SIXTY-NINTH WORLD HEALTH ASSEMBLY

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COMMITTEE A

PROVISIONAL SUMMARY RECORD OF THE EIGHTH MEETING

Palais des Nations, Geneva
Thursday, 26 May 2016, scheduled at 14:30

Chairman: Mr M. BOWLES (Australia)

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Thursday, 26 May 2016, at 14:35

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1. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 14 of the agenda (continued)

Poliomyelitis: Item 14.5 of the agenda (document A69/25) (continued)

The representative of SWITZERLAND, speaking on behalf of the Member States of the European Region, called for the full implementation of the recommendations made by the Emergency Committee under the International Health Regulations (2005) regarding the international spread of poliovirus at its ninth meeting. He welcomed the progress made in Pakistan and Afghanistan on interrupting wild poliomyelitis transmission, with particular regard to cross-border collaboration, which was a priority for 2016. He supported the strong focus under the Polio Eradication and Endgame Strategic Plan 2013–2018 on bringing an end to circulating vaccine-derived poliovirus cases and on strengthening outbreak response capacity, and requested an update from the Secretariat on the progress of the global switch from trivalent oral poliovirus vaccine to bivalent oral poliovirus vaccine, which had taken place in April 2016. Member States affected by the supply shortage of inactivated poliovirus vaccine should be provided with clear guidance on risk mitigation strategies. It was also important to ensure a legacy for the investment that had been made towards poliomyelitis eradication. In that regard, WHO should draw up possible strategies and solutions regarding the future of assets funded by the Global Polio Eradication Initiative, including non-polio eradication functions, and Member States should finalize national legacy plans. In relation to financing, WHO should distribute an updated and disaggregated budget for the period 2016–2019 for efforts towards poliomyelitis eradication; he encouraged donors and affected countries to continue to provide funding.

The representative of AFGHANISTAN said that polio eradication efforts in his country had intensified significantly. Emergency operation centres and provincial coordination units had been established in priority regions to manage poliomyelitis eradication efforts. Permanent transit teams had been deployed to inaccessible areas to increase immunization coverage and regular communication with Pakistan helped to reduce cross-border transmission. However, some challenges still remained, including insecurity and inaccessibility in affected areas. The global shortage of inactivated poliovirus vaccine should be addressed by WHO.

The representative of MONACO said efforts must continue until all forms of poliomyelitis were eradicated. Although the switch to bivalent oral poliovirus vaccine had been a great success, WHO must ensure access to inactivated poliovirus vaccine and provide technical assistance when required. Legacy-planning strategies should include the transfer of knowledge, capabilities, assets and processes and involve all partners. She called on WHO to organize a high-level meeting on legacy planning in 2017.

The representative of CANADA commended the elimination of poliomyelitis in Nigeria, the switch from trivalent to bivalent oral poliovirus vaccine, and the commitment in Pakistan and Afghanistan to stop cross-border transmission. However, work must continue within the framework of

the Polio Eradication Endgame Strategic Plan 2013–2018 to reach inaccessible areas and to enhance surveillance and technical support in countries at risk of vaccine-derived polio and in countries introducing the inactivated poliovirus vaccine. Discussions on legacy should involve major health stakeholders to ensure the effective transfer of assets and personnel.

The representative of TURKEY expressed appreciation for the achievements of Pakistan and Afghanistan and called on WHO and its Member States to support the final efforts to eradicate poliomyelitis. WHO should ensure the transfer of vaccine production technology and provide guidance to vaccine producers and Member States in the face of the bivalent oral poliovirus vaccine shortage. His country had switched to bivalent oral poliovirus vaccine; it continued to offer comprehensive health services, including vaccination and surveillance activities, to high-risk populations, including migrants. A global response was needed to support those areas facing complex health emergencies.

The representative of the UNITED REPUBLIC OF TANZANIA said that his Government had taken measures to address low oral poliovirus vaccine coverage, had switched from trivalent to bivalent oral poliovirus vaccine, and had allocated funding for disease surveillance and response. However, he noted with concern the limited supply of inactivated poliovirus vaccine, and urged WHO to facilitate increased production in line with the scheduled withdrawal of trivalent oral poliovirus vaccine. WHO should also support countries experiencing outbreaks of circulating vaccine-derived poliovirus.

