World Health Organization

SEVENTIETH WORLD HEALTH ASSEMBLY **A70/A/PSR/6**
26 June 2017

COMMITTEE A

PROVISIONAL SUMMARY RECORD OF THE SIXTH MEETING

Palais des Nations, Geneva
Thursday, 25 May 2017, scheduled at 14:30

Chairman: Dr H. M. AL-KUWARI (Qatar)
later: Mr A. HURREE (Mauritius)
later: Dr H. M. AL-KUWARI (Qatar)
later: Mr P. DAVIES (Fiji)
later: Dr H. M. AL-KUWARI (Qatar)

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SIXTH MEETING

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1. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 12 of the agenda (continued)

Poliomyelitis: Item 12.3 of the agenda (continued)

- **Polio transition planning** (continued from the fifth meeting, section 2) (document A70/14 Add.1)

The CHAIRMAN recalled that a draft decision on polio transition planning had been introduced at the fifth meeting.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND stressed the need for robust planning; extensive engagement with partners; an agreed transition plan; and a plan for the future financing of immunization efforts, human resources, and the transfer of key programme assets. Once interruption of transmission had been achieved, it would be essential to maintain that situation and continue to support wider health objectives and systems. She asked for further information on how the Secretariat was working with the other partners of the Global Polio Eradication Initiative in respect of polio transition planning.

The representative of SAUDI ARABIA, speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the focus on ensuring the optimal use of resources and knowledge, particularly in Afghanistan and Pakistan. Cognizant of the risks related to the decrease in funding for poliomyelitis, it was important to make the most of opportunities, experiences and lessons learned. Member States must develop national vaccination programmes in order to overcome pandemics, improve maternal and child health, ensure universal health coverage and meet the Sustainable Development Goals. Polio transition planning should be a key priority and it was important to make sure that the risks related to the budget decrease were as low as possible, with regard to both poliomyelitis and other diseases.

The representative of NORWAY said that, although transition planning had been under way for some time, the programmatic and organizational impact on WHO had not been given much attention. For example, the staff funded by the Global Polio Eradication Initiative spent a significant proportion of their time on non-polio related activities; that work could be lost when the programme was closed down. The Secretariat should clearly outline the capacities that needed to be transitioned into the programme budget and demonstrate, on a country by country basis, their added value for global health and national health targets. The strategic action plan on polio transition requested in the draft decision should be based on active participation in country planning and dialogue with affected States and

relevant partners. Urgent consideration should also be given to possible financing for the transition of polio-funded capacities in the programme budget. Any guidance given by the Seventy-first World Health Assembly on the development of the draft programme budget for 2020–2021 should take into account progress made in mobilizing financial support for the transitioning of polio-funded capacities.

The representative of CHINA emphasized the importance of concerted and effective technical and financial support for all regions affected by poliomyelitis in order to accelerate eradication efforts. At such a critical stage of the eradication timeline, developing countries with a high risk of importation required particular attention and it was important to develop action plans in that respect; enhance cross-border and inter-regional cooperation; and increase surveillance and vaccination efforts. Moreover, greater coordination of global resources and the increased production and supply of inactivated poliovirus vaccines were needed as many countries continued to face supply shortages.

The representative of AFGHANISTAN, underscoring his Government's commitment to ensuring that all children in his country received the polio vaccination, said that to stop poliovirus transmission in the region, cross-border coordination, surveillance and data sharing between Afghanistan and Pakistan had been enhanced. Moreover, the timing of vaccination campaigns had been synchronized in those two countries. Welcoming the draft decision, he stressed the importance of adequate investment in routine immunization programmes at the national and subnational levels to achieve better immunization coverage for vaccine-preventable childhood diseases in developing countries.

The representative of CANADA, speaking on behalf of the Member States of the Region of the Americas, said that the winding down of the Global Polio Eradication Initiative should be guided by comprehensive and strategic country-led planning, which should take into account the long-term programmatic impact on WHO, strengthen national health systems, and build capacity to meet broader health goals. Welcoming the engagement with the Global Policy Group and the Organization-wide approach taken, she expressed concern about the impact of the eventual discontinuation of funding for the Global Polio Eradication Initiative on the field capacity of WHO, including for immunization support, surveillance and emergency response. The Secretariat should engage with all relevant departments, United Nations partner agencies and other stakeholders to identify the capacities, assets and associated costs required to sustain progress in those areas.

Given the complexity and interconnected nature of the polio transition process, WHO and the members of the Global Polio Eradication Initiative should ensure that cuts to staffing were timely and that risk analyses were taken into account. Noting that the indemnities fund had grown, she requested clarification on the measures being taken to reduce overall indemnities and to transition staff where possible. Due diligence should be exercised when awarding contracts and appointments to ensure synchronization with the projected end date of the polio programme. Moreover, the transitioning of polio-related resources away from those countries that had been polio-free for some time should be accelerated, while ensuring that sufficient capacity for immunization support, surveillance and emergency response was maintained at the country and regional levels. Future updates on the transition process should include a country by country dashboard on the polio transition website, which would provide a clearer picture of human resources-transition planning to facilitate understanding of gaps and mitigation measures. In the light of the limited flexibility in the Proposed programme budget 2018–2019, WHO should seek synergies and partnerships within programmes and with other key global health initiatives to address funding gaps. Moreover, the draft programme budget for 2020–2021 and the draft thirteenth programme of work should reflect the transition-related challenges and opportunities.

The representative of ECUADOR said that it was essential to explore financing mechanisms that maintained and built upon the progress made towards eradicating poliomyelitis. Capacity-building

for ethical research and the training of human resources were vital. With the support of the Secretariat and in particular the regional offices, Member States should place particular emphasis on planning and building the technical capacities of health personnel in order to minimize the impact of the reduction in financing. The draft decision should guide the development of a strategic action plan based on the needs, priorities and realities of each country.

The representative of FRANCE, welcoming the fact that the report by the Secretariat contained proposed responses to the challenges caused by the end of the Global Polio Eradication Initiative, said that some of the proposals, especially those related to immunization, needed to be expanded upon. Moreover, he asked how the reduction in the budget for vaccine-preventable diseases in the Proposed programme budget 2018–2019 was compatible with the end of the Global Polio Eradication Initiative, given that the Initiative was currently used to fund vaccination costs. Turning to staffing matters, he asked for additional information on the measures to be taken to redistribute staff and adapt their contracts, particularly with regard to specialists. In addition, he wished to know whether WHO had held discussions with the main donors to the Global Polio Eradication Initiative on whether they intended to transfer funding to other programmes after eradication was achieved.

The EXECUTIVE DIRECTOR (Office of the Director-General), acknowledging comments on the importance of recognizing the high level of risk involved in polio transition and the need for the proper management of that process, said that it was important to have a clear assessment of the risks in all areas, in order to define priorities and develop mitigation measures. Steps had already been taken at the country-level and by the regional offices to analyse the situation in order to ensure that the whole-of-Organization approach would take into account specific regional and country requirements. It was important to ensure that all programmes that would be affected by the winding down of the Global Polio Eradication Initiative were aware of the consequences and were managing the risks appropriately.

The DIRECTOR (Polio Eradication) explained that a number of steps had been taken to minimize the level of indemnity at the end of the Global Polio Eradication Initiative. The maximum amount had been established as US$ 109 million, but with careful planning, it had been possible to bring the amount down to US$ 50 million. Further reductions could be achieved by not issuing new long-term contracts within the polio eradication programme without a review; only filling vacancies that would be vital in the post-certification stage; using temporary contracts; ensuring that the length of fixed-term contracts would not go beyond the programme period; and sharing staff with other programmes.

The EXECUTIVE DIRECTOR (Office of the Director-General) said that, in order to compensate for the drop in voluntary contributions, the Secretariat would work with current donors to identify their long-term plans, ensure increased integration of resource mobilization for the polio programme and for the programme budget as a whole, and consider how the funding dialogue could be used in that respect. Moreover, the Proposed programme budget 2018–2019 did not reflect the winding down of the Global Polio Eradication Initiative; once the strategic action plan had been developed, it would be possible to look at the programme budget and see where changes could be made. Any such changes should fall under the remit of the Director-General and it would therefore not be necessary to consult the governing bodies.

With regard to collaboration between WHO and the other Global Polio Eradication Initiative partners, he explained that the efforts under the Initiative relating to transition were focusing on three key areas, namely country-level planning; the establishment of an independent monitoring board for transition; and the development of a post-certification strategy to ensure that essential polio-related functions were maintained. It was expected that the post-certification strategy would be presented to the governing bodies during 2018.

In terms of next steps, it would be important to ensure that the Director-General elect was fully briefed on polio transition efforts in order to ensure that the work continued. Moreover, a detailed strategic action plan on polio transition would be developed, in collaboration with relevant partners, as requested in the draft decision. That strategic action plan would be adequately reflected in the draft programme budget 2020–2021 and the draft thirteenth general programme of work so as to ensure that functions that were currently funded under the Global Polio Eradication Initiative were adequately reflected within plans for immunization, surveillance and health systems.

