments as she understood the would not change the intent of the draft decision. If that were indeed the case, she was prepared to accept the draft decision, as amended.

The DIRECTOR-GENERAL confirmed that the proposed amendments would not affect the substance of the draft decision and encouraged Member States to support it.

In response to the delegate of the United States of America, she said that comments made in the drafting group would be included, to the best of the Secretariat’s ability. However, she urged Member States to restate their questions and comments in writing before 17 June 2014 in order to ensure that they were included.

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

The draft decision, as amended, was approved.¹

5. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 16 of the Agenda (resumed)

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 16.2 of the Agenda (Documents A67/36 and A67/36 Add.1)

Dr TAFANGY (Madagascar), speaking on behalf of the Member States of the African Region, said that pandemic influenza preparedness was a priority for every Member State in the Region. As pandemic influenza remained a global threat, Member States must: be prepared to respond to it by implementing the International Health Regulations (2005) and integrated disease surveillance and response; recognize the importance of timely virus sharing for vaccine development; and strengthen pandemic and epidemic preparedness and response capacities through updated contingency plans. Influenza surveillance must be sustained and continually improved. Congratulating the Secretariat for its work on pandemic influenza preparedness, he encouraged the Pandemic Influenza Preparedness Advisory Group to continue its work.

Dr AL-TAAE (Iraq) called for one composite influenza surveillance package, based on information from sentinel sites and covering avian influenza A(H1N1), A(H5N1), A(H7N9) and seasonal influenza viruses. WHO had a vital role to play in facilitating such activities, providing technical support to enhance laboratory technologies, including diagnosis using real-time polymerase chain reaction assays, and in frequently reviewing accreditation certificates. WHO should also promote operational research at the national, regional and interregional levels, focusing in particular on influenza A(H7N9) virus and the availability of detection kits.

Mr AGAFONOV (Russian Federation) said that the Pandemic Influenza Preparedness (PIP) Framework had led to more transparent sharing of biological materials and welcomed the approved formula and methodology for determining the distribution of the Partnership Contribution. The criteria

¹ Transmitted to the Health Assembly in the Committee’s sixth report and adopted as decision WHA67(14).
for determining recommended country recipients should continue to be refined with a view to ensuring the rational and fair use of Partnership Contribution resources. He supported the work to conclude negotiations on standard material transfer agreements 2 (SMTA 2), which would facilitate cooperation with the pharmaceutical industry, and noted the work of WHO’s legal team to speed up that process. He also supported the development of guidelines for the use of influenza virus genetic sequence data within the PIP Framework and affirmed his country’s wish to participate in the Technical Expert Working Group on that issue.

Mr ACEP SOEMANTRI (Indonesia) welcomed the work of the Advisory Group to facilitate implementation of the PIP Framework. The emergence of novel influenza viruses meant that the imminent threat of a pandemic persisted, and the PIP Framework therefore remained relevant; Member States would need to continue working to improve their pandemic preparedness capacities. He welcomed the preliminary report of the Technical Expert Working Group on genetic sequence data and encouraged the development of guidelines on handling such data under the Framework. He welcomed the draft guideline principles on the Partnership Contribution and the use of its resources. WHO and other international partners should continue to work towards full implementation of the Framework, including the provisions on benefit sharing.

Mr MAMACOS (United States of America) welcomed the progress in implementing the PIP Framework and the Partnership Contribution and the transparency evident in the report. The improved communication with stakeholders and efforts to establish synergies between the PIP Framework, the Global Action Plan for Influenza Vaccines and the International Health Regulations (2005) were also commendable. He encouraged all stakeholders to plan and strengthen vaccine deployment capacities, building on the WHO Pandemic Influenza A(H1N1) Vaccine Deployment Initiative.

Dr AL HAJERI (Bahrain) said that her Government had taken several measures for pandemic influenza preparedness through building up its monitoring and laboratory capacities. Monitoring had been strengthened at national level for detection of influenza-like outbreaks and acute respiratory syndromes and investigation of viruses. The country’s one specialized laboratory was accredited by WHO as the national influenza centre. Its activities included genetic sequencing. She support WHO’s efforts in influenza preparedness, including coordination of virus sharing and tracing and support for vaccine development.

Dr HANSA RUUKSAKOM (Thailand), commending the progress in implementing the PIP Framework, pointed out that vaccine production capacity remained concentrated in a few high-income countries and the global supply was inadequate. The Global Action Plan for Influenza Vaccines had increased vaccine production, proving that boosting manufacturing capacity in developing countries was feasible, and the Secretariat should continue its support for the Plan, with financing from Partnership Contribution resources. Effective planning and management would be needed in order to redress the mismatch between annual budgets and long-term demand.

Mr LUTNÆS (Norway) said that the Secretariat should continue to focus on implementing the PIP Framework, including collection and use of Partnership Contribution funds to enhance pandemic preparedness and the conclusion of legally binding agreements with vaccine producers. Member States should also continue to strengthen pandemic preparedness at the national level, drawing on lessons learnt from pandemic A(H1N1) 2009.

Dr REN Minghui (China) welcomed WHO’s efforts to establish a transparent and equitable framework for virus sharing, noting that several Chinese vaccine manufacturers were engaged in standard material transfer agreement 2 (SMTA 2) negotiations. Following the detection of human infections with avian influenza A(H7N9) virus, China had launched a mechanism for sharing virus
strains; 24 strains had been shared with 11 national laboratories and regions, including four pandemic research and cooperation centres. The Secretariat should promote implementation of the PIP Framework, improve data, facilitate national implementation plans and adopt measures to improve communication among Member States.

Dr LLACUNA (Philippines) commended the Partnership Contribution implementation plan: 2013–2016, which would facilitate engagement with industry associations and manufacturers. He supported the recommendations of the Advisory Group on the use of Partnership Contribution resources and finalization of the draft document on Regional Office Recommended Country Recipients. Highlighting the need for transparency in the distribution of resources, he expressed the hope that the development of links with industry would enhance Member States’ capacity-building and pandemic preparedness efforts.

Ms GONÇALVES (Brazil) said that the PIP Framework strengthened WHO’s influenza surveillance and response capabilities, improving virus sharing and access to vaccines and other benefits. Care should be taken to avoid conflicts of interest in the selection of countries to receive Partnership Contribution resources and in the establishment of selection criteria. SMTA 2 negotiations should be transparent and in line with the WHO reform process.

Dr Kuy-Lok TAN (Chinese Taipei) said that Chinese Taipei had followed its influenza pandemic preparedness and response plan in responding to the influenza A(H7N9) outbreak. Chinese Taipei had confirmed four imported cases. She thanked Japan and the United States of America for sharing virus strains. Chinese Taipei had been developing an influenza A(H7N9) vaccine since 2013 and would share it with the international community when appropriate. It would continue to invest in vaccine research and production and would welcome international cooperation in that endeavour.

Mrs BARRIA (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, called on the Secretariat to expedite the signing of standard material transfer agreements and to urge manufacturers of vaccines and diagnostic materials to pay their Partnership Contributions promptly. The Secretariat should also ensure that the use of genetic sequence data was subject to benefit-sharing requirements under the PIP Framework. Such data should never be subject to intellectual property claims, and she noted with concern that, if granted, pending patents might well impede access to diagnostic and therapeutic agents for the MERS coronavirus.

Dr BRIAND (Pandemic and Epidemic Diseases) thanked Member States for their comments regarding implementation of the PIP Framework and for continuing to share influenza viruses through the Global Influenza Surveillance and Response System. She also thanked industry partners for their contributions to implementation of the PIP Framework. She acknowledged the need for transparency regarding implementation of the Framework and said that tools were being developed for timely sharing of information with stakeholders. She noted the importance of synergies between the Global Action Plan for Influenza Vaccines, the International Health Regulations (2005) and the PIP Framework. The Secretariat remained committed to ensuring equitable sharing of virus strains and of the resulting benefits and welcomed Member States’ support for the technical expert working group on genetic sequence data and proposals to ensure close communication between WHO and industry representatives.

The CHAIRMAN took it that the Committee wished to note the reports contained in documents A67/36 and A67/36 Add.1.
The Committee noted the reports.

6. ORGANIZATION OF WORK

Professor HALTON (Australia) recalled that during its 134th session the Executive Board had discussed the challenges of managing long agendas, and it had been suggested that the item on progress reports, for example, might be dealt with more efficiently. As there were several other important issues remaining on the Committee’s agenda, she suggested that delegates might consider submitting their statements in writing for publication by the Secretariat.

The CHAIRMAN said that, if he heard no objection, the Committee agreed to this approach.

It was so agreed.

7. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 14 of the Agenda (resumed)

Monitoring the achievement of the health-related Millennium Development Goals: Item 14.1 of the Agenda (Document A67/19)

- Health in the post-2015 development agenda: Item 14.1 of the Agenda (Document A67/20) (continued from the seventh meeting, section 1)

The CHAIRMAN drew attention to a revised version of the draft resolution proposed by the Member States of the African Region on health in the post-2015 development agenda, recalling that a drafting group had been established to agree on a consensus text. The revised text read:

The Sixty-seventh World Health Assembly,

PP1 Having considered the report on Monitoring the achievement of the health-related Millennium Development Goals: Health in the post-2015 development agenda;¹

PP2 Reaffirming the Constitution of the World Health Organization (WHO), which states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions;

PP3 Reaffirming also the principles of the United Nations Millennium Declaration adopted by the United Nations General Assembly in resolution 55/2, including human dignity, equality and equity, and stressing the need for their reflection in the post-2015 development agenda;

PP4 Recalling the United Nations General Assembly resolution 66/288 “The future we want”, which recognizes that health is a precondition for and an outcome and indicator of all dimensions of sustainable development;

PP5 Stressing also that concerns related to health equity and rights should be addressed in efforts to achieve the Millennium Development Goals;

¹ Document A67/20.
PP6 Recalling resolution WHA66.11 on health in the post-2015 development agenda, which urged Member States to ensure that health is central to the post-2015 UN development agenda;

PP7 Reaffirming the need to sustain current achievements and intensify efforts in those countries where accelerated progress is needed towards achievement of the health-related Millennium Development Goals, especially maternal, newborn and child health;

PP8 Cognizant also of the burden of maternal, newborn and child morbidity and mortality, communicable diseases, including HIV/AIDS, tuberculosis, malaria and neglected tropical diseases, emerging diseases and the rising burden of noncommunicable diseases and injuries;

PP9 Acknowledging that universal health coverage implies that all people have access without discrimination to nationally determined sets of the needed promotive, preventive, curative, palliative and rehabilitative essential health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship with a special emphasis on the poor, vulnerable and marginalized segments of the population;

PP10 Recognizing the importance of implementing all relevant internationally agreed commitments, including the Beijing Platform for Action, the Programme of Action of the International Conference on Population and Development and the review conferences to date, the political declaration on the prevention and control of noncommunicable diseases, and the Political Declaration on HIV and AIDS and United Nations General Assembly resolution 67/81 in achieving provision of universal health coverage and improved health outcomes;

PP11 Recognising the importance of strengthening health systems and building capacities for broad public health measures, health protection and addressing determinants of health towards attaining equitable universal coverage;

PP12 Emphasizing that policies and actions in sectors other than health have a significant impact on health outcomes and vice-versa, hence the need to identify synergies between policy objectives in the health and other sectors through a whole-of-government, whole-of-society and Health in All Policies approach to the post-2015 development agenda;

PP13 Reiterating our determination to take action on social determinants of health as collectively as agreed by WHA62.14;

PP14 Recognizing the importance of strengthened international cooperation and honouring commitments towards national and international health financing, and ensuring that international development cooperation in health is effective and aligned with national health priorities;

PP15 Recognizing that the monitoring of health improvement should include measuring health systems performance as well as health outcomes that capture healthy life expectancy, mortality, morbidity and disability;

PP16 Recognizing the importance of the health workforce and its essential contribution to health systems functioning and the need for continued commitment to relevant WHA resolutions, in particular WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel,
OP1 URGES Member States\(^1\), in the context of health in the post-2015 development agenda:

1. to engage actively in discussions on the post-2015 development agenda, respecting the process established by the United Nations General Assembly;

2. to ensure that health is central to the post-2015 development agenda;

3. to ensure that the post-2015 development agenda will accelerate and sustain progress towards the achievement of health-related MDGs including child, maternal, sexual and reproductive health, nutrition, HIV, tuberculosis and malaria;

4. to recognize that additional attention needs to be paid to newborn health and neglected tropical diseases;

5. to incorporate into post-2015 agenda the need for action to reduce preventable and avoidable burden of mortality, morbidity and disability related to noncommunicable diseases, and injuries while also promoting mental health;

6. to promote UHC, defined as universal access to quality prevention, promotion, treatment, rehabilitation and palliation services and financial risk protection as fundamental to the health component in the post-2015 development agenda;

7. to emphasize the need for multisectoral actions to address social, environmental and economic determinants of health, to reduce health inequities and contribute to sustainable development, including Health in All Policies as appropriate;

8. to call for the full realization of the right to the enjoyment of the highest attainable standard of physical and mental health and to consider that this right is fundamental to equitable and inclusive sustainable development;

9. to recognize the importance of accountability through regular assessment of progress by strengthening of civil registration and vital statistics and health information systems with disaggregated data to monitor health equity;

10. to include health related indicators for measuring progress in all relevant dimensions of sustainable development;

11. to emphasize the importance of strengthening health systems, including the six building blocks of a health system (service delivery; health workforce; information; medical products, vaccines and technologies; financing; governance and leadership), to progress towards and sustain universal health coverage and improved health outcomes;

OP2 REQUESTS the Director-General:

1. to continue active engagement with ongoing discussions on the post-2015 development agenda, working with the United Nations Secretary-General, to ensure the centrality of health in all relevant processes;

2. to continue to inform Member States and provide support, upon request, on issues and processes concerning the positioning of health in the post-2015 development agenda.

\(^1\) And, where applicable, regional economic integration organizations.
The financial and administrative implications of the draft resolution for the Secretariat were:

<table>
<thead>
<tr>
<th>1. Resolution</th>
<th>Health in the post-2015 development agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category: 4. Health systems</td>
<td></td>
</tr>
<tr>
<td>Also</td>
<td></td>
</tr>
<tr>
<td>Category: 1. Communicable diseases</td>
<td></td>
</tr>
<tr>
<td>Category: 2. Noncommunicable diseases</td>
<td></td>
</tr>
<tr>
<td>Category: 3. Promoting health through the life-course</td>
<td></td>
</tr>
<tr>
<td>Programme areas: All in categories 1–4</td>
<td></td>
</tr>
</tbody>
</table>

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

It would contribute to ensuring that people obtain the health services they need in all areas – whether for communicable or noncommunicable diseases – and across the life course. It supports the establishment of strong health systems, by acting on all their component parts – financing, health workforce, medical products, information, governance and infrastructure – in order to support the assurance of good-quality health services of all types, not just those for treatment, with financial risk protection. It encourages Member States to support the inclusion of health, including universal health coverage, in an appropriate form in the post-2015 development agenda. It will also encourage (i) the provision of information by the Secretariat to Member States, supporting them in developing their positions on health in the post-2015 development agenda, including by providing policy briefs and appropriate estimates; and (ii) the engagement of the Secretariat in the post-2015 process to support countries in ensuring that health is central to the agenda.

Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US$ 10 000).

(i) Two years (covering the period 2014–2015)
(ii) Total: US$ 1.31 million (staff: US$ 1.16 million; activities: US$ 150 000)

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US$ 10 000).

All the cost falls within the biennium 2014–2015.

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

The provision of support to countries in developing their strategies would cover all regions, with the Secretariat involved at all three levels of the Organization. The preparation of policy briefs and estimations would principally involve headquarters; there would also be some regional office involvement.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.
If “no”, indicate how much is not included.

(c) Staffing implications
Could the resolution be implemented by existing staff? (Yes/no)
Yes.

4. Funding
Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)
Yes.
If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).
Not applicable.

Dr SHAKEELA (Maldives) said that, although the report on monitoring the achievement of the health-related Millennium Development Goals (document A67/19) provided data on current status and trends, it was not clear to which Goals the reported results referred. Moreover, the indicators used to measure progress related to 1990 levels, and situations had changed since then. In addition, the generalized global indices, aggregates and benchmarks used did not take into account individual countries’ vulnerabilities and situations. Data disassociated from geography would yield only a partial picture. For example, on the basis of the indicators for target 7.C under Goal 7, which related to improving access to water and sanitation, many countries in the South-East Asia Region could be considered to have attained that Goal, yet their water was contaminated and unsafe to drink.

Dr VIROJ TANGCHAROENSATHIEN (Thailand), speaking as chairman of the drafting group, reported long hours of intensive and constructive discussions which had led to consensus. He drew attention to two minor changes not reflected in the foregoing text: the word “all” should be deleted from the first line of the tenth preambular paragraph and “/AIDS” should be inserted after “HIV” in subparagraph 1(3). The text was balanced, and he encouraged the Committee to approve it.

Mr PARIRENYATWA (Zimbabwe), speaking on behalf of the Member States of the African Region, stressed that the outstanding elements of the Millennium Development Goals must be central to the post-2015 development agenda. Work on the Goals had highlighted the need to take a holistic approach to the improvement of health and to tackle social and economic determinants of health that lay outside the traditional areas of direct influence and action by the health sector. A multisectoral approach to the post-2015 development agenda would be essential to its success, and it should include additional priorities, including noncommunicable diseases, mental health and neglected tropical diseases. Achieving universal health coverage would assist in the fulfilment of the original aspirations of primary health care, health for all and health systems strengthening enshrined in the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa. The use of modern technology, particularly mobile phones, was one of the strategic ways that accessibility of health services could be ensured in Africa, even in remote areas.

The new development goals should be all-encompassing, the targets realistic and the indicators unambiguous and measurable, and health targets should be included under other relevant development goals. The post-2015 development agenda should be applicable to national contexts, respect national priorities and have a strong emphasis on country ownership. The Health Assembly should adopt a strong resolution, emphasizing the central role of health in the post-2015 development agenda so as to provide a clear mandate for those engaged in negotiations on the agenda.
Dr MAAROUFI (Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region, applauded the Secretariat’s efforts to lower child mortality rates and maternal mortality ratios, improve nutrition and reduce morbidity and mortality due to HIV/AIDS. A plan to reduce infant and maternal mortality was being implemented in nine countries with support from UNFPA, WHO and other partners. Nevertheless, many countries in the Region would have difficulty in achieving the health-related Goals by 2015. Progress in preventing mother-to-child transmission of HIV was slow and the tuberculosis detection rate remained low mainly because the private sector was not obliged to notify cases.

Many of the countries lacked basic services while others had to safeguard hard-won gains in the context of water shortage, conflicts, non-sustainable consumption patterns and climate change. The risks to health as a result of accidents, natural disasters and hazards in general had to be mitigated. The prices, availability and affordability of medicines and vaccines must be monitored and support provided for implementing the WHO Guideline on Country Pharmaceutical Pricing Policies and for sustainable financing to essential medicines. A plan of action, with innovative and strong measures, was needed at the national and regional levels. The health targets were wide-ranging and he called for noncommunicable diseases to be included as a goal or target. The post-2015 development agenda must integrate universal health coverage and work on social determinants of health.

Dr AL-JALAHMA (Bahrain) said that the post-2015 development agenda should encompass work on Goals 4 and 5 to reduce child and maternal mortality and Goal 6 to cover HIV/AIDS, malaria, tuberculosis and other major diseases. The post-2015 goal should also cover noncommunicable diseases, road traffic accidents and mental health as well as universal health coverage, which was a sine qua non. She supported the draft resolution.

Dr ALMEIDA (Timor-Leste), speaking on behalf of the Member States of the South-East Asia Region, said that they had made significant progress towards the achievement of the Millennium Development Goals, but needed to continue their efforts in order to attain all the health-related Goals. She supported the draft resolution.