The representative of IRAQ said the switch to bivalent oral poliovirus vaccine had been completed in his country, and recognized that it was of utmost important to ensure the procurement and sustainability of inactivated poliovirus vaccine and bivalent oral poliovirus vaccine. WHO should ensure access to monovalent oral poliovirus vaccine type 2 in case of outbreak. His Government requested support for immunization campaigns, capacity-building for staff engaged in epidemiological and laboratory surveillance activities, and the introduction of environmental surveillance. Addressing outbreaks was a top priority for the G5 countries (Afghanistan, Islamic Republic of Iran, Iraq and Pakistan, with the support of the WHO Regional Office for the Eastern Mediterranean).

The representative of TOGO, speaking on behalf of the Member States of the African Region, welcomed considerable progress made, such as Nigeria being certified free of wild poliovirus, but expressed concerned over the limited availability of inactivated poliovirus vaccine. In order to completely eradicate transmission, he acknowledged the switch to bivalent oral poliovirus vaccine, the strengthening of routine surveillance and immunization, and legacy planning, which required financial support.

The representative of KENYA drew attention to measures taken by his Government including the introduction of the inactivated poliovirus vaccine into routine immunization schedules, the establishment of environmental surveillance, and the switch from trivalent to bivalent oral poliovirus vaccine. However, progress was being hindered by several challenges including insecurity, inaccessibility of vaccination services in some hard-to-reach areas and inadequate funding for acute flaccid paralysis surveillance activities.

The representative of MALTA acknowledged that it was important not to become complacent, thus her Government had ensured that polio eradication remained a priority in health care, both nationally and within the international community. Once the goal to eradicate polio had been achieved, immunization coverage and surveillance should continue, to ensure that global poliomyelitis-free status was maintained.

The representative of the PHILIPPINES said that her Government supported the Polio Eradication and Endgame Strategic Plan 2013–2018, had destroyed all remaining type 2 vaccine-derived polioviruses and Sabin type 2 strains, and had launched the switch to bivalent oral poliovirus vaccine, which was ongoing. She encouraged Member States to further collaborate to achieve global eradication.

The representative of the REPUBLIC OF KOREA noted the achievements of Pakistan and Afghanistan, but the vaccine shortage still posed a major challenge to global eradication, hindering the stable operation of businesses in many countries and worsening communication with the public. Although the switch from oral to injectable vaccines would be crucial, it could cause further vaccine shortages in countries already using inactivated poliovirus vaccines. She therefore encouraged WHO to intervene on the matter and provide guidance in that regard.

The representative of JAPAN commended the historic progress made, particularly the removal of Nigeria from the list of poliomyelitis-endemic countries. It was vital to ensure a legacy for poliomyelitis eradication assets to help address other health issues, including emergency response to outbreaks of other infectious diseases. As collective immunity had not been fully reached in some areas of the world, including Afghanistan and Pakistan, efforts must continue. She noted with concern the shortage of inactivated poliovirus vaccine, but informed the Committee that a Japanese pharmaceutical company had started production of inactivated poliovirus vaccine, in order to help address that shortage. Her Government was committed to the eradication of poliomyelitis and would continue offering financial and technical assistance in that regard.

The representative of GERMANY said that it was time to take the final step to eradicate poliomyelitis from the remaining two endemic countries, Afghanistan and Pakistan. In addition to the €100 million that his Government had already contributed towards the Polio Eradication and Endgame Strategic Plan 2013–2018, it would provide €2.5 million for eradication in Pakistan in 2016 and hoped to contribute €10 million by 2018. The detection of circulating vaccine-derived poliovirus type 1 in Madagascar and Ukraine had underscored the urgent need for comprehensive inactivated poliovirus vaccine coverage. It was vital that enough vaccine was made available in line with planned introduction timescale. He called for a country-led approach to legacy planning, aligning that work with efforts to strengthen the core capacities under the International Health Regulations (2005).

The representative of the ISLAMIC REPUBLIC OF IRAN said that to reach the target of polio eradication, Member States needed to prioritize the development of inactivated poliovirus vaccine production and provide financial and technical support to vaccine manufacturers in developing countries so as to overcome the severe shortage following the switch to bivalent oral poliovirus vaccine. Global surveillance systems, including environmental surveillance, should be improved to confirm interruption in the circulation of wild poliovirus and vaccine-derived poliovirus type 2. Regional cooperation to monitor and report cross-border transmission was crucial, particularly as his country neighboured the remaining two endemic countries.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND welcomed the removal of Nigeria from the list of endemic countries, the unprecedented global switch from trivalent to bivalent oral poliovirus vaccine, and recent responses to environmental detection. Global eradication would be a significant achievement in public health and would contribute to attainment of the Sustainability Development Goals. The Polio Eradication and Endgame Strategic Plan 2013–2018 needed to be fully financed and, to that end, the United Kingdom had committed £300 million for the period 2013–2019 and urged other countries to commit further resources. The continued high-level commitment of the Governments of Afghanistan and Pakistan and the bravery of frontline health workers were commendable. It was crucial to overcome the shortage of inactivated

poliovirus vaccine as soon as possible, and to consider the value of legacy planning for global health security, with particular regard to other infectious diseases. Finally, he asked the Secretariat to provide Member States with more detail on the funding implications for WHO following the global eradication of poliomyelitis.