The draft decision was approved.[1]

Review of the Pandemic Influenza Preparedness Framework: Item 12.5 of the agenda (documents A70/17 and A70/57)

The CHAIRMAN drew attention to a draft decision on the item, submitted by the delegations of Australia, Finland, Pakistan, Switzerland and the United States of America, which read:

The Seventieth World Health Assembly,

PP1 Having considered the report on the 2016 Pandemic Influenza Preparedness (PIP) Framework Review Group and the reports of the Secretariat in collaboration with the Secretariat of the Convention on Biological Diversity and other relevant international organizations,[2] decided:

(1) to recall the WHO's mandate as the directing and coordinating authority on international health work, and its role under the International Health Regulations (2005) in global outbreak alert and response in respect of public health crises;
(2) to reaffirm the importance of the PIP Framework in addressing present or imminent threats to human health from influenza viruses with pandemic potential, and emphasize its critical function as a specialized international instrument that facilitates expeditious access to influenza viruses of human pandemic potential, risk analysis and the expeditious, fair and equitable sharing of vaccines and other benefits;
(3) to emphasize the importance of prioritizing and supporting global pandemic influenza preparedness and response, including through the strengthening of domestic seasonal influenza virus surveillance and manufacturing capacities and international coordination and collaboration through the Global Influenza Surveillance and Response System (GISRS) to identify and share influenza viruses with pandemic potential rapidly;
(4) to acknowledge the critical role of the WHO Global Influenza Surveillance and Response System (GISRS) in the identification, risk analysis and sharing of influenza viruses with human pandemic potential to allow rapid development of diagnostics, vaccines and medicines;
[4 bis. to [recognize the necessity of timely [[and adequate]] Partnership Contribution payments by] [raise concerns over the underpayment, late payment or default on payment of Partnership Contributions by] certain entities who use GISRS, and concerns over entities that receive PIP Biological Materials, but are not entering into Standard Material Transfer Agreements 2;]

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as decision WHA70(9).

[2] Documents A70/17 (Annex) and A70/57.

(5) to recognize the ongoing consultations and collaboration between WHO and the Secretariat of the Convention on Biological Diversity and other relevant international organizations;

(6) to commend the useful recommendations of the 2016 PIP Framework Review Group;

(7) to request the Director-General:

(a) to take forward expeditiously the recommendations of the PIP Framework Review Group's report;

(b) regarding the Review Group's recommendations concerning seasonal influenza and genetic sequence data, to conduct a thorough and deliberative analysis of the issues raised, including the implications of pursuing or not pursing possible approaches, relying on the 2016 PIP Framework Review and the expertise of the PIP Advisory Group, and transparent consultation of Member States and relevant stakeholders, including the WHO Global Influenza Surveillance and Response System (GISRS);

(c) to continue encouraging manufacturers and other relevant stakeholders to engage in PIP Framework efforts, including, where applicable, by entering into Standard Material Transfer Agreement 2s and making timely annual Partnership Contributions;

(d) to request the External Auditor to perform an audit of PIP Partnership Contribution funds in line with the Review Group's recommendation to: (1) provide assurances that the WHO financial regulations have been appropriately applied in the use of funds and that the financial information reported is accurate and reliable; and (2) provide recommendations to further increase the transparency of reporting on the linkages between expenditure and technical impact;

(e) to continue consultations with the Secretariat of the Convention on Biological Diversity and other relevant international organizations, as appropriate;

(f) to report to the Seventy-first World Health Assembly, on progress in implementing this decision, including the status of the recommendations contained in the report of the PIP Framework Review Group, and to make recommendations on further action.

The financial and administrative implications for the Secretariat of the adoption of the decision were:

Decision:	Review of the Pandemic Influenza Preparedness Framework
A.	**Link to the general programme of work and programme budget**
1.	**Outcome(s) in the Twelfth General Programme of Work, 2014–2019 and output(s) in the Programme budget 2016–2017 to which this decision would contribute if adopted.** **Twelfth General Programme of Work, 2014–2019 outcome(s):** Not applicable. **Programme budget 2016–2017 output(s):** Not applicable.

2.	**Brief justification for considering the draft decision, if there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017.** The Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits contributes to outcomes E.1 and E.2 of the WHO Health Emergencies Programme. Member States are considering the report of the 2016 PIP Framework Review Group. The PIP Framework, section 7.4.2, notes that the Framework and its Appendices will be reviewed by 2016 with a view to proposing revisions reflecting developments as appropriate, to the World Health Assembly in 2017, through the Executive Board.
3.	**Estimated time frame (in years or months) for implementation of any additional deliverables.** Up to 30 months.
B.	**Budgetary implications**
1.	**Estimated total cost to implement the decision if adopted, in US$ millions:** US$ 2.91 million.
2.a.	**Estimated additional budgetary requirements in the current biennium, in US$ millions:** Undertaking the activities outlined in the decision is estimated to require an additional US$ 0.84 million of financing in 2017. Because the PIP Framework sits outside the programme budget, implementing the decision can be accommodated without increasing the budget space.
2.b.	**Resources available during the current biennium** – **Resources available in the current biennium to fund the implementation of the decision if adopted, in US$ millions:** None. – **Extent of any financing gap, in US$ millions:** US$ 0.84 million. – **Estimated resources, not yet available, which would help to close any financing gap, in US$ millions:** None.
3.	**Estimated additional budgetary requirements in 2018–2019 (if relevant), in US$ millions:** US$ 2.07 million. **Has this been included in the Proposed programme budget 2018–2019?** The PIP Framework sits outside the programme budget.
4.	**Estimated additional budgetary requirements in future bienniums (if relevant), in US$ millions:** Not applicable.

The member of the PANDEMIC INFLUENZA PREPAREDNESS FRAMEWORK REVIEW GROUP said that the Pandemic Influenza Preparedness (PIP) Framework was a bold and innovative tool that had been well implemented, and its founding principle of increasing health equity through the sharing of viruses and other pathogens was as relevant as ever. He drew attention to the recommendations made in the report of the Review Group, referring in particular to the need to react to technological change, such as the ability to use genetic sequence data as a substitute for actual viruses. In view of the possible impact of the Nagoya Protocol on Access to Genetic Resources and the

Fair and Equitable Sharing of Benefits Arising from Their Utilization to the Convention on Biological Diversity, the Framework needed to be recognized as a specialized international instrument under the Nagoya Protocol. Other recommendations covered the possible inclusion of seasonal influenza in the Framework, efforts to build on the success of Standard Material Transfer Agreements 2, means of improving the predictability of yearly partnership contributions, the identification of aspects of the global action plan for influenza vaccines that could support the Framework's implementation, the alignment of activity under the Framework with capacity-building efforts under the International Health Regulations (2005) and efforts to broaden WHO's engagement with stakeholders – including laboratories – on the Framework.

Although change could be challenging, it was vital in order to ensure that the Framework remained a nimble and relevant legal instrument that evolved in response to changes in technology. The ongoing need for better surveillance, diagnostics and national capacities in case of an influenza pandemic meant that investment in the Framework was as critical as ever.

The representative of THAILAND, speaking on behalf of the Member States of the South-East Asia Region, said that the PIP Framework had improved global health security significantly, and the global action plan for influenza vaccines had increased vaccine production capacities in developing countries. To drive the PIP Framework still further, it should be recognized as a specialized international instrument, thereby facilitating expeditious access to influenza viruses of human pandemic potential, risk analysis and fair and equitable sharing of vaccines. Collaboration with the Secretariat of the United Nations Convention on Biological Diversity was welcome. She supported the proposed extension of the PIP Framework to cover all biological materials, including genetic sequence data and other products for profit and commercial use, which might require a revision of the PIP Framework. Influenza vaccine security was critical to ensuring an adequate and timely response to pandemics and should be enhanced by securing more virtual pandemic vaccine stockpiling and by strengthening vaccine manufacturing capacity in developing countries. She expressed her support for the draft decision.

The representative of BAHRAIN said that WHO's efforts to build monitoring and laboratory capacities at the country level were commendable, and stressed the importance of ensuring continued voluntary funding to support those efforts. His Government was committed to cooperating in global exchanges of information on influenza, through its National Influenza Centre, and to upholding the provisions of the Standard Material Transfer Agreements 2. Measurable indicators should be devised to monitor progress, identify gaps in pandemic preparedness and facilitate the requisite technology transfers and capacity building to bridge them. A working group should be established, including representatives of relevant international organizations, to prepare guidelines on access to genetic sequence data.

The representative of INDIA said that efforts should be made to ensure that the sharing of samples and genetic sequence data was balanced with benefit sharing. India's National Influenza Centre had been contributing representative influenza virus isolates to WHO collaborating centres and the Government was implementing a road map on influenza surveillance. In addition, the sharing of genetic sequence data must be in line with the Nagoya Protocol. A transparent process should be followed when evaluating States for continuation of funding for activities under the Nagoya Protocol. In order to ensure the sustainability of the PIP Framework, the delivery of results should be regularly monitored, measured and communicated to Member States.

The representative of the BAHAMAS said that global health security was a particular concern for her Government, given the considerable amount of international travel to the Bahamas. The capacity to mount a timely response to a potential pandemic and access appropriate antiviral treatment was therefore crucial. She hoped that the laboratory and viral sharing component of the Global

Influenza Surveillance and Response System would lead to affordable and accessible antiviral treatment. WHO should continue its efforts to balance virus sharing and benefit sharing, ensure effective communication of objectives and progress to Member States, and strengthen the governance of the PIP Framework and its links to WHO programmes.

The representative of the UNITED STATES OF AMERICA, underscoring the importance of the WHO leadership in ensuring that the global community was adequately prepared to respond to another influenza pandemic, said that expeditious implementation of the PIP Framework Review Group's recommendations was essential. WHO should conduct a thorough review, in consultation with Member States and other stakeholders, of the implications, desirability and methodology of including seasonal influenza viruses in the PIP Framework. Steps should be taken, under the WHO leadership, to ensure that virus sharing was balanced with benefit sharing. In line with the outcomes of the third WHO Consultation on the Global Action Plan for Influenza Vaccines, WHO should establish an advisory body to support the development of national influenza policies and ensure sustainable vaccine production. His delegation supported the draft resolution.

The representative of the UNITED REPUBLIC OF TANZANIA expressed support for the recommendations of the PIP Framework Review Group. The Secretariat should use a stepwise approach to address the underpayment, late payment or defaults in payment by entities using the Global Influenza Surveillance and Response System and biological materials under the PIP Framework. He welcomed the PIP Framework Review Group's recommendation on conducting a study to further understand the handling of genetic sequence data and seasonal influenza in relation to the PIP Framework. Regulatory capacities should be enhanced, and burden of disease studies should be conducted on influenza. On financing, 70% of contributions towards influenza activities should be allocated to pandemic preparedness, and 30% to response.