Dr KESKINKILIÇ (Turkey) said that work on the health-related Millennium Development Goals had improved the lives of people in developing countries, but much remained to be done, particularly with regard to providing physically and economically accessible health services to underserved populations. Universal health coverage should be one of the main health priorities in the post-2015 development agenda, with specific targets and activities on maternal and child health. Turkey had a decade of experience in providing all its citizens with equitable access to its health infrastructure and was willing to share that experience.

Mr EMANUELE (Ecuador), expressing support for the draft resolution, stressed that the activities requested of the Director-General in paragraph 2 should be undertaken in consultation with and with the knowledge of Member States, particularly with regard to the proposal of specific goals, targets and indicators.

Dr AMMAR (Lebanon) maintained that health would be high on the post-2015 development agenda and be seen as a pillar of sustainable social and economic development. The main challenge would be to align the health-related goals and targets proposed by the High-level Panel of Eminent Persons on the Post-2015 Development Agenda with the outcome of the thematic consultation on

\[1\] At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered at the meeting.

---

\[1\] At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered at the meeting.
health in the post-2015 development agenda organized by WHO and UNICEF and to accommodate the recommendations of the regional committees. Sustaining efforts to achieve the Millennium Development Goals would be an important starting-point, and reducing the burden of noncommunicable diseases should be a priority. Universal health coverage should be emphasized as both a target and a means to achieve other targets. The text of the draft resolution was acceptable.

Mr AASLAND (Norway)\(^1\) strongly supported the idea of a single aggregate health goal in the post-2015 development agenda, together with several ambitious and quantitative targets. Progress made with regard to the Millennium Development Goals must be consolidated and built upon, and the post-2015 targets must reflect the areas covered by the Goals. Substantive targets were needed in areas such as universal access to sexual and reproductive health, noncommunicable diseases, health systems strengthening and universal health coverage. The new development framework must also cover determinants of health, particularly with regard to education, energy, nutrition and food security, water and sanitation, gender equality, human rights, peace and conflict resolution, poverty eradication and governance.

Ms BRUNET (Canada) said that her country wished to sponsor the draft resolution. In order not to lose the gains achieved and to accelerate progress, maternal, newborn and child health had to remain at the heart of the post-2015 development agenda. Canada would imminently be hosting a high-level summit on maternal, newborn and child health (Toronto, 28–30 May 2014) to consider the progress made and the way forward, including the post-2015 development agenda.

Dr WALAIPorn PATCHARANARUMOL (Thailand) said that Thailand also wished to sponsor the draft resolution.

Ms RUIZ VARGAS (Mexico), speaking also on behalf of Argentina, Botswana, Denmark, Finland, Netherlands, Norway, Sweden and Switzerland, expressed support for the draft resolution. The focus on the post-2015 development agenda should not detract attention from efforts to achieve the Millennium Development Goals, particularly those on which the least progress had been made. The post-2015 agenda should have a human rights-based and life-course approach and aim to ensure that people not only lived longer but also enjoyed the highest attainable standard of health and lived a dignified life. With health both a goal in itself and a means of accelerating development, the new development agenda should clarify the synergies between health and other objectives and should recognize the need for shared solutions and multisectoral action on social determinants of health.

Universal health coverage was essential to ensuring the accessibility, availability and affordability of high-quality health care services provided by well-trained personnel. Accelerating progress on the unmet Millennium Development Goals, reducing the burden of noncommunicable diseases, promoting healthy lifestyles and ensuring sexual and reproductive rights should be key elements in the post-2015 development agenda, with disease prevention and health promotion as priorities. WHO should continue to take an active role in ensuring that health priorities were incorporated into the post-2015 development agenda.

Dr AL-TAAE (Iraq) underlined the importance of maintaining the progress made towards the achievement of the Millennium Development Goals. Other priorities included prevention and control of noncommunicable diseases, addressing the health impacts of mass gatherings, and health systems strengthening.

\(^1\) At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered at the meeting.
Ms BONNER (Germany) said that health, a basic human right and of vital importance for human development, should be part of the post-2015 development agenda. Universal health coverage should be the cornerstone of that agenda.

Dr EVANGELISTA (Philippines), noting that little time remained before the deadline for achievement of the Millennium Development Goals, said that health was central to development and growth. As such, it should receive priority funding from health ministries and in national budgets. She encouraged Member States to commit themselves to sustaining development efforts beyond 2015.

Mr KRANIAS (Greece), speaking on behalf of the European Union and its Member States, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova, Armenia and Georgia, said that progress on the Millennium Development Goals needed to be accelerated; catalytic resources were required, together with investment in national systems, in order to sustain the gains made. Substantial progress was needed on maternal health, particularly with regard to sexual and reproductive health services for young people, and on maternal, infant and young child nutrition. In contrast, the number of deaths among children under five years of age had been substantially reduced. Further progress depended on successful implementation of agreed action plans, with monitoring and evaluation at the country level. Despite good progress towards Goal 6 (Combat HIV/AIDS, malaria and other diseases), the burden of HIV/AIDS, tuberculosis and malaria remained high and drug resistance was a growing challenge. Strong country ownership, inclusive leadership, gender equality, a person-centred and human rights-based approach and effective governance were key elements for achieving the Millennium Development Goals. In order to accelerate progress, more attention should be paid to other cross-cutting challenges, such as tackling the social, cultural, economic and environmental determinants of health, inequalities, gender imbalances and discrimination, and barriers to health services. He expressed support for the draft resolution.

Mr BOISNEL (France) stressed universal health coverage as an overarching objective for the global agenda; such an objective would make it possible to achieve the Millennium Development Goals and pay attention to new issues such as noncommunicable diseases. A cross-cutting approach was required, particularly regarding health systems strengthening.

Ms ALGOE (Suriname), speaking on behalf of the members of the Union of South American Nations, expressed support for the draft resolution.

Dr USHIO (Japan) expressed appreciation for the hard work of the drafting group and requested that Japan be named as a sponsor of the draft resolution.

Dr MSEMO (United Republic of Tanzania), welcoming the inclusion of the subject on the agenda of the Health Assembly, expressed support for the draft resolution.

Ms DOAN PHUONG THAO (Viet Nam), welcoming the progress made towards achievement of the Millennium Development Goals, said that the remaining gaps among and within countries and the need to provide more sustainable results posed challenges to the Secretariat and Member States. Current trends implied that programmes on acute respiratory infections needed to be re-established, as such infections remained the main cause of death among children in many countries. The report

1 At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered at the meeting.
contained in document A67/19 had a narrow focus as it only concentrated on natural morbidity, child mortality and specific infectious diseases as factors affecting the achievement of the Millennium Development Goals. More attention was needed on other issues, including the different determinants of health. The monitoring of goals indirectly related to health, such as those on climate change and poverty, was also needed.

Dr ETALEB (Libya) expressed support for the draft resolution, even though it was not sufficiently realistic. A rational and sustained financing mechanism was needed to support programmes and provide good health services.

Ms Hsiang-Yi HSU (Chinese Taipei) expressed support for the draft resolution. Chinese Taipei had made progress towards achievement of the Millennium Development Goals related to maternal, infant and young child care. It provided health education of women during pregnancy and there had been strong uptake of prenatal examinations, which had helped to reduce maternal and neonatal mortality rates. A life-course approach had been adopted to meet the health care needs of pregnant women and new mothers, and encouragement of and support for breastfeeding had resulted in high rates. Health should be regarded as a core element of sustainable development, and Chinese Taipei had recently merged its health and social welfare departments in order to enable the development of more comprehensive policies and holistic health care systems.

Mr DAWSON (World Vision International), speaking at the invitation of the CHAIRMAN, said that current measures of health and gaps in health information collected concealed inequalities in health care provision. Families and communities had an important role to play in the collection, review and analysis of data that related to their own health and lives. Good data were fundamental to efforts to tackle inequality but were often poor or non-existent in many countries. Member States should invest in and expand work towards universal effective coverage of health information, civil registration and vital statistics systems.

Mrs BAUMGARTEN (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, called for faster progress on newborn survival and greater zeal to end preventable maternal, newborn and child deaths. To do so would need rectifying inequalities in service coverage and financial risk protection. Universal health coverage offered an integrated approach to service coverage without financial hardship, but universal must mean 100% coverage; any lower target ran the risk of institutionalizing inequities, which would undermine States’ responsibilities to respect, protect and fulfil the human right to health.

Professor BEAGLEHOLE (World Heart Federation), speaking at the invitation of the CHAIRMAN, said that the post-2015 development agenda should include a universally applicable, overarching health goal focusing on maximizing healthy lives at all stages of life, with a stand-alone and ambitious target on noncommunicable diseases. Universal health coverage and social determinants of health should be recognized as essential elements of the post-2015 agenda; health indicators should also be integrated into all areas of that agenda.

Dr AHMED MOHAMED GAD (The World Medical Association, Inc.), speaking at the invitation of the CHAIRMAN, urged the inclusion both of the goal of health across all stages of life in the post-2015 framework and of targets on communicable and noncommunicable diseases, mental

---

1 At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.
health, sexual and reproductive health, maternal and child health, neglected tropical diseases and social determinants of health. Universal health coverage should be acknowledged as a means of achieving health for all; to improve the health status of all people, it was vital to strengthen holistic health care systems and link them to social determinants of health. Development goals were interdependent, with health particularly important for the attainment of other goals; all development goals should include health-related indicators.

Mr NETTO (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that, although the proposals for the post-2015 development framework were based on equality and sustainability, global economic policies continued to contribute to widening inequalities. Development was more than economic growth and industrialization: it included social, cultural and institutional aspects. New economic relations and new forms of regulation were needed, based on the principles of equity, rights and 

buen vivir. The issue of universal health coverage was complicated by its multiple interpretations; it had different meanings to different interest groups.

Mr MUNZERT (International Federation of Medical Students’ Associations), speaking at the invitation of the CHAIRMAN, said that achieving equity in health required the inclusion of all target groups of society based on their specific needs; indicators disaggregated by, inter alia, socioeconomic status, age, gender, and location were therefore vital. Health systems needed to be sustainable and adaptable to future risks and challenges. Given that the discussions on the post-2015 development agenda were being led by Member States’ ministries of foreign affairs and permanent missions to the United Nations in New York, it was vital that health ministries provided information to those representatives on the importance of including health in the post-2015 framework.