The representative of the UNITED STATES OF AMERICA said that even with the great progress made in eradication efforts in Pakistan and Afghanistan, especially regarding cross-border transmission, concerns remained that wild poliovirus transmission may not be interrupted in 2016. The unprecedented global switch from trivalent to bivalent oral polio vaccine was a major positive step. Member States should continue to maintain high environmental and acute flaccid paralysis surveillance, to work towards closing any remaining immunity gaps and to maintain what had already been achieved. The continued shortage of inactivated polio vaccine was particularly concerning, and should be addressed by manufacturers. WHO should support efforts to destroy type 2 poliovirus materials and ensure legacy planning. Her Government had increased its financial support to the Global Polio Eradication Initiative and urged other Member States to help meet the funding gap for implementing the Polio Eradication and Endgame Strategic Plan 2013–2018.

The representative of BHUTAN, speaking on behalf of the Member States of the South-East Asia Region, said that the Region had remained free of wild poliovirus for more than five years. All 11 Member States had switched from trivalent to bivalent oral poliovirus vaccine and were introducing inactivated poliovirus vaccine into their routine immunization programmes. Recognizing the high cost and continued global shortfall of inactivated poliovirus vaccine, he said the new WHO guidance on using fractional doses of the vaccine was not enough to overcome that barrier as it would take too long to assess programmatic feasibility in some countries. WHO and relevant partners needed to focus on facilitating the timely, uninterrupted and affordable supply of vaccines to control potential outbreaks. Member States should maintain high vaccine coverage and robust surveillance systems and ensure that the investments made in poliomyelitis eradication would contribute to future health goals. Finally, he requested additional guidance on the containment of poliovirus for research purposes.

The representative of DENMARK said that the collaboration of all Member States was essential to successfully implement the Polio Eradication and Endgame Strategic Plan 2013–2018. However, as Denmark was a poliovirus vaccine manufacturing country, her Government had concerns about the certification process for poliovirus facilities, which could be burdensome and cost-intensive, especially in countries with only one or few such facilities. WHO should play a more prominent role in the certification process and devise a more realistic time frame.

The representative of THAILAND said that while the switch from trivalent to bivalent oral poliovirus vaccine had already been made in Thailand, the country faced clear challenges regarding the high cost and short supply of inactivated poliovirus vaccine, threatening to undermine the immunity of children who had previously been vaccinated. The vaccine shortage should have been anticipated well in advance. The Strategic Advisory Group of Experts on immunization had not properly consulted with stakeholders and her Government accordingly underscored that an inclusive and participatory consultation process was crucial to achieving the Polio Eradication and Endgame Strategic Plan 2013–2018, especially when decision-making required political commitment and changes to national legislation and affected domestic budgets.

The representative of the RUSSIAN FEDERATION said that, while pleased about the work being done to increase vaccine coverage in endemic countries, her Government was concerned that some countries continued to register outbreaks caused by circulating vaccine-derived poliovirus and that the response was sometimes slow. The relevant temporary recommendations of the IHR Emergency Committee regarding the international spread of poliovirus should continue to be applied.

Implementation of the Polio Eradication and Endgame Strategic Plan 2013–2018 would minimise the risk of new international transmission of polioviruses and strengthen global surveillance. Trivalent oral poliovirus vaccine was no longer used in the Russian Federation and measures had been taken regarding the containment of wild and vaccine-derived poliovirus in laboratories in the country.

The representative of ECUADOR said that the global switch from the trivalent to bivalent oral poliovirus vaccine in the given time frame was a major milestone in progress towards global eradication. Despite the earthquake in Ecuador in April 2016, the switch had been successfully completed and all trivalent oral poliovirus vaccines were recovered and destroyed. His Government would continue to ensure the necessary measures were taken to maintain vaccine coverage and develop an effective epidemiological surveillance system.