With regard to the draft decision, he wished to propose two amendments: in paragraph (3), to replace "and manufacturing" by ", manufacturing and regulatory"; and in paragraph (7), between subparagraphs (b) and (c), to add a further subparagraph to read, "to continue to support the strengthening of regulatory capacities and burden of disease studies in Member States, which are fundamental foundations for pandemic preparedness;".

The representative of QATAR, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that a set of measurable indicators should be instituted to periodically monitor the use of partnership contribution funds, and any associated challenges. Technology transfer and capacity building should be conducted for burden of disease studies and risk communications to ensure harmonization between the PIP Framework and the global action plan for influenza vaccines. More middle- and low-income countries in the Eastern Mediterranean Region should be considered for partnership contribution funds, given the progress made in improving epidemiological and virological surveillance capacity for pandemic influenza.

The representative of the RUSSIAN FEDERATION said that closer cooperation was required under the PIP Framework; links with other programmes and legal instruments should be established and information on objectives and progress should be shared with all stakeholders. The PIP Framework should be recognized as an international specialized instrument under the Nagoya Protocol. Implementation of the PIP Framework required effective coordination between all aspects of WHO's global influenza programme. A cautious approach must be taken to the inclusion of seasonal influenza viruses in the PIP Framework, as well as to using it as a model for sharing other pathogens. In addition, clarification was required with regard to the handling of genetic sequence data. She agreed that the definition of biological materials under the PIP Framework should be amended. Implementing the PIP Framework Review Group's recommendations would be a complex process, which would benefit from comprehensive consultations with all global influenza programme participants.

The representative of the PHILIPPINES expressed support for the draft decision. The Government of the Philippines had adopted standards and technical guidelines for a pandemic response to influenza. It remained committed to upholding its obligations under the International Health Regulations (2005), and to strengthening its influenza surveillance and alert systems.

The representative of IRAQ said that the PIP Framework was being implemented in Iraq, through integrated epidemiological and laboratory surveillance. Sentinel sites had been confined to ensure more accurate surveillance. His Government was engaging with neighbouring countries and WHO to consider regional health security and boost pandemic preparedness, especially relating to seasonal influenza. Particular efforts were being made to ensure preparedness in camps for internally displaced persons and areas that had been liberated from Daesh control. Capacity building for health care professionals was essential. Vaccination campaigns for individuals embarking on religious pilgrimage were also an important aspect of preparedness.

The representative of NORWAY said that every effort must be made to ensure that the PIP Framework remained relevant as a strong tool for pandemic preparedness. She welcomed the PIP Framework Review Group's recommendations and shared the view that the scope of the PIP Framework should not be expanded to other pathogens. A better understanding was needed of the consequences of using genetic sequence data on seasonal influenza; expert advice and Member States' active engagement would be required in that regard. She supported the draft decision. Collaboration with the Secretariat of the Convention on Biological Diversity on issues of common interest under the Nagoya Protocol was welcome and should be continued.

The representative of LESOTHO, speaking on behalf of Member States of the African Region, said that he agreed that clarification was required regarding handling genetic sequence data and on whether the scope of the PIP Framework could be extended to include seasonal influenza. Collaboration between the human and animal sectors was crucial when the sharing of human viruses was delayed. With regard to benefit sharing, some companies were not meeting payment deadlines, resulting in an imbalance between expenditure and revenue, which could be misleading when considering whether additional funds were required. Care should be taken to ensure that the rotation of membership of the PIP Advisory Group did not result in gaps in knowledge continuity. Several measures had been taken to advance implementation of the PIP Framework in the African Region. All Member States should strengthen their national capacities in the five core areas funded by partnership contributions, ensure timely sharing of data on viruses, contribute to the benefit sharing scheme, and enhance the capacities of their national regulatory authorities.

The representative of MALTA, speaking on behalf of the European Union and its Member States, said that the candidate countries the former Yugoslav Republic of Macedonia, Montenegro, Serbia and Albania, the country of the stabilization and association process and potential candidate Bosnia and Herzegovina, as well as Ukraine, aligned themselves with her statement.

She expressed disappointment that the report of the latest PIP Advisory Group meeting and the 2016 report on partnership contributions had not been made available to the Committee, but noted with satisfaction that the recommendation to bring the PIP Framework and the Global Influenza Surveillance and Response System under unified management had already been achieved. Determining whether the PIP Framework was up to date with scientific progress and the current legal environment was an important part of the work of the PIP Framework Review Group. The recommendations on seasonal influenza, genetic sequence data and the Nagoya Protocol, however, could not be considered until a comprehensive impact assessment had been made, and she suggested that they be considered at the 142nd session of the Executive Board.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that all efforts to strengthen linkages between the PIP Framework, the International Health Regulations (2005) and the Global Health Security Agenda were welcome. He supported the PIP Framework Review Group's recommendations and was pleased to see that the WHO Secretariat was working with the Secretariat of the Convention on Biological Diversity to decide on criteria for designating the PIP Framework to be a specialized international instrument. He enquired about progress made in that regard since the 140th session of the Executive Board.

Mr Hurree took the Chair.

The representative of FINLAND said that emphasis should be placed on continuing the work to implement the resolutions of the PIP Framework Review Group relating to the legal environment and scientific development. He noted that the Global Influenza Surveillance and Response System had been in place for 65 years, and its ongoing efficient functioning would be a cornerstone of global pandemic influenza preparedness.

The representative of MALAYSIA said that he was in favour of extending the definition of biological materials to include genetic sequence data and agreed that the use of such data should trigger benefit sharing under the PIP Framework. However, stakeholders should seek further clarity before making a decision in that regard. He could not yet support the inclusion of seasonal influenza within the PIP Framework because there was a risk that such inclusion would divert resources and increase the workload for laboratories in the Global Influenza Surveillance and Response System. The Secretariat should evaluate the implications and desirability of such a decision. He welcomed the recommendation to consider the PIP Framework as a specialized international instrument under the Nagoya Protocol and supported the draft decision.

The representative of SENEGAL said that resources should be properly distributed among countries to support pandemic influenza investigation and response. Integrated surveillance of influenza virus and certain arboviruses and zoonoses should be carried out at sentinel sites, which would help support a One Health approach.

The representative of PAKISTAN described progress and achievements made in her country relating to human influenza surveillance, detection and response, which had allowed seasonal surges in influenza A(H1N1) and A(H3N2) to be dealt with effectively between 2015 and 2017. Epidemiological and virological data from Pakistan were regularly shared with the Global Influenza Surveillance and Response System, and representative virus isolates were shared with the Influenza Division of the United States Centers for Diseases Control and Prevention.

The representative of GERMANY said that, although the global action plan for influenza vaccines had closed in 2016, some aspects of the plan, such as the link between seasonal immunization coverage and pandemic vaccine supply, required follow-up. He welcomed the recommendation to review how genetic sequence data were handled under the PIP Framework. However, existing exchanges of genetic sequence data must not be slowed down, and the role of established data-sharing platforms should be taken into account. He fully supported the draft decision.

The representative of CHINA described the steps taken in his country to implement the PIP Framework, including the signature of a Standard Material Transfer Agreement and arrangements for sharing viruses. His Government would continue to take an active part in global surveillance, share virus information and strengthen communications between vaccine manufacturers and WHO. He supported the proposal to extend the validity period of resolution EB131.2 (2012) to February 2018.

The representative of JAPAN said that the implementation of the PIP Framework was fundamental to pandemic influenza preparedness and should not be impeded by the Nagoya Protocol. He hoped that WHO would maintain its leadership role in that regard. He fully supported the draft decision.

The representative of INDONESIA called on the Secretariat to support Member States in developing their early detection capacity through knowledge and technology transfers, risk assessments and research. The PIP Advisory Group should regularly engage with the WHO collaborating centres and the Global Influenza Surveillance and Response System, and laboratories in the System should send genetic sequence data in accordance with Standard Material Transfer Agreements. Moreover, a system should be in place whereby the Secretariat notified the country of origin when a sample shared by that country was used by other institutions.

The representative of AUSTRALIA said that pandemic influenza preparedness complemented broader health security efforts. Opportunities to align work efforts should be maximized, particularly regarding implementation of the International Health Regulations (2005). The PIP Framework's achievements should be built upon to ensure its ongoing success and relevance. She welcomed and supported the findings of the PIP Framework Review Group and expressed the hope that the Secretariat would prioritize the implementation of the recommendations, including by conducting further analysis of the issues of genetic sequence data and seasonal influenza.

The representative of ZAMBIA outlined the influenza pandemic preparedness measures undertaken in his country, including the development of a response plan and the establishment of a national health institute. Zambia was a member of the Global Influenza Surveillance and Response System and acted as a subregional hub under the Africa Centres for Disease Control and Prevention, which required significant support from WHO.

The representative of SWITZERLAND said that he supported strengthened collaboration between the WHO Secretariat and the Secretariat of the Convention on Biological Diversity and the steps towards recognizing the PIP Framework as an international specialized instrument under the Nagoya Protocol. The PIP Framework and the Nagoya Protocol were complementary, and any efforts to promote coordination between the two should be compatible with the specific objectives of each. No decision should be made on extending the PIP Framework to include genetic sequence data until the implications had been fully evaluated. He therefore supported the proposal to conduct an in-depth study in that regard.

The representative of PANAMA said that timely and close international collaboration was necessary in order to respond efficiently to influenza epidemics. WHO's role in that collaboration was vital, and the Organization must ensure that there was benefit sharing as well as information sharing. The PIP Framework must be applied properly and consistently in all regions. She supported the recommendations of the PIP Advisory Group relating to the development of a comprehensive evaluation model for annual reporting on the PIP Framework, and the need for a study on the implications of including seasonal influenza in the PIP Framework.