The CHAIRMAN took it that the Committee wished to approve the draft resolution, as amended by the Chairman of the drafting group during the meeting.

The draft resolution, as amended, was approved.¹

Dr MORALES OJEDA (Cuba), speaking in his capacity as President of the World Health Assembly, welcomed the approval of the draft resolution and encouraged Member States to work as efficiently as possible to ensure that the agenda could be completed on time.

The DIRECTOR-GENERAL explained that Member States had been endeavouring to work as efficiently as possible, with many of them submitting statements in writing in order to save time. She assured those delegates that their submissions would be published on the WHO website.

Addressing the global challenge of violence, in particular against women and girls: Item 14.3 of the Agenda (Document A67/22) (continued from the first meeting, section 3)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Albania, Australia, Belgium, Canada, Guatemala, India, Italy, Latvia, Mexico, Namibia, Netherlands, Norway, Paraguay, Portugal, Republic of Moldova, Switzerland, Thailand, Turkey, Ukraine, Uruguay, United States of America and Zambia, which read:

---

¹ Transmitted to the Health Assembly in the Committee’s sixth report and adopted as resolution WHA67.14.
The Sixty-seventh World Health Assembly,

PP1 Having considered the report on addressing the global challenge of violence, in particular against women and girls;¹


PP3 Cognizant of the many efforts across the United Nations system to address the challenge of violence, in particular against women and girls, and against children including the International Conference on Population and Development, the Beijing Declaration and Platform for Action, and all relevant United Nations General Assembly and Human Rights Council resolutions, as well as all relevant Commission on the Status of Women agreed conclusions;

PP4 Noting that violence is defined by the WHO as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation”²;

PP5 Noting also that interpersonal violence, distinguished from self-inflicted violence and collective violence, is divided into family and intimate partner violence and community violence, and includes forms of violence throughout the life course, such as child abuse, intimate partner violence, abuse of the elderly, family members, youth violence, random acts of violence, rape or sexual assault and violence in institutional settings such as schools, workplaces, prisons and nursing homes³;

PP6 Recalling the definition of violence against women as stated in the 1993 Declaration on the Elimination of Violence against Women A/RES 48/104;

PP7 Concerned that the health and wellbeing of millions of individuals and families is adversely affected by violence and that many cases go unreported;

PP8 Further concerned that violence has health-related consequences including death, disability and physical injuries, mental health impacts and sexual and reproductive health consequences, as well as social consequences;

PP9 Recognizing that health systems often are not adequately addressing the problem of violence and contributing to a comprehensive multisectoral response;

PP10 Deeply concerned that globally, one in three women experience either physical and/or sexual violence, including by their spouses, at least once in their lives⁴;

PP11 Concerned that violence, in particular against women and girls, is often exacerbated in situations of humanitarian emergencies and post-conflict settings, and recognizing that national health systems have an important role to play in responding to its consequences;

PP12 Noting that preventing interpersonal violence against children – boys and girls – can contribute significantly to preventing interpersonal violence against women and girls and children, that being abused and neglected during infancy and childhood makes it more likely that people will grow up to perpetrate violence against women, maltreat their own children, and engage in youth violence, and underscoring that there is good evidence for the effectiveness of

¹ Document A67/22.
parenting support programmes in preventing child abuse and neglect in order to halt the intergenerational perpetuation of interpersonal violence;

PP13 Noting also that violence against girls needs specific attention because they are subjected to forms of violence related to gender inequality that too often remain hidden and unrecognized by society, including by health providers, and while child abuse (physical, emotional) and neglect affects boys and girls equally, girls suffer more sexual violence;

PP14 Deeply concerned that violence against women during pregnancy has grave consequences on the health of both the woman and the pregnancy, such as miscarriage and premature labour, and for the baby such as low birth weight, as well as recognizing the opportunity that antenatal care provides for early identification, and prevention of the recurrence of such violence;

PP15 Concerned that children, particularly in child-headed households, are vulnerable to violence, including physical, sexual and emotional violence, such as bullying, and reaffirming the need to take action across sectors to promote the safety, support, protection, health care and empowerment of children, especially girls in child-headed households;

PP16 Recognizing that boys and young men are among those most affected by interpersonal violence, which contributes greatly to the global burden of premature death, injury and disability, particularly for young men, and has a serious and long-lasting impact on a person’s psychological and social functioning;

PP17 Deeply concerned that interpersonal violence, in particular against women and girls, and children, persists in every country in the world as a major global challenge to public health, and is a pervasive violation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and a major impediment to achieving gender equality, and has negative socioeconomic consequences;

PP18 Recognizing that violence against women and girls is a form of discrimination, that power imbalances and structural inequality between men and women are among its root causes, and that effectively addressing violence against women and girls requires action at all levels of government including by the health system, as well as the engagement of civil society, the involvement of men and boys and the adoption and implementation of multifaceted and comprehensive approaches that promote gender equality and empowerment of women and girls and that change harmful attitudes, customs, practices and stereotypes;

PP19 Aware that the process under way for the post-2015 development agenda may, in principle, contribute to addressing, from a health perspective, the health consequences of violence, in particular against women and girls, and children, through a comprehensive and multisectoral response;

PP20 Acknowledging also the many regional, subregional and national efforts aimed at coordinating prevention and response by health systems, to violence, in particular against women and girls and against children;

PP21 Noting with great appreciation the leading role WHO has played in establishing the evidence base on the magnitude, risk and protective factors, consequences, prevention of and response to violence, in particular against women and girls, and against children, in the

1 Protective factors are those that decrease or buffer against the risk and impact of violence. While much of the research on violence against women and violence against children has focused on risk factors, it is important for prevention also to understand protective factors. Prevention strategies and programmes aim to decrease risk factors and/or to enhance protective factors.


3 Including the WHO Multi-country Study on Women’s Health and Domestic Violence against Women (2005); Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence (2013); Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines (2013).
development of norms and standards, in advocacy and in supporting efforts to strengthen research, prevention programmes and services for those affected by violence;¹

PP22 Also noting that addressing violence, in particular against women and girls and against children is included within the leadership priorities of WHO’s Twelfth General Programme of Work 2014–2019 in particular to address the social, economic and environmental determinants of health;

PP23 Recognizing the need to scale up interpersonal violence prevention policies and programmes to which the health system contributes and that while some evidence-based guidance exists on effective interventions, more research and evaluation of these and other interventions is required;

PP24 Stressing the importance of preventing interpersonal violence before it begins or reoccurs, and noting that the role of the health system in the prevention of violence, in particular against women and girls, and against children, includes supporting efforts to: reduce child maltreatment, such as through parenting support programmes; address substance abuse including the harmful use of alcohol; prevent the reoccurrence of violence by providing health and psychosocial care and/or rehabilitation for victims and perpetrators and to those who have witnessed violence; and, collect and disseminate evidence on the effectiveness of prevention and response interventions;

PP25 Affirming the health system’s role in advocating, as an element of prevention, for interventions to combat the social acceptability and tolerance of interpersonal violence, in particular against women and girls, and against children, emphasizing the role such advocacy can play in promoting societal transformation;

PP26 Recognizing that interpersonal violence, in particular against women and girls, and against children, can occur within the health system itself, which can negatively impact the health workforce, the quality of health care provided and lead to disrespect and abuse of patients, and discrimination to access of services provided;

PP27 Affirming the important and specific role that national health systems must play in identifying and documenting incidents of violence, and providing clinical care and appropriate referrals for those affected by such incidents, particularly women and girls, and children, as well as contributing to prevention and advocating within governments and among all stakeholders for an effective, comprehensive, multisectorial response to violence,

OP1. URGES Member States:²

(OP1.1) to strengthen the role of their health systems in addressing violence, in particular against women and girls, and against children, to ensure that all people at risk and or affected by violence have timely, effective, and affordable access to health services, including health promotion, curative, rehabilitation and support services that are free of abuse, disrespect and discrimination, to strengthen their contribution to prevention programmes and to support WHO’s work related to this resolution;

(OP1.2) to ensure health system engagement with other sectors, such as education, justice, social services, women’s affairs, and child development, in order to promote and develop an effective, comprehensive, national multisectorial response to interpersonal violence, in particular against women and girls, and against children, by, inter alia, adequately addressing violence in health and development plans, establishing and adequately

¹ This work is carried out mainly by the Department of Violence and Injury Prevention and Disability, the Department of Reproductive Health and Research, the Department for Mental Health and Substance Dependence and the Department for Emergency Risk Management and Humanitarian Response, in close collaboration with Regional and Country Offices.