The representative of NIGERIA said that his country had been removed from the list of endemic countries in September 2015 and had achieved the first two objectives under the Polio Eradication and Endgame Strategic Plan 2013–2018. Inactivated poliovirus vaccine had been introduced into the national routine immunization programme and Nigeria had been designated as a tier 1 country for the prioritization of that vaccine. The switch had been made from trivalent to bivalent oral poliovirus vaccine and all poliovirus type 2 material had been destroyed. Legacy planning was ongoing in the country. The Global Polio Eradication Initiative should continue to prioritize Nigeria in vaccine and resource allocation in order to achieve certification and to reduce the risk of outbreaks.

The representative of MEXICO said that, for as long as there continued to be a risk of circulation or importation of poliovirus, it was vital to maintain routine poliovirus vaccine coverage and monitoring of acute flaccid paralysis. The switch from trivalent to bivalent oral poliovirus vaccine and the introduction of inactivated poliovirus vaccine were critical steps towards the eradication of wild poliovirus globally, as was destruction of poliovirus type 2 materials.

The representative of TIMOR-LESTE said that in the past month the country had switched from using trivalent to bivalent oral poliovirus vaccine and had introduced inactivated poliovirus vaccine into its routine immunization programme. However, his Government had still to address the lack of human and financial resources and weaknesses in surveillance systems, and the identification of cases of acute flaccid paralysis. In that regard, he requested ongoing support from WHO and its partners.

The representative of CHINA said that his country had successfully made the switch from trivalent to bivalent oral poliovirus vaccine and was undertaking the recovery and destruction of poliovirus type 2 materials. Inactivated poliovirus vaccine had also been integrated into the national immunization programme. Given the risk in developing countries of the importation or transmission of wild poliovirus, WHO should continue to provide the necessary technical support to Member States to develop action plans, promote cross-border and regional cooperation, and accelerate the eradication process.

The representative of EGYPT reaffirmed her Government's commitment to the transition from trivalent to bivalent oral poliovirus vaccine and to the introduction of the inactivated poliovirus vaccine. However, the switch had not been successful owing to the delay in delivery of inactivated poliovirus vaccine supplies until the third quarter of 2017. Furthermore, an excess of trivalent oral poliovirus stocks remained, which had not passed their expiry date and therefore, under Egyptian law, could not be discarded. While Egypt was a low-risk country, two poliomyelitis-related epidemiological situations had occurred recently, giving cause for concern. She requested clarification on WHO's recommendation with regard to the use of one single or two fractional doses of inactivated poliovirus vaccine, and when those doses should be administered. The delays in provision of the

inactivated vaccine had been disappointing, and shortages should be overcome to enable countries to complete the switch to bivalent oral poliovirus vaccine.

The representative of AUSTRALIA welcomed the removal of Nigeria from the list of poliomyelitis-endemic countries and the reduction in wild poliovirus cases in Pakistan. In Australia, inactivated poliovirus vaccine had been introduced into national immunization campaigns and a poliovirus essential facility had been designated and the relevant biosafety requirements would be met. Legacy planning was particularly important to ensure that investment in poliomyelitis eradication would be of sustained benefit to other health priorities.

The representative of INDONESIA said that, despite Indonesia's reservation to operative paragraphs 2, 3(7) and 4(2) of World Health Assembly resolution WHA68.3, efforts had been made in the country to switch from trivalent to bivalent oral poliovirus vaccine. Nationwide immunization days had been held against poliomyelitis, and more than 23 million children had been vaccinated with trivalent oral poliovirus vaccine. Efforts would be made to introduce the inactivated polio vaccine by July 2016. However, in line with the Polio Eradication and Endgame Strategic Plan 2013–2018, the withdrawal of trivalent oral polio vaccine, the introduction of inactivated poliovirus vaccine and immunization system strengthening should be synchronized in all countries. The global shortage of inactivated poliovirus vaccine was worrying and should be rectified, since it was jeopardizing efforts to meet the objectives of the Strategic Plan.

The representative of SOUTH AFRICA commended Nigeria for its successful eradication of poliomyelitis. In South Africa, the switch from trivalent to bivalent oral poliovirus vaccine had been implemented successfully. She expressed her Government's gratitude to the Secretariat for its support during the planning and implementation of the switch.