The representative of MEXICO, noting that pandemic influenza preparedness was a priority for WHO, said that the Secretariat must support countries in developing their core capacities to contain a possible epidemic. Contributions to the PIP Framework must be maintained, and the PIP Framework could indeed serve as a model to be applied to other pathogens. Work should continue on linking the PIP Framework with the Convention on Biological Diversity and the Nagoya Protocol. It was also important to work with countries to update standards, obtain the financial resources needed to prepare

for possible pandemics, and continue strategic antiviral stockpiling to enable a rapid response. He supported the draft decision.

Dr Al Kuwari resumed the Chair.

The representative of TUNISIA expressed support for efforts to reach agreement on the use of genetic sequence data. Seasonal and pandemic influenza preparedness mechanisms in her country covered coordination with WHO, international aid during epidemics and strengthened immunization capacity for pregnant women and health workers. WHO had a vital role to play within the PIP Framework in building national laboratories' virology capacity and providing gene sequencing technology. Burden of disease studies were particularly important for developing immunization policy. She agreed with the proposed role of the WHO regional offices in supporting countries.

The representative of ECUADOR agreed with the Review Group's recommendations. He nonetheless expressed concern that the lack of achievement by some States of the core capacities under the International Health Regulations (2005) posed a public health threat for all Member States, given that infectious diseases knew no boundaries and given the world's changing and increasingly mobile population. WHO should identify best practice in Member States with a view to facilitating information sharing and thus health systems strengthening. He called on WHO to step up support to Member States to build emergency detection and response capacities.

The representative of BOTSWANA supported the recommendations of the PIP Framework Review Group on the need for regular and more effective communication from WHO and a study of the implications and desirability of expanding the PIP Framework to include seasonal influenza. The PIP Framework could serve as a good model for other pathogens, but its scope should remain limited to pandemic influenza at the current time. Activities under the PIP Framework must be fully resourced, and all recommendations should be implemented.

The representative of BANGLADESH welcomed the establishment of the Standard Material Transfer Agreements 2. His country had undertaken significant efforts to monitor the spread of influenza, share viruses and genetic sequence data, and develop an Influenza Preparedness Plan. Under the PIP Framework, a framework and mechanism for benefit sharing should be developed; an international stockpile of influenza A(H5N1) vaccine should be established; and guidance on vaccine distribution, dose administration and assessment should be prepared.

The representative of CANADA expressed support for the sharing of influenza viruses with pandemic potential and the fact that the PIP Framework Review Group had proposed work to strengthen related activities was a positive step. He said that his country wished to be added to the list of sponsors of the draft decision, and looked forward to the results of the analyses that would be undertaken.

The representative of MAURITANIA noted progress made under the PIP Framework, including in the areas of pandemic preparedness, implementation of the International Health Regulations (2005) and coordination between laboratories. Further steps should be taken in that regard, in addition to developing guidelines on access to pathogenic agents and the fair and equitable distribution of benefits.

The representative of THAILAND said that her country wished to be added to the list of sponsors of the draft decision.

The representative of PARAGUAY said that mechanisms for communicating results under the PIP Framework should be improved. Support was required in order to include the sequence data of influenza viruses with pandemic potential when developing surveillance capacity in Member States without that laboratory capacity, and to strengthen regional strategies on virus sharing. Guidance should be given on how safely to share biological materials, the definition of which should be discussed. She agreed that WHO should provide clarification to Global Influenza Surveillance and Response System laboratories on the interpretation of the terms "timely" and "as feasible". Clarification was needed from WHO on using genetic sequence data, and the best mechanism for tracing products. WHO's role in preparedness and response was paramount, notably within the Global Influenza Surveillance and Response System, and there should be closer collaboration between relevant bodies. Flexible funding mechanisms should be drawn up for developing countries in particular. The Secretariat should publish an update to the interim pandemic influenza risk management guide as soon as possible to provide clearer guidelines on a timely switch from seasonal to pandemic vaccine production.

The representative of the ISLAMIC REPUBLIC OF IRAN said that more focus should be placed on early warning and response systems for future pandemics, especially those involving pathogens of an acute respiratory nature. Linkages between the PIP Framework and capacity building under the International Health Regulations (2005) should also be prioritized, along with efforts to strengthen surveillance capacities. An integrated early warning system and laboratory-based epidemiological surveillance system should be considered. Supporting the launch of the pandemic influenza severity assessment tool, he encouraged WHO to conduct workshops on its methodology.

The representative of the INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS AND ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, said that the implementation of the PIP Framework could be strengthened. Stakeholders should be consulted on the PIP Framework as a whole and on the appropriate use of funds. Furthermore, while WHO should raise awareness among Member States on the important link between pandemic influenza preparedness and seasonal influenza vaccine uptake, the PIP Framework should not be expanded to include seasonal influenza, as to do so may lessen pandemic influenza preparedness and complicate the PIP Framework. It was important to involve industry in the implementation of the Nagoya Protocol, to ensure that it supported and did not undermine public health. She urged WHO to support calls for the PIP Framework and the Global Influenza Surveillance and Response System to have their status raised to that of international instruments.

The representative of KNOWLEDGE ECOLOGY INTERNATIONAL, speaking at the invitation of the CHAIRMAN, noted with concern the decline in virus sharing since 2014 and said that WHO should implement the recommended changes to address the handling of genetic sequencing data. The fact that funding received from vaccine and device manufacturers to the PIP Framework was voluntary limited its scope and reflected governments' inability to address the need for more robust and sustainable systems of finance for the supply of public goods. While the Standard Material Transfer Agreement 2 was an innovative aspect of the PIP Framework, WHO should encourage vaccine and drug manufacturers to grant licences under options A5 and A6 of Article 4.1.1 of the agreement.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, agreed that the use of genetic sequence data should trigger benefit sharing and that those responsible for databases wishing to host genetic sequence data should conclude Standard Material Transfer Agreements. Moreover, the PIP Framework should be expanded to include genetic sequence data. Member States should wait for, and be guided by, the results of the study to be

conducted by the Secretariat of the Convention on Biological Diversity on whether the PIP Framework could be an international specialized instrument. Manufacturers should pay a higher partnership contribution, given the increased running costs of the Global Influenza Surveillance and Response System. There was a need for a process to address benefit sharing and an intergovernmental process should be established to consider the inclusion of seasonal influenza viruses and other pathogens.

The representative of the WORLD MEDICAL ASSOCIATION, INC., speaking at the invitation of the CHAIRMAN, said that prior to the 2021 review of the PIP Framework, WHO should, inter alia, ensure that all Member States understood the PIP Framework and that each National Influenza Centre had a functioning surveillance system; guarantee vaccine supplies and assure quality of vaccines; engage stakeholders in the area of pandemic preparedness; monitor the ethical use of health databases; and take into account ethical and legal questions relating to the sharing of viruses and technologies.

The representative of UNEP, speaking on behalf of the Executive Secretary of the Convention on Biological Diversity, noted that the principles of access and benefit sharing, in relation to the Nagoya Protocol, were being considered in several of WHO's areas of work. The Parties to the Nagoya Protocol had requested the Executive Secretary of the Convention on Biological Diversity to liaise with WHO on the outcomes of the study on implementing the Nagoya Protocol; share relevant information from national reports relating to health emergencies; and conduct a study on what constituted a specialized international access and benefit-sharing instrument, and how that could be recognized. The Executive Secretary had been requested to collect information on the use of digital genetic sequence data and the potential implications of that use. Work would continue in those areas in the biennium 2017–2018, and the Secretariat of the Convention on Biological Diversity would continue to collaborate with WHO.

The member of the PANDEMIC INFLUENZA PREPAREDNESS FRAMEWORK REVIEW GROUP said that the majority of the concerns that had been raised by Member States had been taken into account in the proposed recommendations. Member States clearly recognized the PIP Framework as a unique benefit sharing instrument, and had supported the call for a study into the implications of extending it to cover seasonal influenza. The complex issue of genetic sequence data was a priority and he called on Member States to provide advice on the way forward. The issues that had been raised regarding partnership contributions had already been addressed by the PIP Framework Review Group, in line with the work of the PIP Advisory Group.

The EXECUTIVE DIRECTOR (WHO Health Emergencies Programme) commended all stakeholders for their contributions to the implementation of the PIP Framework. He said that, while influenza was unique, many of the lessons learned from the implementation of the PIP Framework could be applied to other diseases. Such lessons included recognition of the importance of a more efficient management of vaccine stockpiles, global systems of expert laboratories to act as early warning systems and facilitate virus sharing, risk communication, and the model provided by the partnership contribution response fund. He recognized that some complex policy questions had been asked, notably on the potential for inclusion of seasonal influenza in the PIP Framework and the issue of genetic sequence data. Regarding monitoring and evaluation, an independent impact assessment had been conducted, which would be issued shortly with a Secretariat response. Concerning programme monitoring, a strong focus had been placed on developing baselines at the start of implementation and progress was being measured semi-annually and reported in the public portal.

There had been positive developments regarding collection of partnership contributions; between 2013 and 2016, 96–98% of the required amounts had been collected. In relation to the PIP Advisory Group's recommendations on the Partnership Contribution Implementation Plan, the 2018–2022 Plan would include activities under the global action plan for influenza vaccines that

supported the overall objectives of the PIP Framework. In that regard, there was a need to carry out a new evaluation of the running costs of the Global Influenza Surveillance and Response System in order to determine the level of the partnership contribution. Noting that WHO had agreed on ongoing collaboration with the Secretariat of the Convention on Biological Diversity, he explained that additional conversations with other intergovernmental organizations on matters relating to the Nagoya Protocol were continuing. He supported the path outlined in the draft decision and said that the Secretariat was committed to undertaking the study outlined in the decision, subject to funding requirements.

