Documents
[A76/9 Rev.1]
[A76/08]
[A76/10]
[A76/7 Rev.1]

Statement of I.R. Iran on
“Implementation of IHR2005” and “Independent Oversight and Advisory Committee”, "Strengthening Global Architecture for HEPR" and "Strengthening Clinical Trials to provide High Quality Evidence"

We appreciate the secretariat for organizing the documents A76/08 and A76/09 Rev.1

With regard to Agenda item 14.2, Preventing, preparing for, and responding to public health risks and emergencies requires us to strengthen the core capacities of our health systems at the national level. In most cases, the delay in events notification and risk assessment lies in the inadequacy of bio-surveillance and technical capacities at the national level. To develop certain minimum core public health capacities, countries are encouraged to collaborate with each other in providing the required assistance through bilateral, regional and multilateral channels in the spirit of Article 44 of the International Health Regulations.

To effectively respond to future health challenges and emergencies and to strengthen the implementation of the international health regulations, we have to prioritize equity, multilateralism, international solidarity and cooperation in our joint agenda. Guided by these principles and with due respect to the sovereignty of Member States, we can create an enabling environment for building health capacities and removing obstacles that generate global health challenges and inequalities.

In the ongoing amendment process aimed at strengthening of the International Health Regulations (2005), we actively continue our engagement in the process with the understanding that this process should not lead to reopening the entire instrument for renegotiation. The Islamic Republic of Iran will not support any measure that in any way undermines the sovereignty, security and leadership of Members States in health matters.

The amendment process is an opportunity for Member States to help operationalize the notions of equity and international cooperation with a view to promoting the universal application for the protection of all people of the world from the international spread of disease in an equitable manner. We continue our engagement in the IHR amendment process with this understanding that noting will be agreed until everything will be agreed.

With a view to enhancing sub-regional capacities to implement IHR, the Islamic Republic of Iran initiated G5 as a sub-regional health-oriented initiative to help improve the resilience of the health systems at the sub-regional level with participation of Afghanistan, Pakistan, Iraq and the World Health Organization and Tajikistan as an observer.

During the Covid-19 pandemic, the I.R. Iran did not close its borders even to seriously affected countries at the beginning of the outbreak, despite externally imposed restrictions as a result of unilateral coercive measures. Due to Iran's robust PHC structure, the country managed to rapidly foster its National Vaccination & Deployment Plan (NVDP) capacity for COVID-19 through establishment of around 1,200 mass vaccination centers and rival the developed countries coverage in 6 months after the beginning of campaign.

With regard to agenda item 14.1, as rightly mentioned in the document A76/08, during a health emergency, especially a pandemic, the economic and political dimensions are beyond the WHO capacities alone, and cooperation with partners is imperative, and the committee's concern regarding when the world would be better prepared for a new pandemic on the scale of Covid-19 in the future is sound and logical.
Strengthening the capacity of member states especially developing countries requires long-term efforts, and until then, **upon request of the involved Member States**, they rely on the support of the WHO.

With regard to Agenda item 15.1 and document A76/10, WHO support in the following areas is of importance to support countries to build a better architecture for HEPR:

1- Developing preparedness and response plans with an all-hazard approach
2- Compilation of international and integrated standard tools in risk assessment and risk management
3- Developing advanced technology for early warning systems, hazard mapping, damage and injury estimation, simulation exercises, and telemedicine
4- Developing programs and tools for evaluating and improving health system resilience
5- Supporting applied research related to risk reduction management
6- Improving the health workforces capacity in the field of rapid risk management for medical and public health emergencies through the design and implementation of quality training courses with international standards and the provision of PPEs
7- Visiting successful countries and exchange of experiences
8- Training of trainers in the field of risk management and medical emergencies based on the latest international standards
9- Paying more attention to mental-social health, rehabilitation of people and service providers
10- Supporting countries in risk prevention and risk reduction programs (evaluating and improving safety against all kinds of accidents)
11- Strengthening the pre-hospital, hospital and PHC emergency structures
12- Organizing and attracting the support of donors and NGOs in response to health emergencies

In A76/7 Rev.1, we agree that greater international collaboration and coordination are needed for efficient funding of agreed priorities and for multinational and multiregional trials. However, some countries are facing challenges due to unilateral coercive measures of one developed country with over-compliance of other developed ones, which make it difficult to import new technologies or receive grants from other countries to design high-quality clinical trials. Therefore, we highly recommend that a practical solution or at least a WHO resolution to be adopted to address this challenge. It is important that WHO establishes agreements with international banks or grant organizations to provide support for countries that are affected by such unilateral coercive measures.

Also, we acknowledge the need for greater capacity for clinical trials in lower-income countries, with a focus on country leadership and equitable partnerships for research in such countries. Accordingly, we suggest that WHO design a training program for low-income countries, with the curriculum prepared by volunteer countries.

Madam Chairperson, thank you for this opportunity.

I.R. Iran