The representative of the BAHAMAS said that inactivated poliovirus vaccine had been introduced successfully in the national immunization schedule in 2015 and an education campaign for health-care workers had been launched on the various components of the inactivated poliovirus vaccine, the withdrawal of type 2 oral poliovirus vaccines, and the global synchronized switch. The switch had been successfully implemented in his country, and all remaining stocks of trivalent oral poliovirus vaccines in the Bahamas had been destroyed. While he commended WHO's work to promote poliomyelitis eradication, sufficient supplies of inactivated and bivalent polio vaccines must be available to meet demand. Member States must continue to be vigilant, since pockets of disease and lapses in vaccination activities left all countries at risk.

The representative of SOMALIA said that her country had been poliomyelitis-free for nearly two years owing to the high level of political commitment, strong support of partners including WHO, and a flexible, innovative and comprehensive approach to immunization campaigns. However, 17 districts in the south and centre of Somalia remained inaccessible for vaccine coverage and an estimated 397 000 children under five years of age were not vaccinated. Routine immunization coverage remained low, and shortages of inactivated poliovirus vaccine were cause for concern. Partners and donors should continue to provide support until eradication had been achieved worldwide.

The representative of BAHRAIN said that his Government had made progress towards meeting the objectives of the Polio Eradication and Endgame Strategic Plan 2013–2018. Surveillance systems had been enhanced to ensure early detection of any possible cases. The switch to bivalent oral poliovirus vaccine had taken place and was being monitored in a series of site visits.

The representative of BARBADOS, recognizing the costs of vaccine-preventable diseases said his Government continued to implement the Polio Eradication and Endgame Strategic Plan 2013–2018. The switch to bivalent poliovirus vaccine had been successfully achieved and inactivated poliovirus vaccine was being included in the Government's expanded immunization programme. A monitoring and evaluation framework had been established and continued assistance and guidance from WHO would be welcome.

The representative of the DOMINICAN REPUBLIC said that while no cases of wild poliovirus had been registered in the Dominican Republic since 1985, one case of vaccine-associated paralytic poliomyelitis had been registered in 2001. Inactivated poliovirus vaccine had been introduced, and the switch from trivalent to bivalent oral poliovirus vaccine had been completed successfully in the context of Vaccination Week in the Americas. The immunization schedule was being met and a review committee had been established to evaluate the switch.

The representative of MOROCCO said the national immunization plan assured VPO3 oral poliovirus vaccination coverage for 97% of children. Efforts had been made to ensure a successful switch from trivalent to bivalent oral poliovirus vaccine, and to introduce inactivated poliovirus vaccine. He expressed concern with regard to the global shortage of inactivated poliovirus vaccine. WHO should take all the necessary measures to ensure that sufficient vaccine stocks were available to allow Member States to make the progress required of them.

The representative of JORDAN noted that vaccine coverage in his country was over 95% for children, and the national laboratory dealing with poliomyelitis had received WHO certification. Technical assistance received from WHO had enabled the spread of the virus to be restricted despite the threat of reintroduction from neighbouring countries. The switch from trivalent to bivalent oral poliovirus vaccine had been successful. Despite the large intake of refugees, which placed a considerable burden on the health system, efforts were being made to ensure vaccination coverage for residents of Jordan and refugees alike, and to eradicate other communicable diseases. He requested technical assistance from WHO for the acquisition of vaccine stocks to continue its vaccination campaigns.

The representative of GHANA welcomed global efforts to meet the four objectives of the Polio Eradication and Endgame Strategic Plan 2013–2018 and commended Nigeria on the successful interruption of poliomyelitis transmission. The Ghanaian authorities had taken steps to destroy all materials suspected of containing wild poliovirus type 2 and had completed the switch from trivalent to the bivalent oral poliovirus vaccine. Efforts to introduce inactivated poliovirus vaccine had been stepped up. He noted with concern the drop in support for acute flaccid paralysis surveillance and said that urgent steps must be taken to find innovative ways to ensure sustainable funding in that regard.

The representative of JAMAICA said that the risk of reintroduction of poliomyelitis remained high, owing to large influxes of tourists and immunization coverage at less than 95%. Concerted efforts had resulted in improved immunization coverage and the establishment of a strong active surveillance system. The single dose schedule of inactivated poliovirus vaccine had been implemented in September 2015, with a transition to a two dose schedule in 2016. The switch from trivalent to bivalent oral poliovirus vaccine had been successful; a final report on the transition was being prepared. Containment activities had been conducted and progress was being made towards meeting all four objectives of the Polio Eradication and Endgame Strategic Plan 2013–2018.