² And, where applicable, regional economic integration organizations.
financing national multisectoral strategies on violence prevention and response including protection, as well as promoting inclusive participation of relevant stakeholders;

(OP1.3) to strengthen their health system’s contribution to ending the acceptability and tolerance of all forms of violence against women and girls, including through advocacy, counselling and data collection, while promoting the age-appropriate engagement of men and boys alongside women and girls, as agents of change, in their family and community, so as to promote gender equality and the empowerment of women and girls;

(OP1.4) to strengthen the national response, in particular the national health system response, by improving the collection and, as appropriate, dissemination of comparable data disaggregated for sex, age, and other relevant factors, on the magnitude, risk and, protective factors, types, and health consequences of violence, in particular against women and girls, and against children, as well as information on best practices, including the quality of care and effective prevention and response strategies;

(OP1.5) to continue to strengthen the role of their health systems so as to contribute to the multisectoral efforts in addressing interpersonal violence, in particular against women and girls, and against children, including by the promotion and protection of human rights, as they relate to health outcomes;

(OP1.6) to provide access to health services, as appropriate, including in the area of sexual and reproductive health;

(OP1.7) to seek to prevent reoccurrence and break the cycle of interpersonal violence, by strengthening, as appropriate, the timely access for victims, perpetrators and those affected by interpersonal violence to effective health, social and psychological services and to evaluate such programmes to assess their effectiveness in reducing reoccurrence of interpersonal violence;

(OP1.8) to enhance capacities, including through appropriate continuous training of all public and private professionals from health and non-health sectors, as well as caregivers and community health workers, to provide care and support, as well as other related preventive and health promotion services to victims and those affected by violence, in particular women and girls and children;

(OP1.9) to promote, establish, support and strengthen standard operating procedures targeted to identify violence against women and girls, and against children, taking into account the important role of the health system in providing care and making referrals to support services;

OP2. REQUESTS the Director-General:

(OP2.1) to develop, with the full participation of Member States,1 and in consultation with United Nations organizations, and other relevant stakeholders focusing on the role of the health system, as appropriate, a draft global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence in particular against women and girls and against children, building on existing relevant WHO work;

(OP2.2) to continue to strengthen WHO efforts to develop the scientific evidence on the magnitude, trends, health consequences and risk and protective factors for violence, in particular against women and girls and against children, and update the data on a regular basis, taking into account Member States input, and to collect information on best practices, including the quality of care and effective prevention and response strategies in order to develop effective national health systems prevention and response;

---

1 And, where applicable, regional economic integration organizations.
The resolution would contribute to bringing increased attention to bear on violence, in particular violence against women and girls, as a public health issue, on its severe health impacts and its preventability, and on the role that the health sector plays in tackling violence. It would further strengthen the health sector’s role within a multisectoral response and provide committed policy-makers in the health sector with a stronger mandate for dealing with the topic.

The resolution would also help to increase collaboration both between WHO and its external partners and within the Organization.

Yes.
3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost
Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US$ 10 000).

(i) Five years (covering the period 2014–2018)
(ii) Total: US$ 34.65 million (staff: US$ 18.81 million; activities: US$ 15.84 million)

(b) Cost for the biennium 2014–2015
Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US$ 10 000).


Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.
All levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)
Yes.

If “no”, indicate how much is not included.

(c) Staffing implications
Could the resolution be implemented by existing staff? (Yes/no)
Yes, for the biennium 2014–2015.

For the biennium 2016–2017 and beyond, additional staff might be needed, in particular at regional and country levels.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.
The need for additional staff will depend on the development of the global plan of action requested in the resolution.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)
No: approximately US$ 5 million of the US$ 13.54 million for the biennium have currently been secured.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

For the biennium 2014–2015, the funding gap is approximately US$ 8.54 million. It is envisaged that the gap will be closed through the financial dialogue process and coordinated resource mobilization efforts.

He reminded the Committee that a drafting group had been established to discuss the draft resolution and agree on a consensus text.

Dr MAKASA (Zambia), speaking in his capacity as co-chair of the drafting group, said that the drafting group had convened for a total of eight sessions and had agreed on a consensus text. He expressed appreciation for the active participation of and flexibility and spirit of compromise shown by Member States during the deliberations. It was clear that strengthening the role of the health system in addressing violence, particularly violence against women, girls and children in general, was of the utmost importance to all Member States.
Mr McIFF (United States of America), speaking in his capacity as co-chair of the drafting group, paid tribute to Member States for their resilience and their willingness to think creatively in order to achieve consensus and focus international attention on such an important issue. Once the resolution was adopted by the Health Assembly, the hard work of implementation would begin; among the next steps was the formulation by the Secretariat of a draft plan of action to address interpersonal violence. He hoped that the Committee would be able to approve the draft resolution as presented.

Ms HARB (Lebanon) said that as women and children were particularly affected by different forms of violence and abuse, they should be specifically targeted in relevant social and public health programmes, which should include activities such as addressing risk factors and providing medical care (including psychological and social support) and rehabilitation. Multisectoral collaboration was vital and should include a formal framework for the early involvement of law enforcement authorities. Health systems needed to be strengthened in order for them to provide medical and psychological assistance to victims of violence; notify law enforcement; and report to the Ministry of Health. A social network would be a useful tool for referral and follow-up activities. She highlighted the difficult situation of countries experiencing armed conflict, in which violence, including sexual abuse, against women and children was often exacerbated and health workers were often victims of violence.

Dr BASHEIR (Sudan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that during the deliberations of the drafting group, the importance had been recognized of removing sensitive wording that might hinder universal acceptance and prevent the implementation of the draft resolution: it had been agreed to remove the phrase “intimate partner” from the draft resolution and replace it with “spouse”. However, although it had been removed from the tenth preambular paragraph, the phrase remained in the fifth preambular paragraph. The phrase should be removed and replaced with “spouse” as previously agreed. In addition, the paragraph should end with the words “forms of violence throughout the life course” and the remainder of the paragraph should be deleted.

Dr REDDY (India) said that the Secretariat’s report rightly emphasized the importance of multisectoral action on the issue. He encouraged Member States to support the draft resolution and to undertake concerted efforts to develop a comprehensive and multisectoral response and strengthen the role of health systems in addressing violence. He looked forward to working in close collaboration with WHO and relevant organizations of the United Nations system on such an important agenda item.

Mr CANDIA (Paraguay) stressed the importance of the draft resolution, which had been discussed in an extremely detailed and responsible way by the group of sponsors and by the Member States during consultations before and during the current Health Assembly. Violence against women and girls was a worrying reality and no one, much less WHO, could be indifferent to the search for an appropriate solution to the situations faced by women and girls around the world. He urged Member States to approve the draft resolution.

Dr KIBACHIO (Kenya) said that violence, particularly against women, girls and children in general was an important public health issue; Kenya therefore wished to be named as a sponsor of the draft resolution with its original wording, as the phrase referred to by the delegate of Sudan was intended to differentiate between hidden forms of violence within families and within the broader community.

Dr EVANGELISTA (Philippines), welcoming the timely discussion of the issue given the recent abduction by armed men of more than 300 schoolgirls in Nigeria, said that violence against women and children was a problem for all countries; far-reaching preventive actions were needed in all sectors and at all levels to tackle the issue. Particular attention should be paid to violence against
sex workers, girls without parents or mothers, children of migrant workers, adolescent girls and trafficked women. More emphasis should also be placed on the importance of educating and empowering both men and women to create a society free of gender-based violence. Addressing the social determinants of gender-based violence and building societies that upheld women’s rights and inclusion were crucial, and health systems should play a supporting role in that regard.

Dr KARRER (Switzerland) said that countering violence in all its forms, particularly against women, girls and children in general, was of great importance for his country. The issue should be approached from the point of view of its impact on victims and their families, without making any distinction about the nature of the perpetrator or the circumstances of and reasons behind such attacks. No progress could be achieved on the issue without achieving gender equality. Therefore any potential approach had to be based on human rights. The draft resolution had a number of merits, but many Member States had had to make concessions; the role of the health system in treating violence in situations of conflict and other humanitarian crises would have been worthy of inclusion in the operative paragraphs of the resolution, in order to consolidate the gains made on the issue within the United Nations system. He commended the collective efforts by Member States to make progress on the issue.

Ms PADILLA RODRÍGUEZ (Mexico) said that her country was committed to participating actively in drawing up an action plan. Violence was an alarmingly prevalent global public health issue with a variety of causes, particularly intolerance, inequity and impunity. Girls and women were more vulnerable to sexual violence, but boys were at high risk of suffering from physical violence and reproducing that violence later in life. Member States should take steps to ensure that all forms of violence and ill-treatment were not tolerated for any reason and to give due consideration to the short-, medium- and long-term consequences of violence. Efforts should also be made to scale up effective preventive interventions.

Professor HALTON (Australia) asked whether, in the spirit of compromise, the wording of the fifth preambular paragraph could be left as it was, with an explanatory footnote to address the concerns expressed by the delegate of Sudan.

Dr AL-JALAHMA (Bahrain) suggested that the word “intimate” could be removed from the fifth preambular paragraph; the act of violence was the key issue, not whether the perpetrator was an intimate partner or not.

Mr ALSAATI (Saudi Arabia) said that his country strongly condemned violence in all its forms; the difficulty with the term “intimate partner” was that it did not apply to his country’s societal norms, in which there were only marital partners and no other type of intimate relationship. It had been agreed in the drafting group to remove the term from the entire draft resolution.

Dr EL-REFAY (Egypt) said that the phrase “intimate partner” was a term used solely by the Secretariat and was not United Nations-agreed terminology. It therefore created difficulties for Member States if it were used in a formal document such as a resolution. He expressed support for the proposals made by the delegates of Bahrain and Sudan.

Dr MAKASA (Zambia), speaking in his capacity as co-chair of the drafting group, expressed agreement with the suggestion to remove the word “intimate”.

Dr AL-TAAE (Iraq), welcoming the suggestion made by the delegate of Bahrain regarding removal of the word “intimate”, said that in the first preambular paragraph and the first and third lines
of the eighteenth preambular paragraph, the words “and children” should be inserted after “women and girls”. In addition, “and/or emotional” should be inserted after “physical” in the fourth preambular paragraph. The words “sexual and” should be deleted from the phrase “sexual and reproductive health” in the eighth preambular paragraph and in subparagraphs (OP1.6) and (OP2.3); they were unnecessary, as the concept was covered by the term “reproductive”. In the sixteenth preambular paragraph, “boys” should be replaced by “children”.

Mr McIFF (United States of America), speaking in his capacity as co-chair of the drafting group and supported by Mr RUSH (United Kingdom of Great Britain and Northern Ireland) and Mr RIETVELD (Netherlands), agreed that the term “intimate” could be deleted, as proposed by the delegate of Bahrain.

Dr ELOAKLEY (Libya) expressing support for the proposal made by the co-chairs of the drafting group and the delegate of Bahrain, observed that during the present Health Assembly, there had been a large number of different meetings running concurrently and often for long periods of time; such an approach should not be encouraged in future.

Mr AASLAND (Norway) said that although he supported the proposal made by the co-chairs of the drafting group and the delegate of Bahrain, he would prefer to retain the wording originally agreed; there should not be further substantive discussion of the draft resolution.