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

2. HEALTH SYSTEMS: Item 13 of the agenda

Human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth: Item 13.1 of the agenda (document A70/18)

The CHAIRMAN drew attention to a draft resolution on the item, proposed by Argentina, Colombia, Estonia, France, Georgia, Germany, Jamaica, Norway, the Philippines and South Africa, which read:

> The Seventieth World Health Assembly,
>
> **PP1** Having considered the report on human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth;[2]
>
> **PP2** Reaffirming resolution WHA69.19 (2016) on global strategy on human resources for health: workforce 2030, in which the Health Assembly adopted WHO's Global Strategy on Human Resources for Health: Workforce 2030, including its strong call to engage across public and private sectors and stakeholders including government, education and training institutions, employers and health workers' organizations to coordinate an intersectoral health and social workforce agenda towards achieving a fit-for-purpose workforce for the 2030 Agenda;
>
> **PP3** Recalling resolution WHA63.16 (2010) on the WHO Global Code of Practice on the International Recruitment of Health Personnel, which adopted the Global Code, and the Global Code's recognition that an adequate and accessible health workforce is fundamental to an integrated and effective health system, and to the provision of health services, bearing in mind the necessity of mitigating the negative effects of health personnel migration on the health systems of developing countries;
>
> **PP4** Recalling also previous Health Assembly resolutions aimed at strengthening the health workforce;[3]

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as decision WHA70(10).

[2] Document A70/18.

[3] Resolutions WHA64.6 (2011) on health workforce strengthening, WHA64.7 (2011) on strengthening nursing and midwifery, WHA65.20 (2012) on WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies, WHA66.23 (2013) on transforming health workforce education in support of universal health coverage, WHA67.19 (2014) on strengthening of palliative care as a component of comprehensive care throughout the life course, WHA67.24 (2014) on follow-up of the Recife Political Declaration on Human Resources for Health: renewed

PP5 Further recalling the United Nations General Assembly resolutions in 2015 (resolution 70/183) and 2016 (resolution 71/159) that, respectively, requested the establishment of the United Nations' High-Level Commission on Health Employment and Economic Growth (hereinafter "the Commission") and welcomed its report;

PP6 Underlining that investing in the health and social workforce has multiplier effects that enhance inclusive economic growth, both locally and globally, and that it contributes to the ambition of the 2030 Agenda for Sustainable Development and to progress towards achieving the Sustainable Development Goals, including Goal 1 (End poverty in all its forms everywhere), Goal 3 (Ensure healthy lives and promote well-being for all at all ages), Goal 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all), Goal 5 (Achieve gender equality and empower all women and girls), Goal 8 (promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all), and Goal 10 (Reduce inequality within and among countries) and exploiting the interlinkages between the Goals and their targets;

PP7 Acknowledging that twenty-first century health challenges related to demographic, socioeconomic, environmental, epidemiological and technological changes will require a health and social workforce that is fit for purpose for the provision of integrated people-centred health and social services across the continuum of care;

PP8 Recalling decision EB140(3) which, inter alia, welcomed the report of the High-Level Commission on Health Employment and Economic Growth, and its task to lend the necessary political, intersectoral and multistakeholder momentum, through the elaboration of 10 recommendations and the identification of five immediate actions, to guide and stimulate the creation of health and social sector jobs as a means to advance inclusive economic growth and social cohesion;

PP9 Underscoring that skilled and motivated health and social sector workers are integral to building strong and resilient health systems, and underlining the importance of adequate workforce investments to meet needs in respect of universal health coverage and to develop core capacities under the International Health Regulations (2005), including the capacity of the domestic health workforce to ensure preparedness for and response to public health threats;

PP10 Recognizing the need to substantially expand and transform health financing and the recruitment, development, education and training, distribution and retention of the health and social workforce;

PP11 Recognizing also the need to substantially increase the protection and security of health and social workers and health facilities in all settings, including in acute and protracted public health emergencies and humanitarian settings,

OP1 ADOPTS the five-year action plan for health employment and inclusive economic growth (2017−2021) as a mechanism to coordinate and advance the intersectoral implementation of the Commission's recommendations and immediate actions in support of WHO's Global Strategy on Human Resources for Health: Workforce 2030;

commitments towards universal health coverage, and WHA68.15 (2015) on strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage.

OP2 URGES all Member States to act forthwith on the Commission's recommendations and immediate actions, with the support of WHO, ILO and OECD,[1] as appropriate and consistent with national contexts, priorities and specificities;

OP3 INVITES international, regional, national and local partners and stakeholders responsible for health, social and gender matters, and for foreign affairs, education, finance and labour, to engage in and support, the implementation of the Commission's recommendations and the five-year action plan as a whole;

OP4 REQUESTS the Director-General:

(1) to collaborate with Member States, upon request, and with agencies in other relevant sectors, and partners, in implementing the Commission's recommendations and immediate actions as elaborated in the five-year action plan, including to:

(a) strengthen the progressive development and implementation of national health workforce accounts;

(b) strengthen the relevance, effectiveness and implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, including by continuously fostering bilateral and multilateral dialogue and cooperation to promote mutuality of benefits deriving from the international mobility of health workers;

(c) catalyse the scale-up and transformation of professional, technical and vocational education and training, particularly training in community-based settings, and stimulate investments in creating decent health and social jobs with the right skills, in the right numbers and in the right places, particularly in countries facing the greatest challenges in attaining universal health coverage and implementing the Global Strategy on Human Resources for Health: Workforce 2030;

(2) to coordinate and work with ILO, OECD and other relevant sectors, agencies and partners to develop their joint capacity to support Member States, upon request, in this agenda, including with respect to:

(a) the establishment of an inter-agency data exchange and online knowledge platform on the health and social workforce, respecting personal confidentiality and relevant data protection laws, that progressively brings together data and information from multiple agencies, sectors and sources to advance health and social labour market data, analysis, accountability, monitoring and tracking, as an open-access, electronic, and real-time web-based resource; building on the progressive implementation and reporting of National Health Workforce Accounts; and

(b) the establishment of an international platform on health worker mobility for transparent intersectoral policy dialogue, exchange and collective action to achieve a sustainable health and social workforce, maximize mutual benefits, promote ethical recruitment and mitigate adverse effects arising from such mobility;

(3) to utilize the Global Health Workforce Network as a mechanism to engage stakeholders in the implementation of the five-year action plan for health employment and inclusive economic growth (2017−2021);

(4) to explore intersectoral and innovative financing mechanisms necessary for advancing implementation of the five-year action plan for health employment and

[1] And, where applicable, regional economic integration organizations.

inclusive economic growth (2017−2021); and

(5) to submit a regular report to the Health Assembly on progress made on the implementation of the five-year action plan for health employment and inclusive economic growth (2017−2021), aligned with reporting on the Global Strategy on Human Resources for Health: Workforce 2030.

The financial and administrative implications of the adoption of the draft resolution for the Secretariat were:

Resolution:	Human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth
A.	**Link to the general programme of work and programme budget**
1.	**Outcome(s) in the Twelfth General Programme of Work, 2014–2019 and output(s) in the Programme budget 2016–2017 to which this resolution would contribute if adopted.** **Twelfth General Programme of Work, 2014–2019 outcome(s):** Policies, financing and human resources are in place to increase access to people-centred, integrated health services. **Programme budget 2016–2017 output(s):** Output 4.2.2. Health workforce strategies oriented towards universal health coverage implemented in countries. The action plan will also support outputs across other categories, for example: Output 1.1.1. Increased capacity of countries to deliver key HIV interventions through active engagement in policy dialogue, development of normative guidance and tools, dissemination of strategic information, and provision of technical support; Output 2.1.3. Countries enabled to improve health care coverage for the management of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases and their risk factors through strengthening health systems; Output 3.3.2. Countries enabled to integrate and monitor gender, equity and human rights in national health policies and programmes; Output 3.5.1. Countries enabled to assess health risks and develop and implement policies, strategies or regulations for the prevention, mitigation and management of the health impacts of environmental and occupational risks; Output 5.1.1. Implementation and monitoring of the International Health Regulations (2005) at country level and training and advice for Member States in further developing and making use of core capacities required under the Regulations; Output 6.1.1. Effective WHO leadership and management in accordance with leadership priorities.
2.	**Brief justification for considering the draft resolution, if there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017.** Not applicable.

3. Estimated time frame (in years or months) for implementation of any additional deliverables.

The draft five-year action plan for health employment and inclusive economic growth covers the period 2017–2021 and provides further support towards the implementation of the Global Strategy on Human Resources for Health: Workforce 2030, adopted by the Sixty-ninth World Health Assembly in resolution WHA69.19 (2016).

The draft action plan is consistent with the Organization's response to the Sustainable Development Goals. It incorporates a broad-based approach that impacts Goals 3, 4, 5, 8 and 17.

The action plan will be implemented in collaboration with Member States, ILO, OECD and relevant regional and specialized entities. It focuses on instruments of change and enabling factors, such as: intersectoral action involving multiple stakeholders; strengthening health systems for universal health coverage; respect for equity and human rights; sustainable finance; scientific research and innovation; and monitoring and evaluation. Its implementation will make contributions across the category/programme areas of communicable diseases, noncommunicable diseases, promoting health through the life course and the WHO Health Emergencies Programme.

B. Budgetary implications

1. Estimated total cost to implement the resolution if adopted, in US$ millions:

US$ 70.0 million (over the five years), of which US$ 45.0 million would be for WHO.

The indicative budget for staff and activities reflects the combination of country work and global public goods in the action plan. Key actions on the intersectoral agenda and global public goods, integrating the recommendation of the Joint Inspection Unit of the United Nations System for WHO to mainstream full and productive employment and decent work into its programme, will engage the regional offices and headquarters. Focused work on education and employment is anticipated in the 15–20 countries where progress towards universal health coverage is furthest behind. About 50% of the WHO costs will resource staffing and activities at the regional and country levels.