The representative of TUNISIA expressed concern regarding the limited availability of inactivated poliovirus vaccine. In Tunisia, the Ministry of Health had taken key steps to strengthen the national immunization programme and the poliomyelitis eradication initiative, had implemented a

passive and active surveillance system for acute flaccid paralysis, had introduced a single dose of inactivated poliovirus vaccine, and had successfully switched from trivalent to bivalent oral poliovirus vaccine. WHO should be aware of the difficulties faced by countries with developing and transitional economies with regard to vaccine procurement and meeting vaccine schedules.

The representative of the DEMOCRATIC REPUBLIC OF THE CONGO said his country had been declared polio-free in November 2015. The switch from trivalent to bivalent oral poliovirus vaccine had been a success. Insufficient global production of the inactivated poliovirus vaccine and low oral poliovirus vaccine coverage in insecure regions were cause for concern. He encouraged WHO to extend its efforts to ensure a sufficient supply of the inactivated poliovirus vaccine, and provide technical and financial support so that poliomyelitis could be eradicated in 2018 as planned.

The representative of QATAR said his Government was cooperating with other countries to mitigate the risk of wild poliovirus resurgence. He acknowledged poliomyelitis eradication efforts in Afghanistan and Pakistan and said a preparedness and response plan for imported cases was in place in Qatar. He urged WHO to work on the problem of vaccine supply in general, and the inactivated poliovirus vaccine in particular.

The representative of BOTSWANA said that her Government had introduced the inactivated poliovirus vaccine and had switched from trivalent to bivalent oral poliovirus vaccine, but the destruction of the recalled trivalent oral poliovirus vaccine was ongoing. The possible shortage of inactivated poliovirus vaccines was a cause for concern, particularly in countries that had already switched to bivalent oral poliovirus vaccine. She asked WHO to monitor the supply situation closely, as it could affect the success of national immunization programmes.

The representative of INDIA outlined actions taken by his Government to ensure that India would remain poliomyelitis-free, including annual vaccination rounds and vaccination posts at rail and road routes along the country's borders. The switch from trivalent to bivalent oral poliovirus vaccine had been a success and surveillance of acute flaccid paralysis had been expanded. Introduction of inactivated poliovirus vaccine had begun before the switch, but had been phased due to a lack of supply. A fractional dose schedule had been introduced in selected States, as only 13.5 million of the required 47.42 million doses of the inactivated poliovirus vaccine had been assured. Legacy planning was underway to ensure that the investments made towards poliomyelitis eradication would benefit other health initiatives.

The representative of MAURITANIA said that considerable efforts had been made to stop the 2009 and 2010 poliovirus outbreaks in his country, including carrying out supplementary immunization activities and improving surveillance for acute flaccid paralysis. The switch from trivalent to the bivalent oral poliovirus vaccine in April 2016 had been a success. Response capacities should be strengthened to prepare for the potential reimportation of the virus. Immunization systems and surveillance efforts should also be strengthened, and sufficient supply of vaccines must be guaranteed.

The representative of CHAD said that his country had been free of wild poliovirus for nearly four years, thanks to supplementary immunization activities, efforts to strengthen the cold chain through the introduction of solar technology, and building human resources capacity. Innovative strategies included the mixed vaccination of nomadic children and livestock. The trivalent oral poliovirus vaccine had been replaced by bivalent oral poliovirus vaccine, and inactivated poliovirus vaccine had been introduced. Challenges still remained in terms of funding for surveillance and intensified immunization activities. He urged WHO to ensure successful polio legacy planning.

The observer of CHINESE TAIPEI said the transition from oral poliovirus vaccine to the inactivated poliovirus vaccine had been carried out in 2012. All vaccine-derived polioviruses and oral poliovirus vaccines containing the type 2 component stored in laboratories had been destroyed. Surveillance systems were in place to maintain high immunization coverage and a poliomyelitis-free status. He appealed to WHO to ensure the supply of the inactivated poliovirus vaccine and to support the sustainability of immunization programmes.

The observer of the INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES acknowledged that considerable obstacles remained in the way of poliomyelitis eradication in Afghanistan and Pakistan, namely the safety of frontline workers and the immunization coverage of children living in remote communities and areas of conflict. The Red Crescent Societies and volunteers in those two countries were working to increase immunization coverage for those children and ensure access to routine childhood vaccines. He advocated using the lessons learned from poliomyelitis eradication to address other global health priorities.