Mr KLEIMAN (Brazil) supported the proposal by the delegate of the United States of America; Member States could not continue to ignore the issue of violence against girls, women and children.

The DIRECTOR-GENERAL explained that she had held informal consultations with the delegate of Iraq, who had agreed to withdraw his amendments. She expressed sincere thanks to the delegate for his flexibility.

Dr AL-TAAE (Iraq) said that it was important that the draft resolution was approved; he was therefore happy to withdraw all of his amendments. He supported the proposal made by the delegate of Bahrain.

Dr NYIKAL (Kenya) asked whether it was still intended to include the words “and children” in the first preambular paragraph and to retain the word “boys” in the sixteenth preambular paragraph.

The DIRECTOR-GENERAL said that it should be possible to include that phrase and retain that word.

Mr KLEIMAN (Brazil) said that the wording of the first preambular paragraph quoted the title of the report by the Secretariat contained in document A67/22; it would therefore be strange to insert additional wording.

Mrs PENIĆ IVANKO (Croatia) requested that Croatia be named as a sponsor of the draft resolution.
Dr FEARNE (Malta),\textsuperscript{1} reiterating his country’s commitment to full implementation of the Programme of Action adopted at the International Conference on Population and Development and subsequent international instruments such as the Beijing Declaration and Platform for Action, said that any discussion of and reference to reproductive rights and services could not take place outside the framework of one of the most fundamental human rights, namely the right to life. Terms and recommendations that implied practices resulting in abortion were not acceptable in Malta, as the country’s legislation considered the termination of a pregnancy by induced abortion to be illegal. Any recommendation or commitment made by the Health Assembly should therefore not create an obligation on any party.

The CHAIRMAN took it that the Committee wished to approve the draft resolution, as amended.

The draft resolution, as amended, was approved.\textsuperscript{2}

8. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 16 of the Agenda (resumed)

Smallpox eradication: destruction of variola virus stocks: Item 16.3 of the Agenda (Document A67/37)

Ms GURBANOVA (Azerbaijan) said that the report referred to in document A67/37 contained a number of divergent recommendations. Moreover, the conclusions of the advisory bodies were not unanimous, and the issue required further detailed consideration. It was essential that WHO undertook rigorous inspections of the containment facilities at the repositories in the Russian Federation and the United States of America to ensure compliance with biosafety and biosecurity standards.

Mr LEWIS (Canada)\textsuperscript{1} said that he accepted the findings of the WHO Advisory Committee on Variola Virus Research and the Advisory Group of Independent Experts. The remaining stocks of variola virus should be destroyed when it could be definitively established that they were no longer required for public health research purposes and proliferation concerns had been resolved. Canada was not ready to take a decision on setting a date for destruction since further work was required, particularly with respect to synthetic biology, for which his country would be pleased to make technical experts available.

Dr GWINJI (Zimbabwe) drew attention to the conclusion of the Advisory Group of Independent Experts that there was no need, from a global health perspective, to retain live variola virus for any further research. He would not support the establishment of an expert group or any extension or expansion of the research programme. Recalling the existence of WHO recommendations concerning the distribution, handling and synthesis of variola virus DNA and drawing attention to resolution WHA60.1 in which the Health Assembly had requested the Director-General to ensure that any research undertaken did not involve genetic engineering of the variola virus, he asked for a date to be set for destruction of the virus stocks.

\textsuperscript{1} At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered at the meeting.

\textsuperscript{2} Transmitted to the Health Assembly in the Committee’s sixth report and adopted as resolution WHA67.15.
Mr AGAFONOV (Russian Federation) said that the majority view of the WHO Advisory Committee on Variola Virus Research at its fifteenth meeting, that live variola virus was needed for the further development of antiviral agents against smallpox, was consistent with decision WHA64(11) reaffirming the need to reach consensus on a proposed new date for destruction for the variola virus stocks, when research outcomes crucial to an improved public health response to an outbreak so permitted. The Russian Federation was willing to participate in the continued work on an operational framework for access to WHO’s emergency stockpile of smallpox vaccines in response to a smallpox event, and considered that a similar mechanism should be developed for stockpiles of smallpox medication. The WHO Advisory Committee on Variola Virus Research was fully competent to evaluate the potential impact of new technologies on smallpox preparedness and countermeasures. All Member States should have equitable access to all medication and, as the host of one of the two variola virus repositories, the Russian Federation was working towards that goal.

Mr KOLKER (United States of America) said that his country supported the retention of variola virus stocks until sufficient countermeasures against smallpox had been developed. Recalling that advances in synthetic biology had made it increasingly possible to recreate variola, he strongly endorsed the conclusion of the Executive Board at its 134th session that the Director-General should organize a group of experts to review advances in gene synthesis technology, in particular whether the variola virus could be created synthetically and whether additional research on countermeasures should be considered. Having noted that such a step was fully in accordance with resolution WHA60.1, he said that the United States was committed to making the benefits of the research as widely available as possible.

Ms GAILIUTE (Lithuania) welcomed the recommendation of the Strategic Advisory Group of Experts on immunization and paid tribute to the ongoing work of the WHO biosafety teams. However, rapidly advancing technologies gave rise to concerns that complex viruses could be recreated without the need for seed stocks. Those new risks dictated the need to consider the adequacy of existing countermeasures. Since more than 40% of the world’s population had not been vaccinated against smallpox, there were significant risks in the event of an outbreak of the disease. She agreed with other speakers that it might therefore be premature to set a date for the destruction of smallpox virus stocks at the current Health Assembly, and considered that preparedness offered the best solution for the elimination of smallpox risks.

Dr ELOAKLEY (Libya), speaking on behalf of the Member States of the Eastern Mediterranean Region, noted that the WHO Advisory Committee had concluded that there was no need to retain variola virus stocks for further diagnostics for smallpox or for the development of safer vaccines. The Strategic Advisory Group of Experts on immunization had made recommendations on the vaccine stockpile, addressing outbreak control requirements and the protection of laboratory workers, among other matters. For that reason, the Member States of the Region considered that the variola stocks had already served their purpose in terms of global and public health, and that their maintenance was a concern in terms of possible laboratory accidents. He urged the Director-General to take all necessary measures to establish a deadline for the destruction of those stocks, in line with decision WHA64(11).

Dr DAHN (Liberia), speaking on behalf of the Member States of the African Region, drew attention to the conclusion of the Advisory Group of Independent Experts and said that the destruction of the live variola virus was in the best interests of the global community. Noting with satisfaction that

---

1 At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.
the WHO biosafety inspection teams had visited the two variola virus repositories in 2012 and had confirmed that the research therein was being done safely and securely, she said that a timeline should be set for the two repositories to reduce their research, in stages defined by percentages and under the supervision of WHO biosafety teams, in order to arrive at dates for final destruction of the live virus.

Dr GAMKRELIDZE (Georgia), having commended the work of the advisory groups, expressed support for the position expressed by the delegate of the United States of America and would welcome the organization of a group of experts to study new evidence for and against a decision on the destruction of variola virus stocks. Live strains must be maintained under the control of WHO until the final decision was taken.

Dr BUGTI (Pakistan) recalled the conclusion of the Advisory Group of Independent Experts that there was no public health reason for continued retention of the virus. Noting that WHO had stringent rules on the distribution, handling and synthesis of variola virus DNA, which could effectively control any risks related to biotechnology, she said that a date should be set for destruction of virus stocks.

Dr REN Minghui (China) agreed that the live variola virus should no longer be used in research. He proposed starting the process of destruction and strictly banning synthesis of the variola virus. The Secretariat should inform Member States of variola research findings, and he encouraged exchanges of experience with respect to diagnosis, treatment and vaccines. The WHO Advisory Committee on Variola Virus Research should provide support to developing countries.

Dr REDDY (India), noting the conclusion of the Advisory Group of Independent Experts and the majority view of the WHO Advisory Committee on Variola Virus Research, said that there were no serious technical obstacles to setting a date for destruction of variola virus stocks under the supervision of the Director-General. India was not convinced about the passive new threats from smallpox. Recalling resolution WHA60.1, he did not support the formation of any group of experts to study the implications of technologies for biological synthesis and their potential impact on smallpox preparedness.

Mr CORRALES HIDALGO (Panama) expressed support for the establishment of a group of experts that could agree on rules for moving forward, and agreed that WHO should continue to provide assurances that existing stocks were kept in appropriate conditions.

Mr LUTNÆS (Norway), noting the recommendations from the advisory groups, said that the technology for synthetic production of the smallpox virus existed. A laboratory-produced virus could potentially have the same capacities as the original virus. More information was needed about the implications of that development for public health preparedness against potential future outbreaks. He therefore supported the proposal to organize a group of experts to provide an up-to-date assessment of those technologies and their potential impact on smallpox preparedness, as had also been agreed by the Executive Board at its 134th session.

Dr Y. PILLAY (South Africa) said that he was pleased to confirm that the destruction and disposal of the remaining cloned variola virus DNA fragments in South Africa had been completed in January 2014 under the observation of WHO. The international community should be working towards the establishment of clear timelines for the destruction of remaining stocks.

Mr KIM Ganglip (Republic of Korea) said that his country recognized bioterrorism as a national threat and remained concerned about the development of recreated complex viruses. Given the
possibility of a threat to health security that could not be addressed appropriately through the use of existing vaccines, he called for further research and discussion through a group of experts. Caution should be exercised in taking the decision on the destruction of virus stocks, in the light of the need to safeguard global health and security.

Dr EVANGELISTA (Philippines) applauded the outcomes of the fifteenth meeting of the WHO Advisory Committee on Variola Virus Research. In the light of the report contained in document A67/37, he recommended that a reasonable timeline should be provided for the destruction of all remaining variola virus stocks once all essential public health research had been completed; that the Health Assembly should reaffirm its decision not to authorize variola virus research not essential to public health; and that countries should be kept updated on the progress of research and be involved in the development of the laboratory network for smallpox as part of the WHO Emerging and Dangerous Pathogens Laboratory Network.