2.a. Estimated additional budgetary requirements in the current biennium, in US$ millions:

US$ 1 million.

The additional activities and deliverables in the remaining six months of the biennium are feasible within the category 4 budget space.

2.b. Resources available during the current biennium

– **Resources available in the current biennium to fund the implementation of the resolution if adopted, in US$ millions:**

US$ 0.5 million in category 4, output 4.2.2, to implement the priority activities in the remaining six months of the biennium.

– **Extent of any financing gap, in US$ millions:**

US$ 0.5 million.

– **Estimated resources, not yet available, which would help to close any financing gap, in US$ millions:**

WHO, ILO and OECD will jointly coordinate resource mobilization in support of the action plan.

3.	**Estimated additional budgetary requirements in 2018–2019 (if relevant), in US$ millions:** US$23.0 million, to be accommodated within the Proposed programme budget 2018–2019. **Has this been included in the Proposed programme budget 2018–2019?** The five-year action plan, developed in consultation and collaboration with Member States, ILO, OECD and relevant regional and specialized agencies over the period December 2016–April 2017, will be accommodated within the Proposed programme budget 2018–2019, supported by additional resource mobilization activities.
4.	**Estimated additional budgetary requirements in future bienniums (if relevant), in US$ millions:** US$ 21.0 million.

The representative of SOUTH AFRICA, speaking on behalf of the Member States of the African Region, said that health workforce shortages were a main obstacle to the delivery of health services. Indeed, estimates suggested that almost 18 million additional health workers, including more than 14 million in developing countries, were needed to achieve universal health coverage with a view to attaining the Sustainable Development Goals.

Although the High-level Commission on Health Employment and Economic Growth estimated that the global economy could create 40 million new health-sector jobs by 2030 – mostly in middle- and high-income countries – there would still be a projected shortage of 6 million health workers in Africa. To close the human resource gap, innovative approaches were required to recruit and retain health workers. For example, well-structured health-sector recruitment and training programmes could help reduce high unemployment levels, including among women and young people. It was also important to adopt cost-sharing arrangements in the health-care sector, address the issue of migration and ensure compliance with the WHO Global Code of Practice on the International Recruitment of Health Personnel. Recalling the High-level Commission's recommendation regarding service model reform, she underscored that community health workers could help address the shortfall in health care workers.

The draft five-year action plan for health employment and inclusive economic growth (2017–2021) was a key instrument that would facilitate efforts by Member States to address workforce challenges in a multidisciplinary and holistic manner. Member States and the Secretariat should increase their financial support to health workforce programmes.

The representative of JAPAN said that his delegation wished to sponsor the draft resolution. Each country had a unique health context; therefore, in addition to well-trained health personnel, countries needed policy-makers who could design, implement and assess evidence-based health sector human resource policies. Multisectoral efforts involving the education, labour and private sectors were also indispensable. Furthermore, the Secretariat should collaborate with ILO and OECD to support Member States' efforts to implement the draft five-year action plan. He noted that the action plan included a table showing the division of labour among the three agencies, and looked forward to the future achievement of the deliverables outlined therein.

The representative of the RUSSIAN FEDERATION said that, for the draft five-year action plan to be successful, country and regional contexts must be taken into account. It was important to promote life-long learning for health workers, including with a view to strengthening their preparedness for emergency situations and ensuring that they had the skills to match population needs. To that end, it was important to ensure the availability of up-to-date technology and innovative plans. Robust protections must also be provided to ensure the well-being of health workers. WHO, in collaboration with ILO and OECD, must give priority consideration to promoting the prestige of

health-sector professionals. In that connection, her Government had increased health-worker salaries and was developing legislation to create better and safe working conditions for health workers and was working with the media to enhance the image of medical professionals. It was also providing funding and expertise to help improve human resources for health. She supported the adoption of the draft five-year action plan and draft resolution.

The representative of ZAMBIA, endorsing the recommendations of the High-level Commission, agreed that investment in the health workforce could promote economic growth and create employment, particularly among women and young people. The recommendations had provided further political impetus to implement WHO's Global Strategy on Human Resources for Health: Workforce 2030. His Government had recruited 9400 health workers in 2016 and 2017, who had been deployed in various parts of the country, with priority given to remote and hard-to-reach areas. It was also expanding the training of health workers and had embraced e-learning, which was already playing a key role in health-worker training. Moreover, it was seeking to raise additional financial resources to expand the country's health workforce.

The representative of NORWAY warmly welcomed the draft five-year action plan and commended its close alignment with WHO's Global Strategy on Human Resources for Health: Workforce 2030. Provided that they were coupled with appropriate measures in other sectors, initiatives promoting the education and employment of health workers were a cost-effective investment. Every effort must be made to ensure that the recommendations made in the action plan promoted the education and employment of women, appropriate labour market intervention and policies, and the attainment of universal health coverage. For States to establish robust and competent health workforces, it was crucial to have the strong commitment of and close collaboration between all key stakeholders, including governmental stakeholders, private institutions and civil society actors.

The representative of BARBADOS said that her country had lost much of its health workforce, particularly its nurses, because of early retirement and international recruitment. To address that challenge, the Government had drawn up a nurses' human resources strategy for 2013–2018. The strategy promoted recognition and support of nursing professionals in Barbados, the recruitment and retention of nurses as a valued resource in the health sector, better training for nurses, the development of the nursing profession as a career of choice, and the design of innovative ways to retain Barbadian nurses in the country. The Ministry of Health was seeking technical assistance to develop a new human resources for health strategy that would support a collaborative approach to health-workforce training and the design of effective and efficient strategies for the retention and orderly movement of skilled health workers, in line with the High-level Commission's recommendations. The Ministry of Health had drawn up a discussion paper on ways to mobilize the financial resources needed to achieve those objectives, achieve universal health coverage and access, and attain the Sustainable Development Goals, which would in turn boost economic growth and accelerate the country's development.

The representative of MALTA, speaking on behalf of the European Union and its Member States, said that the candidate countries the former Yugoslav Republic of Macedonia, Montenegro, Serbia and Albania, the country of the stabilization and association process and potential candidate Bosnia and Herzegovina, as well as Ukraine, the Republic of Moldova and Georgia, aligned themselves with her statement. The European Union welcomed the draft five-year action plan, particularly the priority given to the development of intersectoral plans and investment in transformative education, the promotion of decent job creation in the health and social sectors and the need to ensure mutual benefits from the international mobility of health workers. Promoting universal health coverage must go hand in hand with efforts to foster inclusive economic growth and social cohesion. Strong health systems were essential prerequisites for the achievement of several

Sustainable Development Goals, including Goals 1, 3, 4, 5 and 8. She called on WHO to work closely with ILO and OECD, and with other relevant agencies, partners and sectors, to support implementation of the action plan. She also requested the Director-General to collaborate with Member States in implementing the High-level Commission's recommendations and immediate actions. She expressed her strong support for the draft resolution.

The representative of GERMANY welcomed the draft five-year action plan and looked forward to collaborative efforts by ILO, OECD and WHO to promote its implementation. The High-level Commission's recommendations were highly relevant to global efforts to enhance countries' health- and social-sector workforces and achieve the Sustainable Development Goals, including target 3.8 on universal health coverage. Health employment and economic growth had been included on the agenda of the German G20 Presidency in 2017; G20 ministers had recently highlighted the role of the draft five-year action plan and encouraged Member States to make strategic investments to develop and retain human resources in the health sector to maximize the impact and the resilience of national health systems.

The representative of SLOVAKIA said that the draft five-year action plan underscored the need for ILO, OECD and WHO to work together to help Member States formulate comprehensive, intersectoral and integrated national human resource strategies in the health sector. Moreover, Member States should adopt a common vision that would enable them to raise the resources needed to manage and retain health workers, and seek ways to involve relevant stakeholders in addressing imbalances in the health sector workforce. While respecting data protection laws, governments must work together to draw up common mobility indicators and exchange information on the mobility of health care workers; further investment in data collection and analysis in that area would therefore be required. Health-worker education must keep abreast with new and emerging challenges facing national health systems. She supported the draft resolution.

Mr Davies took the Chair.

The representative of IRELAND strongly supported the draft five-year action plan, and particularly welcomed its call for WHO, ILO and OECD to work together to support implementation of the Commission's recommendations and the development of comprehensive, intersectoral and integrated national health workforce strategies. Her Government had long supported efforts to develop human resources for health at the global level, had provided input in the formulation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, and had actively supported the establishment of the Global Health Workforce Network. In November 2017, Ireland would host the Fourth Global Forum on Human Resources for Health. The event would provide a key opportunity for all stakeholders to discuss and debate innovative approaches towards advancing the implementation of WHO's Global Strategy on Human Resources for Health: Workforce 2030 and the Commission's recommendations, and demonstrate their collective commitment to developing and making available the workforce required to achieve the Sustainable Development Goals.

The representative of PAKISTAN said that recent outbreaks of disease had underscored the urgency of building resilient health systems and strengthening global health security. Health workers and health employment lay at the heart of the 2030 Agenda for Sustainable Development; indeed, one of the targets of Sustainable Development Goal 3 was to substantially increase health financing and the recruitment, development, training and retention of health workers in developing countries, and especially in least developed countries. He urged the Secretariat to support Member States' efforts to implement the High-level Commission's recommendations and drew attention to Pakistan's National

Health Vision 2016–2025, which had prioritized health workforce development with a view to addressing challenges in that area in a holistic manner.