The representative of the ORGANISATION OF ISLAMIC COOPERATION, speaking at the invitation of the CHAIRMAN, said that her organization remained committed to poliomyelitis eradication, and was working closely with several partners in this regard. She commended the globally synchronized switch to bivalent oral poliovirus vaccine and encouraged Member States to intensify routine immunization campaigns. The lack of adequate inactivated poliovirus vaccine had been communicated to her organization's Vaccine Manufacturers Group, and steps would be taken to mitigate the risks associated with the shortage.

The representative of the GAVI ALLIANCE, speaking at the invitation of the CHAIRMAN, said that challenges still remained to the global eradication of poliomyelitis, as evidenced by recent detection of vaccine-derived poliovirus in environmental specimens in previously polio-free countries. The GAVI Alliance had worked closely with the Global Polio Eradication Initiative to facilitate the introduction of inactivated poliovirus vaccine into routine immunization programmes worldwide. The global shortage of inactivated poliovirus vaccine raised concerns regarding the potential re-emergence of polioviruses. Attention should be given to legacy planning to ensure that immunization coverage would not be adversely affected as funding declined for poliomyelitis programmes, and that assets could be used for other public health interventions. Discussions on how to leverage poliomyelitis assets and personnel for routine immunization would be particularly important in priority countries that had human resources funded either by the GAVI Alliance or the Global Polio Eradication Initiative.

The representative of ROTARY INTERNATIONAL, speaking at the invitation of the CHAIRMAN, praised the global switch from trivalent to bivalent oral poliovirus vaccine. However, key challenges remained. Transmission of poliovirus in Pakistan and Afghanistan had to be stopped and he encouraged a continued focus in those countries to reach every child, recognizing the dedication of frontline workers. An additional US$ 1.5 billion was needed in the period until 2019 to maintain high levels of immunization and surveillance. Finally, the physical and intellectual assets resulting from 30 years of eradication efforts must be leveraged to benefit broader public health priorities.

The representative of the GLOBAL HEALTH COUNCIL, speaking at the invitation of the CHAIRMAN, said that urgent attention must be paid to sustaining the public health gains made by poliomyelitis eradication programmes. as well as extending immunization coverage, improving the planning and supply of vaccines, and developing a safer version of the oral poliovirus vaccine, with less potential to cause vaccine-derived polioviruses. Human resources, facilities and processes funded directly by the Global Polio Eradication Initiative should be transferred to other health service areas,

such as immunization, surveillance, and emergency response. WHO should work with countries to develop detailed strategies to maintain poliomyelitis-free status, and ensure the effective management of assets and resources following global eradication. She also recommended that WHO consult with major donors to map donor-supported activities that could be continued when eradication programmes came to an end.

The DIRECTOR (Polio Eradication) said that, thanks to the extraordinary efforts of the coalition of Member States in applying the Polio Eradication and Endgame Strategic Plan 2013–2018, the world was closer than ever to eradicating poliomyelitis, and he commended efforts in Pakistan and Afghanistan. Wild poliovirus type 2 had been declared eradicated, no cases of wild poliovirus type 3 had been detected in three years, and only type 1 was circulating in two countries. It was therefore vital to prevent cases of vaccine-derived poliovirus, and to maintain high levels of acute flaccid paralysis and environmental surveillance. The current epidemiology constituted a Public Health Emergency of International Concern for countries affected by wild poliovirus and those affected by circulating vaccine-derived poliovirus.

Regarding the update requested on the global coordinated switch to bivalent oral poliovirus vaccine, 147 out of 155 Member States had submitted validation reports to regional offices. Validation by the remaining eight Member States was ongoing and the reports would be sent shortly. There was no shortage of bivalent oral poliovirus vaccines. However, stocks of inactivated poliovirus vaccines were insufficient, as the vaccine industry had been unable to scale up production in line with the speed at which countries had committed to introduce the vaccine. Consequently, 45 countries would have to wait until 2017 for access. The allocation of the vaccines had been prioritized for countries at the highest risk of an emergence of vaccine-derived type 2 poliovirus. However, there was a global stockpile of monovalent type 2 oral poliovirus vaccines, which could be deployed very quickly in the event of an outbreak in those countries.

Every effort was being made to increase production of inactivated poliovirus vaccines, including work to facilitate and support technology transfer for vaccine production. The possibility of stretching the supply of inactivated poliovirus vaccines had been explored, although one of the solutions found, which involved administering two fractional doses intradermally, required more thorough planning and greater capacity among the health workforce. WHO would work with Member States to accelerate progress to contain the virus in vaccine-production facilities and laboratories, and address the concerns raised about the shared timelines. It was time to begin planning ahead to ensure that the investments made in poliomyelitis eradication would not be lost and were used effectively to support routine immunization and emergency response, among other public health priorities. A detailed budget for the Global Polio Eradication Initiative had already been made available to all of the Member States receiving support and was available online.