Mr PIPPO (Argentina) said that he did not oppose maintaining virus collections at the two WHO Collaborating Centres for further research on diagnostics, vaccines and antiviral agents. He agreed with the recommendations of the Strategic Advisory Group of Experts on immunization concerning donations to and the current size of the WHO vaccine stockpile. Discussions with national regulatory agencies of donating countries on establishing a regulatory framework for the donation of smallpox vaccine should continue. He expressed support for the Secretariat’s proposal to convene a group of experts to provide an up-to-date assessment of the relevant technologies and their potential impact on smallpox preparedness.

Mr FERDINAN TARIGAN (Indonesia) said that WHO should take a leading role in maintaining a stockpile of vaccines and antiviral medicines, and arrange outbreak response guidelines that would include the operational framework for access to such a stockpile. In the light of the conclusion of the Advisory Group of Independent Experts to review the smallpox research programme, to the effect that there was no need to retain stocks of variola virus, Indonesia supported WHO’s efforts to foster agreement among Member States on the final destruction of the remaining variola virus stocks.

Dr USHIO (Japan) recalled that the ultimate goal of smallpox eradication was the destruction of the remaining laboratory virus stocks. However, in view of threats to international health security, such as bioterrorism, the time was not yet right for destruction. Discussions should continue on vaccine stocks and research and development, with an appropriate timeframe established. He supported the Secretariat’s proposal to convene a group of experts.

Dr ELENWUNE (Nigeria), noting that destruction of the official stocks would not prevent rogue countries or organizations from retaining their own, said that authorized stocks of variola virus should be retained until appropriate countermeasures had been put in place to respond to a potential smallpox outbreak.

Dr TAKIAN (Islamic Republic of Iran), recalling decision WHA64(11), by which the Health Assembly had strongly reaffirmed its previous decisions that the remaining stocks of variola virus should be destroyed, observed that none of the three separate deadlines that it had set had been met. All necessary research with live variola virus had been completed, and any further studies would have

---

1 At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.
only limited public impact and delay destruction further. The Health Assembly should exercise its leadership and decide on the destruction of the remaining stocks of live variola virus at an early date; terminate authorization of research involving live variola virus; ensure universal and equitable ownership of the achievements of all previous research activities, including antiviral agents, vaccines and diagnostic tools; prohibit genetic engineering of the variola virus; and put in place strict, transparent and accountable oversight mechanisms, in particular for the destruction of existing stocks.

Ms LANTERI (Monaco) called on the Secretariat to convene a group of experts to review technologies for advances in biosynthesis technology in the near future, noting that the conclusions of that group would facilitate the setting of a date for destruction.

Mr KLEIMAN (Brazil), emphasizing the importance of smallpox preparedness, said that it would be premature to set a date for destruction of virus stocks, which were under WHO’s supervision and would be an asset in further research. He would support the convening of a group of experts to consider issues including biological synthesis of the virus.

Dr MANAMOLELA (Lesotho) said that she would support the convening of a group of experts to review recent scientific advances in gene synthesis technology with a view to preventing the re-emergence of smallpox.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland) endorsed the views expressed by the delegate of the United States of America on delaying destruction of the virus stocks, noted that the international scientific community was not fully aligned on the evidence, and supported convening a group of experts to consider the risks of synthetic creation of the virus and the potential need for more research.

Ms RUIZ VARGAS (Mexico) agreed with others that it would be in the public health interest to retain a stock of variola virus for use in research, noting the potential danger of biological and bacteriological threats to human security in the twenty-first century.

Ms Li-Ying LAI (Chinese Taipei) expressed support for resolution WHA60.1. In 2011, Chinese Taipei had developed a mass vaccination programme to respond to a potential outbreak; it had sufficient quantity of the first-generation vaccine to cover its population and had procured a small amount of the third-generation vaccine despite the high cost.

Mrs DE TROEYER (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, called on the Health Assembly to set an early and irrevocable date for the destruction of smallpox virus stocks. All elements of the WHO authorized research programme requiring smallpox virus had been completed, and the Organization’s own experts had concluded that there was no public health reason for the continued retention of stocks. The case for retaining the virus appeared to rest on the risk of unauthorized or unforeseen release of the virus, but the remaining stocks were held at WHO-authorized repositories. Their continued existence presented a real and significant risk in terms of laboratory biosafety and security. Their immediate destruction was the single most effective means of ensuring that the smallpox virus would not reappear, either accidentally or deliberately.

The DIRECTOR-GENERAL noted that Member States were divided on whether to destroy existing stocks of variola virus. Her understanding of the discussion was that there was agreement that the stocks should, ultimately, be destroyed. However, some Member States felt that more work was needed to find safe countermeasures to smallpox before destruction was undertaken, while others
urged that a destruction date be set quite soon. Even the experts on the WHO Advisory Committee on Variola Virus Research were not unanimous on the need for further research.

She had heard no destruction date mentioned, however, and therefore supposed that the discussion would continue. In the meantime, the Secretariat would enhance its understanding of the underlying biological issues, on which the scientific community was divided, by consulting with independent scientific opinions worldwide and with the regional directors and, as requested by some speakers, would maintain the two stockpiles in the United States of America and the Russian Federation, ensuring biosafety and biosecurity. She asked the Member States to agree to the convening of a geographically representative, gender-balanced group of people from different fields of expertise to advise her on the advantages and disadvantages of the technology and the science, so that she could in turn advise the Member States.

It was so decided.

The CHAIRMAN invited the Committee to note the report.

The Committee noted the report.

9. PROGRESS REPORTS – Item 17 of the Agenda (Document A67/40)

Mr BOISNEL (France) said that, as certain Executive Board functions had been transferred to the Health Assembly, it was a shame that the progress reports were unable to be addressed in a comprehensive manner. He called on all Member States and the Secretariat to ensure that they received due attention during the next Health Assembly.

Mr VEGA MOLINA (Spain) agreed with the delegate of France that sufficient time had to be set aside for the examination of progress reports and regretted that such had not been the case.

Communicable diseases

A. Global health sector strategy on HIV/AIDS, 2011–2015 (resolution WHA64.14)

Dr Y. PILLAY (South Africa) noted global progress in combatting HIV/AIDS but said that much remained to be done, particularly in sub-Saharan Africa. In South Africa, which had the largest burden of people living with HIV, 2.5 million people were now receiving antiretroviral therapy, but it was important to ensure that significant drug resistance did not develop. He called on WHO to reduce the prices of third-line antiretroviral medicines; work with partners to develop better paediatric formulations and begin drafting the next global health sector strategy for HIV/AIDS, taking into account the global strategy for tuberculosis, and the global strategy for human resources that was being drawn up.

Ms VALLINI (Brazil) supported the comment made by the delegate of South Africa, reiterating the need for transparent discussions on a new global health sector strategy for HIV/AIDS, to be ready for approval by Member States in 2015.

1 At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.
Mr USTINO (Russian Federation) said that the number of HIV tests carried out each year in the Russian Federation was one of the highest in the world, and the number of people receiving antiretroviral treatment would increase with the implementation of new clinical guidelines and treatment eligibility criteria. Vertical transmission had been almost eradicated, and the Russian Federation was willing to share its experience in that regard. He supported WHO’s “Treatment as Prevention” strategy and coordinated efforts to reduce the cost of antiretroviral medicines worldwide. The number of HIV-positive people in the Russian Federation did not confirm earlier expert predictions of an epidemic.

The primary cause of HIV infection in the Russian Federation and the former Soviet Union was intravenous drug use; the country’s medical profession was of the unanimous view that the best way to solve the problem was to ban the use of all illegal drugs. In terms of rehabilitation, drug-dependent patients (including, recently, those in Crimea and Sebastopol) were offered various treatments, including antiretroviral drugs and opioid antagonists. Russian nongovernmental organizations had played a positive role in rehabilitation after drug replacement therapy.

Ms BONNER (Germany) joined the delegates of South Africa and Brazil in calling for the development of a follow-up strategy on HIV/AIDS, as the current global health sector strategy on HIV/AIDS was due to come to an end in 2015.

Mr McIFF (United States of America) welcomed the mid-term review of the global health sector strategy on HIV/AIDS. WHO had a leadership role to play in achieving an AIDS-free generation and control of the HIV epidemic, providing normative guidance based on science and innovation. WHO must continue to prioritize its work on HIV and ensure that regional efforts were targeted, effective and results-based.

Mr SOSSOU (Benin), speaking on behalf of the Member States of the African Region, noted with satisfaction the progress made in implementing the global health sector strategy on HIV/AIDS, 2011–2015. With the technical and financial support of their partners, the Region’s governments had considerably reduced the number of new infections across the Region, improved access to antiretroviral drugs, reduced the number of AIDS-related deaths and curbed the mother-to-child transmission rate. However, the continent’s excessive dependence on international donors and funding compromised the sustainability of the action it took to fight the disease. In order to fight HIV/AIDS, the Region’s Member States had to give effect to the Abuja commitment and allocate 15% of the State budget to the health sector and promote innovative health funding mechanisms. Strengthening public–private partnerships was a strategic component of domestic funding for HIV/AIDS activities. At the first meeting of African ministers of health, convened jointly by WHO and the African Union Commission (Luanda, April 2014), the need had been recognized to establish the African Medicines Agency, which would promote the subregional production of medicines and inputs and reorganize drug supply systems. He appealed to the international community to support that initiative.

Mr VEGA MOLINA (Spain) said that, in line with the WHO global health sector strategy on HIV/AIDS, 2011–2015 and the UNAIDS Reaching Zero strategy, Spain had adopted a plan to prevent and control HIV infection that was based on scientific knowledge, best practices and innovation, and was directed in particular at the most vulnerable groups. The plan constituted the common core for action by all administrations and governmental and nongovernmental organizations responding to the epidemic. It was predicated, inter alia, on a coordinated response to the epidemic, early diagnosis and

¹ At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered at the meeting.
prevention of the associated disabilities and comorbidities, improved access to early treatment, follow-up and continued care, guaranteed equality of access and non-discrimination of persons living with HIV.

Ms Li-Ying LAI (Chinese Taipei) said that Chinese Taipei was facing a growing HIV epidemic among men who had sex with men, primarily as a result of using recreational drugs. She called on WHO to provide guidance on how to prevent and control the use of recreational drugs among young people, so as to reduce transmission of HIV.