The representative of IRAQ, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the High-level Commission's report underscored that investing in health and health employment was the most powerful means to promote health, global security and inclusive growth, particularly in a world experiencing growing economic uncertainty, high unemployment, growing inequities, major socioeconomic, epidemiological and demographic change and increasing threats to human security. Investing in health professionals' education and in health-sector job creation was of key importance in his Region, where many States faced a shortage of health workers. Ensuring that the countries in the Region could rely on a sustainable health workforce would necessitate an intersectoral approach and coordinated leadership and action by those countries' finance, labour, education and health authorities. The Commission's recommendations would encourage relevant stakeholders to assess how they could boost investments made in the education and employment of health workers.

The representative of ARGENTINA said that, in order to improve the quality of health care, the training of health workers must be better regulated. Greater cooperation between the health, education and labour sectors was also crucial. Institutional capacity-building and transformative policies and practices for the health and social workforce were the pillars of universal health coverage. The draft five-year action plan provided a useful framework for ILO, OECD and WHO joint efforts, and Member States and the Global Health Workforce Network could serve as a cross-cutting mechanism to facilitate the implementation of the action plan at all levels. Given the crucial role of the health workforce in the implementation of the Sustainable Development Goals, she strongly supported the Commission's recommendations and immediate actions. Health authorities should provide better regulatory frameworks to ensure decent working conditions for health workers, and review and update training for health care professionals to make them fit for purpose.

The representative of NAMIBIA said that implementation of WHO's Global Strategy for Human Resources for Health: Workforce 2030 was an integral part of her Government's efforts to strengthen the health system. Namibia had also concluded bilateral agreements for the recruitment of foreign health workers and the training of Namibian nationals in health-related fields in order to address the shortage of trained health workers. Incentives in the form of allowances were offered to attract health workers to rural and remote areas. In order to achieve a fit-for-purpose health and social workforce, particular efforts were needed to strengthen information systems aimed at human resources for health, promote intersectoral collaboration at all levels, undertake robust research and analysis of health labour markets, and establish wellness centres for health workers in the workplace.

The representative of AFGHANISTAN said that his Government had established a special commission to facilitate human resource development, including in the health sector, with a focus on women's economic empowerment. Although Afghanistan had come a long way since 2002, matching skills to health needs and equitable distribution of health workers remained problematic. Efforts to overcome those challenges included the adoption of a plan for human resources for health in 2015, the establishment of the first-ever medical council, and the introduction of a decentralized human resource management system.

The representative of ZIMBABWE said that investment in the health workforce was crucial. Levels of funding had a major bearing on the way in which health workers were remunerated and supported with the tools of the trade, and thus on access to quality health care. Community health workers played a key role, especially in rural areas. Zimbabwe was currently conducting a staffing needs assessment to inform health workforce planning and forecasting. With regard to the

recommendations of the Commission, she highlighted the importance of the draft five-year action plan, the establishment of inter-agency global data exchange on the health labour market, and the development of an international platform on health workforce mobility.

The representative of the UNITED STATES OF AMERICA said that his delegation also wished to sponsor the draft resolution. Investment in the health workforce would yield health, social and economic benefits at the local and global levels. He commended the extensive intersectoral consultative process that had led to the outcome of the Commission and highlighted the particular relevance of the recommendations concerning job creation and financing. His delegation supported the idea of promoting public policies to generate private sector co-financing. The Global Health Workforce Network could be a useful mechanism to engage stakeholders in the implementation of the Commission's recommendations and the draft five-year action plan.

The representative of the PHILIPPINES supported the adoption of the draft five-year action plan. Her Government was planning to propose a policy dialogue on the health workforce involving the labour and health sectors of the Asia-Pacific Economic Cooperation countries; WHO support for the initiative would be greatly appreciated. The Philippines had benefited greatly from the experience of other Member States in its effort to guarantee social protection and decent work for its migrant health workers. The Government was committed to investing in human resources for health at the national level in order to maximize the retention and equitable distribution of the health workforce. At the global level, a unified global health force was needed to respond to common health concerns.

The representative of BOTSWANA said that the shortage of skilled health workers placed major constraints on the achievement of the relevant Sustainable Development Goals and universal health coverage. Innovative, practical, effective and adequately financed human resource reforms were needed to attract and retain a skilled health workforce. Her Government was supporting family and community health care in particular. She supported the Commission's recommendations and the draft five-year action plan and looked forward to WHO support in their implementation.

The representative of INDIA said that a national health policy introduced by his Government aimed to ensure the availability of paramedics and doctors trained to national standards in high-priority districts by 2020. In order to counter the negative effects of intra-country and intercountry health workforce migration, it was crucial to expedite implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel. He requested WHO to generate normative figures on: the proportion of the total workforce that should be employed in health for a certain level of development; the proportion of total health expenditure and public health expenditure spent on the health workforce; the proportion of workforce that had employment security and health care benefits; and the increase in and quality of economic growth for a given level of expenditure on health workforce and public health expenditure.

Dr Al-Kuwari resumed the Chair.

The representative of JORDAN said that investment in health, transformative education, gender equality and inclusive economic growth were closely linked. Education and training must be geared towards health promotion and disease prevention. In Jordan, the health sector played a major role in terms of employment and economic revenue. The implementation of the Commission's recommendations would help Member States address the uneven distribution of health workers. With regard to the deliverables of recommendation 9 regarding international migration, he noted that his country was bound only by the international instruments to which it was a party.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND supported the development of tools and methodologies to improve the security and protection of health workers in humanitarian and emergency settings. The collection and sharing of data on attacks on health facilities and the protection of health workers must be made a priority of the draft five-year action plan.

The representative of AUSTRALIA said that Australia also wished to be added as a sponsor of the draft resolution. Australia welcomed the 10 recommendations of the High-level Commission on Health Employment and Economic Growth, and commended the tripartite collaboration between WHO, OECD and ILO. Implementation of the Commission's recommendations would require multisectoral cooperation and long-term political commitment. The draft five-year action plan provided a sound basis for multisectoral and multiagency action at all levels. Its workstreams were clearly defined and mapped across existing WHO strategies, placed a strong emphasis on the tripartite relationship and clearly articulated monitoring, evaluation and reporting requirements.

The representative of MEXICO said that job creation and transformative education were crucial to building a highly skilled health workforce. Job creation must be based on sound needs analyses. Capacity-building and a focus on patient-centred service delivery were needed. The implementation of the Commission's recommendations required a coordinated, multisectoral approach, taking into account country-specific needs and capacities. WHO and ILO support was vital.

The representative of CANADA said that universal and publicly funded health care was the foundation for economic prosperity. She strongly condemned the targeting of health facilities and medical personnel overseas and praised the dedication of humanitarian workers and medical personnel to delivering life-saving assistance to those most in need. Ensuring the better protection of health workers and facilities in conflict areas was paramount.

The representative of THAILAND said that the effective implementation of the draft five-year action plan by Member States was critical to the strengthening of the health workforce and achieving good outcomes. Moreover, strengthening nursing and midwifery was crucial to achieving Sustainable Development Goals 3, 4, 5 and 8. The deliverables, key indicators and implementation timelines should be set out in table 3 of the action plan. That should be done immediately, before the session of the United Nations General Assembly in September 2017, and it should not be delayed until completion of the operational plan. The action plan should be brought into line with existing commitments highlighted in the WHO's Global Strategy on Human Resources for Health: Workforce 2030, the WHO Global Code of Practice on the International Recruitment of Health Personnel and the WHO's recommendations on increasing access to health workers in remote and rural areas. In addition, the rural retention rate must be added to the deliverables under recommendation 3 in table 3. WHO should involve more key partners such as the World Bank, UNESCO and labour and finance ministries.

She proposed amendments to paragraph 4 of the draft resolution. In paragraph 4(1)(c), she proposed adding "including interprofessional education" after "and training" and "and health systems-" before "based settings", so that the first two lines of the subparagraph would read: "catalyse the scale-up and transformation of professional, technical and vocational education and training, including interprofessional education, particularly training in community- and health systems-based settings". She proposed inserting a new subparagraph (1)(d) into paragraph 4, which would read: "to accelerate monitoring progress of health workforce with the application of national health workforce accounts and ensure appropriate number, competency and equitable distribution".

The representative of INDONESIA said that her Government focused on training and scholarships for health workers in order to improve the availability and geographical distribution of

skilled health workers. The promotion of healthy lifestyles, including at the community level, the expansion of access to primary health care, and the strengthening of health information systems were also a priority.

The representative of JAMAICA said that bilateral and multilateral dialogue and cooperation to promote the mutual benefits of the international mobility of health workers were crucial. The Commission's recommendations and immediate actions aligned closely with Jamaica's national priorities.

The representative of BANGLADESH said that greater investment in the health workforce was crucial. Her Government had focused on job creation, set up a special unit for health human resources, and adopted a national health workforce strategy. Despite those efforts, there was a persistent shortage of skilled health workers. There was a need for comprehensive, needs-based human resources for health plans, strengthened human resource data management capacity and use of data and evidence for decision-making and accelerated health-care delivery, and partnerships for intersectoral, multistakeholder collaboration to accelerate the health workforce agenda. WHO should support such initiatives.

The representative of NEW ZEALAND asked how WHO would prioritize the implementation of the draft five-year action plan, given the need for resource mobilization and new funding sources. The need to deliver quality health care was common to all Member States and the initiative must not fail.

The representative of MALDIVES said that delivering quality health services in a country as geographically dispersed as her own was a daunting task. In order to optimize performance, use available resources effectively and improve training, her Government had adopted a national plan covering the main objectives of the WHO's Global Strategy on Human Resources for Health: Workforce 2030. Under the Decade for Health Workforce Strengthening in the South-East Asia Region 2015–2024, focus had been placed on transformative education and rural retention. A new salary structure had been introduced for doctors and incentives offered to those working in remote locations. Human resources for health monitoring in 2019 should be synchronized with the WHO's Global Strategy on Human Resources for Health: Workforce 2030, the High-level Commission's report and the WHO Global Code of Practice on the International Recruitment of Health Personnel. More effective human resources for health governance, coordination and intersectoral action and better data were needed. She endorsed the adoption of the draft resolution and the draft five-year action plan.