The Committee noted the report.

2. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 13 of the agenda (continued)

Operational plan to take forward the Global Strategy for Women's, Children's and Adolescents' Health: Item 13.3 of the agenda (continued from the third meeting) (document A69/16)

The CHAIRMAN recalled that a draft resolution on committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health had been introduced at an earlier meeting of the Committee. He informed the Committee that the numbering of the operative paragraphs

in that draft resolution was incorrect, and the paragraph that began "INVITES Member States" should have been numbered as paragraph (OP) 1., and the two subsequent operative paragraphs should therefore be renumbered as paragraphs (OP) 2. and (OP) 3. respectively.

The representative of URUGUAY read out two amendments to the draft resolution agreed informally by several Member States. In renumbered operative paragraph 1.(2) he proposed replacing the words "upon their request" with "as appropriate". In renumbered operative paragraph 3.(2), the word "funds" should be added before the words "partners and stakeholders".

The representative of PANAMA said that her Government was striving to overcome health challenges and inequalities through the implementation and revision of legal frameworks, national initiatives and intersectoral actions on poverty reduction, vulnerable groups and sexual and reproductive health, including a master plan on health in infancy, childhood and adolescence, which sought to provide universal access to integrated health care.

The representative of ZAMBIA called for comprehensive accountability frameworks and the strengthening of health information systems to monitor programmes and levels of integration, as part of the Global Strategy. Her Government would prioritize development of a health financing strategy, in order to progressively increase the allocation of domestic resources and attain the national goals for women's, children's and adolescents' health. She supported the draft resolution.

The representative of CAMEROON highlighted the accomplishments made by her Government in relation to implementation of the Global Strategy, including the revision of the national health sector strategy and development of a financing strategy, as well as seeking investment for reproductive, maternal, newborn, child and adolescent health under the Global Financing Facility in support of Every Woman Every Child. She supported the draft resolution.

The representative of PORTUGAL said that her Government was committed to implementing the Global Strategy and asked that her country be added to the list of sponsors of the draft resolution.

The representative of BRAZIL said that, while the Global Strategy's focus on conflict situations and fragile States was important, it did not encompass the breadth of the 2030 Agenda for Sustainable Development. The coordinated multisectoral actions and multistakeholder engagement required to implement the Global Strategy should remain within a United Nations framework. Governments should ensure accountability, and develop progress indicators, and programmatic guidance. The Paris Declaration and Accra Agenda for Action were not universal and many Member States used other equally valid frameworks for development cooperation, principles and actions.

The representative of JAMAICA said that several interventions had been made to combat problems related to adolescent health in Jamaica, including the establishment of an adolescent policy working group comprising members of civil society and other ministries, and a policy to reintegrate teenage mothers into the formal school system.

The representative of PAKISTAN said that his Government had developed a national action plan, based on the Global Strategy, to address the slow progress made regarding maternal, newborn and child health and nutrition. Strengthened health systems staffed with adequately-skilled health workers were required to significantly improve and maintain access for women and children to affordable health care. The work of all health-sector partners should be aligned with government priorities, and involve concerted efforts to promote human rights, gender equality and poverty reduction.

The representative of REPUBLIC OF KOREA emphasized that a continuous approach was needed for relief efforts and development projects that benefited women, children and adolescents. In that regard, her Government had launched an initiative on health and education for disadvantaged girls in developing countries, and would contribute US$ 200 million to that project over five years.

The representative of NIGER said that major progress towards improving maternal and child health had been made in his country, including the implementation of a road map to reduce maternal and neo-natal mortality, and a maternal death surveillance and response programme.

The representative of INDONESIA informed the Committee of a number of initiatives carried out by her Government with a view to attaining the Millennium Development Goal targets and implementing the Global Strategy, such as a strategic plan to reduce maternal and neonatal mortality, and a commitment to extending universal health coverage to all Indonesians by 2019.

The representative of the RUSSIAN FEDERATION drew attention to some of the action taken on women's, children's and adolescents' health in her country, such as universal access to free health care, the construction of perinatal centres and the development of health prevention programmes. The Global Strategy could only be implemented through an intersectoral, and interdisciplinary approach.

The meeting rose at 17:30.

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