B. Eradication of dracunculiasis (resolution WHA64.16)

Noncommunicable diseases

C. Child injury prevention (resolution WHA64.27)

Promoting health through the life course

D. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)

Dr SHAKEELA (Maldives), speaking on behalf of Australia, Belgium, Botswana, Brazil, Bulgaria, Denmark, Ecuador, Estonia, Finland, France, Ghana, Germany, Iceland, Latvia, Lithuania, Luxembourg, Mexico, Monaco, Nepal, Netherlands, New Zealand, Norway, Portugal, Slovenia, South Africa, Spain, Sweden, Switzerland, Thailand, Tunisia, United Kingdom of Great Britain and Northern Ireland, Uruguay and Zambia, said that the Programme of Action from the International Conference on Population and Development recognized the importance of reproductive rights and was the cornerstone of WHO’s reproductive health strategy. While some progress had been made on sexual and reproductive health and rights, attainment of Millennium Development Goal 5 (Improve maternal health) remained a challenge, and implementation of WHO’s strategy at global, regional and national levels was crucial. Improving sexual and reproductive health and rights would contribute to attaining gender equality, eradicating poverty and achieving sustainable development and universal health coverage. The areas requiring more attention had been rightly identified in the progress report, and there was a particular need to reach all people, particularly those in marginalized situations.

E. Female genital mutilation (resolution WHA61.16)

Ms ANDERSSON (Sweden), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, welcomed plans to focus on research and guidelines and to scale up treatment and rehabilitation for girls and women who had undergone female genital mutilation. WHO should ensure adequate resources to support health workers and implement resolution WHA61.16 and United Nations General Assembly resolution 67/146. Female genital mutilation must remain high on global and national health agendas.

---

1 At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered at the meeting.
F. Youth and health risks (resolution WHA64.28)

Mr McIFF (United States of America) emphasized that people of all ages should be involved in discussions and decisions about their own health. For that reason, a youth representative had been part of his national delegation for the first time, and he encouraged other delegations to adopt that practice.

Mr OSEI (Ghana), speaking on behalf of the Member States of the African Region, welcomed continued efforts to promote the health of young people. The health sector should play a leading role in multisectoral approaches to adolescent health, and several youth-focused national policies and strategies had been developed in the Region. However, the coordination of activities related to the health of young people remained inadequate, and the lack of financial and human resources had affected the provision of support to Member States. He encouraged the Secretariat to redouble efforts to mobilize the funds required to promote the health of young people.

G. Implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children (resolution WHA66.7)

Ms ANDERSSON (Sweden), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden and recalling resolution WHA66.7, commended the progress made by the eight pathfinder countries, technical partners and the Reproductive, Maternal, Newborn and Child Health Trust Fund. Member States were encouraged to strengthen the implementation of initiatives to overcome barriers to accessing essential reproductive, maternal, newborn and child health commodities.

H. Climate change and health (resolution EB124.R5)

Mr VEGA MOLINA (Spain) encouraged WHO to pursue its efforts to include the present and future challenges related to climate change and health on the list of global public health priorities. The only way to ensure greater resilience and promote health sector adaptation to climate change was to prepare health systems to detect, reduce, prevent and respond to the effects of climate change observed in various parts of the world.

Ms ANDERSSON (Sweden), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, noted that the WHO work plan on climate change and health had expired and should be renewed, particularly in the light of the Conference on Health and Climate, which was to take place in August 2014. Recalling WHO’s contribution to the Climate and Clean Air Coalition, she said a draft resolution on air pollution and health would be submitted to the Sixty-eighth World Health Assembly, and the matter should be a priority for the Organization.

Health systems

I. Global strategy and plan of action on public health, innovation and intellectual property (resolution WHA61.21)

Mrs NAARENDORP (Suriname) recalled that the global strategy and plan of action on public health, innovation and intellectual property envisaged the award of prizes to incentivize innovation

1 At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.
and the delinkage of costs. However, as the update on the global strategy did not provide any information in that regard, she requested clarification from the Secretariat.

J. Availability, safety and quality of blood products (resolution WHA63.12)

K. Human organ and tissue transplantation (resolution WHA63.22)

Mr VEGA MOLINA (Spain) said that the increasingly widespread use in clinical practice of medical products of human origin (including cells, tissue and organs, blood and breast milk) called for a shift in focus. All were donated and therefore exposed to the same risks. The WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation should be applied to such products in view of their origin, their non-commercial nature and the need to establish traceability mechanisms. He therefore welcomed the Secretariat’s special initiative on medical products of human origin and asked that it continue to be developed.

Mr PIPPO (Argentina) emphasized the non-commercial nature of medical products of human origin and supported the statement made by the delegate of Spain in that regard.

L. WHO strategy on research for health

Preparedness, surveillance and response

M. WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies (resolution WHA65.20)

Mrs LAMPIRANOU (Greece), speaking on behalf of the Member States of the European Union, said that Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with her statement.

She welcomed the enhancement of WHO’s preparedness and surge capacity at all organizational levels and encouraged the Secretariat to ensure that its internal procedures, including temporary recruitment, would guarantee rapid responses. She also welcomed WHO’s efforts under the Transformative Agenda of the Inter-Agency Standing Committee, which had been implemented in recent and current crisis situations. Enhanced cluster coordination would result in targeted, prioritized and swift delivery of aid. Performance of the Global Health Cluster should be further strengthened, seeking continuity of humanitarian actions and long-term development. The Secretariat was encouraged to cooperate further with the International Committee of the Red Cross on the Health Care in Danger project, as violent acts against health care personnel were increasing in conflict-driven emergencies. In view of the increasing funding gap, voluntary donations would be required to support WHO’s Emergency Response Framework, and she requested updated information on humanitarian funds received by WHO.

Dr LAHTINEN (Finland) commended the progress made in implementing resolution WHA65.20 and the increased recognition of WHO’s central role by Member States. Sufficient capacity was required to enable WHO to respond to humanitarian crises in an effective, efficient and timely manner, for which Member States should allocate adequate core funding.

1 At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered at the meeting.
Dr CARTIER (Belgium)\(^1\) recognized the growing trend of increased and often deliberate violence against health care workers and users in humanitarian crises and expressed concern regarding its dramatic consequences, including short-term limitations of access to services and long-term impacts on health. That was a violation of international humanitarian law. Fifty Member States had signed a joint declaration during the Syrian Humanitarian Forum, which recalled countries’ obligations under the Geneva Conventions; another declaration signed by 27 Member States called for all parties involved in the conflict to protect civilians and medical personnel and infrastructure. He supported the Health Care in Danger project and welcomed WHO’s collaboration. All Member States should respond to the recommendations issued from that project and ensure that health care professionals and service users were protected, in the Syrian Arab Republic and around the world.

Mr GAI KOK (South Sudan),\(^1\) speaking on behalf of the Member States of the African Region, recalled that African ministries of health were working closely with WHO, as the Health Cluster Lead Agency, to support the planning, coordination, implementation and monitoring of key strategies to improve the lives of conflict-affected communities. The overall goal of the Health Cluster Lead was to ensure a coordinated approach for provision of essential health care services to people affected by humanitarian emergencies. WHO was expected to show leadership in coordinating the health cluster to facilitate the transition from emergency response to development. There was an urgent need to strengthen the capacity of Member States and health partners to adequately prepare for, and respond to, the health needs of people affected by disasters and other public health emergencies by implementing comprehensive disaster management strategies.

### Corporate services/enabling functions

#### N. Multilingualism: implementation of action plan (resolution WHA61.12)

Mr BOISNEL (France),\(^1\) speaking on behalf of the countries that were members or observers of the Organisation Internationale de la Francophonie, emphasized the importance of multilingualism, thanked the Secretariat for its implementation of the corresponding action plan, and recalled that multilingualism should be fully included in the WHO reform process. He asked how the appointment of a coordinator for multilingualism would be translated into specific action within the various departments of the Organization. The Secretariat should collaborate with other organizations of the United Nations system to share good practices and seek out synergies. The increase in multilingual content on the website was to be welcomed, although there was a persistent disparity between the number of pages uploaded in English and in WHO’s other official languages, in particular on the financing dialogue web portal and in social media. He welcomed the free language training made available to staff members and drew attention to the importance of multilingualism in the recruitment process. Statistics on the fluency of professional staff members in the official languages should be made available, as called for in resolution WHA61.12.

Mr VEGA MOLINA (Spain)\(^1\) acknowledged the Secretariat’s efforts to increase the multilingual content of the WHO website. The point was not merely to reduce the gap between the amount of content in English and other languages, but rather to treat all official languages equally. For Member States, the section of the website on the Organization’s financing and, in particular, the portal on the financing dialogue were key components that should be available in the official languages. Documents could be translated in time if they were published in advance.

---

\(^1\) At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.
Multilingualism was a fundamental principle of the work of the United Nations and its staff selection and recruitment processes. It was unacceptable for meetings to be continued without interpretation. Whenever possible, Secretariat staff should make presentations in the various official languages and all delegates should use interpretation services when available. The Grupo de Apoyo al Español (Spanish Support Group), launched several months earlier by several Member States, hoped to work closely with WHO.

Dr NDIAYE (Senegal), speaking on behalf of the Member States of the African Region, welcomed the increases in multilingual content on the WHO website and in WHO’s Institutional Repository for Information Sharing; the authorization of almost 400 translations in 49 languages; and the free language training offered to staff members.

The CHAIRMAN urged delegates to read the statements provided by nongovernmental organizations under the agenda item, which were available on the WHO website, as time would not allow them to be read out at the current meeting.

The Committee noted the progress reports.

10. SIXTH REPORT OF COMMITTEE A (Document A67/72)

Dr MBUGUA (Kenya), Rapporteur, read out the draft sixth report of Committee A.

The report was adopted.

11. CLOSURE OF THE MEETING

After the customary exchange of courtesies, the CHAIRMAN declared the work of Committee A completed.

The meeting rose at 20:40.