The representative of BHUTAN said that, despite numerous initiatives to train and recruit health workers, his Government had been unable to meet the increasing demand. Bhutan had an excellent health infrastructure, but a shortage of skilled health workers. The draft five-year action plan was commendable, but needed more clearly specified indicators and timelines. A stronger monitoring framework to support implementation and accountability would also be useful.

The representative of ILO said that millions more health-sector jobs needed to be created, in particular for young people. New strategies should be developed among different sectors and stakeholders to address health workforce shortages, and further investment was needed in the health and care sectors. The ILO would continue to work with WHO and OECD to support the implementation of the draft five-year action plan and the Commission's recommendations. To ensure that efforts to address health workforce gaps were sustainable, jobs should be decent and safe, working conditions should be improved and workers' rights recognized.

The representative of IOM said that, to achieve the Sustainable Development Goals and universal health coverage, multisectoral action was needed to develop migration-sensitive health systems accessible to all. The global health workforce was central to the migration health response. She commended the work already undertaken by WHO and the Commission, in particular the recognition of issues relating to crises and humanitarian settings. IOM would actively support the creation of an international platform on health worker mobility. More needed to be done to ensure that the skills of displaced health professionals were recognized and to increase capacity-building among health workers in challenging environments.

The observer of the INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES said that his federation supported the Secretariat's report, noting the Commission's recommendations 4 and 6 in particular. However, quality assurance measures were needed to accompany all task-shifting initiatives, and governments should enhance community health systems by developing a framework to support volunteers working with local health-care organizations. The International Federation of Red Cross and Red Crescent Societies was ready to share its humanitarian health competency matrix, which focused on skills development, with the Global Health Cluster and health ministries. The protection and security of all health workers in humanitarian settings, to be achieved by strengthening relevant national legislation, and the move from commitment to action were priorities.

The representative of the INTERNATIONAL PHARMACEUTICAL FEDERATION, speaking at the invitation of the CHAIRMAN, said that her federation had adopted goals in line with the Commission's principles at a recent conference. She outlined measures taken to improve education among the pharmaceutical workforce and affirmed her federation's commitment to data collection and policy development to help achieve indicator 3.c.1 (health worker density and distribution) under target 3.c of the Sustainable Development Goals.

The representative of the WORLD ORGANIZATION OF FAMILY DOCTORS, speaking at the invitation of the CHAIRMAN, welcomed the Organization's commitment to supporting health workforce reforms, noting the Commission's recommendation 4 in particular. She recommended that stakeholders should recognize family medicine as the key medical speciality, since appropriately trained family doctors provided cost-effective, comprehensive person-centred care that met multiple patient and community needs and improved health outcomes in all populations. States could transform their health workforce by training more family doctors as vital components of multidisciplinary primary health care teams.

The representative of the FDI WORLD DENTAL FEDERATION, speaking at the invitation of the CHAIRMAN, endorsed the High-level Commission's recommendations, agreeing that investment in education and job creation in the health and social sectors would benefit inclusive economic growth. Implementation should be driven by Member States, include national and regional priorities and entail close work between public and private sector funding sources, government policy-makers and national and local health-worker representatives. Health organizations should have access to the online knowledge platform envisaged in the draft five-year action plan. Cost-cutting, market access and workforce mobility posed challenges to the health sector. Necessary advances in health-care delivery was an area that would require a sufficiently educated and sizeable workforce.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIRMAN, expressed her satisfaction that the draft five-year action plan deliverables were aligned with the goals of the global strategic directions for strengthening nursing and midwifery 2016–2020. She encouraged WHO, OECD and ILO to establish a working group, involving key nursing stakeholders, to help meet the action plan goals and implement the

Commission's recommendations. Health worker job creation and shortfalls should be reported at least annually, and WHO should gather evidence on improved health outcomes resulting from implementation of the recommendations. States should develop policies to combat gender bias and inequality in health workforce education and the health labour market.

The representative of INTRAHEALTH INTERNATIONAL, speaking at the invitation of the CHAIRMAN, called for the draft five-year action plan to be approved and its implementation to be prioritized. Urgent action was needed to support Member State investment to ensure a resilient global health workforce. She urged Member States to implement the Commission's recommendations, in particular the scaling-up of education and training in low-income countries, prioritizing those with shortfalls in universal health coverage. Data collection tools should be developed to monitor attacks on health workers in conflict settings, and Member States and civil society must make a firm commitment to provide financing in that connection.

The representative of the WORLD FEDERATION OF PUBLIC HEALTH ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, called on the Secretariat to engage young people in health workforce planning and encouraged Member States to include a young health professional in their official delegation to the World Health Assembly. Equitable health workforce planning and engagement of young medical professionals should also take into account gender, ethnicity, geographic and income-level perspectives.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, supported the Commission's recommendations and the focus on education and youth empowerment in the draft five-year action plan. Investment in the health workforce would lead to improvements in the areas of education, gender equality, working conditions and inclusive economic growth; however, simply increasing the number of educated health professionals would be an insufficient response to global health challenges. Member States should ensure quality in education by aligning health worker qualifications and educational frameworks with modern health workforce requirements and advancing the international recognition of health workers' qualifications.

The representative of the WORLD MEDICAL ASSOCIATION INC., speaking at the invitation of the CHAIRMAN, welcomed the focus on investment in health. The assurance of basic rights, decent working conditions, staff recognition and a gender perspective were essential for the successful implementation of the Commission's recommendations and thus for the recruitment and retention of health workers, which would be increasingly important given demographic trends. Professional organizations played a key role in health employment policy and should be involved in decision-making. In the light of growing violence against health workers, he reiterated the right of health workers to safe and decent working conditions.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, welcomed the emphasis on expanding human resources for health in low- and middle-income countries. However, the prioritization of the economic returns on investment was problematic given the inherent value of investing in strengthening health systems. The ability of the health workforce to provide accessible, quality services would be jeopardized by the withdrawal of international aid. Unpaid community health workers should be recognized as human resources for health and the public sector should cover the costs of integrating trained health workers into the formal health system. Health workers should not need to migrate to receive adequate remuneration and high-income countries should build their own health workforce. It was essential that labour rights should be respected.

The representative of the INTERNATIONAL ASSOCIATION FOR HOSPICE AND PALLIATIVE CARE, speaking at the invitation of the CHAIRMAN, welcomed the promotion of a needs-based, people-centred approach to health care. She encouraged Member States to train community-based palliative care providers, given the diverse benefits of palliative care. Partnering with civil society organizations would help WHO to achieve targets under at least five of the Sustainable Development Goals. She welcomed the Commission's recommendation to shift the focus from hospital care to prevention and people-centred primary and ambulatory care. Country-level universal health coverage strategies should support partnerships with local communities to train paraprofessional caregivers and palliative care providers. Nurses in rural areas should be trained and licensed to prescribe affordable medicines for palliative care.

The representative of the INTERNATIONAL FEDERATION FOR MEDICAL AND BIOLOGICAL ENGINEERING, speaking at the invitation of the CHAIRMAN, said that medical information and communications technology professionals should be listed as health professionals in WHO's Global Strategy on Human Resources for Health: Workforce 2030. Engineers, technicians and physicists working in the field of health should be considered indispensable when selecting technologies and interventions for universal health coverage strategies. He recommended that WHO should increase the number of staff working on medical device and non-drug technologies at headquarters and in the regional offices; encourage ILO to include biomedical engineers in the International Standard Classification of Occupations 2018; and adopt an e-learning platform to train biomedical engineers and health technology managers.

The representative of the GLOBAL HEALTH COUNCIL, INC., speaking at the invitation of the CHAIRMAN, expressed strong support for the draft five-year action plan and called for its urgent implementation. Attacks on health services and health care workers and the obstruction of patient access to care, as well as the lack of accountability for such attacks, were alarming. The Secretariat had made significant progress in the creation of a system to collect and disseminate data on attacks. Member States should collect information on such attacks and share it with the Secretariat.

The representative of the WORLD FEDERATION OF SOCIETIES OF ANAESTHESIOLOGISTS, speaking at the invitation of the CHAIRMAN, commended the draft five-year action plan. Universal health coverage would require surgical services to be scaled up worldwide. Safe surgery required safe anaesthesia and her organization had therefore helped develop educational projects for anaesthesiologists and tools to assess capacities and workforces to ensure that programmes fulfilled the health needs of populations. Member States should support human resources for health and seek adequate funding for transformative education and the required number of health professionals in surgery, obstetrics and anaesthesia.

The ASSISTANT DIRECTOR-GENERAL (Health Systems and Innovation) said that, in the interests of brevity, she would not acknowledge individually the many excellent comments, suggestions and offers of collaboration provided by Member States, international organizations and non-State actors. The Secretariat would address directly with the representative of India his specific request for normative figures on certain indicators. The amendment to the draft resolution proposed by Thailand strengthened the original version and she understood that the sponsors of the draft resolution would be willing to consider the revised text. In response to comments from New Zealand, she said that WHO, ILO and OECD had been exploring possible funding to support implementation of the draft five-year action plan, and the Secretariat was confident that it would be able to raise the resources needed, given the high priority of the issue and the commitment demonstrated by many Member States.

The Committee noted the report.

At the invitation of the CHAIRMAN, the SECRETARY read out the proposed amendments to the draft resolution. The first two lines of paragraph 4(1)(c) would read: "catalyse the scale-up and transformation of professional, technical and vocational education and training, including interprofessional education, particularly training in community- and health systems-based settings". A new subparagraph (1)(d) would be inserted into paragraph 4, which would read: "to accelerate monitoring progress of health workforce with the application of national health workforce accounts and ensure appropriate number, competency and equitable distribution".

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

The meeting rose at 19:20.

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[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA70.6.